

HIV Medicare and Medicaid Working Group

Recommendations for Improving the Medicaid Safety-Net for People with HIV/AIDS

Medicaid must provide coverage that meets the HIV standard of care to all low-income persons living with HIV/AIDS. Medical progress has revolutionized HIV/AIDS treatment, yielding an 80% reduction in HIV-associated deaths and related complications. As the largest payer of AIDS care in the U.S., Medicaid has allowed many low-income people with HIV disease to benefit from these life-saving treatment advances. The program provides access to medical treatment to 44% of adults living with HIV disease, 55% of all people living with AIDS, and 90% of children with AIDS nationwide. Medicaid is the cornerstone of the broader publicly-supported health system response to the care and treatment needs of low-income people living with HIV/AIDS.

Medicaid must include low-income persons in earlier stages of HIV disease. Unfortunately, Medicaid's strict eligibility criteria deny access to many poor and low-income people with HIV infection who are not yet disabled by AIDS. This policy must be changed to ensure that low-income persons diagnosed with HIV infection have earlier access to Medicaid to prevent the disabling and life-threatening infections that characterize HIV infection late in disease progression. Access to medical care is also a public health imperative given the demonstrated reduction in transmission-related behaviors noted in persons with HIV/AIDS receiving primary care, and the potential reduction in transmission associated with viral suppression in individuals effectively treated with antiviral therapy.

Medicaid must provide comprehensive coverage to all who qualify. The Medicaid benefit package must be sufficient to meet the medical needs of persons with disabilities and chronic illnesses, such as HIV/AIDS. Reduced benefit packages, designed to cut costs rather than provide health care, make the entitlement to Medicaid-covered services an empty promise. In particular, Medicaid must offer access to treatment consistent with the HIV standard of care and other basic standards of medical practice. These necessary health care services must be affordable to the poorest among us, without the financial barriers of premiums and cost-sharing. Cutting or capping an efficient health care program that low-income seniors, children and people with disabilities depend on is unfair and unacceptable.

Below are key program components that must be maintained or adopted if the Medicaid program is to continue to serve as a viable health care safety net for people with HIV:

Expand Medicaid to provide early coverage to all low-income persons with HIV disease. Currently, most poor single adults with HIV must develop AIDS before they are eligible for the medical treatment that would prevent them from developing AIDS. Congress should promote early access to health services for people with HIV by enacting the *Early Treatment for HIV Act* (S 860 and HR 3326) and encouraging states to cover non-disabled, low-income individuals with HIV through Medicaid. For any beneficiary with HIV/AIDS, Congress should also require states to provide benefits in sufficient amount, duration and scope to ensure that beneficiaries receive the standard of care for treatment of HIV infection and related co-morbidities.

All Medicaid beneficiaries should be counseled about the risks of HIV transmission and infection, offered an HIV test, and linked to quality HIV care. Studies have shown that as many as 22% of persons recently diagnosed with HIV infection were Medicaid beneficiaries at the time of their diagnosis. As many as one-third of persons infected with HIV in the U.S. are unaware of their infection. This vital federal-state health care safety net program can and must play an important role in counseling individuals about their risk of contracting HIV infection, offering confidential, voluntary HIV testing, and identifying those already infected and linking them to quality HIV care. The Center for Medicare and Medicaid Services (CMS) should continue to work with state Medicaid programs encouraging routine testing in healthcare settings, and urge states to cover the cost of HIV screening, counseling and testing in Medicaid-financed primary care settings and to require HIV screening, counseling and testing in state Medicaid managed care contracts.

Maintain the federal commitment to fully share in the cost of Medicaid coverage. States must be able to count on the federal government as a reliable partner in sharing the cost of Medicaid and SCHIP. If more people become eligible for Medicaid or SCHIP, if health care costs rise, if new medical technologies become available, or if states choose to make new investments to better meet the needs of their residents, the federal government must maintain its commitment to providing ongoing matching financing. Over the past four decades, this financing structure has been critical to ensuring stability in coverage as states' cycle through good and bad economic times and it has been critical to supporting states that are committed to implementing innovative programs that expand access to more people in need of health care services.

Provide federal leadership to ensure that state Medicaid programs provide adequate health care coverage by establishing prescription drug coverage as a mandatory benefit and conducting careful oversight of state Medicaid programs. Given the major role of federal financing, it is appropriate for federal policy to minimize variability across states and assure adequate benefits coverage in all states. State flexibility should be focused on improving the delivery of services and should not entail flexibility to provide sub-standard care. Current flexibility permits states to make arbitrary and dangerous decisions that eliminate or limit coverage to essential health services. It is critical that the federal government assert new leadership to ensure that states provide a level of coverage that meets the needs of the diverse and needy populations served by Medicaid.

CMS' new case management and targeted case management (TCM) interim regulation must be revised as it threatens access to vital medical, social and educational services and goes well beyond the statutorily-enacted policies of the Deficit Reduction Act. While Congress passed bipartisan TCM provisions in the DRA, the CMS rule strays far beyond congressional intent in an effort to cut \$1.28 billion from this important state optional program. The "integral component test" as proposed in the interim regulation must be rejected as it will cause great harm to Medicaid beneficiaries living with HIV/AIDS who rely on Medicaid case management services. At least 12 states have TCM programs designed specifically for Medicaid beneficiaries with HIV/AIDS (Alabama, Georgia, Indiana, Louisiana, Maine, Massachusetts, New York, North Carolina, Pennsylvania, Rhode Island, Washington and Wisconsin) In addition, state flexibility must be retained to allow beneficiaries with complex and multiple medical conditions to have more than one case manager as this may be necessary to successfully coordinate beneficiaries housing, health care, and social service needs across multiple systems.

Expand Medicaid to cover all beneficiaries up to 100 percent of the federal poverty level and ensure that coverage is affordable and that care is not denied due to an inability to pay. In most states, mandatory coverage for persons with disabilities and seniors is set at 74% of the federal poverty level. It is time to raise the bar and, at a minimum, establish mandatory eligibility for all seniors and people with disabilities up to the federal poverty level. Also, near perfect adherence to antiretroviral medications is required for successful treatment of HIV infection and avoidance of drug resistant strains of the virus. Medicaid serves a very low-income population and many beneficiaries, including persons with HIV/AIDS, require extensive care and numerous medications. For the impact on an individual's health, as well as the public health at large, no one should be dissuaded from seeking care or denied coverage for prescriptions due to the inability to pay a co-payment or other forms of cost-sharing.

The HIV Medicaid and Medicare Working Group (HMMWG) HMMWG is a coalition of nearly 100 national and community-based AIDS service organizations that represent HIV medical providers, advocates and people living with HIV/AIDS and provide critical HIV-related health care and support services. For more information, contact the HMMWG co-chairs Laura Hanen with the National Alliance of State and Territorial AIDS Directors at 202.434.8091 or Robert Greenwald with the Treatment Access Expansion Project at 617.390.2584.