STATE HEALTH REFORM IMPACT MODELING PROJECT

Illinois

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Prepared by the Center for Health Law and Policy Innovation of Harvard Law School
and the Treatment Access Expansion Project

BACKGROUND

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

The State Health Reform Impact Modeling Project (the Modeling Project) assesses the impact that healthcare reform will have on people living with HIV by compiling and analyzing Ryan White program and AIDS Drug Assistance Program (ADAP) data to predict the shift of uninsured people living with HIV from these discretionary programs to Medicaid or private insurance in all 50 states pursuant to the ACA. In addition, in 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 onto 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 and a summary of the limitations on the modeling process.

In Illinois, 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?

ILLINOIS

ILLINOISANS LIVING WITH HIV/AIDS

UNMET NEED

As of March 2012, there were 34,197 Illinoisans known to be living with HIV/AIDS (HIV+ aware).[3] An additional 8,300 individuals are estimated to not know their HIV+ status.[4] In 2007,* about 50% (16,150) Illinoisans living with HIV were non-Hispanic blacks and about 32% (10,410) were non-Hispanic whites.[5] Moreover, in 2010, approximately 47% of HIV+ aware persons (15,251) were not receiving primary care.[6] These undiagnosed individuals are not accounted for in the following modeling of the number of individuals who will transition over to Medicaid or subsidized private insurance under the Patient Protection and Affordable Care Act (ACA) because they are not currently receiving 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. Thus, fully implementing the ACA (including the Medicaid expansion), while maintaining necessary Ryan White services as wraparound support, is critical not only to increase access to care but also to reduce health disparities.

THE RYAN WHITE PROGRAM IN ILLINOIS

The Ryan White program is a discretionary, federally funded program providing HIV-related services across the United States to those who do not have other means of accessing HIV/AIDS treatment and care. In 2010, the Ryan White program in Illinois received $86,358,320 in funding and served 29,310 duplicated clients.[7,†] About 52% of the state's Ryan White funds were federal AIDS Drug Assistance Program (ADAP) Part B grants.[7] Of these, 21.4% covered core medical services, 1.6% covered supplemental services, 66.1% funded ADAP, and 10.1% provided ADAP supplemental funding.[7]

ADAP IN ILLINOIS

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 HIV+ enrollees. In July 2011, state funding cuts for ADAP resulted in a reduction in income eligibility from 500% to 300% of the federal poverty level (FPL).[8,‡] This change means that many low-income individuals are not accessing the medicines they need and may need to wait until they are eligible for private insurance subsidies in 2014 to begin a medically necessary ART regimen. To be eligible for ADAP in Illinois today, one must now be[9]:

- An Illinois resident diagnosed with HIV;
- Ineligible for Medicaid on the date drugs are obtained;
- Living at or below 300% FPL (and uninsured) or at or below 500% FPL with prescription coverage (if enrolled after July 1, 2011); or
- Living at or below 500% FPL (if enrolled prior to July 1, 2011).

In fiscal year 2010, ADAP served 6,447 unduplicated clients in Illinois.[10] The total ADAP budget in fiscal year 2011, including state ($18,792,290) and federal ($33,405,740) funds, was $52,198,030.[11] Illinois' state contribution to ADAP constitutes a critical 36% of funding for the program. Illinois' ADAP expenditures in fiscal year 2010 totaled $49,676,175.[10,§] Of these, 88.2% ($46,055,583) was spent on prescription drug payments, 3.1% ($1,592,799) was spent on prescription dispensing costs, and 2.7% ($1,402,148) went toward insurance assistance (copays and deductibles).[10]

*More recent disaggregated data are not available, but the 2007 data are expected to be relatively representative of current trends.

†The number of duplicated clients reflects the cumulative number of clients served by each provider (clients are counted more than once if they receive services from two or more providers).

‡Importantly, the Illinois General Assembly consolidated other HIV funding accounts to help facilitate continued ADAP funding. Illinois General Assembly Adjourns, Reduces HIV Funding Cuts, AIDS Foundation of Chicago (June 7, 2011), *available at* http://www.aidschicago.org/illinois-news/336-illinois-general-assembly-adjourns-reduces-hiv-funding-cuts.

§The difference between the budget and expenditures reflects administrative overhead and differences between project and actual vendor costs.

THE ACA AND ITS IMPACT ON HIV+ ILLINOISANS

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).[12,**] Although the 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.[13] Newly eligible enrollees will receive a benchmark benefits package that will include ten categories of essential health benefits (EHB), described in the "Essential Health Benefits" section.[14]

Counties may apply for a §1115 Waiver to facilitate early transition of newly eligible patients onto Medicaid as part of a Center for Medicare & Medicaid Innovation (CMI) demonstration to help inform the statewide transition.[15] Because Cook County successfully applied for a §1115 Waiver, many Ryan White patients may be eligible to transition onto Medicaid prior to 2014 through the new CountyCare program.[16] This program will serve as an important test for determining to what extent Medicaid will be able to meet the needs of people with HIV/AIDS.

THE BASIC HEALTH PLAN

The ACA provides an option for states to create a Basic Health Plan (BHP) that would be largely federally funded (states would receive up to 95% of the premium credits an individual would have been entitled to for purchase of a plan on the exchange).[17] 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.[18] 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.[19] Cost sharing on BHPs can be subsidized, either for all beneficiaries or for those with specific chronic conditions (eg, HIV/AIDS).[20] In addition to improved affordability, BHPs can minimize "churning" on and off Medicaid as individuals fluctuate around 133% FPL. Because state Medicaid offices can design and manage BHPs, these individuals would more easily transition onto a plan with similar provider networks and administrative procedures.

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

The ACA requires states to establish state-run insurance exchanges, to partner with the federal government to set up a hybrid state-federal exchange, or to default into a federally facilitated exchange.[21] Insurance exchanges will provide individuals and families with a choice of plans, tiered by actuarial value of coverage (bronze, silver, gold, and platinum).[22] 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 paragraphs.[23] All exchanges will be operational January 1, 2014.[24]

Illinois submitted the BlueCross BlueShield of Illinois BlueAdvantage small-group plan as its base-benchmark for purposes of defining EHB.[25] In other states that fail to submit a benchmark plan, the largest small-group market plan in the state is the default benchmark plan.[26]

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

** Legal residents who haven't lived in a state for 5 years and illegal residents are excluded.

ESSENTIAL HEALTH BENEFITS

The ACA requires both Medicaid and private health insurance plans sold on state-based insurance exchanges to provide a minimum of EHB, to be defined by the Secretary of HHS.[28] EHB must include items and services within the following ten benefit categories[29]:

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.[30] The Centers for Medicare & Medicaid Services has indicated that the HHS rule on EHB will also apply to newly eligible Medicaid beneficiaries, in addition to the protections provided for under the Social Security Act.[31] This means that benefits provided by Medicaid will likely be more robust than on the private market. For example, the Social Security Act requires that a Medicaid benchmark plan cover any US Food and Drug Administration–approved drugs with significant clinically meaningful therapeutic advantage over another.[32]

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

Given the ACA-instituted reforms, a large number of HIV+ individuals in Illinois are expected to become eligible for Medicaid or a BHP in 2014, provided that Illinois expands Medicaid and institutes a BHP. An estimated 14% 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.[33] An estimated 68% of Illinois' ADAP clients will be newly eligible for Medicaid following its expansion, and an additional 17% are estimated to be eligible for private insurance subsidies (see Appendix A). Finally, most of the estimated 15,251 HIV+ Illinoisans who did not access care in 2010 will likely be eligible for Medicaid, a BHP, or a subsidized private plan in 2014. The opportunity the ACA offers to expand access to treatment for HIV/AIDS is unprecedented.

The percentage of Illinois' ADAP clients who will be newly eligible for Medicaid (68%) is considerably higher than the national proportion of newly eligibles (29%) (see Appendix A). This is primarily because Illinois' ADAP mostly serves individuals with income below 133% FPL (approximately 78% of the state's ADAP clients were below 133% FPL in June 2011), but also because the state's ADAP clients are almost entirely uninsured.[34]

The percentage of Illinois' ADAP clients who are expected to qualify for private insurance subsidies (17%) is slightly higher than the national proportion (15%) (see Appendix A), probably because Illinois' ADAP serves few individuals with income above 133% FPL (only about 22% of the state's ADAP clients had income above that threshold in June 2011).[34]

COMPARING SERVICES PROVIDED BY RYAN WHITE, ADAP, AND MEDICAID TO HIV+ ILLINOISANS

Since a significant number of HIV+ individuals in Illinois who are currently served by the Ryan White program or ADAP are likely to be eligible for Medicaid in 2014, it is important to assess the outcome of transitioning clients from these discretionary programs into Medicaid or private insurance plans. This assessment compares and contrasts the services and treatments that the Ryan White program, ADAP, Medicaid, and the exchange benchmark plan (BlueCross BlueShield of Illinois BlueAdvantage small-group plan) currently provide to HIV+ adults in Illinois. Forthcoming federal guidance on the Essential Health Benefits (EHB) provided to newly eligible Medicaid beneficiaries under the ACA will also affect the scope of coverage provided in 2014 (a proposed rule was released on November 20, 2012).

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

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 versus support services). Both medical and ancillary services are critical to maintaining the health of low-income individuals who may not have access to many necessities that affect access to HIV/AIDS treatment and care (eg, child care, stable housing). While the latter are generally not covered by Illinois' Medicaid programs, a number of these services—including some that are not covered by Ryan White—are covered by a §1915(c) Waiver to HIV+ Medicaid clients who have functional limitations placing them at risk of nursing facility placement.[36,37] Still, this waiver applies to a limited number of HIV+ Illinoisans, and virtually none of these ancillary services are covered by the proposed exchange benchmark plan.

Accounting for inconsistencies among Medicaid, the exchange benchmark plan, and Ryan White will be critical in transitioning beneficiaries onto Medicaid to ensure that their health status does not deteriorate (due to lack of access to child care, housing, or non-emergency medical transportation). The Illinois and Chicago Departments of Public Health (Ryan White program grantees) will need to work closely with Medicaid to determine which Ryan White program services can be provided to fill gaps in Medicaid without violating Ryan White's payer of last resort requirements.

Table 1 provides a comparison of covered services on Illinois' Ryan White and Medicaid programs (as of 2010), as well as BlueCross BlueShield of Illinois' BlueAdvantage plan.

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

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

Covered Service	Ryan White[35]	Medicaid[38]	BlueCross BlueShield of Illinois: BlueAdvantage Small-Group Plan[39]
Home Health Care		X (PA or § 1915(c) Waiver)[40,††]	X
Mental Health	X	X	X
Substance Abuse (outpatient)	X	X	X
Substance Abuse (inpatient)	X	X	X
Medical Case Management (for ART)	X	X[41] (via § 1915(c) Waiver)	
Community-based Care	X (1 organization)	X[42,43]	
Ambulatory/Outpatient Care	X	X[44,45]	X
Oral Health Care	X	X[46] (emergencies only)	
Early Intervention Clinic	X		
Intermediate Care Facilities for the Mentally Retarded		X[47]	
Ambulance		X[48]	X
Family Planning		X[49]	X
Durable Medical Equipment		X[50]	X
Hospital Services		X[51]	X
Lab and X-ray Services		X	X
Nursing Facility		X[52]	

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†† Also available without PA following discharge from acute care or rehabilitation hospital inpatient stay of at least 24 hours, where patient requires visits within first 60 days and visits are initiated within 14 days of discharge. Illinois Department. of Healthcare and Family Services, Handbook for Home Health Agencies: Policy and Procedures for Home Health Agencies (2011), *available at* http://www.hfs.illinois.gov/assets/r200.pdf (last visited Oct. 18, 2012).

Table 1. (continued)

Midwife/NP Services		X[53]	X
Private Duty Nursing		X[54] (via § 1915(c) Waiver)	
Physician Services		X	X
Non-Medical Case Management Services	X	X[55] (pregnant women and women with children aged <1 year)[56]	
Child Care	X (1 organization)		
Emergency Financial Assistance	X		
Food Bank/Home Delivered Meals	X	X[57] (via § 1915(c) Waiver)	
Housing Services	X		
Health Education/Risk Reduction	X	X (pre- and postnatal only)[58]	X (diabetes only)
Legal Services	X		
Linguistic Services	X (1 organization)	X[59] (20 visits/year)	
Non-Emergency Medical Transportation	X	X[60] (PA)	X
Outreach Services	X		
Psychosocial Support	X		X
Referral Agencies	X	X	X
Treatment Adherence Counseling	X		
Chiropractor			X (capped at $1000/year)
Podiatry		X[61] (diabetes only)	X
Hospice		X[62]	X
Respiratory Therapy		X	X
PT, OT, and Speech Therapy		X[63,64] (20 visits/year)	X
Orthotics and Prosthetics		X[65]	X
Personal Care		X[66] (via § 1915(c) Waiver)	
Home Infusion Therapy			
Adult Day Care		X[67] (via § 1915(c) Waiver)	
Respite Services		X[68] (via § 1915(c) Waiver)	X
Personal EM Response		X[69] (via § 1915(c) Waiver)	

NP = nurse practitioner; OT = occupational therapy; PA = prior authorization; PT = physical therapy.

As Table 1 indicates, the Ryan White program offers HIV+ individuals a number of ancillary services that Medicaid and Illinois' benchmark plan do not cover. The AIDS Foundation of Chicago has identified housing, mental health, and substance treatment services (particularly for adults) as areas in need of additional financial support.[70] Since these ancillary services are important for the well-being of HIV+ individuals, those individuals who leave the Ryan White program for Medicaid or a private insurance plan are likely to be at a disadvantage. However, it is worth noting that many current Medicaid beneficiaries are enrolled in a Medicaid managed care plan, discussed in more detail in the following section. Through these plans, newly eligible individuals who have access to similar case management strategies and may obtain some nonmedical benefits similar to those offered by Ryan White. However, Medicaid EHB are unlikely to require these benefits for newly eligibles.[71]

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

ADAP provides funding for a robust drug formulary that is necessary to afford low-income individuals access to a combination of drugs that 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. Ensuring that Medicaid and plans sold on the exchange provide coverage for a sufficient number of antiretroviral medications will be critical to maintaining the health of Illinoisans living with HIV/AIDS.

Table 2 provides a comparison of the ART formularies included in the state's ADAP and Medicaid programs, as well as BlueCross BlueShield of Illinois' BlueAdvantage plan.

As Table 2 indicates, ADAP has a more robust ART formulary than both Medicaid and the proposed benchmark plan. Although antiretroviral drugs (as well as oncolytics, contraceptives, immunosuppressives, and antibiotics) are exempt from the Medicaid prescription drug limits, Medicaid

Table 2. ADAP Versus Medicaid and the Benchmark Plan: Covered Drugs[72]

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[73,‡‡,§§] must use lowest cost alternative (generic); $2,000/month benefits cap**	**Medicaid[74,***] PA required for brand name if generic available unless otherwise indicated**	**BlueCross BlueShield of Illinois: BlueAdvantage Small-Group Plan[75,†††]**
Multiclass Combination Drugs	**3 Drugs Covered**	**2 Drugs Covered**	**1 Drug Covered**
Atripla; *efavirenz + emtricitabine + tenofovir DF*	X (counted as 3 drugs)	X	X (PA)
Complera; *emtricitabine + rilpivirine + tenofovir disoproxil fumarate*	X	X (PA)	
Stribild; *elvitegravir + cobicistat + emtricitabine + tenofovir disoproxil fumarate*	X (PA)		
NRTIs	**12 Drugs Covered**	**11 Drugs Covered**	**12 Drugs Covered**
Combivir; *zidovudine + lamivudine*	X (counted as 2 drugs)	X	X (PA required for Combivir)
Emtriva; *emtricitabine*	X	X	X
Epivir; *lamivudine*	X	X	X (PA required for Epivir)

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‡‡ PA required if more than five drugs from Category 1 (and Fuzeon) are prescribed concurrently (up to two protease inhibitors or a protease inhibitor and an NNRTI may be provided concurrently and Ritonavir [Norvir], at a reduced dosage, may be prescribed for pharmacokinetic [PK] boosting). Kaletra contains Norvir at a reduced dosage and is considered one plus PK-boosted drug when ordered.

§§ 30-day prescription refills. No copays.

*** Four-prescription drug limit. ARTs are exempt from prescription drug limits. Illinois Cares Rx Program covers some of the copayment cost for HIV/AIDS medications for disabled individuals.

††† Generic copay is $10, formulary copay is $20, and non-formulary copay is $35. When generic drug is available, participant must use generic or pay non-formulary brand copay plus the cost difference between the generic and non-formulary brand.

Table 2. (continued)

Epzicom; *abacavir sulfate + lamivudine*	X (counted as 2 drugs)	X	X
Retrovir; *zidovudine*	X	X	X (PA required for Retrovir)
Trizivir; *abacavir + zidovudine + lamivudine*	X (counted as 3 drugs)	X	X
Truvada; *tenofovir DF + emtricitabine*	X (counted as 2 drugs)	X	X
Videx; *didanosine (buffered versions)*	X	X	X
Videx EC; *didanosine (delayed-release capsules)*	X		X (PA required for Videx EC)
Viread; *tenofovir disoproxil fumarate DF*	X	X (PA)	X
Zerit; *stavudine*	X	X	X (PA required for Zerit)
Ziagen; *abacavir*	X	X	X
NNRTIs	**5 Drugs Covered**	**5 Drugs Covered**	**4 Drugs Covered**
Intelence; *etravirine*	X	X	X
Rescriptor; *delavirdine mesylate*	X	X	X
Sustiva; *efavirenz*	X	X	X
Viramune; *nevirapine*	X	X	X
Edurant; *rilpivirine*	X	X	
Protease Inhibitors	**10 Total**	**9 Drugs Covered**	**9 Drugs Covered**
Agenerase; *amprenavir*	X (solution only)		
Aptivus; *tipranavir*	X	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 (PA for non-tablet formulations)	X	X
Prezista; *darunavir*	X	X	X
Reyataz; *atazanavir sulfate*	X	X	X
Viracept; *nelfinavir sulfate*	X	X	X
Fusion Inhibitors	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Fuzeon; *enfuvirtide*	X (PA; capped at 15 clients; does not count toward monthly benefits cap)	X	X (PA)
Entry Inhibitors – CCR-5 Coreceptor Antagonist	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Selzentry; *maraviroc*	X (PA based on tropism assay)	X (PA)	X (PA)
HIV Integrase Strand Transfer Inhibitors	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Isentress; *raltegravir*	X	X	X
"A1" Opportunistic Infection Medications	**24 Drugs Covered**	**25 Drugs Covered**	**26 Drugs Covered**
Ancobon; *flucytosine*			X (PA required for Ancobon)
Bactrim DS; *sulfamethoxazole/trimethoprim DS*	X	X	X (PA required for Bactrim DS)

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Table 2. (continued)

Biaxin; *clarithromycin*	X	X	X
Cleocin; *clindamycin*	X	X	X
Dapsone	X	X	X
Daraprim; *pyrimethamine*	X	X	X
Deltasone; *prednisone*			X
Diflucan; *fluconazole*	X	X	X (PA required for Diflucan; 180-day limit)
Famvir; *famciclovir*	X	X (PA)	X (PA required for Famvir)
Foscavir; *foscarnet*			
Fungizone; *amphotericin B*	X (IV only)		
INH; *isoniazid*	X	X	X
Megace; *megestrol*		X	X (PA required for Megace)
Mepron; *atovaquone*	X (PA if used for more than 21 days, or as prophylaxis more than once a year)	X	
Myambutol; *ethambutol*	X	X	X (PA required for Myambutol)
Mycobutin; *rifabutin*	X	X	X (PA required for Mycobutin)
NebuPent; *pentamidine*	X	X	
Nydrazid; *isoniazid, INH*	X	X	X
Probenecid			X
Procrit; *erythropoetin*		X	X (PA)
Pyrazinamide (PZA)	X	X	X
Rifadin, Rimactane; *rifampin*	X	X	X (PA required for Rifadin or Rimactane)
Sporanox; *itraconazole*	X	X	X (PA required for Sporanox; 180-day limit)
Sulfadiazine – Oral	X	X	X (PA)
Valcyte; *valganciclovir*	X (PA; oral only; capped at 35 clients; does not count toward monthly benefits cap)	X	X
Valtrex; *valacyclovir*	X	X	X (PA required for Valtrex)
VFEND; *voriconazole*			X (PA)
Vistide; *cidofovir*	X	X	
Wellcovorin; *leucovorin*	X	X	X
Zithromax; *azithromycin*	X	X	X (PA required for Zithromax)
Zovirax; *acyclovir*	X	X	X (PA required for Zovirax)

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

beneficiaries are limited to four other prescriptions per month (additional prescriptions require prior approval).[76] Because management of HIV/AIDS diagnoses may require many and varied prescription drugs, Medicaid's and private insurance plans' prescription drug coverage could pose challenges for people living with HIV/AIDS. Although it is possible for patients to exceed the four-drug limitation, it requires getting prior approval, which is currently a cumbersome and lengthy process.

While Illinois' benchmark plan covers fewer antiretroviral drugs than ADAP or Medicaid, it offers thorough coverage of drugs for opportunistic infections. Nevertheless, the plan imposes prior authorization requirements on most prescriptions, and reserves the right to conduct utilization review, an often masked process. These practices can delay or inhibit access to lifesaving drugs for Illinoisans living with HIV/AIDS.

It is important to note that this analysis uses Illinois' current Medicaid formula, which will not necessarily apply to newly eligible beneficiaries under the ACA. Nonetheless, Medicaid EHB is unlikely to prohibit cost-containment practices that currently threaten access to comprehensive ART (eg, prior authorization and quantity limits).[71]

If people living with HIV/AIDS are unable to access appropriate ART through Medicaid or subsidized private insurance, Ryan White and ADAP will continue to be necessary as payers of last resort.

MEDICAID MANAGED CARE PROFILE

Illinois currently has three managed care delivery systems: Integrated Care Program (ICP), Primary Care Case Management (PCCM), and Voluntary Managed Care Organization (VMCO).[77] In September 2012, more than 2 million clients were enrolled in a managed care program,[55] up from just over 1.3 million in July 2010.[78] While dual eligibles in Illinois are currently ineligible for Medicaid Managed Care, Illinois has submitted a Financial Models to Support Efforts to Coordinate Care for Medicare-Medicaid Enrollees Demonstration Proposal to the Centers for Medicare & Medicaid Services (CMS) to test the potential for dual eligibles to access services through health plans offering a holistic approach to coordinated care delivery.[79] If approved by CMS, this demonstration would allow Illinois to significantly expand the number of Medicaid clients in managed care through a pilot project expected to launch in fall 2013.[80]

State legislation passed in 2011 requires that 50% of all Medicaid beneficiaries be enrolled in "care coordination" by 2015.[81] Care coordination is defined as "delivery systems where recipients will receive their care from providers who participate under contract in integrated delivery systems that are responsible for providing or arranging the majority of care."[59] In addition, they must include risk-based payments.[59]

While they offer important ancillary services, not all Medicaid Managed Care programs are equipped to comprehensively and appropriately address the needs of clients transitioning from Ryan White programs onto Medicaid. For instance, ICP, PCCM, and VMCO programs do not cover dental, outpatient behavioral health, outpatient substance abuse, or pharmacy services. Under the ACA, if Medicaid EHB are defined to include these benefits, HIV+ individuals will avoid unnecessary disruptions in care as they move from Ryan White onto Medicaid.

The state's PCCM, Illinois Health Connect, is available to most individuals covered by Medicaid, including parents in the FamilyCare Program and adults with disabilities.[82] Individuals enrolled in this plan use their primary care providers as medical homes (ie, coordinators of care). In November 2012, 1,797,317 clients were enrolled in a PCCM (87% of Medicaid Managed Care enrollees).[83] It will be important to ensure that these clients' continuity of care is not disrupted by the Medicaid expansion.

VMCO coverage extends to mothers and children as well as FamilyCare clients, who may also choose a primary care provider as their medical home. In November 2012, 228,482 clients were enrolled in a VMCO (11% of Medicaid Managed Care clients).[84] Preserving a comparable degree of choice in primary care providers is essential to keeping the vulnerable populations served by these managed care programs enrolled in care. ICP is a mandatory program for disabled adults who are eligible only for Medicaid and who live in the Cook County suburbs and collar counties.[54] Clients can choose between Aetna Better Health Plan and IlliniCare Health Plan, both of which use performance measures that may be useful in informing the development of specific performance measures for patients living with HIV/AIDS.[54] In November 2012, 35,983 clients were enrolled in an ICP (2% of Medicaid Managed Care enrollees).[54] The Illinois Department of Healthcare and Family Services (HFS) has indicated that it intends to expand the ICP to the rest of the population of adults with disabilities, including in Chicago, and to newly eligible Medicaid beneficiaries in 2014.[85]

COMMUNITY HEALTH CENTERS

The ACA has provided Illinois with $118.3 million to fund new and existing community health centers.[86] Additionally, Chicago has been awarded $239,967 in Health Center Planning grants.[87] All community health centers in Illinois (521 as of 2010) provide primary care services, and 81% provide HIV preventive care.[88] There are also two designated AIDS Education Training Centers (AETC)—National Centers for HIV Care in Minority Communities—sites in Illinois.[89] Medicaid expansion in Illinois should strive to integrate these community health centers into the new roster of available service providers, and use these community-based models to inform the expansion of programs available for individuals living with HIV/AIDS. In particular, the AETC centers, which are sensitive to the needs of minority HIV/AIDS patients, are models for expansion of HIV/AIDS services in minority-dominant urban areas like Cook County.

CONCLUSIONS AND NEXT STEPS

This report provides detailed analyses of the Ryan White program, AIDS Drug Assistance Program (ADAP), Medicaid, and Illinois' benchmark plan for purposes of defining essential health benefits (EHB) on the exchange, 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 Patient Protection and Affordable Care Act (ACA) in a manner that serves the needs of Illinoisans.

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 eligibility standard (extending eligibility to individuals living under 133% of the federal poverty level [FPL]). Given that 68% of uninsured ADAP clients would transition onto Medicaid in Illinois, implementing the ACA's expansion option—while maintaining necessary Ryan White wraparound services—is crucial to improving health outcomes and reducing transmission of HIV across the state.

Nonetheless, the Medicaid system must be ready and able to handle the needs of low-income people who have HIV/AIDS. This report provides an initial analysis of the capacity of the Illinois Medicaid program to handle the needs of an influx of individuals living with HIV/AIDS. The Medicaid benefits that will be available to newly eligible beneficiaries, including those living with HIV/AIDS, have not yet been defined. As such, an analysis of the barriers to care that this population is likely to face (based on the existing Medicaid program) is timely as states prepare for the transition to Medicaid. Comparing current Ryan White and ADAP services with existing Medicaid formularies allows for a baseline analysis of the needs of individuals living with HIV/AIDS moving into the Medicaid system. Medicaid expansion and the transition into private insurance in Illinois should recognize the importance of, and avoid disrupting, the continuity of care currently provided by Ryan White. This report identified several challenges:

1. First, a number of services that are currently provided by the Ryan White program are not available under Illinois' current Medicaid program or proposed exchange benchmark plan, and vice-versa, which may reduce the ability of those living with HIV/AIDS to access services. For instance, the Ryan White program, unlike Medicaid and the proposed exchange benchmark plan, covers housing, health education/risk reduction, and legal, linguistic, and outreach services, as well as psychosocial support, treatment adherence counseling, child care, and emergency financial assistance. On the other hand, Medicaid, unlike Ryan White, covers several specialty medical services: physician and nursing services; respite and hospice care; physical, respiratory, occupational, and speech therapies; personal care; adult day care; and emergency medical response. The proposed Illinois exchange benchmark plan only covers some of these services. Creating a comprehensive health coverage program is essential in ensuring that continuity of care is readily accessible to vulnerable populations, including low-income Illinoisans living with HIV/AIDS;
2. Second, housing, mental health, and substance abuse services have been identified by Illinois as an area requiring more attention for individuals living with HIV/AIDS. Medicaid's limits on the amount and types of these services available to clients pose a significant concern. Importantly, the services provided by the § 1915 Waiver for HIV/AIDS patients, such as case management, should serve as a starting point for the development of Medicaid Essential Health Benefits (EHB). How and to what extent these benefits are incorporated into the ACA's EHB criteria for Medicaid and the exchange benchmark plans (for newly eligible beneficiaries), respectively, will be crucial to meeting the needs of individuals living with HIV/AIDS;

3. Third, HIV/AIDS patients in Illinois are currently subject to virtually no limitations on the type or quantity of antiretroviral prescriptions they may receive through ADAP or Medicaid. Illinois' proposed exchange benchmark plan is even more limited than Medicaid in its prescription drug benefits, which will likely define the prescription drug EHB on the private market. Any new limitations on current ADAP clients' pharmacy benefits would pose significant health risks for individuals who currently rely on particular antiretroviral therapy (ART). They would also pose challenges for those who are in need of multiple prescriptions; those living with HIV/AIDS are likely to exceed any monthly limits on prescription medications. The forthcoming definition of Medicaid EHB and any further revisions to the proposed exchange benchmark plan will be crucial in this respect. In many cases, HIV/AIDS patients cannot change their drug regimens because of drug-resistance issues; and
4. Fourth, the delivery of services to HIV/AIDS patients should build on and learn from the strengths of existing care coordination and community-based networks to take advantage of the ACA's provisions for health homes. Health homes can help promote the continuity of care needed by HIV/AIDS patients as they transition onto Medicaid, a BHP, or a private plan. Implementing health homes beyond care coordination entities may also help facilitate the transition of Ryan White into a wraparound program. Health homes can also serve as valuable assets in prevention efforts. By expanding beyond care coordination entities and reaching individuals who are at risk but not already disabled, health homes can be important focal points for treatment as prevention, health education, and risk reduction.

Illinois ADAP clients will transition to subsidized private insurance in 2014 at roughly the same rate as the national average, and it is essential that private insurance plans provide a level and scope of services that are sufficient to meet the needs of these individuals. As benchmark plans are used to define the scope of EHB, both for Illinois' exchange and Medicaid programs, as well as a potential Basic Health Plan (BHP), it is essential to keep these challenges to healthcare access in mind.

Expanding Medicaid, with particular attention to the needs of individuals living with HIV/AIDS, is critical not only to ensure that Illinoisans have access to HIV medicines and services but also to relieve ADAP's fiscal burden on the state. As 2014 approaches, Illinois should ensure that no additional cuts are made to ADAP's funding or eligibility, as it will soon have the option to transition a majority of its ADAP clients onto an expanded Medicaid program and/or subsidized private insurance plans funded primarily by federal, as opposed to state, resources. In the long term, expanded federal resources under the ACA will go further, both for treatment and prevention, if newly eligible individuals have already begun a stable ART regimen. Therefore, state contributions to ADAP should be made based on long-term effectiveness of treatment rather than sustainability of funding. Regardless, there will likely remain an ongoing demand for Ryan White and ADAP services to fill the gaps left by Medicaid 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 Illinoisans.

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. Adopting the Medicaid expansion, pursuant to the ACA. Illinois must extend Medicaid 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;
2. Effectively defining the EHB, patient navigation, and outreach systems and opting into prevention and health home program resources will maximize the potential for the state to meet the care and service needs of individuals living with HIV/AIDS; and
3. Ensuring that Ryan White and ADAP services are available where coverage or affordability gaps exist (eg, psychosocial support, nonmedical case management, and treatment adherence counseling).

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APPENDIX A

2014 STATE-SPECIFIC ESTIMATES

Medicaid Estimates

The 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 newly eligible for Medicaid in 2014, the following formula was used:

	Total #	ADAP clients being served in the fiscal year 2010[90]
−	**est. #**	ADAP clients living above 133% FPL[26,‡‡‡]
−	**est. #**	insured ADAP clients living below 133% FPL
−	**est. #**	undocumented ADAP clients living below 133% FPL in June 2011[91]
=	**Total #**	ADAP clients who will be newly eligible for Medicaid in 2014[§§§,****]

Illinois' ADAP served 6,447 individuals in fiscal year 2010. Of those, it is estimated that 1,418 (22%) are living above 133% FPL. Further, we estimate that 5,029 ADAP clients living below 133% FPL are insured. Approximately 3% of Illinoisans were undocumented as of 2008 (amounting to approximately 169 undocumented, uninsured ADAP clients living below 133% FPL). Thus, the calculation for Illinois is:

	6,447	ADAP clients served in fiscal year 2010
−	**1,418.34**	ADAP clients with income above 133% FPL
−	**5,028.66**	insured ADAP clients with income below 133% FPL
−	**169.49**	undocumented immigrants with incomes below 133% FPL in June 2011
=	**4,374**	(ADAP clients who will be newly eligible for Medicaid in 2014; or approximately 68% of ADAP clients served in fiscal year 2010

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

State	# ADAP Clients Newly Eligible for Medicaid	% ADAP Clients 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	1,336	22%
South Carolina	1,428	39%
Tennessee	2,505	60%
Texas	8,797	53%
Virginia	2,690	66%
Wisconsin	696	40%
United States	**62,971**	**29%**

Note: Data on the insurance status of ADAP clients in Maryland, North Carolina, Ohio, and Kentucky came from the 2011 NASTAD Report instead of the 2012 NASTAD Report.[92] (The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages of insured clients exceed 100% for Maryland and Ohio.)

The percentages of ADAP clients who will be newly eligible for Medicaid in 2014 vary considerably from state to state. These differences can be explained by the different eligibility standards currently in place for ADAP eligibility within each state, as well

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

§§§ The final estimate provided is likely 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 on figures largely taken from 2010-2011.

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 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[90]
–	**est. #**	ADAP clients living below 133% FPL[9,††††]
–	**est. #**	ADAP clients living above 400% FPL[9]
–	**est. #**	insured ADAP clients living between 133-400% FPL[29]
–	**est. #**	ADAP clients who are undocumented immigrants living between 133-400% FPL[91]
=	**Total #**	ADAP clients who will be newly eligible for subsidized private insurance

Illinois's ADAP served 6,447 individuals in fiscal year 2010. Of those, we estimate that 5,093 (79%) were living below 133% FPL or above 400% FPL. This leaves 21% (1,354) of ADAP clients living between 133-400% FPL. We also estimate that there were 182 insured ADAP clients with income between 133-400% FPL. Approximately 3% of Illinois' population was undocumented as of 2008 (amounting to approximately 46 ADAP clients living between 133-400% FPL). Thus, the calculation for Illinois is:

	6,447	ADAP clients served in fiscal year 2010
–	**5,093.13**	ADAP clients with incomes below 133% FPL or above 400% FPL
–	**1,353.87**	insured ADAP clients with incomes between 133-400% FPL
–	**45.63**	uninsured undocumented immigrants with incomes between 133-400% FPL in June 2011
=	**1,127**	ADAP clients who will be eligible for insurance subsidies in 2014; or 17% 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	27%
California	8,580	22%
DC	829	30%
Florida	4,134	29%
Georgia	1,404	24%
Illinois	1,127	17%
Kentucky	269	18%
Louisiana	no data available	no data available
Maryland	1,726	28%
Massachusetts	932	14%
Mississippi	384	26%
New Jersey	1,879	26%
New York	4,502	21%
North Carolina	621	11%
Ohio	901	26%
Pennsylvania	1,567	26%
South Carolina	1,091	30%
Tennessee	1,531	37%
Texas	4,301	26%
Virginia	896	22%
Wisconsin	401	23%
United States	**32,758**	**15%**

Note: Data on the insurance status of ADAP clients in Maryland, North Carolina, Ohio, and Kentucky came from the 2011 NASTAD Report instead of the 2012 NASTAD Report.[92] (The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages of insured clients exceed 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)

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 250-399% 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 Illinois, 56% of adults living below 133% FPL are insured, 78% of adults living between 133-400% FPL are insured, and 95% living above 400% FPL are insured;

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

   In Illinois, we gave the figure 56% the baseline number 1. 78% is 1.39 times 56%, and 95% is 1.22 times 78%. In other words, an adult in Illinois with income between 133-400% FPL is 1.39 times more likely to be insured than an adult with income below 133% FPL, while an adult with income above 400% FPL is 1.22 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).[93] 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 Illinois, we estimated that about 676.9 of the state's 6,447 ADAP clients served in 2010 were insured. The insurance rate for ADAP clients in that state stood at 10.5% in 2011;

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

   In Illinois, 78% of ADAP clients are living below 133% FPL, 21% are living between 133-400% FPL, and 1% are living above 400%; and finally

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 previously), 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 called *a*.

   We relied on two formulas:

Formula 1:

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

Formula 2:

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

[‡‡‡‡] 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.

Thus, for Illinois:

$$
\begin{aligned}
& 6{,}447 \\
= \; & (1 \times 0.78 \times a) \\
+ \; & (1.39 \times 0.21 \times a) \\
+ \; & (1.22 \times 0.01 \times a)
\end{aligned}
$$

Solving for a,

$a = 621.7$

Applying the determined value of a to Formula 1:

The estimated number of insured ADAP clients in Illinois with,

Income below 133% FPL = 485
Income between 133-400% FPL = 182
Income above 400% FPL = 10

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

METHODOLOGY

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

Ryan White Program Data

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

Estimates of unmet needs 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 among states is limited. Information about unmet need available from other sources has also been included.

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

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

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

Data were collected from the BlueCross BlueShield of Illinois coverage website and the Standard Prescription Drug Formulary.

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.[94] (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 program appear 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 to avoid double-counting individuals who may be enrolled in multiple Ryan White programs (ie, seeing multiple providers). The estimates presented here, therefore, are only for the proportion of ADAP clients who will be eligible for Medicaid and private insurance subsidies;
2. Data for ADAP clients served were used rather than data for clients enrolled because the number of individuals enrolled may exceed the actual number of clients accessing ADAP services. Potential clients who are currently on ADAP waiting lists in several states are also not included in these calculations. Thus, the numbers provide a conservative estimate of ADAP beneficiaries who will transition onto Medicaid or into subsidized private insurance;
3. National data (NASTAD and HRSA) were used in calculations instead of state-specific data to ensure that these estimates could be compared across the states surveyed; and
4. The number of undocumented immigrants on ADAP is a rough estimate extrapolated from estimates of the overall number of undocumented immigrants in the state as a whole as of 2008. It is possible that this estimate either overestimates or underestimates the actual number of undocumented immigrants currently served by ADAP.

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

These estimates are for ADAP recipients only, and are of limited analytical assistance in determining percentages of all people living with HIV/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 additional information about the unmet need within states before attempting to make such calculations.

APPENDIX C

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

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

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

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A collaboration between the HIV community and Bristol-Myers Squibb