Women, HIV, and Medicaid: 
Challenges and Opportunities

Jina Dhillon, JD, MPH
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“Securing Health Rights for Those in Need”
NHeLP

- NHeLP is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people.
- Offices in Washington D.C., Los Angeles, and North Carolina
- Comprehensive analysis of health care reform law was released in June 2010 – see website
- Updated “Advocate’s Guide to the Medicaid Program” – see website
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Agenda

• Overview
  – Recent Developments
  – Women and HIV

• Women with HIV and the Medicaid Program
  – Eligibility and Challenges

• Opportunities
  – Medicaid
  – Health Reform
Recent Developments

• February 2011
  – Surgeon General of the United States Public Health Service determines that a demonstration needle exchange program (syringe services program, SSP) would be effective in reducing drug abuse and the risk of HIV infection.
    • Supported by strong evidence dating from early 1990s that SSPs are cost-effective interventions that reduce HIV risk behavior, and serve as gateway to social services and drug treatment—with few, if any, negative effects.

• July 2011
  – CDC releases 2 new studies showing that AIDS drugs used to treat HIV can also be taken to significantly prevent the virus among heterosexual men and women—reducing the chance of infection by 62% to 73%.
Women and HIV: A “Hidden Epidemic”

- **HIV Incidence and Women**
  - 80% of HIV cases in women occur in black and Hispanic women (who make up approx. 25% of U.S. female population)
  - Two-thirds of new infections occur in black women
  - HIV incidence declining among white men aged 20-25, but increasing in women in same age group
  - Epidemic is concentrated in Northeast and South, especially high poverty areas
    - Heterosexual activity is major mode of acquisition
  - 3rd most common cause of death for black women aged 35-44; 4th most common for black women aged 25-34
Why is the epidemic hidden?

• Impact of HIV on women, compared with other groups such as IDU and MSM, is much less appreciated in the prevention dialogue, both by women at risk and the scientific community.
What’s behind the hidden epidemic?

- Gender inequalities hinder adequate condom negotiation
- Interpersonal Violence
- Poverty
- Lack of medical care access
- Low knowledge of HIV/AIDS
- Lower social status
- Financial dependence on male partner
- Assortative mixing with HIV prevalence communities
- Feeling of invincibility
- Low self-esteem
- Alcohol and drug use
- Underestimation of risk status of partner (incl. bisexual status of partner)
- Sexual mixing patterns and concurrent partnerships put women at increased risk (esp. among black women in South)
Resulting Problems and Needs

- We Need:
  - Rigorous HIV incidence data for at-risk women
  - Behavioral strategies addressing male partners of women (to positively influence gender norms and behaviors of heterosexual and bisexual men)
  - Increased HIV testing and linkage to care (esp. for those living in social, political, economic chaos)

- But mostly, we need:
  - To assure that future programming and policies around HIV prevention focus on proven strategies, esp. for women
  - To support advocates & organizations focusing on women and HIV
Women with HIV and Federal Programs

• Medicaid
  – Eligibility (until 2014): impoverishment and severe disability as a result of HIV
  – Medicaid is primary payor for over half of all persons living with HIV, and for 90% of all children

• Ryan White and ADAP
  – Appropriation to provide coverage for thousands living with HIV and with no or limited coverage
  – Inadequate funds, growing wait lists
Medicaid

• Entitlement to “medically necessary” care
  – Not a block grant*

• Dilemma: is it ethical or cost-effective to delay coverage until person is severely disabled?
  – Answer from health reform: No
Medicaid Eligibility for Women with HIV

• Fictional AFDC
  – Delinkage of Medicaid from welfare programs means many poor women may not know they’re eligible

• Pregnant Women
  – Must get coverage if income is ≤ 133% FPL
  – Up to 60 days postpartum

• Disability (tied to SSI)
  – Immune system deterioration limits ability to work
  – Also possible if concurrent alcohol or drug addiction disability (time limited)
Challenges in Medicaid

- **Time-limited coverage**
  - Drug interruption due to lapse in Medicaid coverage can cause drug resistance, irrevocable harm

- **Outreach**
  - Women must know they’re eligible, how to apply, and how to appeal denials

- **Medicaid managed care**
  - Getting women into care faster can control the disease and reduce long-term costs
Opportunities in Medicaid

• Amount/Duration/Scope requirement
  – States may not arbitrarily deny or reduce coverage on basis of diagnosis/disability

• Contracts with managed care organizations
  – States are bound by these contracts, but also have significant bargaining power—can require aggressive outreach for early detection and linkage to care
Opportunities in Medicaid

• Section 1115 Waivers
  – Leverage federal match!!

• State plans
  – Reduce barriers around eligibility for women—aggressive outreach and retention of enrollees to ensure treatment initiation and adherence
Opportunities in Medicaid

- **Section 1915(c) Home and Community Based Services (HCBS) Waivers**
  - Provide long-term services and support in community as institutional alternative
  - 13 states currently use this to serve individuals with HIV—including for case management, attendant care, home health, specialized medical equipment and supplies, private duty nursing, personal care, home maker services, personal assistance, home delivered meals

CMS, *Dear State Medicaid Director Letter* (June 6, 2011).
Opportunities in Medicaid

• **Section 1915(i) HCBS State Plan Option**
  - Modified by ACA (§ 2402) expanding eligibility criteria, ability for state to target benefit to certain populations, and expanded array of services
  - HCBS can offer essential benefits to individual’s care continuum, supporting and bolstering clinical interventions
  - 5 states currently operate approved Section 1915(i) HCBS in their state plans

CMS, Dear State Medicaid Director Letter (June 6, 2011).
Opportunities in Medicaid

• Section 1115 Waivers
  – States can waive certain provisions of Medicaid Act to conduct experimental, pilot, time-limited demonstration programs. If approved, can allow for federal financial participation for expenditures that would otherwise not apply under a state plan.
  – Can get individuals into treatment faster, improve outcomes, and promote healthier and longer lives for people living with HIV.
  – CMS support: budget neutrality, draft application
Opportunities in Health Reform

• **Community First Choice (ACA § 2401)**
  – State plan option to offer home and community based services and supports
  – FMAP increased by 6% for these services

• **Health Home for Enrollees with Chronic Conditions (ACA § 2703)**
  – State plan option to provide coordinated care for individuals with chronic conditions (can include HIV; BUT limitations: 2 or more chronic conditions, or 1 and at risk of more)
Opportunities in Health Reform

• Money Follows the Person (MFP) Rebalancing Demonstration Program
  – MFP Programs help Medicaid beneficiaries transition to the community
  – § 2403 of ACA extends MFP Demonstration Program through 2016 ($2.25 billion in Federal Funds)
  – Offers substantial resources and program flexibilities
  – Can amend Optional Protocols to include individuals living with HIV as target populations
And of course...Coverage Expansions!

- Medicaid
  - Starting 2014 there is a mandatory Medicaid expansion for nearly all uninsured individuals up to 133% FPL

- State-based Exchanges
  - ACA creates state-based health insurance exchanges starting 2014 with strong protections for the purchase of insurance coverage
Thank you

Jina Dhillon
dhillon@healthlaw.org