Assessment of Medicaid Coverage of HIV/AIDS Prevention, Screening, and Care Services

A Ten State Review
# TABLE OF CONTENTS

- **RATIONALE FOR REPORT: MEDICAID MATTERS FOR HIV/AIDS COVERAGE**  1
- **FORMAT OF THE REPORT**  2
- **ACRONYMS**  3
- **EXECUTIVE SUMMARY**  5
- **ASSESSMENT METHODS**  7
- **MEDICAID BASICS: AN INTRODUCTION**  9
- **MEDICAID COVERAGE: HIV/AIDS SERVICES**  12
  - **MEDICAID COVERAGE: HIV TESTING**  14
  - **MEDICAID COVERAGE: COUNSELING AND PREVENTIVE SERVICES**  17
  - **MEDICAID COVERAGE: CONDOMS**  20
  - **MEDICAID COVERAGE: PrEP**  22
  - **MEDICAID COVERAGE: HIV CARE SERVICES**  23
- **APPENDICES**  27
- **RESOURCES**  31
RATIONALE FOR REPORT: MEDICAID MATTERS FOR HIV/AIDS COVERAGE

Rapid changes in the healthcare landscape are taking place under the Patient Protection and Affordable Care Act (ACA), offering new opportunities for HIV prevention, screening, and care providers to shift their reliance on grant funds to reimbursement from public and private health insurance plans. Of particular importance is reimbursement by Medicaid, currently the largest payer of HIV/AIDS services in the US. Medicaid is likely to grow even more important as more states expand Medicaid eligibility under the ACA. Medicaid reimbursement is essential for the Ryan White HIV/AIDS Program (RWHAP) funded agencies, which must adhere to "payer of last resort" grant requirements to secure reimbursement by other payers before using RWHAP funds for provided services.\(^1\)

Medicaid payment for HIV prevention services, including HIV counseling and testing services (CTS), is also likely to increase substantially to reflect expanded coverage of prevention as a required service by the ACA.\(^1\)

To help HIV providers in their third party reimbursement (TPR) efforts, HealthHIV conducted a 10 state assessment of Medicaid program coverage for HIV prevention, screening, and care services through fee-for-service (FFS), demonstration and waiver programs, and managed care delivery and payment systems. The goals of this assessment are to:

- Raise awareness among HIV programs about opportunities to advocate for and participate in HIV prevention, screening, and care services covered by their state Medicaid programs.
- Provide examples of how state Medicaid programs are organizing and paying for HIV services and how these models might be adopted by other states to expand HIV service coverage.
- Illustrate the extent to which federal prevention, screening, and clinical recommendations are being implemented by state Medicaid programs.

FORMAT OF THE REPORT

This document outlines current coverage of HIV/AIDS services by a select set of ten states and presents insights for other states as they explore ways to maximize Medicaid reimbursement of these prevention services and care. Sections include:

- **ASSESSMENT METHODS:** Explains how information was collected from states and what documents were reviewed.
- **AN INTRODUCTION TO MEDICAID BASICS:** Provides readers with a foundation to improve their understanding of Medicaid coverage opportunities and limitations.
- **FINDINGS:** Results of the assessment of Medicaid fee-for-service (FFS) and Managed Care Organization (MCO) and MCO contracts.
- **RESOURCES:** Website links for state Medicaid websites, FFS schedules, provider manuals and MCO websites and contracts.

This report is based on Medicaid data available in November 2014. Data may have changed since this report was developed.
AAHIVM  American Academy of HIV Medicine
ABP  Alternative benefit plans
ACA  Patient Protection and Affordable Care Act
APHL  Association of Public Health Laboratories
CBO  Community-based organization
CDC  Centers for Disease Control and Prevention
CHIP  Children’s Health Insurance Program
CHW  Community health workers
CMS  Centers for Medicare and Medicaid Services
CTS  Counseling and testing services
DDS  Disability Determination Services
EHB  Essential Health Benefit
EIA  Enzyme Immunoassay
ELISA  Enzyme-linked immunosorbent assay
FDA  Food and Drug Administration
FFS  Fee for service
FPL  Federal poverty level
FQHC  Federally qualified health center
HCBS  Home and community-based services
HP  High-impact prevention
IFA  Immunofluorescence assay
MCO  Managed care organization
MSA  Metropolitan statistical area
NAT  Nucleic acid test
NHAS  National HIV/AIDS Strategy
NYSDOH  New York State Department of Health
PMPM  Per member per month
POCT  Point-of-care testing
PREP  Pre-exposure prophylaxis
QHP  Qualified health plan
RHC  Rural health center
RWAP  Ryan White HIV/AIDS Program
SPA  State plan amendment
SSA  Social Security Administration
SSDI  Social Security Disability Insurance
SSI  Social Security Insurance
STI  Sexually transmitted infection
TPR  Third party reimbursement
USPSTF  US Preventive Services Task Force
EXECUTIVE SUMMARY

FINDINGS AT A GLANCE

Below is a recap of Medicaid coverage for various types of HIV/AIDS prevention and care services in the ten states examined in this assessment.

HIV/AIDS Prevention Services

There are highly variable levels of coverage of HIV CTS, condoms, and pre-exposure prophylaxis (PrEP) in the ten state Medicaid programs assessed by HealthHIV. For those services that are covered, there are few limitations in terms of pre-authorization, documentation of medical necessity, or other requirements. Services most likely to be covered include condoms and established HIV testing technologies performed by independent labs. Coverage was also common for Truvada® (emtricitabine and tenofovir disoproxil fumarate) for use as Pre-Exposure Prophylaxis (PrEP) for HIV-negative individuals, rather than treatment for HIV positive (+) beneficiaries. Below are details on coverage for specific categories of HIV prevention services:

- **Established HIV Tests Covered.** HIV testing technologies most likely to be covered include confirmatory, antibody, EIA, and DNA/RNA tests—tests that have been in use for many years. In contrast, the older ELISA test and more recently licensed HIV rapid and oral tests are less likely to be covered. State Medicaid programs require that a clinician order an HIV test for an independent lab to be paid—a barrier to payment for point of care testing (POCT) by HIV prevention providers in conducting community-based CTS.

- **MCO Contracts: Only Half of State Managed Care Organization (MCO) Contracts Match Federal Guidelines.** All ten Medicaid MCO model contracts include coverage of HIV testing. However, five of the ten states are not aligned with the Centers for Disease Control and Prevention (CDC) or US Preventive Services Task Force (USPSTF) HIV screening recommendations. Routine HIV testing paid by Medicaid MCOs is often limited to pregnant women, reflecting dated guidance on the value of broader HIV testing.

- **MCO Contracts: Payment Limited for Community Health Workers (CHWs).** Among MCO contracts of the ten Medicaid programs assessed, only three covered CHW services. CHWs are emerging as an important part of the HIV prevention and care workforce and may undertake behavioral prevention counseling, adherence counseling, engagement and retention services, patient navigation, treatment education, home visiting and assessment, lost to follow-up services, and care management.

- **FFS and MCO Contracts: Condom Coverage Is Largely Framed as a Family Planning Service.** Female and male condoms are widely covered by states under both FFS and MCO contracts. However, condoms are typically classified by state Medicaid programs as family planning supplies and not as a disease prevention service. In addition, condoms covered as a Medicaid covered service must be ordered by licensed clinicians.

- **FFS and MCO Contracts: PrEP is Commonly Covered as an HIV Biomedical Prevention Service.** Nine of ten examined states cover Truvada®. However, these programs generally do not make clear determinations on prescribing Truvada®, the sole PrEP medication approved by the Food and Drug Administration (FDA) at the time of the assessment, for use in preventing HIV infection. In contrast, none of the 10 model contracts reviewed by HealthHIV addressed PrEP coverage.

- **MCO Contracts: Payment Limited for Community Health Workers (CHWs).** Among MCO contracts of the ten Medicaid programs assessed, only three covered CHW services. CHWs are emerging as an important part of the HIV prevention and care workforce and may undertake behavioral prevention counseling, adherence counseling, engagement and retention services, patient navigation, treatment education, home visiting and assessment, lost to follow-up services, and care management.

- **Variable Coverage of HIV Service Delivery and Payment Models.** All state Medicaid programs assessed by HealthHIV operate managed care systems. Two of the ten Medicaid programs have enhanced capitated managed care payment for HIV/AIDS services and require MCOs to implement HIV/AIDS service delivery systems. Four of the ten programs operate Medicaid waiver demonstration programs designed for HIV+ beneficiaries.
ASSESSMENT METHODS

HealthHIV, a national organization serving HIV/AIDS prevention and care providers, reviewed a select set of state Medicaid programs to identify opportunities and challenges for HIV service providers in maximizing Medicaid payment for HIV prevention and care services.

STUDY POPULATION

Ten states were selected for the assessment based on:
- Population-adjusted HIV and AIDS living case rates,
- Adoption by their state Medicaid programs of innovative strategies for the delivery and payment of HIV and other services,
- Expansion of Medicaid eligibility for low income individuals and families, and
- Regional representation.

The ten states, listed below, represent 51% of new HIV infections reported in 2011 and include eight of the twelve metropolitan statistical areas (MSAs) with the highest AIDS prevalence in the US.

- District of Columbia (DC)
- Florida (FL)
- Georgia (GA)
- Illinois (IL)
- Massachusetts (MA)
- New Mexico (NM)
- New York (NY)
- Pennsylvania (PA)
- Texas (TX)
- Virginia (VA)

STATES THAT HAVE EXPANDED MEDICAID

<table>
<thead>
<tr>
<th>State</th>
<th>Expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>District of Columbia (DC)</td>
<td>Yes</td>
</tr>
<tr>
<td>Florida (FL)</td>
<td>No</td>
</tr>
<tr>
<td>Georgia (GA)</td>
<td>No</td>
</tr>
<tr>
<td>Illinois (IL)</td>
<td>Yes</td>
</tr>
<tr>
<td>Massachusetts (MA)</td>
<td>Yes</td>
</tr>
<tr>
<td>New Mexico (NM)</td>
<td>Yes</td>
</tr>
<tr>
<td>New York (NY)</td>
<td>No</td>
</tr>
<tr>
<td>Pennsylvania (PA)</td>
<td>Yes</td>
</tr>
<tr>
<td>Texas (TX)</td>
<td>No</td>
</tr>
<tr>
<td>Virginia (VA)</td>
<td>No</td>
</tr>
</tbody>
</table>

February 12, 2015

HIV/AIDS SERVICES ASSESSED

State Medicaid programs in the selected states were contacted to verify coverage for:
- HIV-related testing procedures,
- Pre- and post-testing counseling provided during HIV screening,
- Truvada® (emtricitabine and tenofovir disoproxil fumarate) for use in PrEP,
- Counseling related to preventive services,
- Condoms as an HIV preventive service,
- HIV care services including medical case management services, and
- HIV clinical service delivery and payment systems.

DATA COLLECTION METHODS

Data collection for the ten states focused on three areas:
- **FFS Coverage.** State Medicaid programs’ FFS websites were reviewed to gather data on coverage of Medicaid services from fee schedules, provider manuals, or other provider materials that address coverage of the services of interest. The code set used to conduct the assessment is included in the Appendix. Telephone calls were made to state Medicaid staff, with follow-up email requests to complete checklist charts on coverage and requirements. HealthHIV sent checklists to state Medicaid representatives to secure confirmation of the review of website information.

- **Medicaid MCO.** Medicaid MCO program model contracts were requested or obtained from the Medicaid program websites, and coverage for HIV prevention, screening, and care was assessed. In addition to HIV prevention and screening services, information was gathered about required coverage by MCOs for case management, enhanced capitation payment systems for HIV+ beneficiaries, and services provided by CHWs.

- **State Medicaid Information.** State Medicaid waiver and demonstration program descriptions and related materials were analyzed to identify HIV-related programs. State Medicaid Plans and State Plan Amendments (SPAs) posted on the Centers for Medicare and Medicaid Services (CMS) website were reviewed to identify recent changes in service delivery and payment systems resulting from the ACA.

HealthHIV also conducted outreach to notify state HIV/AIDS offices about the project and enhance Medicaid and state HIV/AIDS office coordination. Several state HIV/AIDS offices facilitated information gathering from state Medicaid programs.
MEDICAID BASICS: AN INTRODUCTION

This section of the report provides readers with basic information about Medicaid, covered services, and payment arrangements.

Medicaid is the single largest source of health insurance in the US and the primary source of publicly funded insurance for low income and disabled individuals. CMS estimates that Medicaid and the Children’s Health Insurance Program (CHIP) insure almost 67.9 million individuals, or over one in five Americans.

Federal and state governments jointly funded Medicaid, with broad federal requirements based on Medicaid legislation. The federal government pays states for a specified share of program costs, which varies based on the state population’s per capita income and related factors. The average federal share is 57%, but ranges from 50% for higher income states to 75% for lower income states.

ELIGIBILITY

Medicaid covers specific categories of low-income individuals including children, pregnant women, parents of dependent children, disabled individuals, and adults 65 years of age or older. About 15% of Medicaid enrollees are dually enrolled in Medicare due to their low income. These “dual eligible” elderly and younger disabled individuals are assisted with their Medicare premiums and cost sharing. Many dual eligible receive full Medicaid benefits due to low income. The Kaiser Family Foundation estimates that more than 230,000 HIV+ individuals participate in Medicaid, with HIV+ individuals about three times more likely than other Americans to be enrolled in Medicaid. About three-quarters (74%) of HIV+ Medicaid beneficiaries qualify due to low-income and permanent disability. About one-third (29%) of HIV+ Medicaid beneficiaries are dually eligible.

The Aca expanded Medicaid enrolment to most adults under 65 years of age with income at or below 138% of the federal poverty level (FPL). The Supreme Court, however, ruled that Medicaid expansion was a voluntary state choice. Among the states included in the HealthHiv assessment, six (60%) expanded Medicaid eligibility as of November 2014 (DC, IL, NM, NY, PA, and MA) and four (40%) had not expanded Medicaid (FL, GA, TX, and VA).

The pathway to Medicaid and dual enrollment in Medicare/Medicaid for many HIV+ individuals is through enrolment in Social Security Administration (SSA) disability programs. To be eligible for Supplemental Security Income (SSI) an applicant must reside legally in the US and be low-income and either 65 years or older, blind, or disabled. SSI beneficiaries are commonly eligible for Medicaid. Eligibility is determined by state Disability Determination Services (DDS) that contract with SSA to make determinations. Social Security Disability Insurance (SSDI) is a payroll tax-funded federal government program that provides income supplements to individuals with long-term disabilities. SSDI benefits are tied to the number of quarters the applicant has been employed and paid Social Security taxes. SSDI beneficiaries are eligible for Medicare after a 24-month qualifying period. As the table below shows, SSI and SSDI applications vary considerably, resulting in disparities in disability income and access to Medicaid and Medicare benefits. Allowance rates are the percentage of claims accepted for disability benefits. Among the ten states assessed by HealthHiv, SSDI application acceptance rates ranged from 32.6% (GA) to 46.5% (DC). SSI application acceptance rates ranged from 27.6% (GA) to 46.0% (NM). For example, while DC ranked first in SSDI application allowance awards, it ranked fifth in SSI allowance awards. In contrast, GA ranked tenth in SSDI and SSI allowance rates.

<table>
<thead>
<tr>
<th>State</th>
<th>SSDI Allowance Rates</th>
<th>Rank</th>
<th>SSI Allowance Rates</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>DC</td>
<td>46.5</td>
<td>1</td>
<td>36.5</td>
<td>5</td>
</tr>
<tr>
<td>FL</td>
<td>32.7</td>
<td>9</td>
<td>30.5</td>
<td>8</td>
</tr>
<tr>
<td>GA</td>
<td>32.6</td>
<td>10</td>
<td>27.6</td>
<td>10</td>
</tr>
<tr>
<td>IL</td>
<td>40.6</td>
<td>7</td>
<td>32.5</td>
<td>7</td>
</tr>
<tr>
<td>MA</td>
<td>44.3</td>
<td>3</td>
<td>41.6</td>
<td>2</td>
</tr>
<tr>
<td>NM</td>
<td>46.2</td>
<td>2</td>
<td>46.0</td>
<td>1</td>
</tr>
<tr>
<td>NY</td>
<td>42.6</td>
<td>5</td>
<td>38.9</td>
<td>3</td>
</tr>
<tr>
<td>PA</td>
<td>42.3</td>
<td>8</td>
<td>28.0</td>
<td>9</td>
</tr>
<tr>
<td>TX</td>
<td>37.1</td>
<td>8</td>
<td>36.9</td>
<td>4</td>
</tr>
<tr>
<td>VA</td>
<td>43.6</td>
<td>4</td>
<td>35.9</td>
<td>6</td>
</tr>
<tr>
<td>US</td>
<td>41.5</td>
<td>36.5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Covered Benefits**

States’ Medicaid programs have the authority to design and administer the “type, amount, duration, and scope of services.” Within that framework, however, federal Medicaid legislation requires that state Medicaid programs cover specific mandatory services if they are medically necessary. Key mandatory services required by individuals at-risk for or infected with HIV include inpatient and outpatient services, physician services, federally qualified health center (FQHC) services, lab and X-ray services, and transportation. Key optional services required by HIV at-risk or infected individuals include prescription drugs (covered voluntarily by all states), clinic services, case management, and other diagnostic screening and preventive and rehabilitative services. State Medicaid programs may also propose to CMS optional home and community-based services through their state plans, or provide HCBS (Home and Community-Based Services) through demonstration programs. HCBS may include targeted case management, housing coordination to assist beneficiaries in obtaining community housing, and an array of other services.

The ACA resulted in other sweeping changes in Medicaid, including simplifying enrollment, offering new funding opportunities for designing innovative health-care delivery and payment systems, and promoting and paying for preventive services. Medicaid law requires that preventive services be medical or remedial. They must also involve direct patient care for the purpose of diagnosing and treating or preventing illness, injury, or other impairments to an individual’s physical or mental health. Medicaid does not cover non-medical preventive services “that address broader social or environmental concerns.”

The ACA requires that adults enrolling through Medicaid expansion must receive “alternative benefit plans (ABPs).” The services must include the ten “essential health benefits (EHBs)” required for Marketplace Qualified Health Plans (QHPs). State Medicaid programs must also provide the full range of EHB prevention services to beneficiaries enrolling through expansion. ABPs must cover EHBs, including all preventive services rated “A” or “B” by the USPSTF; at no cost to the beneficiary. State Medicaid programs must also cover family planning services and supplies (e.g., condoms), parity between physical health and behavioral health services, non-emergency transportation services, and federally qualified health center (FQHC) and rural health center (RHC) services.

The ACA does not require state Medicaid programs to cover the EHBs under their traditional Medicaid benefit packages. As a result, coverage of preventive services in traditional Medicaid benefit packages is optional. In addition, some groups, such as the disabled, dual eligible and medically frail individuals, are exempt from enrollment in ABPs and may choose to obtain traditional Medicaid services.

State Medicaid programs must design and pay for “delivery systems”—the combination of healthcare providers, organizational settings, and covered benefits required to prevent and treat illness among their beneficiaries. Many state Medicaid programs have transitioned from traditional fee for service (FFS) service delivery and payment systems to contracts with comprehensive MCOs. In those models, MCOs agree to an established per member per month (PMPM) capitated payment for a specified set of services. Capitated payments shift some financial risk to MCOs if their enrolled beneficiaries incur high cost services, such as inpatient stays, or have unpredictably frequent and expensive healthcare services. All ten of the state Medicaid programs assessed contract with MCOs.

MCOs are financially incentivized to promote preventive services and help chronically ill and other expensive beneficiaries through effective care management strategies. Capitated arrangements with MCOs allow Medicaid programs to plan for the delivery of covered services to beneficiaries, reduce costs, and better manage healthcare use. By contracting with MCOs, Medicaid programs can monitor and improve MCO performance, healthcare quality, and clinical outcomes. Over one-half of Medicaid beneficiaries are enrolled in Medicaid MCOs with increased enrollment likely in the next several years as more states move to comprehensive managed care and similar delivery and payment models. The American Academy of HIV Medicine (AAHIVM) maintains a list of all Medicaid MCOs, their general website addresses, and provider website addresses.

---

**USPSTF A and B Recommendations Concerning HIV**

**Grade A:** The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 13 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened. April 2013

**Grade A:** The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown. April 2013

**Grade A:** The USPSTF recommends intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections. September 2014
The Centers for Disease Control and Prevention (CDC) estimates that among the 1.1 million HIV+ residents in the US, 15.8% are unaware of their infection. To increase awareness of HIV status among Americans, the CDC released revised screening guidelines in 2006 that recommend routine HIV screening in all healthcare settings for 13-65 year-olds, with the ability to opt out. Expanding HIV preventive, screening, and diagnostic testing for Medicaid beneficiaries offers the opportunity to:

- Reduce primary and secondary HIV infection among a large portion of Americans at a scale not previously achieved through public health funding;
- Increase accessibility of these services among historically disenfranchised low income and disabled individuals with limited access to healthcare services;
- Identify individuals at high risk for HIV infection and offer them preventive and other education services;
- Rapidly identify and treat HIV+ individuals early in their infection to avoid illness and death;
- Promote integration of HIV testing in primary care as a basic preventive service; and
- Free up limited CDC and state/local government funds for prevention, counseling, and testing among uninsured individuals.

Increasing Medicaid-funded HIV preventive, screening and diagnostic testing also addresses key actions recommended in the National HIV/AIDS Strategy (NHAS):

**HIV Prevalence by State**

- Increase HIV prevention efforts in communities where HIV is most heavily concentrated;
- Expand targeted efforts to prevent HIV infection using a combination of effective, evidence-based approaches (including HIV testing, condoms, and HIV treatment);
- Adopt community-level approaches to reduce HIV infection in high-risk communities; and
- Educate all Americans about the threat of HIV and how to prevent it.

**MEDICAID COVERAGE OF HIV/AIDS SERVICES**

Each of the following sections addresses a specific category of HIV services, starting with background on the service under discussion to provide context to readers, followed by results of the ten state assessment.

**MEDICAID COVERAGE: HIV TESTING**

**BACKGROUND ON: HIV TESTING**

According to a 2014 Kaiser Family Foundation survey, around two-thirds of state Medicaid programs cover routine HIV testing, while a smaller number will do so only for what is deemed “medically necessary” HIV testing. In 2013, USPSTF assigned an “A” grade to routine HIV testing for individuals between 15-65 years of age and reaffirmed its “A” grade for routine HIV testing of pregnant women. The USPSTF also assigned an “A” grade for HIV testing of individuals below 15 years of age and over 65 years of age at increased risk for HIV. Traditional Medicaid programs serving pre-expansion populations are required only to cover medically necessary lab services. State Medicaid programs may voluntarily cover broader routine HIV testing. The ACA offers financial incentives to non-expansion states to cover routine HIV testing and other USPSTF “Grade A” and “Grade B” services — with a 1% increase in the federal Medicaid match for preventive services. In contrast, expansion states must cover routine HIV testing and other preventive services graded “A” or “B” by USPSTF without beneficiary copayment.

In 2014, the CDC and the Association of Public Health Laboratories (APHL) released recommendations for HIV lab testing among patients greater than 24 months of age. The recommended algorithm for HIV test sequencing in combination “to enhance the accuracy of lab diagnosis of HIV based on testing of serum or plasma specimens” includes:

- Labs should initiate HIV testing with an FDA-approved antigen/antibody combination immunoassay that detects HIV-1 and HIV-2 antibodies and HIV-1 p24 antigen to screen for HIV-1 or HIV-2 infection for acute HIV-1 infection;
- Screeners with a reactive antigen/antibody combination immunoassay result should be tested with an FDA-approved antibody immunoassay that differentiates HIV-1 antibodies from HIV-2 antibodies;
- Specimens that are reactive on the initial antigen/antibody combination immunoassay and nonreactive or indeterminate on the HIV-1/HIV-2 antibody differentiation immunoassay should be tested with an FDA-approved HIV-1 nucleic acid test (NAT); and
- Labs should use this testing algorithm, beginning with an antigen/antibody combination immunoassay, with serum or plasma specimens submitted for testing after a reactive (i.e., preliminary positive) result from any rapid HIV test.
BACKGROUND ON: HIV TESTING (continued)

The recommendations also state that HIV-1 Western blot and HIV-1 indirect immunofluorescence assay (IFA) previously recommended for lab diagnosis of HIV-1 infection are no longer part of the recommended algorithm. The recommendations also state that HIV+ results from the algorithm indicate the need for HIV medical care and an initial evaluation that includes diagnostic lab tests (e.g., HIV-1 viral load, CD4+ test, and antiretroviral resistance assay to confirm HIV infection), staging of HIV disease, and guiding selection of initial antiretroviral (ARV) treatment regimen.

The New York State Department of Health (NYSDOH) points out in a subsequent correspondence to New York healthcare providers that while third-generation HIV-1/2 immunoassays can detect HIV infection early in seroconversion, they cannot detect HIV-1 infection in the acute stage before antibodies are produced.\(^{xxv}\) The NYSDOH stresses that in community-based settings, rapid POCT (Point of Care Testing) continues to be an approved method for HIV screening, with the CDC-recommended algorithm used to complete further testing.

FINDINGS ON: HIV TESTING

HealthHIV assessed Medicaid FFS coverage of HIV testing modalities by independent labs, or commercial labs that are not affiliated with a hospital. As the table below shows:

- Older HIV test modalities were generally covered by the ten assessed states.
- Consistent with the CDC recommended algorithm, all states assessed except FL covered fourth generation HIV testing by independent labs.
- Most states cover rapid HIV testing by independent labs.

CBOs and other HIV providers may experience barriers in receiving Medicaid payment for POCT. The CDC uses POCT to describe the location where testing is performed. With the adoption of rapid HIV testing, POCT may take place in community settings in which individuals are offered testing outside a healthcare setting and no clinician has ordered the HIV test. Such settings might include mobile testing units, health fairs, homeless shelters, community service agencies, and others. CBOs may not meet their Medicaid program’s definition as an independent lab or other type of healthcare provider eligible for compensation for lab services. Additionally, Medicaid programs commonly require that a clinician or other licensed provider order the HIV test. Absence of an ordering clinician on a Medicaid claim, for example, is likely to result in the claim being rejected for payment. Education of Medicaid policymakers regarding the efficacy of HIV POCT by CBOs is needed to ensure that CBOs can be reimbursed by Medicaid to provide rapid testing. Additionally, CBOs might consider offering contracted HIV POCT within healthcare settings, for which patients may be offered CTS through standing orders. This approach addresses the requirement for an ordering clinician.\(^{xxv}\)

### Table: Medicaid Coverage for HIV Test Modalities Provided by Independent Labs, by Common Procedure Terminology (CPT), September 2014

<table>
<thead>
<tr>
<th>CPT</th>
<th>DC</th>
<th>FL</th>
<th>GA</th>
<th>IL</th>
<th>MA</th>
<th>NM</th>
<th>NY</th>
<th>PA</th>
<th>TX</th>
<th>VA</th>
<th>% Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>8659</td>
<td>Antibody HIV or HIV antibody confirmation test (e.g., Western Blot)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>100%</td>
</tr>
<tr>
<td>86701</td>
<td>Antibody: HIV-1</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>100%</td>
</tr>
<tr>
<td>86701-92</td>
<td>Antibody: HIV-1, rapid</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>100%</td>
</tr>
<tr>
<td>86702</td>
<td>HIV-2: single result</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>100%</td>
</tr>
<tr>
<td>86703</td>
<td>Antibody: HIV-1 and HIV-2, single assay</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>100%</td>
</tr>
<tr>
<td>86705</td>
<td>Antibody: HIV-1 and HIV-2, single assay rapid</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>100%</td>
</tr>
<tr>
<td>87389</td>
<td>HIV-1/2 antigen and antibodies, fourth generation, with reflex</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>100%</td>
</tr>
<tr>
<td>87390</td>
<td>Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semi-quantitative, multiple step method: HIV-1</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>100%</td>
</tr>
<tr>
<td>87391</td>
<td>Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semi-quantitative, multiple step method: HIV-2</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>87544</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA): HIV-1, direct probe technique</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>70%</td>
</tr>
<tr>
<td>87545</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA): HIV-1, amplified probe technique</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>60%</td>
</tr>
<tr>
<td>87555</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA): HIV-1, quantification</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>60%</td>
</tr>
<tr>
<td>87557</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA): HIV-2, direct probe technique</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>60%</td>
</tr>
<tr>
<td>87558</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA): HIV-2, amplified probe technique</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>60%</td>
</tr>
<tr>
<td>87559</td>
<td>Quantification</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>70%</td>
</tr>
</tbody>
</table>

KEY: Y = Procedure Covered by Medicaid, N = Procedure Not Covered by Medicaid. CPT codes with a -92 modifier should be used when lab testing is performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified as a multiple step procedure.

All Medicaid programs assessed by HealthHIV contract with MCOs. MCO requirements for HIV CTS were assessed by reviewing their current MCO model contracts. The table below summarizes general model contract requirements for HIV CTS:

- The DC and NM Medicaid programs require MCOs to cover HIV CTS as part of the USPSTF recommendations.
- The NY and TX Medicaid programs require MCOs to cover HIV CTS, but do not reference the USPSTF recommendations. In NY, MCOs must pay through FFS for CTS provided by public health clinics regardless of whether they participate in the MCOs' provider networks.
- IL requires MCOs to cover CTS as a medical necessity.
- MA and PA Medicaid MCOs must cover HIV CTS as a family planning benefit, but do not address coverage of CTS if provided by other types of providers.
- FL and GA Medicaid model contracts only require MCOs to cover HIV CTS for women.
- The VA model contract specifically only requires MCOs to provide rapid testing to pregnant women.

Thus, five of the ten Medicaid MCO model contracts are not aligned with CDC or USPSTF HIV screening recommendations.
MEDICAID COVERAGE: COUNSELING AND PREVENTIVE SERVICES

BACKGROUND ON: HIV COUNSELING

Counseling is a critical component of CTS. HIV test kits, venipuncture to obtain blood specimens for assay, lab procedures, and related medical visits are generally covered by state Medicaid programs. Counseling services by non-licensed providers generally have not been covered, although these services are important to explain HIV test results, provide HIV education and behavioral interventions, and link HIV+ individuals to medical care. While the Medicaid MCO model contracts reviewed by HealthHIV discuss counseling as a component part of CTS, payment specifically for counseling services and the types of providers undertaking counseling are not specified.

CMS has afforded new opportunities to pay for HIV counseling and other preventive and care services. In 2014, new regulations were released to enhance payment for home and community-based services. Following approval by CMS of Medicaid State Plan Amendments (SPAs), Medicaid FFS programs may reimburse for preventive services recommended by licensed providers and provided by non-licensed providers. State Medicaid Programs are authorized to define the qualifications of workers providing preventive services, the scope of those services, and how services will be paid. MCOs contracting with Medicaid already are allowed to reimburse for such services. The final rule was widely interpreted as defining a role for CHWs, however, the specific types of HIV preventive services personnel is not addressed.

The January 2014 CMS ruling has launched collaborative actions across the US among Medicaid programs, healthcare advocates, and organizations employing CHWs that undertake an array of services that meet the CMS preventive services criteria. The scope of CHWs’ services must be defined at the state-level, as has already been undertaken in several key states with experience in deploying CHWs for prevention services. In the HIV care continuum, Medicaid payment for CHWs’ services might be sought for behavioral counseling to prevent HIV, PrEP treatment adherence counseling, linkage to care for HIV+ individuals, engagement and retention services, patient navigation, ARV treatment education and adherence, home visiting and assessment, lost to follow-up services to re-engage HIV+ individuals that dropped out of care, and case management services.

BACKGROUND ON: PREVENTIVE SERVICES

CMS afforded new opportunities for HIV preventive services by announcing in January 2014 new regulations designed to enhance home and community-based services. Following approval by CMS of Medicaid State Plan Amendments (SPAs), Medicaid FFS programs will be allowed to reimburse for preventive services recommended by licensed providers and provided by non-licensed providers. As discussed earlier, an ordering clinician is needed if non-licensed providers are to be paid for preventive services. State Medicaid programs are authorized to define the qualifications of workers providing preventive services, the scope of those services, and how their services will be paid. MCOs contracting with Medicaid already are allowed to reimburse for such services.

The January 2014 CMS ruling has launched collaborative actions across the US among Medicaid programs, healthcare advocates, and organizations employing CHWs that undertake an array of services that meet the CMS preventive services criteria. The scope of CHWs’ services must be defined at the state-level, as has already been undertaken in several key states with experience in deploying CHWs for prevention services. In the HIV care continuum, Medicaid payment for CHWs’ services might be sought for behavioral counseling to prevent HIV, PrEP treatment adherence counseling, linkage to care for HIV+ individuals, engagement and retention services, patient navigation, ARV treatment education and adherence, home visiting and assessment, lost to follow-up services to re-engage HIV+ individuals that dropped out of care, and case management services.
**BACKGROUND ON: PREVENTIVE SERVICES (continued)**

HealthHIV assessed the extent to which the Medicaid programs included in the assessment cover individual “preventive medicine counseling” as a FFS procedure. As the table below illustrates, Medicaid coverage of counseling is limited among the assessed states.

- Only half of the states cover 15 minutes of preventive counseling.
- There is considerably less Medicaid coverage for preventive counseling for longer sessions (i.e., 30, 45 and 60 minutes).

### MEDICAID COVERAGE FOR PREVENTIVE MEDICINE COUNSELING, INDIVIDUAL, BY CPT AND DURATION, SEPTEMBER 2014

<table>
<thead>
<tr>
<th>CPT</th>
<th>Procedure</th>
<th>Approximate Duration</th>
<th>DC</th>
<th>FL</th>
<th>GA</th>
<th>IL</th>
<th>MA</th>
<th>NM</th>
<th>NY</th>
<th>PA</th>
<th>TX</th>
<th>VA</th>
<th>% Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99401</td>
<td>Preventive medicine counseling, individual</td>
<td>15 minutes</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>50%</td>
</tr>
<tr>
<td>99402</td>
<td>Preventive medicine counseling, individual</td>
<td>30 minutes</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>30%</td>
</tr>
<tr>
<td>99403</td>
<td>Preventive medicine counseling, individual</td>
<td>45 minutes</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>20%</td>
</tr>
<tr>
<td>99404</td>
<td>Preventive medicine counseling, individual</td>
<td>60 minutes</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>10%</td>
</tr>
</tbody>
</table>

Y = Procedure Covered by Medicaid, N = Procedure Not Covered by Medicaid

Among the ten Medicaid programs assessed, only three MCO model contracts (MA, NM, TX) state that CHW services are covered.

- Payment models for CHW services were not specifically addressed.
- The NM model contract provided a detailed narrative in the model contract that addresses the training and scope of covered services provided by CHWs.

**BACKGROUND ON: CONDOMS**

High-impact HIV prevention (HIP) services commonly include condom distribution, HIV CTS, and linkage to HIV medical care. A meta-analysis on the availability, accessibility, and acceptability of condoms found that structural-level condom distribution interventions or programs increase condom use, increase condom acquisition or condom carrying, promote delayed sexual initiation or abstinence among youth, and reduce STIs. Condom distribution programs that have also been demonstrated to be cost-effective. The CDC suggests a comprehensive HIV prevention approach in which condom distribution programs are integrated with other prevention strategies and healthcare. The CDC suggests that condom distribution programs:

- Provide wide-scale distribution of free condoms,
- Implement social marketing campaigns to promote condom use,
- Target individuals at high risk or residing in jurisdictions with high HIV incidence,
- Achieve organizational support for condom distribution in traditional and non-traditional venues, and
- Conduct community-wide mobilization encouraging condom use.

Medicaid has covered condoms as a component of the family planning services and supply benefit since the early 1970s. Before the ACA, Medicaid family planning benefits were limited to individuals enrolled in traditional Medicaid programs. With the ACA enactment, individuals who were otherwise ineligible for Medicaid are now eligible to receive family planning benefits, including non-disabled adults without children and parents with incomes higher than the States’ eligibility requirements. State Medicaid programs may apply for Section 1115 family planning demonstration to expand family planning benefits to previously ineligible individuals. Expanded benefits are offered to men and women who are not pregnant. The federal Medicaid match (90%) incentivizes states to participate voluntarily in the demonstration program. Among assessment states, FL, GA, IL, PA, and TX have 1115 family planning demonstrations.

All state Medicaid programs except GA cover male and female condoms. However, when Medicaid programs discuss condom usage in provider manuals and guidance, they tend to do so in the context of family planning and not as a disease prevention service. This finding is consistent with an earlier 2009 report from Kaiser Family Foundation that the majority of states classify condom coverage as a family planning service.
HealthHIV assessed Medicaid coverage of male and female condoms among the ten assessment states.

- Almost all state Medicaid programs cover both male and female condoms through FFS payment and in MCO contracts.
- Condoms are typically classified in FFS provider manuals as a family planning supply and not, specifically, as disease prevention services.
- Condoms covered as a Medicaid FFS covered service must be ordered by licensed clinicians for the pharmacy or other dispensing provider to be paid.

### FINDINGS ON: CONDOMS

<table>
<thead>
<tr>
<th>HCPSC</th>
<th>DC</th>
<th>FL</th>
<th>GA</th>
<th>IL</th>
<th>MA</th>
<th>NM</th>
<th>NY</th>
<th>PA</th>
<th>TX</th>
<th>VA</th>
<th>% Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4267</td>
<td>Male condom</td>
<td>MCO</td>
<td>MCO</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>100%</td>
</tr>
<tr>
<td>A4268</td>
<td>Condom</td>
<td>MCO</td>
<td>MCO</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>100%</td>
</tr>
</tbody>
</table>

**KEY**: Y = Procedure covered by Medicaid, MCO = Condoms are not referred to specifically in MCO contracts, however, family planning supplies are referenced

### MEDICAID COVERAGE: PRE-EXPOSURE PROPHYLAXIS (PrEP)

**BACKGROUND ON: PrEP**

PrEP includes a biomedical prevention strategy that includes Truvada®, HIV and sexually transmitted infection (STI) testing, condoms, medication adherence counseling, behavioral risk reduction support, and symptom assessment.

Almost all of the state Medicaid programs assessed by HealthHIV reported that Truvada® was covered. However, these programs generally do not make clear determinations on prescribing Truvada® for treatment versus as a preventive measure to reduce the risk of HIV infection in those not infected.

- Only the DC Medicaid program reported that they do not cover Truvada® for HIV negative beneficiaries.
- Only one state, NY, places prior authorization requirements on use of Truvada® as PrEP. NY Medicaid reported that an automated Medicaid Management Information System (MMIS) claims edit algorithm identifies beneficiaries for which no other HIV medication is prescribed. Prescribing clinicians must verify that the beneficiary is being prescribed Truvada® for PrEP before the prescription is paid.
- None of the ten model contracts reviewed by HealthHIV address coverage for PrEP.

### FINDINGS ON: PrEP

<table>
<thead>
<tr>
<th>NDC</th>
<th>Drug</th>
<th>DC</th>
<th>FL</th>
<th>GA</th>
<th>IL</th>
<th>MA</th>
<th>NM</th>
<th>NY</th>
<th>PA</th>
<th>TX</th>
<th>VA</th>
<th>% Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>61958-0701</td>
<td>Truvada®</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>90%</td>
</tr>
</tbody>
</table>
MEDICAID COVERAGE: HIV CARE SERVICES

HealthHIV examined HIV care services covered by Medicaid MCOs including HIV clinical service delivery models and HIV medical case management.

BACKGROUND ON: CLINICAL SERVICES

Increasing Medicaid-funded HIV clinical services addresses key actions recommended in the NHAS:

- Establish a seamless system to immediately link people to continuous and coordinated quality care when they are diagnosed with HIV;
- Support people living with HIV with co-occurring health conditions and those who have challenges meeting their basic needs, such as housing; and
- Reduce HIV-related mortality in communities at high risk for HIV infection.  

The NHAS operational plan and progress reports that CMS is undertaking efforts to address the actions steps outlined above.  

FINDINGS ON: CLINICAL SERVICES

Medicaid MCO model contracts are highly variable to the extent that they address and provide specific coverage of HIV clinical services.

- FL and NY Medicaid programs offer enhanced HIV/AIDS capitated payments to MCOs to ensure funds are sufficient to cover the cost of HIV care, including antiretrovirals (ARVs) and other HIV-related medications.
- FL, NY, and TX have extensive MCO model contract sections that address HIV clinical services. The FL and NY model contract sections address the HIV care continuum to be offered by MCOs and capitated specifications.
- DC, MA, NM, and PA Medicaid MCO model contracts include minimal specifications related to HIV clinical services.
- GA and IL model contracts do not address HIV clinical services.

BACKGROUND ON: HIV MEDICAL CASE MANAGEMENT

The RWHAP defines medical case management as:

- "ensuring timely and coordinated access to medically appropriate levels of health and support services and continuity of care, provided by trained professionals, including both medically credentialed and other healthcare staff who are part of the clinical care team, through all types of encounters including face-to-face, phone contact, and any form of communication. Activities that include at least the following: initial assessment of service needs; development of a comprehensive individualized care plan; coordination of services required to implement the plan; continuous client monitoring to assess the efficacy of the plan; periodic re-evaluation and adaptation of the plan at least every six months, as necessary.”

Specific services included by the RWHAP’s medical case management standard include: client-centered services that link clients with healthcare, psychosocial, and other services; coordination and follow-up of medical treatments; ongoing assessment of the client’s and other key family members’ needs and personal support systems; treatment adherence counseling to ensure readiness for, and adherence to complex HIV/AIDS treatments; and client-specific advocacy and/or review of utilization of services.

CMS promotes the use of innovative delivery and payment models by state Medicaid programs to expand access to care, ensure high quality clinical services, achieve positive clinical outcomes, and expand services through cost-effective covered services and payment models. The Deficit Reduction Act authorized CMS to cover case management in 2005. Case management, sometimes referred to by state Medicaid programs as care or disease management, is a key component used to achieve CMS innovation strategies.
ALL STATE MEDICARE PROGRAMS INCLUDED IN THE HEALTHHIV ASSESSMENT OPERATE WAIVER DEMONSTRATION PROGRAMS DESIGNED WHOLLY OR IN PART FOR HIV+ BENEFICIARIES:

- DC operates a 1915(b4) demonstration related to distribution and dispensing of ARVs and other HIV-related medications.
- FL operates the 1915(c) waiver demonstration, FL Project AIDS Care (PAC) that covers case management, day health care, homemaker, personal care, skilled nursing care (RN/LPN), specialized medical equipment and supplies, therapeutic management of substance abuse, chore-pest control/other, education and support, environmental accessibility adaptations, home delivered meals, restorative massage, and specialized personal care for HIV+ children in foster care.
- IL operates the 1915(c) Waiver for Persons with HIV or AIDS, which provides adult day care, homemaker, personal assistant, respite, home health aide, intermittent nursing, occupational, physical, and speech therapy, environmental accessibility adaptations, home-delivered meals, in-home shift nursing, and specialized medical equipment for individuals.
- PA operates a 1915(c) AIDS Waiver that provides home health services, specialized medical equipment and supplies, nutritional consultation, and personal assistance services to HIV+ adults 21 years of age or older.

All state Medicare programs included in the HealthHIV assessment operate 1915(b) demonstration waivers with covered services that directly impact HIV+ individuals.

NM and VA previously operated HIV/AIDS waiver demonstration projects, whose authority from CMS has expired.

FINDINGS ON: HIV SERVICE DELIVERY AND PAYMENT MODELS THROUGH WAIVER DEMONSTRATIONS

In addition to participating in MCO provider networks, HIV providers have several other opportunities to provide care and support for beneficiaries with chronic conditions (including HIV) through waiver demonstrations and Community First Choice.

Medicaid expansion and other ACA legislative features complement, but do not supersede, the authority granted by CMS to design and implement waiver demonstration programs. These programs offer flexibility in designing HIV-specific innovative design and payment systems. This approach has been used creatively in recent years to address previously restrictive covered benefits or lack of adoption of Medicaid expansion.

Waivers include:

- **Section 1115 Research and Demonstration Waivers:** States can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP.
- **Section 1915(b) Managed Care Waivers:** States can apply for waivers to provide services through managed care delivery systems or otherwise limit people’s choice of providers.
- **Section 1915(c) Home and Community-Based Services Waivers:** States can apply for waivers to provide long-term care services in home and community settings rather than institutional settings.
- **Combination waivers that address two or more waiver designs.**

MEDICAID COVERAGE: HIV CARE SERVICES

Medicaid Coverage: HIV Care Services

BACKGROUND ON: HIV SERVICE DELIVERY AND PAYMENT MODELS THROUGH WAIVER DEMONSTRATIONS

Medicaid expansion and other ACA legislative features complement, but do not supersede, the authority granted by CMS to design and implement waiver demonstration programs. These programs offer flexibility in designing HIV-specific innovative design and payment systems. This approach has been used creatively in recent years to address previously restrictive covered benefits or lack of adoption of Medicaid expansion.

Waivers include:

- **Section 1115 Research and Demonstration Waivers:** States can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP.
- **Section 1915(b) Managed Care Waivers:** States can apply for waivers to provide services through managed care delivery systems or otherwise limit people’s choice of providers.
- **Section 1915(c) Home and Community-Based Services Waivers:** States can apply for waivers to provide long-term care services in home and community settings rather than institutional settings.
- **Combination waivers that address two or more waiver designs.**

FINDINGS ON: HIV MEDICAL CASE MANAGEMENT

All 10 state Medicaid programs assessed by HealthHIV require that MCOs cover case management services, which are sometimes called care or disease management services. The model contracts provide detailed descriptions of services that reflect aspects of medical case management, as defined by the RWHAP. HIV medical case manager programs should consider offering to Medicaid MCOs case management services for HIV+ individuals and other beneficiaries. The HealthHIV contracting guide, “Health Insurance Contracting for HIV Prevention and Wrap-around Service Providers,” offers specific strategies for marketing HIV services to Medicaid and other MCOs.
These websites are highly variable in their design and functionality. In general, these websites contain fee schedules, provider manuals, guidance, and other resources.

### State Medicaid Websites

<table>
<thead>
<tr>
<th>State Name</th>
<th>Department Name</th>
<th>Program Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>District of Columbia</td>
<td>Department of Health Care Finance</td>
<td><a href="https://www.dc-medicaid.com/dcwebportal/home">https://www.dc-medicaid.com/dcwebportal/home</a></td>
</tr>
<tr>
<td>Florida</td>
<td>Agency for Health Care Administration</td>
<td><a href="http://www.fdhc.state.fl.us/medicaid/">http://www.fdhc.state.fl.us/medicaid/</a></td>
</tr>
<tr>
<td>Georgia</td>
<td>Department of Community Health</td>
<td><a href="http://dch.georgia.gov/medicaid">http://dch.georgia.gov/medicaid</a></td>
</tr>
<tr>
<td>Illinois</td>
<td>Department of Healthcare and Family Services</td>
<td><a href="http://www2.illinois.gov/hfs/Pages/default.aspx">http://www2.illinois.gov/hfs/Pages/default.aspx</a></td>
</tr>
<tr>
<td>New Mexico</td>
<td>Department of Human Services</td>
<td><a href="http://www.dpw.state.pa.us/foradults/healthcaremedicalassistance/">http://www.dpw.state.pa.us/foradults/healthcaremedicalassistance/</a></td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>Department of Public Welfare</td>
<td><a href="http://www.hhsc.state.tx.us/">http://www.hhsc.state.tx.us/</a></td>
</tr>
<tr>
<td>Texas</td>
<td>Health and Human Services Commission</td>
<td><a href="http://www.hhsc.state.tx.us/">http://www.hhsc.state.tx.us/</a></td>
</tr>
</tbody>
</table>

### HIV/AIDS Drug and Procedure Codes Used in the Assessment

<table>
<thead>
<tr>
<th>Code</th>
<th>Item Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Drug Code (NDC)</td>
<td></td>
</tr>
<tr>
<td>61958-0701</td>
<td>Truvada® (Prescribed for PrEP for prevention of HIV)</td>
</tr>
<tr>
<td>86689</td>
<td>Antibody; HTLV or HIV antibody, confirmatory test (e.g., Western Blot)</td>
</tr>
<tr>
<td>86701</td>
<td>Antibody; HIV-1</td>
</tr>
<tr>
<td>86701-92*</td>
<td>Antibody; HIV-1, rapid</td>
</tr>
<tr>
<td>86702</td>
<td>HIV-2, single result</td>
</tr>
<tr>
<td>86703</td>
<td>Antibody; HIV-1 and HIV-2, single assay</td>
</tr>
<tr>
<td>86703-92*</td>
<td>Antibody; HIV-1 and HIV-2, single assay, rapid</td>
</tr>
<tr>
<td>87389</td>
<td>Enzyme immunoassay (EIA) HIV-1 antibody with HIV-1 &amp; HIV-2 antigens; qualitative or semi-quantitative; single step; HIV-1</td>
</tr>
<tr>
<td>87390</td>
<td>Infectious agent antigen detection by enzyme immunoassay technique; qualitative or semi-quantitative; multiple step method; HIV-1</td>
</tr>
<tr>
<td>87391</td>
<td>Infectious agent antigen detection by enzyme immunoassay technique; qualitative or semi-quantitative; multiple step method; HIV-2</td>
</tr>
<tr>
<td>87534</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, direct probe technique</td>
</tr>
<tr>
<td>87535</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, amplified probe technique</td>
</tr>
<tr>
<td>87536</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); HIV-1 quantification</td>
</tr>
<tr>
<td>87537</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, direct probe technique</td>
</tr>
<tr>
<td>87538</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, amplified probe technique</td>
</tr>
<tr>
<td>87539</td>
<td>DNA/RNA; HIV-2 quantification</td>
</tr>
<tr>
<td>99401</td>
<td>Preventive medicine counseling, individual, approximately 15 minutes</td>
</tr>
<tr>
<td>99402</td>
<td>Preventive medicine counseling, individual, approximately 30 minutes</td>
</tr>
<tr>
<td>99403</td>
<td>Preventive medicine counseling, individual, approximately 45 minutes</td>
</tr>
<tr>
<td>99404</td>
<td>Preventive medicine counseling, individual, approximately 60 minutes</td>
</tr>
</tbody>
</table>
### PROVIDER ENROLLMENT AND FEE SCHEDULES

State Medicaid programs present fee schedules in variable formats on their websites. Some websites have searchable databases, by codes, while others present fee schedules as downloadable files. Fee schedules contain variable levels of detail (e.g., pre-authorization requirements).

<table>
<thead>
<tr>
<th>STATE NAME</th>
<th>FFS PROVIDER WEBSITE</th>
<th>FFS FEE SCHEDULE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Florida</td>
<td><a href="http://www.fdhc.state.fl.us/Medicaid/index.shtml">http://www.fdhc.state.fl.us/Medicaid/index.shtml</a></td>
<td>Provider_ProviderSupport/Provider_ProviderSupport_FeeSchedules/tabId/44/Default.aspx</td>
</tr>
<tr>
<td>Illinois</td>
<td><a href="http://www2.illinois.gov/hfs/ManagedCare/ProviderInformation/FeeSchedules/tabId/6/Default.aspx">http://www2.illinois.gov/hfs/ManagedCare/ProviderInformation/FeeSchedules/tabId/6/Default.aspx</a></td>
<td><a href="http://www2.illinois.gov/hfs/ManagedCare/ProviderInformation/FeeSchedules/tabId/6/Default.aspx">http://www2.illinois.gov/hfs/ManagedCare/ProviderInformation/FeeSchedules/tabId/6/Default.aspx</a></td>
</tr>
<tr>
<td>New Mexico</td>
<td><a href="http://www.hsd.state.nm.us/mad/EnrollmentPolicy.html">http://www.hsd.state.nm.us/mad/EnrollmentPolicy.html</a></td>
<td><a href="http://www.hsd.state.nm.us/mad/EnrollmentPolicy.html">http://www.hsd.state.nm.us/mad/EnrollmentPolicy.html</a></td>
</tr>
<tr>
<td>Pennsylvania</td>
<td><a href="http://www.dwp.state.pa.us/provider/ProviderEnrollment/Pages/ProviderInformation/default.aspx">http://www.dwp.state.pa.us/provider/ProviderEnrollment/Pages/ProviderInformation/default.aspx</a></td>
<td><a href="http://www.dwp.state.pa.us/provider/ProviderEnrollment/Pages/ProviderInformation/default.aspx">http://www.dwp.state.pa.us/provider/ProviderEnrollment/Pages/ProviderInformation/default.aspx</a></td>
</tr>
</tbody>
</table>

### STATE MEDICAID MANAGED CARE WEBSITES AND CONTRACTS

<table>
<thead>
<tr>
<th>STATE NAME</th>
<th>MANAGED CARE WEBSITE</th>
<th>MODEL MANAGED CARE CONTRACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illinois</td>
<td><a href="http://www2.illinois.gov/hfs/ManagedCare/Pages/default.aspx">http://www2.illinois.gov/hfs/ManagedCare/Pages/default.aspx</a></td>
<td><a href="http://www2.illinois.gov/hfs/ManagedCare/Pages/default.aspx">http://www2.illinois.gov/hfs/ManagedCare/Pages/default.aspx</a></td>
</tr>
<tr>
<td>New Mexico</td>
<td><a href="http://www.hsd.state.nm.us/mad/ClinicDirectory.html">http://www.hsd.state.nm.us/mad/ClinicDirectory.html</a></td>
<td><a href="http://www.hsd.state.nm.us/uploads/files/Looking%20For%20Information/General%20Information/Policy%20Manuals/MedicaidManagedCarePolicy%20Manual%20Feb%202014.pdf">http://www.hsd.state.nm.us/uploads/files/Looking%20For%20Information/General%20Information/Policy%20Manuals/MedicaidManagedCarePolicy%20Manual%20Feb%202014.pdf</a></td>
</tr>
</tbody>
</table>
RESOURCES


xvi. AAIHM. Health Reform in My State. Available from http://aaihm.org/chapter/exec/healthreformbystate/


Fiscal Health: Systems to Sustainability™ is an education and training program run by HealthHIV that addresses the fiscal sustainability of Ryan White funded grantees by building their organizational fiscal management capacity. This HRSA/HAB-supported program (#U69HA27222) utilizes a diverse and culturally competent team of fiscal management experts to design and implement effective trainings focusing on HRSA program and fiscal requirements and contracts management.

An enhanced approach to building the organizational, and specifically the fiscal health, of Ryan White-funded organizations and providers, the Fiscal Health: Systems to Sustainability™ trainings help develop and/or enhance operational fiscal systems, with emphasis on monitoring standards, budgeting, fiscal standards, diversifying income streams, and quality controls for recipients, subrecipients and contractors.

For more information on the Fiscal Health: From Systems to Sustainability™ program, or to request technical assistance, please email Training@HealthHIV.org.
To Request Technical Assistance or to Participate in Training, Contact:

E-mail: Training@HealthHIV.org
Telephone: 202.232.6749
Fax: 202.232.6750

Website: www.HealthHIV.org

@HealthHIV
www.Facebook.com/HealthHIV
http://www.YouTube.com/HealthHIV
http://tinyurl.com/HealthHIVLinked