Medicaid Expansion: How Does it Impact HIV Outcomes in One Non-urban Southeastern Ryan White HIV/AIDS Program Clinic?

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Background

- Ryan White HIV/AIDS Program (RWHAP) supports high-quality HIV care
- Medicaid is complementary to the RWHAP as it provides access to non-HIV care
- People living with HIV (PLWH) with Medicaid historically have low viral suppression (VS) rates; VS rates achieved by PLWH with Medicaid Expansion has been less explored

Objective

- To examine HIV outcomes by primary insurance status during the first year of Medicaid expansion (2019) in a state with previously high Qualified Health Plan coverage of PLWH

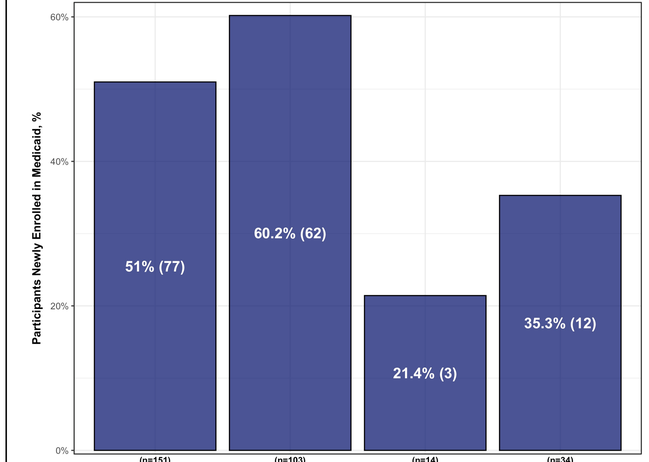
Methods

- Participants: PLWH ages 18-63 who attended ≥ 1 HIV medical visit/year in 2018 and 2019
- We estimated associations of sociodemographic characteristics with Medicaid Expansion enrollment prevalence for primary insurance coverage and associations between insurance status and outcomes of engagement in care and VS

Results- Medicaid Enrollment due to Medicaid Expansion

- The cohort (n=577) had many PLWH with Medicare. Since it was rare (2.2%) for one's primary insurance to switch from Medicare to Medicaid, they were excluded from enrollment analyses.
- For PLWH without Medicare (n=455), 151 (33%) were newly eligible for Medicaid, and 77 (51%) enrolled (Figure 1). Enrollment was higher for PLWH with incomes <100% Federal Poverty Level (adjusted prevalence ratio [aPR] 1.67; 95% confidence interval [CI] 1.00-1.86) compared to others (Table 1).

Figure 1. Medicaid Enrollment for Participants who were Newly Eligible for Medicaid due to Medicaid Expansion (n=151)



Before Medicaid Expansion in Virginia, PLWH with low incomes had high insurance coverage rates with state-purchased Qualified Health Plans.

In the first year of Medicaid Expansion in Virginia, PLWH who gained Medicaid had high rates of engagement in care and lower rates of viral suppression.

Table 1: Associations of Sociodemographic Characteristics with Medicaid Enrollment in 2019 for People Living with HIV who were Newly Eligible for Medicaid due to Virginia's Medicaid Expansion (n = 151)

Characteristic	Enrollment, n (%)	Adjusted PR[1] (95%CI)
Overall	77 (51.0)	
Age (per 10 year increase)	NA	1.07 (0.95-1.23)
Race/Ethnicity		
Non-Hispanic White	40 (65.6)	Ref
Non-White	37 (41.1)	0.77 (0.57-1.04)
Income (2018)		
<100% FPL	62 (59.6)	1.67 (1.00-1.86)
>101% FPL	15 (31.9)	Ref
Primary Insurance Status (2018)		
Private	65 (55.6)	Ref
Uninsured	12 (35.3)	0.82 (0.49-1.13)
HIV Risk Factor		
Non-IDU HIV Risk Factor	67 (48.2)	Ref
IDU HIV Risk Factor	10 (83.3)	1.50 (0.90-1.94)
Baseline Engagement in HIV Care		
Not Engaged	8 (33.3)	Ref
Engaged	69 (54.3)	1.33 (0.87-2.48)

1. Covariates that had prevalence ratios that were statistically significant ($p<0.05$) or of large magnitude (< 0.83 or > 1.20) in an unadjusted model were included in the adjusted model.

Abbreviations: PR: Prevalence Ratio, CI: Confidence Interval, FPL: Federal Poverty Level, HIV: Human Immunodeficiency Virus, IDU: Injection Drug Use

Results (con't)

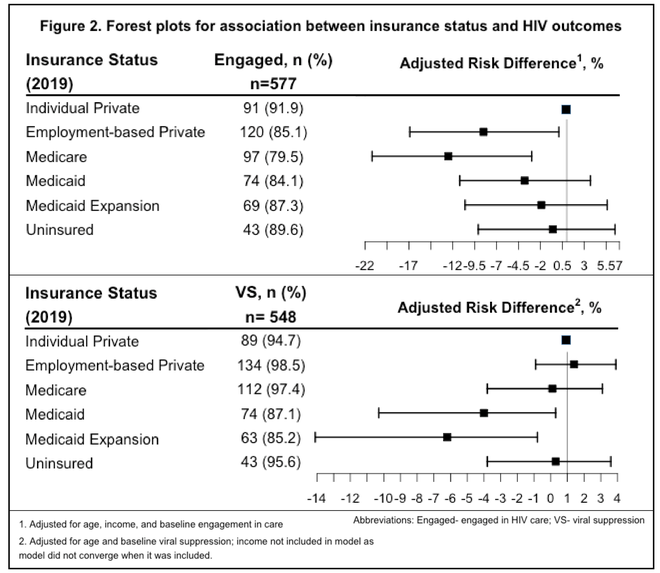
Engagement in Care- Figure 2

- For the full cohort (n=577), after controlling for age, income, and 2018 engagement, PLWH with employment-based private insurance (adjusted risk difference [aRD] -8.5%, 95% CI -16.9-0.1) and Medicare (aRD -12.5%, 95% CI -21.2--3.0) had lower 2019 engagement than participants with other insurance.

Viral Suppression- Figure 2

- For participants with VS data (n=548), after controlling for age and baseline VS, PLWH with Medicaid (aRD -4.0%, 95% CI -10.3-0.3) and with Medicaid due to Medicaid Expansion (aRD -6.2%, 95% CI -14.1- -0.8) were less likely to achieve VS compared with participants with other insurance.

Figure 2. Forest plots for association between insurance status and HIV outcomes



1. Adjusted for age, income, and baseline engagement in care
2. Adjusted for age and baseline viral suppression; income not included in model as model did not converge when it was included.

Abbreviations: Engaged- engaged in HIV care; VS- viral suppression

Conclusions

- Interventions should be developed to increase Medicaid uptake among newly eligible PLWH.
- Given that PLWH who newly enrolled in Medicaid had high engagement in care, the finding of lower VS is surprising.
- The discordance may be due to medication access gaps associated with changes in medication procurement logistics.

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