

# Medicare Part D & Ryan White HIV/AIDS Program

*As of October 2007*

The below discussion can guide Ryan White HIV/AIDS programs in understanding implications of the Medicare Part D prescription drug benefit on HIV/AIDS care.

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## The Basics

### The Medicare prescription drug benefit.

People with HIV/AIDS can benefit substantially from Medicare’s new drug coverage (Part D). Medicare prescription drug plans provide insurance coverage for prescription drugs. These plans are offered by insurance companies and other private companies. Plans cover both generic and brand-name prescription drugs.

Part D plans are offered in two ways: as stand-alone plans and as prescription drug coverage added to Medicare Advantage Health Plans (like HMOs and PPOs). Eligible individuals can choose the plan that meets their needs. Drug plans may vary by state as they are packaged and offered to regions across the nation.

### Enrolling in a Part D Medicare plan.

Medicare-eligible individuals who do not have prescription drug coverage that is at least as good as a Medicare prescription drug plan (called “creditable coverage”) should enroll in a Medicare prescription drug plan. There may be a penalty for failure to join by the deadline, as follows:

- **Newly Medicare Eligible.** You have a 7-month window for enrolling without a penalty: 3 months prior to the month your eligibility begins and 4 months after the start of your Medicare eligibility.
- **Lose Creditable Coverage:** If you lose creditable coverage, you will face a penalty if you fail to join within 63 days of losing that creditable coverage. If not enrolling within this time frame, the next opportunity to join is November 15 - December 31 of each year. This penalty is added to the monthly premium and is 1% more for every month of delayed enrollment. This penalty will be in force for as long as the individual has Medicare prescription drug coverage.

- **With Creditable Coverage:** For those individuals with creditable coverage who decide to join Part D at a later time, there is no penalty for not joining. For those who lose creditable coverage, there is no penalty for late enrollment if a Part D plan is joined within a 63 day period.

Since ADAP typically covers only HIV-related medications, it is not creditable coverage. Those individuals whose only coverage is ADAP and who delay enrollment in Medicare Part D will have to pay this penalty when joining Part D late. One exception is when ADAP offers comprehensive drug coverage under, for example, a health insurance continuity arrangement.

### **How eligible persons get on a Medicare prescription drug plan.**

Individuals should select a prescription drug plan that meets their medication, financial, and other needs. The Medicare Prescription Drug Plan Finder on <http://www.medicare.gov> can help individuals select the right plan. It provides detailed cost sharing and formulary information for prescription drug plans and Medicare Advantage prescription drug plans. CMS also operates the 1-800-MEDICARE help line.

### **How dually eligible individuals enroll in Part D.**

Dually eligible individuals are auto-enrolled in a plan. They can stick with the assigned plan or choose another one. In picking a drug plan, dual eligibles should use the same considerations and resources as are used by all Medicare-eligible individuals.

### **When you can change to another Part D plan.**

There are various conditions under which a person can change to a new plan, as follows:

- Everyone on Part D can switch to a new plan during the annual open enrollment period, November 15 – December 31 of each year.
- Those eligible for any type of low income subsidy can make changes in plans at any time.
- A person who moves to a new geographic location that does not offer the same plan can switch to a different plan.
- A Medicare beneficiary who believes he was misled into enrolling into a Private Fee-for-Service plan has the opportunity to change plans under a Special Enrollment Period (call 1-800-MEDICARE and describe the misleading information and a customer service representative can assist with this issue).

## **Prescription Drug Plans and Drugs Covered**

### **Drugs that are included—or not included—in Part D prescription drug plans.**

Part D covers all FDA-approved drugs except the following: drugs covered under Medicare Parts A and B and seven categories of what are called excluded drugs. Examples of excluded drugs most relevant to HIV-related care include those for weight loss or weight gain (although drugs used for AIDS-related wasting or cachexia are considered Part D drugs), over the counter drugs, vitamins and minerals, and benzodiazepines. For dual eligibles, these excluded drugs may still be available to them under Medicaid.

Part D prescription drug plans have flexibility in determining what drugs to cover and how to cover them, such as cost-sharing requirements. Plans can decide which drugs to include by using a formulary (a list of covered drugs) or by covering all FDA-approved prescription drugs.

If using a formulary, the plan is required to cover both generic and brand-name prescription drugs and include at least two drugs in each class. In order to protect against discrimination, CMS requires access to all or substantially all drugs in six drug classes in the formulary. One of these classes of drugs is antiretrovirals. All Medicare prescription drug plans will be required to cover all antiretroviral drugs, including single chemical entities as well as combination products.

When it comes to adding new FDA-approved drugs to plan formularies, Part D plans have Pharmacy and Therapeutic (P&T) committees that are responsible for making this decision. They are to make reasonable efforts to review new chemical entities (including new antiretrovirals) within 90 days of their release on the market and make decisions about whether to add them to a plan's formulary within 180 days. A clinical justification is to be provided if this timeframe is not met. Part D plans must add drugs recommended by their P&T Committee.

### **How drug plans differ, such as drugs that are covered and their costs.**

Yes. Drugs may be offered by plans at different co-pay levels and plans may supplement the benefit for those patients who are willing/able to pay a higher monthly premium. Plans may have different policies with respect to commonly prescribed drugs—and drugs for which there is evidence of clinical equivalency. HIV therapy may necessitate access to specific drugs within a class. Thus, formulary access to (and cost-sharing requirements for) non-HIV medications may be particularly important to consider when selecting a prescription drug plan.

## How to file an appeal if the drug is medically necessary but not included in a plan's formulary.

Prescription drug plans under Part D have a choice on what drugs to cover and how they will cover them, such as cost sharing and other tools to manage drug utilization in keeping the cost of the drug benefit affordable. Following are some specifics about drug coverage under plans:

- If a specific drug is covered but the plan changes its formulary during the year, the plan must keep patients on that drug for the remainder of the plan year.
- If a specific drug is not covered by the drug plan, or is included but at a high cost tier, the first step is for the patient and clinician to discuss which drugs are best for their treatment. If the physician determines that the drug(s) is medically necessary, a request for an exception to the formulary or cost sharing can be filed with the plan. Medicare drug plans are required to make the initial decision on an exceptions request within 72 hours or within 24 hours for urgent situations. Requests for exceptions that are declined by drug plans twice may be appealed to a process external to the plan. Clinicians and other staff may act on behalf of patients in requesting exceptions and appeals. Information on the exceptions and appeals process, including a form for clinicians to use (as a patient's representative) to request an exception, can be found at <http://www.cms.hhs.gov/center/provider.asp>

## Costs and Cost Sharing

### Costs for drugs under Part D.

Yes, there are several levels of costs under the Part D standard benefit. However, low income individuals can apply for extra help in paying these costs. Dually eligible individuals automatically qualify for extra help. Also, many plans offer cost sharing that is more generous than the standard benefit. (The vast majority of Medicare beneficiaries living with HIV/AIDS have lower costs than those under the standard benefit.)

- **Monthly Premium.** This is the amount the individual must pay each month, regardless of how many drugs are used. (Those who enroll late will be charged a premium penalty—1% for every month after the deadline.)
- **Deductible.** The individual must spend this amount on prescription drugs before the plan starts paying for drugs.
- **Co-Pay.** The individual next pays 25% of total drug costs in the co-pay cost sharing band.
- **Coverage Gap.** At this point Part D does not cover any costs. The individual pays 100% of costs. This is called the coverage gap or “donut hole.”

- **Catastrophic Coverage.** After spending the designated amount of total drug costs and true out-of-pocket costs (TrOOP), the individual pays 5% of costs or a certain amount per prescription, whichever is greater.

<b>Cost Sharing Under the Part D Standard Benefit *</b>		
<b>Total Drug Costs</b>		
	<b><u>2007</u></b>	<b><u>2008</u></b>
Deductible	\$265	\$275
Co-Pay (25% for enrollee)	\$266 to \$2,400	\$276 to \$2,510
Coverage Gap (100% for enrollee)	\$2,401 to \$5,451.25	\$2,511 to \$5,726.25
Catastrophic Coverage	>\$5,451.25 and \$3,850 in TrOOP	>\$5,726.25 and \$4,050 in TrOOP
Cost Sharing Per Drug Generic/Brand Name	5% or \$2 / \$5	5% or \$2.25 / \$5.60

\* In addition to monthly premiums.

### **TrOOP costs.**

In moving along the various levels of cost sharing under the Part D standard benefit, the individual must pay such costs as the initial deductible and subsequent co-payments before Part D's full "catastrophic coverage" begins. After reaching the catastrophic level, the individual is only obligated to pay 5% of prescription drug costs or co-pays for each drug, whichever is higher. Medicare will pay the rest.

These costs to the beneficiary are called TrOOP, or true out-of-pocket costs. In general, when an individual incurs the required TrOOP costs, they reach the catastrophic coverage level. Certain low income individuals do not have to pay these costs if they qualify for extra help under Low Income Subsidies.

### **Ryan White funds and TrOOP.**

Entities, such as Ryan White grantees (ADAPs and other Ryan White programs) can help individuals with HIV/AIDS by covering Medicare drug plan premiums, deductibles, co-insurance and/or co-pays. However, there is an important limitation to this: Ryan White funds (such as ADAP payments) cannot be counted toward TrOOP, which is essential in reaching the catastrophic level where Medicare picks up most costs. Thus, Ryan White funds, such as ADAPs, can pay the individual's deductible or co-payments, but these payments will not count as TrOOP.

In contrast, payments made by CMS on behalf of a low-income enrollee who qualifies for Low Income Subsidies count toward TrOOP. In addition, cost sharing payments made by

individuals (such as family members), charitable organizations, and State pharmacy assistance programs also count as TrOOP costs, thus helping the individual reach the catastrophic coverage level.

### **How Ryan White HIV/AIDS programs (Parts A, B, C, D, F) can help clients pay Medicare Part D out-of-pocket costs.**

Although such contributions do not count towards TrOOP, Ryan White CARE Act grantees (ADAPs and other Ryan White programs) can help individuals with HIV/AIDS pay their Medicare drug plan premiums, deductibles, co-insurance and/or co-pays. However, doing so entails numerous administrative and operational challenges. Among these are mechanisms to make payments to prescription drug plans on behalf of clients (Ryan White payments cannot be made directly to clients for Part D) and to track Part D contributions made for specific clients to ensure coordination of payments across payer sources. Standardized procedures are also essential in managing emergency situations where Medicare payment authorization is denied and clients cannot pay co-payments. Finally, since ADAP programs must assess and compare the costs of providing medications through a health insurance option (such as Part D) versus ADAP, any Medicare Part D payments made by other Ryan White programs would complicate their ability to undertake such analyses.

The above challenges suggest that coordination with Part D may best be handled at the State level. Ryan White Part A, C, and D grantees considering Medicare Part D cost sharing assistance for Medicare-eligible clients should coordinate with their Ryan White Part B programs so that standardization of approaches and administrative efficiencies can be achieved. Such coordination can also enhance decisions about funding drug assistance, such as Ryan White Part A contributions to State ADAP programs. Grantees are encouraged to contact their Federal project officers to discuss these issues.

### **Pharmacists and filling prescriptions if the individual cannot afford the co-pay.**

Yes. Under the new Part D benefit, pharmacists can refuse to fill a prescription if the individual cannot afford the co-pay. (This differs from Medicaid, where dual eligibles were not refused medications if they did not pay the Medicaid co-pay.) However, pharmacies are permitted to waive cost-sharing on an individual basis. They can do so if they do not always waive cost-sharing, if they do not advertise, and if they have made a good faith effort to determine that the beneficiary is unable to pay their cost-sharing.

## **Low Income Subsidies: Getting Help With Costs**

### **Extra help available to pay prescription drug costs under Medicare.**

Individuals with limited income and resources may qualify for extra help in paying Medicare prescription drug costs.

Some people automatically qualify for extra help and do not need to apply for it. They include the dually eligible (Medicare beneficiaries who also receive Medicaid); those

covered by a Medicare Savings Program; and those who are covered by Supplemental Security Income (SSI). These individuals are required to make co-pays for each prescription drug until their total drug costs reach the catastrophic level for the year. Above this amount, they will not need to pay for their drugs at all.

Others with limited incomes and resources do not automatically qualify. They need to apply.

### **Eligibility criteria for those who apply for extra help.**

Income and resource limits for qualifying change each year and include:

- Annual income caps (which vary for those who are single versus married and living with the spouse). These amounts may be higher for those who: provide at least half of the support of other relatives living in your household, reside in Alaska and Hawaii, or are working. There are also income exclusions for the working blind and disabled.
- Resource limits (which vary for those who are single versus married and living with your spouse). Examples of resources that are counted include real estate (other than primary residence); bank accounts, including checking, savings and certificates of deposit. Resources that are not counted include, for example, primary residence, personal vehicle(s), jewelry and home furnishings, household goods and personal possessions, and federal income tax refunds. Other things not counted as resources include designated amounts for burial expenses and life insurance policies owned by an individual with a combined face value as designated each year.

### **How to apply for extra help in paying for Part D costs.**

Individuals can apply for extra help through the Social Security Administration (SSA) or Medicaid. An application must be completed—either an original application or one submitted online.

SSA sends people with certain incomes an application for extra help to pay for Medicare prescription drug coverage. Those who think they are eligible should fill out the application and return it in the postage paid envelope. Only original applications are accepted. Photocopies are not accepted. Another application can be requested and it will be mailed, but this can delay submission of the application. If the application does not arrive, one can be requested by calling SSA at 1-800-772-1213. Alternatively, individuals can apply online. SSA notifies applicants if they qualify for extra help.

Please note that SSA is just one place to go to apply for extra help with Medicare Part D costs. Those wishing to be screened for Medicaid and Medicare Savings programs, as well as for Part D extra help, should apply for all these programs at their State Medicaid office. SSA will not screen individuals for Medicaid or the Medicare Savings programs.

### **Co-payments and lowering them for those getting extra help.**

Yes. For those covered by a Low Income Subsidy (LIS), clinicians can decrease the cost of co-pays by writing prescriptions for 60 or 90 days when appropriate, as opposed to just 30 days. This is because the same co-pay applies, regardless of the number of days covered by the prescription.

### **Part D impact on Medicare beneficiaries who qualify for Medicaid through "spend down" or medically needy programs.**

Once a Medicare beneficiary becomes eligible for Medicaid (also known as "dually eligible"), the individual is deemed eligible for the low-income subsidy. This includes individuals who qualify for Medicaid through "spend down" or medically needy programs. Ryan White funds may not be used to cover an individual's Medicaid "spend-down" costs.

Beneficiaries who are listed in data from states and SSA as recipients of Medicaid, a Medicare Saving Program (MSP) or Supplemental Security Income (SSI) will receive the subsidy. If they are again listed in data from states and SSA in the fall of each subsequent year, they will receive the subsidy for the following calendar year. If they cease to appear in data from the states or SSA as eligible for Medicaid, MSP, or SSI, they will not automatically receive the subsidy for the following calendar year and would have to apply in order to continue to qualify for the subsidy.

## **Using Prescription Drug Plans**

### **Determining the PDP enrollment status of a client.**

The PDP Finder can be used to identify an individual's plan. Take the example of a client who comes to their case manager not knowing if they have been auto enrolled in a Medicare plan. The case manager can use the PDP Finder (available at <http://medicare.gov>) and enter the following client information to determine the plan name: health insurance claim number, date of birth, last name, Medicare Part A or B effective date, and zip code of record. For those clients not currently enrolled but with a future enrollment date, the PDP Finder will show details about their future plan. Individuals can also call 1-800-MEDICARE (800-633-4227) to get enrollment information.

### **Rules for Patient Assistance Programs (PAP) under Medicare Part D.**

Patient assistance programs (PAPs) are programs that provide free medication or financial assistance to patients who otherwise lack the means to obtain needed therapies. Many PAPs, particularly those that provide free or reduced-cost medications, are sponsored by pharmaceutical manufacturers. Many ADAPs work with PAPs to provide antiretroviral drugs to clients, particularly in providing drugs to those on ADAP waiting lists who have no other way to pay for their drugs. Under Medicare rules issued in April

2006, PAPs may provide assistance to Medicare beneficiaries but such assistance will not count toward TrOOP.

## **AIDS Drug Assistance Programs (ADAP)**

### **Comparing drug coverage under Medicare versus ADAP.**

ADAPs only cover HIV/AIDS related medications—not all drugs a Medicare beneficiary may need. Thus, ADAP coverage is not as good as Medicare coverage. An additional consideration in comparing ADAP to Medicare Part D coverage is that individuals on ADAP will have to pay a penalty for joining Part D after the deadline as ADAP is not considered to be creditable coverage by CMS.

### **Use of ADAP funds to pay a Medicare beneficiary's prescription benefit costs. Consideration of factors such as ADAP payments not counting toward true-out-of-pocket (TrOOP) costs.**

Yes, ADAP funds may be used to pay all or part of a beneficiary's prescription drug costs (premium, deductible, coinsurance, and/or co-pays), if the individual meets the State's ADAP eligibility criteria. Grantees have flexibility in this matter, and are encouraged to develop policies regarding coverage of some or all of these costs after considering the ADAP program's structure, costs, and resources, Medicare beneficiary need, and competing access issues such as waiting lists and the number of uninsured persons in the State living with HIV disease.

In developing these policies, there are several factors that grantees should keep in mind.

- Most Medicare beneficiaries living with HIV/AIDS will qualify for a full or partial low-income subsidy (LIS) to help cover their prescription benefit costs.
- Determining the costs to the ADAP for beneficiaries who do not qualify for the LIS will be a complex process. Grantees must take into account that these clients will not meet their TrOOP costs and satisfy the catastrophic level through ADAP payments. In addition, when these clients' drug costs reach the Medicare Part D threshold (i.e., the point at which the client is responsible for the full cost of drugs), grantees should assess the relative merits of providing their HIV/AIDS medications through the ADAP for the remainder of the year.

However, if ADAP funds are used to cover the Medicare Part D premium for any ADAP-eligible clients in a given fiscal year, then ADAP should cover that cost for the entire year so that the client will be able to use Part D for their HIV/AIDS prescriptions the following year without incurring a penalty.

## **ADAPs and requiring clients who are Medicare-eligible to participate in Part D.**

Yes. While participation in Medicare's drug plans is voluntary, the Ryan White Program is the payer of last resort for HIV/AIDS care and treatment. Section 2617(b)(6)(F) of the CARE Act states that grantees must:

“...ensure that grant funds are not utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to that item or service—(i) under any State compensation program, under an insurance policy, or under any Federal or State health benefits program.”

Since Medicare is a Federal health benefits and entitlement program, the Ryan White payer-of-last-resort requirement applies. Grantees must require Medicare-eligible ADAP clients to enroll in the prescription benefit.

There are multiple reasons that ADAP and other Ryan White programs should actively pursue enrollment of their Medicare-eligible clients into Part D.

- Most people on Medicare with HIV/AIDS will qualify for extra help in paying for the Medicare drug plan, and Part D covers non HIV/AIDS drugs.
- Declining the Part D prescription benefit would mean losing access to the complete range of FDA-approved medications that people living with HIV typically need. ADAP programs best serve their clients who are Medicare beneficiaries—or who later become eligible—by making sure they know where to obtain comprehensive counseling on the health and financial consequences of declining enrollment.
- Under Medicare rules, beneficiaries will have to pay a late enrollment penalty in future years if they are eligible to enroll in the prescription benefit, do not enroll by the deadline, and do not have creditable coverage for a continuous period of 63 days or longer.

Because ADAP formularies are limited to HIV/AIDS-related medications, basic ADAP coverage will not meet Medicare's standard for creditable drug coverage. Therefore, beneficiaries who decline the prescription benefit and then change their mind when they need access to a broader range of medicine for other health problems will be subject to late penalties. The late enrollment penalty is one percent more per month for the premium for each month the beneficiary waits to enroll; and beneficiaries will have to pay the higher premium penalty for as long as they have Medicare prescription drug coverage.

## **ADAPs and ensuring that Medicare-eligible clients enroll in Medicare Part D, and what they can do if a client refuses to enroll.**

As the payer of last resort, ADAPs can ensure enrollment in Medicare Part D using a process consistent with their policies for ensuring that eligible clients enroll in the Medicaid program. Since states historically have had flexibility in implementing policies

and processes regarding Medicaid eligibility and ADAP coverage, and as the issues are similar regarding Medicare Part D, HRSA would expect to see consistency in how an individual ADAP handles Medicaid and Medicare eligibility within their state. Like the Medicaid program, participation in Medicare Part D is voluntary for the individual but there are significant penalties attached to the refusal of an eligible client to participate. If after extensive counseling, an individual refuses to participate in Medicare Part D, the ADAP has the option of disenrolling the person from ADAP and finding other viable options for medication coverage, or documenting the client's refusal and continuing coverage in ADAP. In such a situation, under no circumstances should ADAP funds be used to pay Medicare Part D penalties if a client chooses to participate at a later date.

**ADAP as the payer-of-last-resort and retaining/dropping current clients who are Medicare beneficiaries and directing them to get their HIV/AIDS medications through Part D.**

While it is true that ADAP is the payer of last resort and therefore must require that their Medicare beneficiaries enroll in Part D, this does not mean that ADAPs must drop these clients. States do have flexibility in determining their eligibility criteria as well as policies with respect to covering the Part D out-of-pocket costs of ADAP clients. However, HRSA expects and strongly encourages ADAPs to NOT disenroll any ADAP clients—including those who are Medicare beneficiaries—without first making sure they have a viable option for continuing their antiretroviral drug coverage.

In most cases, it will be more cost-effective for an ADAP to cover the Part D out-of-pocket costs for HIV/AIDS-related drugs for clients who are Medicare beneficiaries (rather than providing those drugs through ADAP), because the majority of people living with HIV/AIDS who are on Medicare will qualify for extra help. For beneficiaries who do not qualify for extra help, there are a variety of options that ADAPs may consider, including the following.

- Cover the beneficiary's Part D cost-sharing expenses and use Part D to provide their HIV/AIDS drugs until the client reaches the coverage gap (donut hole); then use the ADAP program for the balance of the year.
- Utilize an alternative health insurance option if one is available through the ADAP and it meets Medicare's criteria of creditable insurance.
- If the State operates a state pharmacy assistance program (SPAP), ADAPs can explore with state officials the feasibility of coordinating ADAP and SPAP eligibility and enrollment. (Please also see the other Q's/A's regarding SPAPs.)

**ADAPs and administratively handling Medicare Part D costs (premiums, deductibles, coinsurance and co-pays). Who receives payments for premiums. How to manage other costs at the pharmacy point-of-service. How to keep track of multiple plan choices that beneficiaries can select.**

CMS requires Part D drug plans to coordinate with ADAPs. Because ADAPs are structured differently in different States and have differing resources, each ADAP considers what mechanism allowable under CMS guidelines is most efficient and cost-effective. CMS' Coordination of Benefits (COB) guidance at [http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CobGuidance\\_07.01.05.pdf](http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CobGuidance_07.01.05.pdf) indicates how secondary payers like ADAPs can coordinate with plans on premium payments and wraparound assistance. The automated COB option, which requires that ADAPs enter into front-end data-sharing agreements with CMS for eligibility file exchanges, is probably preferable for beneficiaries because it provides the most seamless coverage (benefits are provided at point of sale and TrOOP is also updated on a real-time basis). However, to do so requires administrative and operations capacity on the part of ADAPs. ADAPs can participate in the CMS eligibility data exchange and pay for their wrap around benefits at the point of sale or they can submit paper claims after the point of sale transaction. Information on the various plan options, as well as their formularies, is available at <http://medicare.gov>

**Administrative challenges of working with a large number of prescription drug plans, Can ADAPs limit the number of plans with which they will provide cost assistance.**

Yes. While Part D drug plans are required to coordinate with ADAPs, CMS cannot require ADAPs to coordinate with all drug plans. CMS does not determine the level of benefits ADAP will provide and to whom these benefits should be provided. Additionally, ADAP assistance with Medicare costs is not required for ADAPs.

Limiting plans they work with may be the only way some ADAPs can administer such assistance, especially in the short-term. For example, ADAPs may wish to limit assistance to those Medicare beneficiaries enrolled in plans that have contracts with 340b pharmacies that ADAPs work with. While this may theoretically limit choice for Medicare beneficiaries, participation in ADAP is voluntary for Medicare beneficiaries.

**Use of ADAP funds—Federal or State—to contract with a charitable organization to pay the Medicare Part D premium, deductible, co-insurance and/or co-pays of clients who are Medicare beneficiaries.**

ADAP (and other Ryan White) funds used to make Part D cost-sharing payments on behalf of clients will not count towards TrOOP, whether ADAP dollars are used directly or indirectly through a charitable organization.

A grantee may choose to contract a portion of ADAP funds for the purpose of making and tracking payments on behalf of clients to cover their Part D premium, deductible, coinsurance and/or co-pays costs, if doing so will provide the most efficient, cost-

effective mechanism for handling those payments. The grantee must make sure that the contractor has adequate systems in place to:

- Track client-level Medicare Part D payments
- Coordinate with each client's prescription drug plan, and
- Provide the grantee with the time-sensitive documentation needed to assess the cost-neutrality of using Medicare Part D in relation to providing the client's HIV/AIDS medications through ADAP.

**Situations where a 340B participating ADAP covers the Part D out-of-pocket costs for clients who are Medicare beneficiaries. ADAP collection of full rebates through the State ADAP 340B rebate program from drug manufacturers on co-payment, or partial payment costs for the drugs provided to these clients through a Medicare prescription drug plan.**

Yes. Consult the letter to Ryan White Part B (Title II) grantees and ADAPs from the HIV/AIDS Bureau dated 4/29/2005. It clarified conditions under which ADAPs participating in the State ADAP 340B rebate program, and using ADAP funds to purchase health insurance for clients to provide their HIV/AIDS medications, can request full rebates for partial payments from the drug manufacturers through the State ADAP 340B rebate program.

ADAPs can claim full rebates on partial pay claims if the grantee pays the client's deductible and/or their coinsurance and co-pays. This applies regardless of whether or not the ADAP pays the premium; **but** just paying the premium does not entitle the ADAP to rebates under the State ADAP 340B rebate option as the ADAP does not make a payment directly for the drugs.

To collect the rebates, ADAPs need to work out arrangements with Medicare prescription drug plan(s) (PDP) to do the following.

- ADAPs need to make payments to the PDP on behalf of beneficiaries because ADAPs and Ryan White grantees may NOT make payments directly to clients.
- ADAPs need to receive from the PDP claim-level data to collect rebates on prescriptions for beneficiaries who are ADAP clients, keeping in mind that rebates are usually collected quarterly. For example, ADAPs probably need to know the following for each National Drug Code (NDC) dispensed during a reporting period:
  - The drug name for that NDC
  - The form of drug dispensed
  - The quantity dispensed
  - The number of ADAP-covered prescriptions filled for that NDC
  - The amount(s) reimbursed by the ADAP to the PDP for those prescriptions (i.e., payments toward deductible, coinsurance, co-pays)

## **State Pharmacy Assistance Programs (SPAP)**

**Reallocation of State contributions to an ADAP to a State Pharmacy Assistance Program (SPAP) so that Medicare cost-sharing payments made on behalf of clients will count toward TrOOP.**

State funds allocated to an ADAP in order to meet the State's Part B or ADAP matching requirement may NOT be redirected to another program.

ADAP funds used to make Part D prescription drug benefit cost-sharing payments on behalf of clients will not count towards TrOOP. This rule applies, regardless of whether ADAP dollars are used directly or indirectly through an SPAP or charitable organization.

A State could use State-only dollars historically used to support ADAP in order to establish a qualified SPAP to cover Part D beneficiary costs for low-income Medicare beneficiaries living with HIV/AIDS, but this would have to be done at the State appropriations level. In addition, States must continue to comply with the Ryan White maintenance-of-effort (MoE) requirement. To be MoE compliant, the State must be able to document that the amount of funds historically appropriated for ADAP are used to pay Medicare beneficiary costs only for people living with HIV/AIDS. Grantees are reminded that the MoE requirement is a condition-of-award and subject to audit, and therefore requires States to maintain appropriate records. Also, if a State chooses to do this, the State may not use those State funds in order to qualify for ADAP funding AND act as a SPAP.

**Creation of new groups by SPAPs to meet the Part D cost-sharing requirements of Medicare Part D.**

A: Yes.