Medicare Prescription Drug Benefit
Implications for HIV/AIDS Care

Q&A: Medicare Part D/Ryan White CARE Act

As of 10/19/05

The following questions and answers were developed as a tool to help Ryan White CARE Act programs understand implications of the new Medicare Part D prescription drug benefit on HIV/AIDS care, with a focus on CARE Act programs. This document is an initial outline of key Part D/CARE Act issues. These questions and answers, and those to be added in the future, are incorporated into the HRSA Q/A System.

The Basics

Q: What is the Medicare prescription drug benefit?

A: Medicare's new prescription drug coverage (Part D) becomes available to everyone with Medicare starting January 1, 2006. People with HIV/AIDS can benefit substantially from Medicare's new drug coverage.

Medicare prescription drug plans provide insurance coverage for prescription drugs. These plans will be offered by insurance companies and other private companies. Plans will cover both generic and brand-name prescription drugs. At least two Medicare prescription drug plans will serve people in any given area. Eligible individuals can choose the plan that meets their needs. Since drug plans will be packaged and offered to regions across the nation, they may vary across areas.

Q: How will drug benefit plans be offered under Part D?

A: Part D plans can be offered in two ways. Prescription drug plans will add medication coverage to Original Medicare fee-for-service. Plans can also add prescription drug coverage to Medicare Health Plans (like HMOs and PPOs). You would get all of your Medicare health care through these plans.

Q: Who should enroll in a Part D Medicare plan?

A: Medicare-eligible individuals who do not currently 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. For most people, joining by May 15, 2006, means they will pay a lower monthly premium than if they wait to join at a later date. That's because in most cases there will be a penalty for joining after this date. Future opportunities to enroll may be limited to November 15 - December 31 of each year. The late enrollment penalty is added to the monthly premium and is 1% more for every month of delayed enrollment. Individuals will have to pay this penalty for as long as they have Medicare prescription drug coverage.

If the individual has creditable coverage and later decides to join Part D, the penalty will not apply. 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 if joining Part D after the deadline—except when ADAP is offering comprehensive drug coverage under, for example, a health insurance continuity arrangement.

Q: How does an eligible person get on a Medicare prescription drug plan?

A: On November 15, 2005, Medicare beneficiaries may begin enrolling in Medicare Part D by choosing and enrolling in a specific drug plan. It is important for individuals to select a prescription drug plan that matches their needs, according to their individual health status, medication needs, financial situation, and other considerations. To help people make choices, on October 13, 2005, CMS will release the Medicare Prescription Drug Plan Finder tool on http://www.medicare.gov. This tool will provide detailed cost sharing and formulary information for prescription drug plans and Medicare Advantage prescription drug plans. CMS will also mail a "Medicare and You" booklet to every beneficiary, which will provide plan choices and benefits information specific to the geographic location of the beneficiary.

Q: How do dually eligible individuals enroll in Part D?

A: The process for enrolling is different for dually-eligible individuals (those covered by both Medicare and Medicaid). Because their medication coverage will be switched from Medicaid to Medicare on January 1, 2006, they will be automatically enrolled in Medicare Part D. In October 2005 CMS will notify dual eligibles of the drug plan Medicare will randomly enroll them in if they do not choose a different plan by December 31, 2005. In picking a drug plan, dual eligibles should use the same considerations and resources as all Medicare-eligible individuals.

Prescription Drug Plans and Drugs Covered

Q: What drugs are included—or not included—in Part D prescription drug plans?

A: 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, over the counter drugs, vitamins and minerals, and benzodiazepines. For dual eligibles, these 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, using a model similar to that outlined in the U.S. Pharmacopoeia Guidelines.

In order to protect against discrimination, CMS will require access to 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.

Q: Will drug plans differ, such as drugs that are covered and their costs?

A: 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. Since HIV therapy may necessitate access to specific drugs within a class, formulary access to (and cost-sharing requirements for) non-HIV medications may be a particularly important consideration when advising patients on the selection of a prescription drug plan.

Q: What if a drug is not included in a plan's formulary? Can an appeal be filed if the drug is medically necessary?

A: 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. 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 physician 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, the CMS appeals process. Physicians may act on behalf of patients in appealing to plans and to CMS.

Costs and Cost Sharing

Q: Are there costs for drugs under Part D?

A: Yes, but low income individuals can apply for extra help in paying these costs. There are several levels of costs under Part D.

- **Monthly Premium**. The first is the monthly premium, which is expected to average $32.20 per month in 2006, although plans can charge higher premiums for better coverage. (Also, those who enroll late, after May 2006, will be charged a premium penalty—1% for every month after the deadline.)

- **Deductible**. The next cost is the deductible, which is $250 in 2006. It will go up each year. The individual must spend this amount on prescription drugs before the plan starts providing coverage.

- **Co-Pay**. From this point, costs vary at different levels. From $251 to $2,250 in total drug costs, the individual pays 25% of costs.

- **Coverage Gap**. From $2,251 to $5,100 in total drug costs, Part D does not cover any costs. The individual pays 100% of costs. This is called the coverage gap or "donut hole."

- **Catastrophic Coverage**. Above $5,100 in total drug costs and $3,600 in true out-of-pocket costs (TrOOP), the individual pays 5% of costs or $2/$5 per prescription, whichever is greater.

Q: What costs count as TrOOP?

A: In moving along the various levels of cost sharing under the Part D standard benefit, the individual must pay such costs as the initial $250 deductible and subsequent co-payments amounting to $3,600 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 $2/$5 co-pays, 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 $3,600 in TrOOP, 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.

> **Case Study: TrOOP Costs**. Peter Jones is 65 years old and HIV positive. He aged into Medicare. His income is $1,600 per month (200% FPL). He is not eligible for a Low Income Subsidy. His antiretroviral regimen is Efavirenz (Sustiva) + FTC/TDF (Truvada). Peter's drugs cost $1,300 per month. Peter pays: $32.20 per month premiums. In Month 1, his costs were: $250 deductible plus $262 (25% coinsurance) towards $1050 balance. In Month 2, his costs were: $237 coinsurance (25% of $950 balance to reach $2250 co-insurance limit) plus $350 (100% coinsurance for balance of $1300 pharmacy cost). In Month 3, costs were:

$1,300 prescription cost (100% coinsurance). Peter has now paid $2,399 out-of-pocket towards his drugs.

In Month 4, costs were: $1,201 prescription cost (100% coinsurance for a total of $3,600 in out-of-pocket costs). Total drug costs are also $5,200 (above the $5,100 limit) so the catastrophic coverage level has been reached. In Months 5-12, Peter pays just $65 per month (5% co-pay). Overall, Peter has paid $4,506 for the year: $386.40 in premiums, $3600 out-of-pocket and $520 in co-pays.

Q: Can individuals receive help in paying TrOOP costs?

A: Entities, such as Ryan White CARE Act grantees (ADAPs and other CARE Act 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: CARE Act funds (such as ADAP payments) cannot be counted toward TrOOP or the catastrophic level. Thus, CARE Act 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.

Q: Can a pharmacist refuse to fill a prescription if the individual cannot afford the co-pay?

A: 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

Q: What extra help is available to pay prescription drug costs under Medicare?

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

Those who automatically qualify for extra help 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 will be required to make co-pays of between $1 and $5

per prescription until their total drug costs reach $5,100 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 will need to apply.

Q: What are the eligibility criteria for those who must apply for this extra help?

A: In general, income and resource limits for qualifying are as follows:

- Annual income below $14,355 (or $19,245 if married and living with your 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.

- Countable resources valued below $11,500 (or $23,000 if 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, federal income tax refunds, and property needed for self-support such as rental property or land used to grow produce for home consumption. Other things not counted as resources include $1,500 per person for burial expenses and life insurance policies owned by an individual with a combined face value of $1,500 or less (or $3,000 for an individual and spouse).

Q: How does an individual apply for extra help in paying for Part D costs?

A: 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.

From May and through August 16, 2005, SSA is sending people with certain incomes an application for extra help paying 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 will be accepted. Photocopies will not be 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, as of July 1, 2006, individuals can apply online. SSA will notify all applicants if they qualify for extra help.

Please note that SSA is just one place to go to apply for this extra help with 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.

Q: Can co-payments for those getting extra help be lowered further?

A: 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.

> **Case Study: Lowering Co-Pays**. Jane has been receiving Social Security Disability Income (SSDI) for over 2 years and has Medicare. Her SSDI benefit is $780 per month, which is below 100% FPL. She also has full Medicaid benefits. Jane is enrolled in a Medicare drug plan, and starting January 1, 2006, Medicare covers her prescription drug costs instead of Medicaid. Her antiretroviral regimen is Efavirenz (Sustiva) + FTC/TDF (Truvada) and costs $1,300 per month. With the full low income subsidy, Jane pays $6 in co-pays ($3 for each brand-name drug) per month. By April, the total drug costs are more than $5,100 ($1,300 x 4 = $5,200), so she will no longer have to pay co-payments and therefore has no drug costs for the rest of the year. Jane pays $18 in co-pays for 2006. If her physician gives her prescriptions for 60 or 90 days, Jane's total co-pays for the year will be even lower, as the $3 co-pay amount applies per script, regardless of the days' supply.

Q: What should people do if they do—or do not—qualify for extra help?

A: Those who qualify for extra help will need to join a Medicare prescription drug plan in their area. They should select a plan that meets their drug needs and can enroll starting November 15, 2005. For those who do not choose a plan and enroll, Medicare will assist them in enrollment by May 15, 2006.

Those who do NOT qualify for extra help can still join a Medicare prescription drug plan that meets their drug needs. They will have to pay a monthly premium (generally around $32.20 per month in 2006), the deductible, and co-payments. They should select a plan that meets their drug needs and can enroll starting November 15, 2005.

Q: How will the Part D benefit affect Medicare beneficiaries who qualify for Medicaid through "spend down" or medically needy programs?

A: 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. Beneficiaries who are listed in data from states and SSA as of March 2005 as recipients of Medicaid, a Medicare Saving Program (MSP) or Supplemental Security Income (SSI) will receive the subsidy for calendar year 2006. 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.

Q: Do medication costs not covered by the Medicare benefit count toward Medicaid spend-down? Some states are saying that, since medications are a benefit under Medicare, medications no longer count as an allowable expense for spend down.

A: At this time, additional spend down related issues are still under discussion by CMS.

AIDS Drug Assistance Programs (ADAP)

Q: How does drug coverage under Medicare compare to ADAP?

A: 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 Part D coverage is that you will have to pay a penalty for joining Part D if you do not have coverage at least as good as Medicare and if you delay joining a Medicare plan until after the deadline.

Q: Can ADAP funds be used to pay a Medicare beneficiary's prescription benefit costs? Do factors such as ADAP payments not counting toward true-out-o-f pocket (TrOOP) costs need to be considered?

A: 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. CMS estimates between 70 to 80 percent of Medicare beneficiaries living with HIV/AIDS will qualify for a subsidy.

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.

Q: Should ADAPs require clients who are Medicare-eligible to participate in the Medicare Prescription Drug Benefit (Part D)?

A: Yes. While participation in Medicare's drug plans is voluntary, the CARE Act 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 CARE Act 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 CARE Act 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 May 15, 2006, and are not covered under a creditable prescription drug plan for a continuous period of 63 days or longer. Beneficiaries can decline to enroll without penalty only if they have "creditable drug coverage" as defined by Medicare; that is, if the coverage equals or exceeds the actuarial value of defined Medicare standard prescription drug coverage.

  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.

Q: Since ADAP is the payer-of-last-resort, can an ADAP simply drop current clients who are Medicare beneficiaries and tell them to now get their HIV/AIDS medications through Part D?

A: 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.)

Q: How are ADAPs to administratively handle covering the costs (premiums, deductibles, coinsurance and co-pays) of Medicare Part D? To whom do they pay the premiums? How do they manage other costs at the pharmacy point-of-service? How are they to keep track of up to 20 possible plan choices that beneficiaries may make in a state?

A: CMS requires Part D drug assistance plans to coordinate with ADAPs. Because ADAPs are structured differently in different States and have differing resources, each ADAP will need to carefully consider what mechanism allowable under CMS guidelines will be most efficient and cost-effective. CMS' Coordination of Benefits (COB) guidance (http://www.cms.hhs.gov/pdps/cobguidancefinal.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). ADAPs can participate in the CMS eligibility data exchange and pay for their wrap around benefits at the point of sale (p. 27 of guidance) or they can submit paper claims after the point of sale transaction.

Information on the various plan options, as well as their formularies, will be available on www.medicare.gov and www.cms.hhs.gov beginning Fall 2005.

Q: Due to the 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 assistance 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.

Q: Can ADAP - funds & Federal or State - be used 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?

A: ADAP (and other CARE Act) 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.

However, 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.

Q: If a 340B participating ADAP covers the Part D out-of-pocket costs for clients who are Medicare beneficiaries, can the ADAP collect rebates from the pharmaceutical companies for the drugs provided to these clients through a Medicare prescription drug plan?

A: Yes. A letter to Title II grantees and ADAPs from the HIV/AIDS Bureau dated 4/29/2005, clarified conditions under which ADAPs participating in the 340B program and using ADAP funds to purchase health insurance for some clients to provide their HIV/AIDS meds, can claim 340B rebates.

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 340-b program.

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

- ADAP will need to make payments to the PDP on behalf of beneficiaries, because ADAPs and CARE Act grantees may NOT make payments directly to clients.

- PDPs will need to report to the ADAP all information needed to collect rebates on prescriptions for beneficiaries who are ADAP clients, keeping in mind that rebates are usually collected quarterly. For example, ADAPs may 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)

General CARE Act Issues

Q: Will the portion of clawback funds that States are required to the pay the federal government to help fund Medicare Part D be countable for Maintenance of Effort (MOE) purposes?

A: Yes. In the past, grantees have had the option of counting the state portion of Medicaid expenditures for HIV/AIDS medications provided to dual eligibles towards their MOE

State Pharmacy Assistance Programs (SPAP)

Q: Can State contributions to an ADAP be reallocated to a State Pharmacy Assistance Program (SPAP), so that Medicare cost-sharing payments made on behalf of clients will count toward TrOOP?

A: State funds allocated to an ADAP in order to meet the State's Title II 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 CARE Act 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.

Q: Can SPAPs create new groups to meet the Part D cost-sharing requirements of Medicare Part D?

A: Yes.