NASTAD
NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS

ADAP TECHNICAL ASSISTANCE BRIEF NO. 4
COORDINATION OF BENEFITS
NOVEMBER 2012

Introduction

AIDS Drug Assistance Programs (ADAPs) are state administered programs authorized under Part B of Title XXVI of the Public Health Service Act as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Ryan White Program).[1] ADAPs provide Food and Drug Administration (FDA) approved medications to low-income, uninsured or underinsured individuals with HIV who have no other means to obtain these necessary medications. All 50 states, the District of Columbia, American Samoa, the Federated States of Micronesia, Guam, the Marshall Islands, the Northern Mariana Islands, Puerto Rico, the Republic of Palau and the U.S. Virgin Islands are eligible to receive ADAP funding. This is the last in a series of four ADAP technical assistance briefs focusing on cost effectiveness strategies. Other topics include: Eligibility Criteria, Formulary and Utilization Management and Waiting List Management.

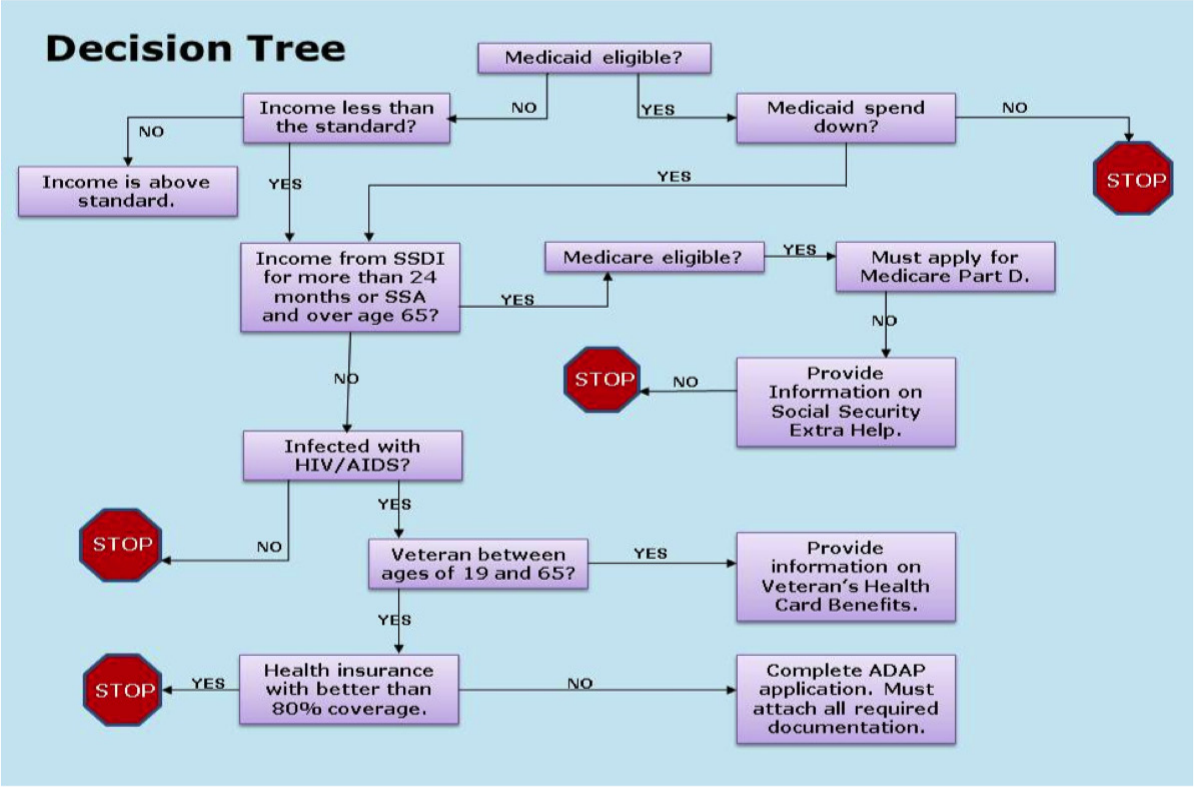
ADAPs are required to be the payer of last resort, meaning they can provide prescription drug coverage when it has been determined that no other coverage exists.[2] Grantees are prohibited from using Ryan White Program funds for services that would otherwise be covered by a federal or state health benefits programs. This provision is widely known as "payer of last resort," and has important implications for ADAPs' coordination with other payer sources.

What is Coordination of Benefits?

ADAPs coordination benefits for their clients by working with other payers of pharmaceuticals (e.g., Medicare, Medicaid, employer provided health insurance, a state high risk insurance pool or pre-existing condition insurance plan (PCIP), or other Ryan White programs) to ensure that ADAP remains the payer of last resort and the responsible entity is billed first. ADAPs must ensure that all clients have been accurately screened and, if eligible, enrolled in other sources of coverage for which they may be eligible. ADAPs can then use their federal and state funds to wrap-around a client's primary source of coverage, for example, Medicare Part D. If gaps exist within the benefits (e.g., a limited number of prescriptions provided per month, a required deductible before benefits begin, or a maximum annual benefit), ADAPs can pay for remaining costs or provide services as a third-party payer to ensure that the applicant receives a comprehensive prescription or health insurance benefit.

ADAPs are responsible for educating clients on payer sources and prescription options available to them beyond the Ryan White Program, many of which can provide more comprehensive coverage. While many clients report preferring ADAP services due to ease of accessibility, ADAP enrollment should be considered only as a last resort; individuals can be enrolled while eligibility for other programs is determined. Once eligibility is determined clients can be transitioned to the appropriate program and expenditures may be back-billed (e.g., Medicaid). ADAPs should ensure that program staff are trained in effective screening methods for eligibility in other prescription drug programs. Some ADAPs have created "decision tree"[3] diagrams to help the client navigate the eligibility screening process and guarantee that all other payers are eliminated prior to ADAP enrollment (see Figure One).

Figure One:



Public and private payers

Medicaid

The priority in collaboration between ADAP and Medicaid is to ensure that ADAP is the payer of last resort. ADAPs also are encouraged to build strong relationships with their state Medicaid program to avoid duplication of services. Some examples of this collaboration are:

- ADAPs provide "wrap around" coverage in states with limited Medicaid formularies for HIV-positive Medicaid beneficiaries to ensure that they receive the full complement of needed medications.
- Memoranda of Understanding (MOU) or Agreement (MOA) to facilitate effective data sharing between ADAP and Medicaid to ensure that ADAP is the payer of last resort.
- Data matches are performed regularly to confirm changes in eligibility for ADAP clients and transition them onto Medicaid, when eligible.
- Support greater coordination of the transition of clients from ADAP to Medicaid as part of the Affordable Care Act's Medicaid expansion plan.
- Ensure proper enrollment and bill payment of clients into Medicaid and reimbursement through back-billing when necessary.

EXAMPLES OF ELEMENTS IN ADAP/MEDICAID MOU/MOA

- Medicaid will communicate HIV/AIDS issues as they arise to the state HIV/AIDS program and allow them to provide input into regulatory changes, standards and quality improvement activities affecting HIV/AIDS specifically.
- ADAP will request periodic review of enrollees with Medicaid. Data specific data may include:
  - First effective date of eligibility
  - Spend down period
  - Spend down amount
  - Third party liability (TPL)
  - Updates on pending applications
  - Patient identification codes
- Medicaid will provide a listing of ADAP clients that have Medicaid numbers and the enrollment dates, so ADAPs ensure they are payer of last resort.
- Medicaid will collaborate with the state HIV/AIDS program to disseminate to Medicaid providers the current standards of care for HIV-positive clients.
- Medicaid will provide the state HIV/AIDS program with information semi-annually on the amount of money spent on patients enrolled in the HIV/AIDS program and expenditures within the program on HIV-related drugs.

Medicare Part D

HRSA/HAB requires ADAPs to ensure that all Medicare Part D eligible clients are enrolled in a prescription drug plan (PDP). Under Medicare Part D, individuals who have an income above 150 percent of the federal poverty level (FPL) and who do not qualify for the low-income subsidy (LIS) are required to make significant payments to receive their drugs. Therefore, most ADAPs have chosen to provide "wrap around" coverage for people living with HIV/AIDS enrolled in Medicare Part D in several ways, including picking up costs for the beneficiaries when they reach the "donut hole" and paying monthly premiums, deductibles and prescription co-payments. As of January 2011, ADAP expenditures made for eligible clients while in the "donut hole" can count towards an individual's true out of pocket (TrOOP). Clients can now get to the catastrophic coverage level faster than before and their Medicare Part D plan will again provide the coverage. For these expenditures to count correctly, ADAPs need to ensure they have a Supplemental Drug Program Data Sharing Agreement with the Centers for Medicare and Medicaid Services (CMS).

State Pharmacy Assistance Programs

State Pharmacy Assistance Programs (SPAPs) are state funded programs that provide financial assistance for prescription drugs to low-income and medically needy senior citizens and individuals with disabilities. As of July 2011, there are 38 states that have laws establishing SPAPs to provide prescription coverage, but only 28 states and the U.S. Virgin Islands currently have programs in operation.[4] Not all SPAPs are the same. According to CMS, some SPAPs are strictly for older adults and people with disabilities, while some have been expanded to include HIV-positive individuals deemed to be disabled and receiving Social Security Disability Insurance. Colorado, Idaho, Illinois, Montana, Oregon, Pennsylvania, Texas and Virginia have SPAPs specifically for HIV-positive individuals.[5]

High Risk Insurance Pools/Pre-existing Condition Insurance Plans (PCIP)

Many states have offered plans that provide coverage if an individual has been locked out of the insurance market because of a pre-existing condition. High-risk pools may also offer coverage if the individual is HIPAA eligible or meets other requirements. High-risk pool plans offer health insurance coverage that is subsidized by a state government. Typically, the premium is up to twice the cost for healthy individuals. Thirty-four states have high risk pools. PCIPs are temporary high risk pools that were created as part of the Affordable Care Act (ACA). These plans are effective until December 31, 2013. Twenty-seven states manage their own PCIP, while 23 states have a federally supported PCIP. ADAPs are able to cover the cost of premiums, deductibles, and prescription co-payments for qualified individuals for either their state's high risk pool or PCIP.

Insurance Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA)[6] gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances (e.g., voluntary or involuntary job loss; reduction in the hours worked; transition between jobs, death, divorce and other life events). Qualified individuals may be required to pay the entire premium for coverage up to 102 percent of the cost of the plan. ADAPs can cover a portion or the full amount of the premiums, as well as deductibles and prescription co-payments under these plans.

Income Screening

It is generally easier for individuals to identify their source of income than it is to identify their source of health coverage.[7] Evaluating an individual's source of income will provide a good indicator of their health coverage.

Determining Health Coverage Based on Income Sources

If the individual's income is:	Their health coverage is:
• Social Security Disability Insurance (SSDI)	• Medicare
• Social Security Retirement	• Medicare
• Supplemental Security Income (SSI)	• Medicaid
• Employment or Support from Spouse or Domestic Partner	• Potential Group Insurance Coverage
• Unemployment, state disability or short-term disability	• Potential COBRA
• Veteran's Compensation/Pension	• Potential VA Health Coverage

Social Security Listing

In June 2008, the Social Security Administration (SSA) implemented revisions to the immune disorders disability criteria, including the criteria for HIV/AIDS related disability.[8] The last major revision to the SSA's immune systems disorders criteria, including their HIV/AIDS disability criteria, occurred in 1993. The revised criteria recognize disabling complications related to HIV and provide instructions for HIV/AIDS disability evaluation. The updated criteria clarify disability evaluation instructions, improving definitions of complications related to treatment, treatment resistance, structured treatment interruptions, and recurrence of symptoms and/or conditions.

As well, the criteria provide improved instructions regarding evaluating disability based on "new" (post-1993) laboratory tests and diagnostic procedures. The criteria also:

- Define unique complications for women with HIV
- Clarify complications related to chronic conditions and treatment side-effects
- Include criteria for cognitive and mental limitations

Individuals who were denied eligibility under the 1993 disability criteria may consider re-applying under the current criteria. The revision to the criteria also presents an opportunity for HIV/AIDS education for third-party payers.

Coordination of Benefits Checklist

When ADAP is coordinating benefits for clients, ADAPs should:

- Provide complete eligibility screening at enrollment and recertification to identify clients who are eligible or have become eligible for other payer sources.
- Collect income and asset information at enrollment and recertification for all clients.
- Re-certify clients as other payer programs update their eligibility criteria in order to transition clients to other payers, if applicable.
- Create and/or conduct training for case managers or other direct client staff on how to effectively screen clients for eligibility in other prescription drug or health insurance programs.
- Educate clients on other payer sources and options.
- Communicate with your HRSA Project Officer and NASTAD when the state is considering changes to your coordination of benefits process, when and if significant challenges arise, and when any changes are actually implemented.

Resources

- National Alliance of State and Territorial AIDS Directors (NASTAD) – www.NASTAD.org
  - National ADAP Monitoring Project Annual Report
  - ADAP Glossary
  - ADAP Frequently Asked Questions
  - 340 B Drug Pricing and ADAP
  - Financial Forecasting
  - ADAP Crisis Task Force
  - Coordination of Benefits
  - Medicaid and Medicare
- HRSA HIV/AIDS Bureau – www.hab.hrsa.gov
- HRSA 340B Prime Vendor Program – www.340bpvp.com
- HRSA Target Center – Technical Assistance for the Ryan White Community - http://careacttarget.org
- HRSA Office of Pharmacy Affairs – www.hrsa.gov/opa
- Kaiser Family Foundation – www.kff.org/hivaids/index.cfm
- Pharmacy Services Support Center – http://pssc.aphanet.org
- ADAP listserv sponsored by NASTAD – NASTADTA@NASTAD.org
- Ryan White HIV/AIDS Treatment Extension Act, Pub. L. No 111-87, October 30, 2009. – www.gpo.gov/fdsys/pkg/PLAW-111publ87/html/PLAW-111publ87.htm
- Current treatment guidelines – http://aidsinfo.nih.gov
- Comprehensive information on ARVs and OI medications – www.aidsmeds.com

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[1] Ryan White HIV/AIDS Treatment Extension Act, Pub. L. No 111-87, October 30, 2009. Available at http://www.gpo.gov/fdsys/pkg/PLAW-111publ87/html/PLAW-111publ87.htm

[2] The Ryan White CARE Act of 1990 [Pub. L. 101-381; SEC. 2605 (a) 4].

[3] Decision Tree figure is reprinted with permission from the Illinois Department of Public Health, AIDS Drug Assistance Program.

[4] National Conference of State Legislatures. (2011) State Pharmaceutical Assistance Programs (Subsidies and discounts for seniors, disabled, uninsured, and others). Available at http://www.ncsl.org/issues-research/health/state-pharmaceutical-assistance-programs-2011.aspx

[5] State Pharmaceutical Assistance Programs. Available at http://www.medicare.gov/pharmaceutical-assistance-program/state-programs.aspx

[6] The original health continuation provisions were contained in Title X of COBRA, which was signed into law (Pub. L. No. 99-272) on April 7, 1986.

[7] Health Coverage Based on Income Sources figure is reprinted with permission from Julie Cross.

[8] Social Security Administration Disability Listing. Available at www.ssa.gov/disability/professionals/bluebook/14.00-Immune-Adult.htm

The National Alliance of State and Territorial AIDS Directors (NASTAD) strengthens state and territory-based leadership, expertise, and advocacy and brings them to bear on reducing the incidence of HIV and viral hepatitis infections on providing care and support to all who live with HIV/AIDS and viral hepatitis. NASTAD's vision is a world free of HIV/AIDS and viral hepatitis

NASTAD is funded under HRSA Cooperative Agreement U69HA22733 to provide technical assistance to states on ADAP program administration. States interested in investigating cost effectiveness strategies may contact NASTAD at NASTADTA@NASTAD.org to discuss specific technical assistance needs. Part B grantees and ADAPs may also request technical assistance through their HRSA project officer.

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