NASTAD

RWHAP PART B/ADAP

Coordination with Medicare

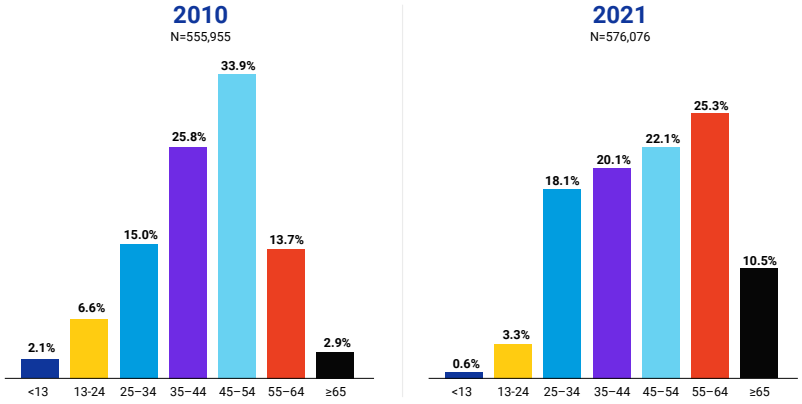
MAY 2023

I. The Growing Importance of Medicare for RWHAP Clients

The demographics of Ryan White HIV/AIDS Program (RWHAP) clients indicate that the number of clients aged 65 years and older is growing. As a result, the proportion of RWHAP Part B and AIDS Drug Assistance Program (ADAP) clients who are Medicare-eligible continues to rise each year. Historically, the majority of Medicare enrollees with HIV were under age 65 and qualified for Medicare based on a disability determination. As more RWHAP clients enter the Medicare program at age 65 and older, the RWHAP must be prepared to adapt to meet the unique needs of these clients.

This resource walks through some of the basic elements of the Medicare program and provides information to support RWHAP Part B/ADAP staff in adapting program activities to better coordinate with Medicare coverage, including providing premium and cost-sharing assistance for clients. For a more comprehensive overview of the Medicare program as well as client-facing resources, please visit the Medicare resources created as part of the Access, Care, & Engagement (ACE) Technical Assistance Center.

FIGURE 1. RYAN WHITE HIV/AIDS PROGRAM CLIENTS, BY AGE GROUP, 2010 AND 2021—UNITED STATES AND 3 TERRITORIES



Source: https://ryanwhite.hrsa.gov/data/

II. Medicare Eligibility and Benefits

Medicare eligibility criteria depend on a client's age and disability status:

Under 65

Citizens and certain lawful permanent residents automatically qualify for Medicare if they receive a disability determination making them eligible for Social Security Disability Insurance (SSDI) or Railroad Retirement Board disability benefits. In addition, individuals who have amyotrophic lateral sclerosis (ALS) or who have End Stage Renal Disease (ESRD) are also eligible for Medicare.

65 years and older

Citizens and certain lawful permanent residents qualify for Medicare when they turn 65.

Medicare pathway	Eligibility criteria
Age	• Over 65 years of age • Most individuals are eligible for premium-free Medicare Part A (can purchase Medicare Part A if not) • Must be U.S. citizen or lawfully present non-citizen (non-citizens with fewer than 10 years of work history in the U.S. are only eligible for Medicare after living in the U.S. for at least five continuous years immediately prior to enrollment)
Disability	• Individuals must qualify for Social Security Disability Insurance (SSDI) or railroad disability annuity payments and have received SSDI or railroad disability payments for at least 24 months (*Exception: Individuals diagnosed with ALS are eligible for Medicare the first month they receive SSDI or railroad disability payments*) • HIV status alone generally does not meet SSDI criteria for a disability, but a person with HIV that demonstrates a combination of physical and mental health conditions may meet the disability criteria
End-stage renal disease (ESRD)	• To be eligible for ESRD Medicare, a person must be under 65, diagnosed with ESRD by a doctor, and demonstrate sufficient work history to qualify for SSDI, Social Security retirement benefits, or Railroad Retirement benefits • Individuals who have coverage through a group health plan (job-based, retiree, or COBRA coverage) may, but are not required to, keep that coverage and delay Medicare enrollment for up to 30 months

Note: Medicare is only available to U.S. citizens and lawful permanent residents. Lawful permanent residents with fewer than 10 years of work history in the U.S. are only eligible for Medicare after living in the U.S. for at least five continuous years immediately prior to enrollment.

The Medicare program consists of the following parts, which will be referenced throughout this resource.

Part A

Medicare Part A provides coverage for inpatient care, which includes inpatient hospital care, skilled nursing facility care, home health care, and hospice care.

Part B

Medicare Part B provides coverage for outpatient medical care. This includes medically necessary outpatient services received from medical providers, durable medical equipment (DME), emergency transportation, preventive care, therapy services, mental health services, some home health services not covered by Part A, and x-rays and lab tests. Part B also covers prescription drugs administered by a licensed medical provider, including long-acting injectable antiretrovirals (ARVs), but it does not cover outpatient prescription drugs.

Together, Medicare Part A and Part B are referred to as **"Original Medicare."**

Part C

Medicare Advantage Plans, sometimes called Part C or MA Plans, are an alternative to Original Medicare (Medicare Parts A and B). They are private plans offered by insurance companies that contract with the federal government to provide Medicare benefits, and cover all Part A and Part B services. Most, but not all, Medicare Advantage Plans include prescription drug coverage. They may also have lower out-of-pocket costs compared to Original Medicare, and some cover extra benefits such as vision, hearing, or dental.

Part D

Medicare Part D plans only cover outpatient prescription drugs. Part D coverage is available only through private insurance companies that have contracted with the federal government. Clients may purchase a Part D plan if they have Medicare Parts A and B, or a Medicare Advantage Plan that does not include prescription drug coverage.

Medigap

Medigap is supplemental insurance for people who have Original Medicare (but not Medicare Advantage). Medigap policies are sold by private companies and help pay for out-of-pocket costs not covered by Medicare, such as copays and deductibles. These plans do not provide assistance for most prescription drug cost-sharing, but could be used to cover cost-sharing for long-acting injectable antiretrovirals and other provider-administered drugs covered under Medicare Part B.

III.
Medicare Enrollment Considerations for RWHAP Part B/ADAP Clients

The RWHAP Part B/ADAP should consider the following areas to ensure that clients are maximizing access to Medicare:

1. Enrollment timing
2. Choosing the right type of Medicare coverage
3. Eligibility for cost-saving programs

Enrollment timing

Like enrollment in Health Insurance Marketplaces, Medicare enrollment is governed by enrollment periods and specific rules for when clients can enroll in coverage. There are three different enrollment periods during which clients can sign up for the different Medicare parts:

An **Initial Enrollment Period (IEP)** is a seven-month period that includes the three months before someone becomes eligible for Medicare, the month they become eligible, and the three months after they become eligible. Individuals who qualify for Medicare based on age become eligible for Medicare the month they turn 65; individuals who qualify based on disability become eligible for Medicare the month in which they receive their 25th disability payment. *(Exception: Individuals diagnosed with ALS are eligible for Medicare the first month they receive a disability payment)*. Individuals may use their IEP to enroll in any Medicare Part for which they are eligible.

A **General Enrollment Period (GEP)** is available for anyone who missed their Initial Enrollment Period and doesn't qualify for a Special Enrollment Period (SEP). The GEP runs from January 1 to March 31 each year. Individuals can enroll in Part A (with premiums) and/or Part B during the GEP. Individuals who enroll in Part B during the GEP can enroll in either a Part D plan or a Medicare Advantage plan between April 1 and June 30.

A **Special Enrollment Period (SEP)** is available in certain circumstances to sign up for coverage outside of the IEP or GEP. Medicare SEPs are available for Part A (with premiums), Part B, Part C, and/or Part D, depending on circumstances.

There are also two annual enrollment periods during which clients who are already enrolled in Medicare can make changes to their coverage:

A **Fall Open Enrollment Period** is available for individuals currently enrolled in Original Medicare or Medicare Advantage to make changes to their coverage. The Fall Open Enrollment Period runs from October 15 to December 7 each year. During this time, individuals can switch between Original Medicare and Medicare Advantage, change their Medicare Advantage plan, change or drop their Part D plan, or join a Part D plan for the first time.

A **Medicare Advantage Open Enrollment Period** is available for individuals currently enrolled in Medicare Advantage to make changes to their coverage. The Medicare Advantage Open Enrollment Period runs from January 1 to March 31 each year. During this time, individuals can switch to a different Medicare Advantage plan (with or without prescription drug coverage) or return to Original Medicare (with or without a standalone Part D plan). However, switching from Original Medicare to Medicare Advantage is permitted only during the Fall Open Enrollment Period.

Enrollment for people turning 65:

Individuals who meet citizenship/residency requirements for Medicare become eligible for the program at age 65. Most clients eligible for premium-free Part A are automatically enrolled in Part A and Part B. Clients ineligible for automatic enrollment in premium-free Part A, residents of Puerto Rico, and people who must pay a Part A premium must actively enroll in Part A and/or Part B during a valid enrollment period.

Medicare Part D enrollment is never automatic, so clients must actively enroll in a Part D plan during a valid enrollment period. Clients must enroll in Part D directly through the insurance company providing the coverage.

Clients who wish to enroll in a Medicare Advantage plan may do so during their IEP, or they may switch from Original Medicare to Medicare Advantage during the annual Fall Open Enrollment Period. Like with Part D enrollment, clients enroll in Medicare Advantage directly through the insurance company providing the coverage.

It is important to enroll in Medicare during the IEP or an SEP to avoid paying a lifetime late enrollment penalty (LEP) for Medicare Part A (only for individuals who must pay a Part A premium), Part B, and/or Part D. Penalties are calculated separately for each Medicare Part and result in more expensive premiums. In most cases, individuals subject to an LEP must pay the higher premium every month for as long as they have Medicare. RWHAP/ADAP may pay the full Medicare premium on behalf of eligible clients, inclusive of the late enrollment penalty.

Enrollment for people qualifying based on disability:

To qualify for Medicare earlier than age 65, a person must receive disability benefits for at least 24 months from Social Security (SSDI) or the Railroad Retirement Board. Enrollment in Medicare Parts A and B occurs automatically at the beginning of the 25th month in which the client receives disability benefits. However, individuals diagnosed with ALS are eligible for Medicare the first month they receive SSDI or railroad disability payments. There is no premium for Part A, but the Part B premium still applies.

If an individual eligible for Medicare based on disability wants to enroll in a Medicare Advantage plan or a Medicare Part D plan, they must enroll directly with the plan during their IEP or another

valid enrollment period. Individuals must enroll during their IEP or an SEP to avoid a Medicare Part D late enrollment penalty (however, clients eligible for Medicare on the basis of disability who have a Part D late enrollment penalty will no longer need to pay the penalty after they turn 65).

Transitioning to Medicare from other coverage

Many clients may be transitioning to Medicare from other forms of coverage, including Marketplace plans and employer-sponsored coverage.

	Transitioning from Marketplace Plans	Transitioning from Employer-Sponsored Coverage
Can clients keep their plan and have Medicare?	Yes, clients can have both Marketplace and Medicare coverage. Medicare acts as the primary payer. However, coverage across Marketplace plans and Medicare may be duplicative. In addition, clients with Medicare are no longer eligible for premium tax credits and cost-sharing reductions for Marketplace plans. Clients may not newly enroll in a Marketplace plan after they enroll in Medicare because it is illegal for insurers to sell Marketplace plans to Medicare beneficiaries.	A client may already have coverage from their employer or a spouse's employer when they become eligible for Medicare. Having both Medicare and employer-sponsored coverage may help reduce out-of-pocket costs. However, clients with employer coverage may choose to delay Medicare enrollment because of the additional monthly premium.
Can clients delay Medicare enrollment and keep existing coverage?	To avoid a late enrollment penalty, clients must enroll in Medicare at age 65 when they are first eligible.	Generally, if clients have employer-sponsored coverage for themselves or through a spouse, they do not have to sign up for Medicare right away. The client can delay Medicare enrollment without incurring late enrollment penalties, as long as they transition to Medicare during a Special Enrollment Period (SEP). Both Medicare Part B and Part D have SEPs that are triggered when employer-sponsored coverage ends. These SEPs allow someone to enroll in Medicare Part B up to eight months after coverage ends and in Medicare Part D up to two months after coverage ends. In most cases, clients should only delay Medicare enrollment if their employer coverage is the primary payer and Medicare is secondary (meaning the employer plan pays first for medical bills and Medicare pays second). If the client's employer-based coverage pays secondary and the client delays Medicare enrollment, the employer coverage alone may provide little or no coverage for needed care. Whether Medicare acts as the primary or secondary payer depends on the size of the employer.

RWHAP Part B/ADAP Tip: Programs should work with clients to proactively determine a client's eligibility date for Medicare and help them enroll during their Initial Enrollment Period to avoid penalties.

Helping Clients Choose the Right Medicare Coverage

RWHAP Part B/ADAP clients who are eligible for Medicare face many choices when it comes to their Medicare coverage. The most significant choice is whether to enroll in traditional Medicare (Medicare Part A and Part B) or to enroll in a Medicare Advantage plan (Medicare Part C). Medicare Advantage options vary by state, as do Medicare Part D options. Considerations that may guide a client's decision include:

- **Will the client have access to their providers?**
  Medicare Advantage plans use provider networks that may provide more limited access to providers than traditional Medicare. RWHAP Part B/ADAP programs should work with clients to assess provider availability to help inform a client's choice.
- **What is the most affordable option?**
  Traditional Medicare has a standard cost-sharing design where beneficiaries will generally pay 20% of the cost of the service for most cost-sharing. Medicare Advantage plans, however, may use different plan designs and may sometimes have lower cost-sharing for some services.
- **Are there extra benefits available through Medicare Advantage that are particularly important to the client?**
  Medicare Advantage plans may offer supplemental services that are not available through traditional Medicare. These could include nutrition services, adaptive technology, and sometimes even dental services. Medicare Advantage plans in some states also include "Special Needs Plans," which may provide integrated services for individuals eligible for both Medicare and Medicaid. Some Medicare Advantage plans also help pay some or all of a client's Part B premium.
- **What is the cost-sharing for HIV medications?**
  Federal law requires Medicare Part D plans to cover all HIV antiretroviral medications without prior authorization or step therapy. However, Part D plans may choose on which tier to place HIV drugs, which in turn impacts the cost-sharing associated with the drug. Specialty tiers can sometimes carry very high cost-sharing for clients. It is important to assess Part D options available to determine the best plan for the client.

RWHAP Part B/ADAP Tip: Programs should ensure that assisters, case managers, and other front-line RWHAP staff working with clients on Medicare enrollment are aware of Medicare Advantage and Medicare Part D plan options available, for instance, by using the Medicare Plan Finder tool.

Dually Eligible Beneficiaries and Medicare Savings Programs

Many Medicare enrollees are dually eligible for Medicaid. Dually eligible beneficiaries are enrolled in Medicare and receive full Medicaid benefits and/or assistance through Medicare Savings Programs (MSPs). MSPs are paid for by state Medicaid programs and assist Medicare enrollees in bringing down their premium and/or out-of-pocket costs. To qualify for an MSP, a client must have Medicare Part A and meet their state's income and asset guidelines, including any spend-down requirements. Dually eligible individuals are automatically enrolled in the Extra Help program to help with their prescription drug costs.

Some dually eligible enrollees may be able to enroll in a special type of Medicare Advantage plan called a "Special Needs Plan" that combines Medicare and Medicaid benefits. These Special Needs Plans are not available in every state, but may be an option in some states. To see what Medicare Advantage plans are available in your area, see the CMS Plan Finder Tool.

Program	Benefits	Eligibility
Aged, Blind, and Disabled (ABD) Medicaid (Full Medicaid Benefits)	Medicare enrollees who qualify under their state's Medicaid eligibility criteria are eligible for full Medicaid benefits in addition to Medicare. The types of Medicaid available for people with Medicare varies by state. Medicaid can cover services that Medicare does not, such as transportation to medical appointments. For services covered by both forms of insurance, Medicare pays first and Medicaid may cover the client's cost-sharing. Many Medicare enrollees with full Medicaid also qualify for an MSP that provides premium and/or cost-sharing assistance; however, some state Medicaid programs pay for Part B premiums for clients with full Medicaid who are not eligible for an MSP.	States decide income and asset criteria. Some states offer a "spend-down" program for clients whose income is above the state Medicaid income criteria. Enrollees may need to show that they meet state-specific medical criteria to qualify for certain Medicaid categories.
MSP: Qualified Medicare Beneficiary (QMB)	Medicaid pays for Medicare Part A and Part B premiums. Medicaid also pays for out-of-pocket costs (deductibles, coinsurance, and copayments) when seeing a Medicare provider or a provider in the client's Medicare Advantage plan network. QMB enrollees can also receive full Medicaid benefits, if eligible ("QMB Plus").	Monthly income limit of 100% FPL. Most states also have an asset limit. Enrollees must be enrolled in Medicare Part A. In many states, clients who do not have Part A but are eligible for QMB may be able to enroll in Part A outside of regular Medicare enrollment periods.
MSP: Specified Low-Income Medicare Beneficiary (SLMB)	Medicaid pays for Medicare Part B premiums, including up to three months of retroactive reimbursement for Part B premiums. SLMB enrollees can also receive full Medicaid benefits, if eligible ("SLMB Plus").	Monthly income limit of 101-120% FPL. Most states also have an asset limit. Enrollees must be enrolled in Medicare Part A.
MSP: Qualifying Individual (QI)	Medicaid pays for Part B premiums, including up to three months of retroactive reimbursement for Part B premiums (limited to premiums paid in the same calendar year as the MSP effective date). QI applications are approved on a first-come, first-served basis due to limited federal funding for the program.	Monthly income limit of 121-135% FPL. Most states also have an asset limit. Enrollees must be enrolled in Medicare Part A and be ineligible for any other Medicaid coverage.
MSP: Qualified Disabled Working Individual (QDWI)	Medicaid pays Part A premiums.	Monthly income limit up to 200% FPL. Most states also have an asset limit. Enrollees must be under age 65 and employed with a qualifying disability. Enrollees must be ineligible for any other Medicaid coverage.

RWHAP Part B/ADAP Tip: As part of their obligation to vigorously pursue comprehensive coverage options for clients, programs should work with low-income clients on Medicare to ensure they are accessing any Medicaid benefits or financial assistance to accompany their Medicare benefits.

IV.
Medicare Premiums and Cost-Sharing

Medicare charges monthly premiums and cost-sharing. The following chart walks through typical premium and cost-sharing amounts charged across Medicare Parts.

Medicare Premiums and Cost-Sharing (not including Medicare Savings Programs or Extra Help)		
	PREMIUMS (2023)	COST-SHARING AND OUT OF POCKET CAPS (2022)
Medicare Part A	Many clients will not have a premium for Part A. Clients are eligible for premium-free Part A if they (or their spouse) worked and paid Medicare taxes for at least 10 years, if they receive Railroad Retirement benefits, or if they worked as a federal, state, or local government employee. For clients who do not meet the criteria for premium-free Part A, the premium can be up to $506/month depending on how many years they (or their spouse) have worked in the U.S.	$1,600 deductible for each benefit period (benefit periods are based on hospital stays); coinsurance for longer inpatient stays No out-of-pocket cap
Medicare Part B	Varies depending on income, but standard premium is $165/month	$226 annual deductible, followed by 20% coinsurance No out-of-pocket cap
Medicare Part D	Varies depending on income, but average Part D premium is $33/month	Annual deductible varies by plan, but cannot be more than $505. Copayment and coinsurance vary depending on plan and drug tier. No out-of-pocket cap, but costs change throughout the year
Medicare Advantage	Most plans do not charge a premium. For plans that have a premium, the premium is typically $100 or less per month.	Consists of copayments and coinsurance for services Annual out-of-pocket cap (for Part A and Part B services only) of ~$7,550 (plans may set lower limits)
Medigap	Premiums vary considerably depending on location, age, type of plan, and other factors	N/A

The chart above does not include the assistance many clients may be eligible for through Medicare Savings Programs and Medicare Part D Extra Help. RWHAP Part B/ADAPs may also consider assisting clients with their Medicare premiums and cost-sharing. The following sections walk through program considerations for RWHAP Part B/ADAP premium and cost-sharing assistance across Medicare Parts.

Medicare Premium Assistance

RWHAP Part B/ADAP may cover Medicare Part B, Medicare Part D, and Medicare Advantage premiums on behalf of clients (note: RWHAP recipients may not pay premiums for Medicare Part A, which only covers hospital/inpatient services). Programs should review the HRSA HIV/AIDS Bureau (HAB) Policy Clarification Notice 18-01: Clarifications Regarding the Use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost-Sharing Assistance.

- **Paying Medicare Part B premiums**
  For most individuals, the Medicare Part B premium is deducted directly from monthly Social Security benefits. Though HRSA HAB explicitly allows RWHAP Part B/ADAP to cover a client's Medicare Part B premiums (as long as the program is also providing assistance with Medicare Part D premiums or cost-sharing), there is currently no mechanism for RWHAP to make Medicare Part B premium payments directly to the Social Security Administration.
- **Paying Medicare Part D premiums**
  Payment of Medicare Part D premiums are administered in a similar manner as payment of private insurance premiums on behalf of clients. The Medicare Part D program is administered through private health plans, all of which have systems in place to accept payments made by RWHAP Part B/ADAPs. Like private insurance, this may include the option to provide batch premium payments to the plan on behalf of multiple clients.
- **Paying Medicare Advantage premiums**
  RWHAP Part B/ADAPs may pay premiums for Medicare Advantage plans as long as the Medicare Advantage plan has a prescription drug benefit or the RWHAP Part B/ADAP is also paying for standalone Medicare Part D premiums or cost-sharing. The premium payments for Medicare Advantage plans are administered in the same manner as premiums for Medicare Part D plans described above.
- **Paying Medicare supplemental plan/Medigap premiums**
  RWHAP Part B/ADAPs may pay premiums for clients enrolled in a Medicare supplemental plan, or Medigap. The premium payments for Medigap policies are administered in the same manner as premiums for Medicare Part D and Medicare Advantage plans described above.

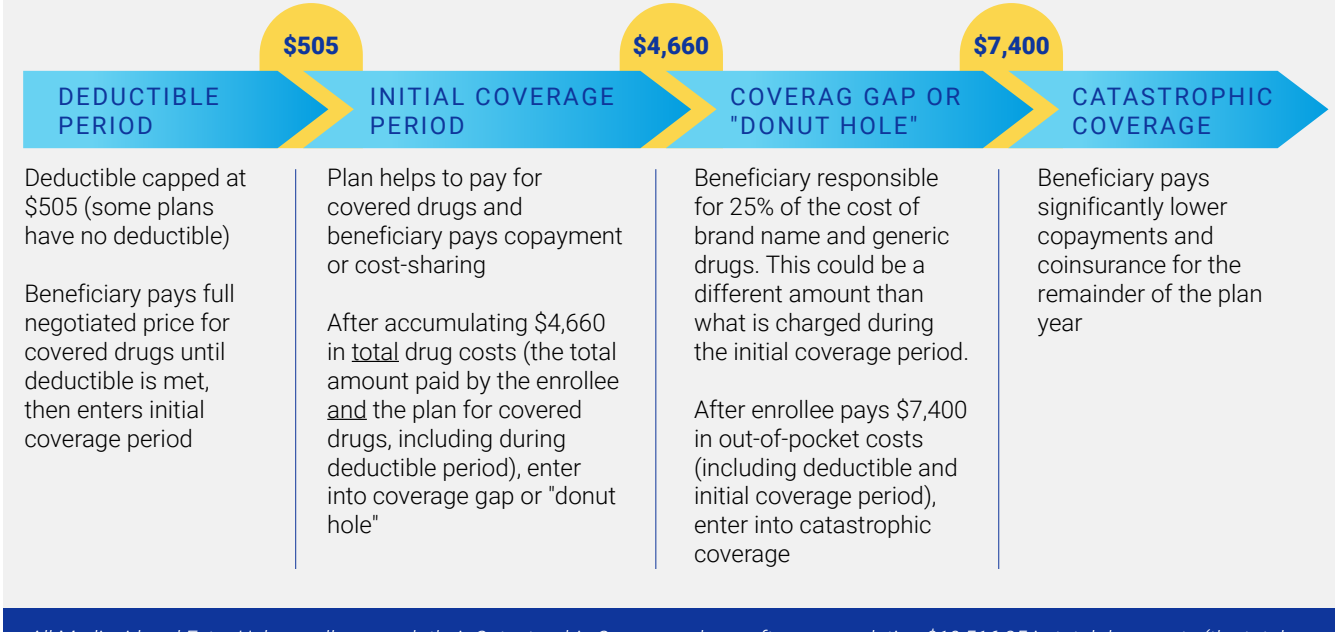
RWHAP Part B/ADAP Tip: Programs should ensure that the Medicare plan includes prescription drug coverage or that the program is also paying for Medicare Part D premiums or cost-sharing to meet HRSA HAB requirements for insurance assistance.

Medicare Prescription Drug Cost-Sharing

RWHAP Part B/ADAP may pay prescription drug cost-sharing for clients enrolled in Medicare Part D and Medicare Advantage plans. Federal law requires Medicare plans to cover all HIV antiretroviral medications; however, plans have flexibility to place medications on cost-sharing tiers, including specialty tiers with high coinsurance.

Many low-income clients may also be eligible for a program called "Extra Help" or "low-income subsidy" (LIS), which helps qualifying Medicare Part D beneficiaries with their premiums, deductibles, copayments, and coinsurance. The level of assistance individuals receive depends on their income and resources and the other programs for which they are eligible. Individuals who have Medicaid, SSI, or one of the Medicare Savings Program discussed above are automatically enrolled in Extra Help. Other individuals eligible for Extra Help must enroll through the Social Security Administration. Individuals who qualify for Extra Help will not be charged a Medicare Part D late enrollment penalty. These individuals will also qualify for a Special Enrollment Period that allows them to change Medicare Part D plans outside of the regular open enrollment period (once per calendar quarter during the first nine months of the year).

The following figure describes the different phases of Medicare prescription drug cost-sharing in 2023.



All Medicaid and Extra Help enrollees reach their Catastrophic Coverage phase after accumulating $10,516.25 in total drug costs (the total amount paid by the enrollee and the plan for covered drugs). Enrollees eligible for full Extra Help or full Medicaid benefits have no annual deductible, pay copays ranging from $1.45 to $10.35 per fill until they reach the Catastrophic Coverage phase, and have no copays after they reach the Catastrophic Coverage phase. Enrollees eligible for partial Extra Help have an annual deductible of no more than $104, pay 15% coinsurance for all covered drugs until they reach the Catastrophic Coverage phase, and pay reduced cost-sharing after they reach the Catastrophic Coverage phase.

Through the passage of the Affordable Care Act (ACA), ADAP payments count toward a beneficiary's true out-of-pocket cost (TrOOP). This means ADAP cost-sharing payments help clients meet the out-of-pocket costs needed to get the client out of the Medicare Part D "donut hole" and into catastrophic coverage, where the client will pay significantly lower (or no) cost-sharing. To ensure that ADAP cost-sharing payments are counted appropriately, ADAPs must execute a data-sharing agreement with the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees the Medicare program. This data exchange allows ADAPs to send monthly information to CMS about prescription drug cost-sharing made on behalf of clients enrolled in Medicare Part D. This data is in turn shared by CMS with Part D plans to ensure that the cost-sharing is counted appropriately. More information on how to initiate a data-sharing agreement with CMS and the data elements this agreement must include can be found in the CMS ADAP Data-Sharing Agreement User Guide. While most states provide Part D cost-sharing assistance through ADAP, several states have what are called "State Pharmaceutical Assistance Programs" (SPAPs) that may be operated separately from ADAP and provide assistance specifically for Medicare beneficiaries. Qualified SPAP payments also count toward TrOOP.

Finally, ADAPs should be aware of any opportunities, limitations, and requirements associated with the submission of partial pay rebate claims to manufacturers for prescription drug copayments made on behalf of Medicare Part D beneficiaries. ADAPs should check with NASTAD and the ADAP Crisis Task Force-negotiated agreements with manufactures on file via the Online Technical Assistance Platform (OnTAP) for this information.

RWHAP Part B/ADAP Tip: Programs should ensure that they have a data-sharing agreement with CMS. They should also ensure they are abiding by manufacturer requirements for submission of partial pay rebate claims for Medicare Part D cost-sharing paid on behalf of clients.

Medicare Medical Cost-Sharing

RWHAP Part B/ADAP clients enrolled in Medicare will also face cost-sharing for medical services (for example, provider visits and necessary laboratory services). RWHAP Part B funds may be used to assist clients with this cost-sharing. Unlike premium payments, which are typically made to a plan, medical cost-sharing payments must go directly to the medical provider. RWHAP Part B recipients set up their medical cost-sharing programs in different ways, including engaging a medical benefits manager or other third-party vendor.

RWHAP Part B/ADAP Tip: Programs that do not currently have a mechanism to pay medical cost-sharing for clients should investigate the feasibility of doing so as assisting with these payments may help clients maintain uninterrupted access to necessary care and treatment.

Provider-Administered ARV Medications (Including Long-Acting Injectables)

As of April 2022, there are two Food and Drug Administration (FDA)-approved provider-administered ARV medications for the treatment of HIV, including an intravenously administered biologic for heavily treatment-experienced patients and co-packaged long-acting injectables that achieve virologic suppression on a stable antiretroviral regimen. These medications are covered differently than oral medications, including by Medicare. Unlike oral medications, medications that generally required administration by a licensed medical provider are often covered under Medicare Part B. This means that cost-sharing associated with medication is likely to be 20% coinsurance for those on Original Medicare. For clients enrolled in a Medicare Advantage plan, the coverage and cost-sharing may be different and programs will have to assess the medical benefit drug formulary for those plans. Some Medicare Advantage plans that include Part D may cover provider-administered antiretrovirals as a pharmacy benefit.

RWHAP Part B/ADAPs assisting Medicare clients with cost-sharing associated with provider-administered ARV medications should also consider the cost-sharing for a provider visit and administration of the drug, both of which are also Medicare Part B services. For more information on procurement considerations for long-acting injectable ARVs, see NASTAD's "Cabenuva Considerations for AIDS Drug Assistance Programs."

RWHAP Part B/ADAP Tip: Programs assisting clients with cost-sharing associated with long-acting injectable and other antiretroviral medications requiring provider administration should consult the HRSA HAB Program Letter on long-acting injectables for guidance on allowable uses of RWHAP Part B/ADAP funds.

V.
Partnerships and Resources

RWHAP Part B/ADAPs should consider partnerships with experts in their states who are well-versed in Medicare and may provide additional resources to assist clients with navigating Medicare enrollment. There are also existing national resources – including resources focused on the RWHAP – that may help programs to increase their knowledge of Medicare. Resources include:

- **The State Health Insurance Assistance Programs (SHIPs)** provide local insurance counseling and assistance to Medicare-eligible individuals, their families, and caregivers. SHIPs are available in every state and offer an important resource to help clients understand their Medicare options.
- **The Access, Care, and Engagement Technical Assistance (ACE TA) Center** is funded through a HRSA HAB cooperative agreement and builds the capacity of the RWHAP community to navigate the changing health care landscape and help people with HIV access and use their health coverage to improve health outcomes. Resources include extensive information on Medicare enrollment.
- **Medicare Interactive** is a free independent online reference tool thoughtfully designed by the Medicare Rights Center to help older adults and people with disabilities navigate the complexities of health insurance. It provides easy-to-understand answers to questions posed by Medicare enrollees, their families and caregivers, and the professionals serving them.
- **NASTAD's ADAP Glossary** is a resource for ADAPs that provides definitions and links to relevant resources for terms that are frequently used as part of ADAP administration.

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