NASTAD

RWHAP PART B/ADAP

Coordination with Medicare

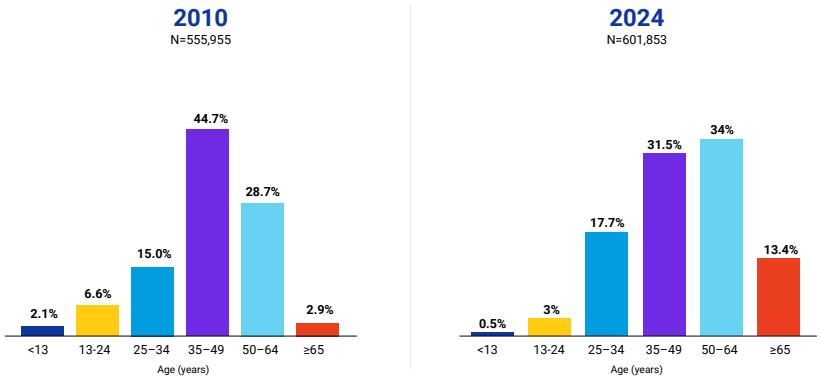
FEBRUARY 2026

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 needsthe 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 more resources on working with Medicare-eligible Ryan White clients, please visit the Access, Care, & Engagement (ACE) Technical Assistance Center.

FIGURE 1. RYAN WHITE HIV/AIDS PROGRAM CLIENTS, BY AGE GROUP, 2010 AND 2024—UNITED STATES AND 3 TERRITORIES



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

II. Medicare Eligibility and Benefits

Effective July 2025, only U.S. citizens, lawful permanent residents (LPRs, or "green card" holders), Cuban/Haitian Entrants, and Compact of Free Association (COFA) migrants can newly enroll in Medicare. Coverage for existing Medicare enrollees who do not meet the new eligibility restrictions will terminate by January 2027.

Medicare eligibility criteria depend on an individual's age and disability status:

Under 65

Individuals may 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

Individuals may qualify for Medicare after they turn 65.

Medicare pathway	Eligibility criteria
Age	• Aged 65 years and older • Eligible individuals with at least 10 years of cumulative work history in the U.S. are eligible for premium-free Medicare Part A (can purchase Medicare Part A if not) • Must be U.S. citizen, LPR, Cuban/Haitian entrant, or COFA migrant (eligible 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*) • Must be U.S. citizen, LPR, Cuban/Haitian entrant, or COFA migrant • 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

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 (ARTs), but it does not cover outpatient prescription drugs.

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.

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

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. Individuals may purchase a Part D plan if they have Medicare Part A and/or Part 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 eligible individuals can enroll in coverage. There are three different enrollment periods during which individuals 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. The coverage start date depends on when the individual enrolls during the seven-month IEP.

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, with coverage starting the first day of the month following enrollment. Individuals will have an SEP to join a Part D plan starting the day they submit their application for premium Part A or Part B. Individuals eligible for premium-free Part A may enroll at any time and do not need to wait for the annual GEP.

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. Coverage start dates vary. Enrolling in Part A or Part B through an SEP will generally not result in late enrollment penalties (LEPs); however, individuals may face Part D LEPs if they delay coverage and later sign up through an SEP.

Beginning January 1, 2023, individuals who miss an enrollment opportunity due to an "exceptional circumstance" may be eligible for an SEP to sign up for Medicare Part A (with premiums) or Medicare Part B. Exceptional circumstances include: release from incarceration, loss of Medicaid coverage, receiving incorrect information from a health plan or employer, natural disasters, or other conditions outside of an individual's control that made them miss a Medicare enrollment period. Individuals who enroll through this SEP will have two months to join a Medicare Advantage Plan (with or without drug coverage) or a standalone Part D plan. Individuals eligible to enroll in Medicare using an "exceptional circumstances" SEP should submit Form CMS-10797.

SEP for individuals released from incarceration on or after January 1, 2023. Individuals who did not enroll in Part B or premium Part A when first eligible because they were incarcerated may use this SEP. Clients have 12 months from the day they are released from incarceration to sign up for Medicare Part A (with premiums) and/or Part B. Coverage will begin the first day of the month following enrollment, or up to 6 months retroactive. More information about accessing Medicare and Social Security benefits after incarceration can be found here.

SEP for individuals who have lost Medicaid on or after January 1, 2023. This SEP begins when the enrollee receives their Medicaid termination notice and ends six months after their Medicaid ends. Coverage will begin the first day of the month following enrollment, or retroactive up to the last day of the client's Medicaid coverage.

More information about "exceptional circumstances" SEPs can be found here.

There are also two annual enrollment periods during which individuals 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. Coverage begins on January 1 of the next year.

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. Coverage begins the first of the month after the plan receives an application.

Enrollment for people turning 65:

Individuals who meet citizenship/residency requirements for Medicare become eligible for the program at age 65. Clients receiving retirement benefits from Social Security or the Railroad Retirement Board when they turn 65 are automatically enrolled in Part A and Part B. Clients not yet receiving retirement benefits, 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.

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.

Once they are enrolled in Part A and/or B, the individual can choose to sign up for Medicare Part C (Medicare Advantage) or Medicare Part D (prescription drug coverage). Individuals can enroll in Part C or D during their IEP, an SEP, or the Fall Open Enrollment (October 15 – December 7). Individuals can compare plan options and enroll by visiting the Medicare website or calling 1-800-MEDICARE.

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

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 when they are first eligible or within a specified timeframe after they lose other coverage.	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 may cover some or all client cost-sharing). However, if the client's employer-based coverage pays secondary and the client delays Medicare enrollment, the employer plan 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 Original Medicare (Medicare Part A and Part B) with a standalone Part D plan, or 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 Original 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?**
  Original 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 Original Medicare. These could include nutrition services, adaptive technology, and sometimes even dental services. Medicare Advantage plans in some states also include "Special Needs Plans (SNPs)," 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 state-funded Medicaid programs that help Medicare enrollees reduce their premiums and/or out-of-pocket costs. To qualify for an MSP, an individual 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 (See the Medicare Prescription Drug (Part D) Cost-Sharing section for more information about Extra Help).

Some dually eligible individuals can enroll in a Medicare Advantage "Special Needs Plan (SNP)" that combines Medicare and Medicaid benefits into one plan. 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 also meet their state's Medicaid eligibility criteria can receive full Medicaid benefits in addition to Medicare. Medicaid can cover services that Medicare does not, such as transportation to medical appointments. For services covered by both programs, Medicare pays first and Medicaid may cover the client's cost-sharing. Many Medicare enrollees with full Medicaid also qualify for an MSP that covers their premium and/or cost-sharing. However, some states cover the Medicare Part B premium for clients with full Medicaid even if they do not meet the separate MSP criteria.	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. Applicants for QMB must already be enrolled in Medicare Part A. Clients who owe Part A premiums can enroll in Medicare "conditionally" while they wait for their QMB application to be approved. In "Part A buy-in" states, QMB-eligible clients who do not have Part A but are eligible for QMB may be able to can 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. 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 (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 (2026)	COST-SHARING AND OUT OF POCKET CAPS (2026)
Medicare Part A	Many clients will not have a premium for Part A. For clients who do not meet the criteria for premium-free Part A, the premium can be up to $565/month depending on how many years they (or their spouse) have worked in the U.S.	$1,736 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	Standard premium is $202.90/month	$283 annual deductible, followed by 20% coinsurance No out-of-pocket cap
Medicare Part D	Average Part D premium is $34.50/month	Annual deductible varies by plan but cannot be more than $615. Annual out-of-pocket cap of $2,100
Medicare Advantage (Part C)	Most plans do not charge a premium. For plans that have a premium, the national average is $24/month	Consists of copayments and coinsurance for services Annual out-of-pocket cap (for Part A and Part B services only) of $9,250 (plans may set lower limits) Out-of-pocket prescription drug costs are capped at $2,100/year
Medigap	Premiums vary considerably depending on location, age, type of plan, and other factors	N/A

Medicare Premium Assistance

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.

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**
  Medicare Part D premiums are handled the same way as private insurance premiums paid on behalf of clients. All Medicare Part D plans 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 on behalf of multiple clients.
- **Paying Medicare Advantage (Part C) premiums**
  RWHAP Part B/ADAPs may pay premiums for Medicare Advantage plans as long asif 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 (however, in most cases, clients with Part C do not need to purchase a separate drug plan). As with Part D plans, Medicare Advantage premiums are paid directly to insurance companies.
- **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. As with Part C and Part D plans, Medigap premiums are paid directly to insurance companies.

RWHAP Part B/ADAP Tip: Due to Medicare's "Six Protected Classes" policy, it is expected that all Medicare drug plans (Part D plans and Medicare Advantage plans providing drug coverage) will meet HRSA's minimum prescription coverage requirements for insurance assistance, but programs must ensure that a client's Medicare Advantage plan includes prescription drug coverage. In most cases, Medicare Advantage enrollees do not need to also purchase a separate Part D plan.

Programs are also encouraged to review every plan for which RWHAP pays a premium to confirm that the plan meets criteria important to the ADAP, for example, that preferred pharmacies are in-network and the client's non-ARV drugs are covered.

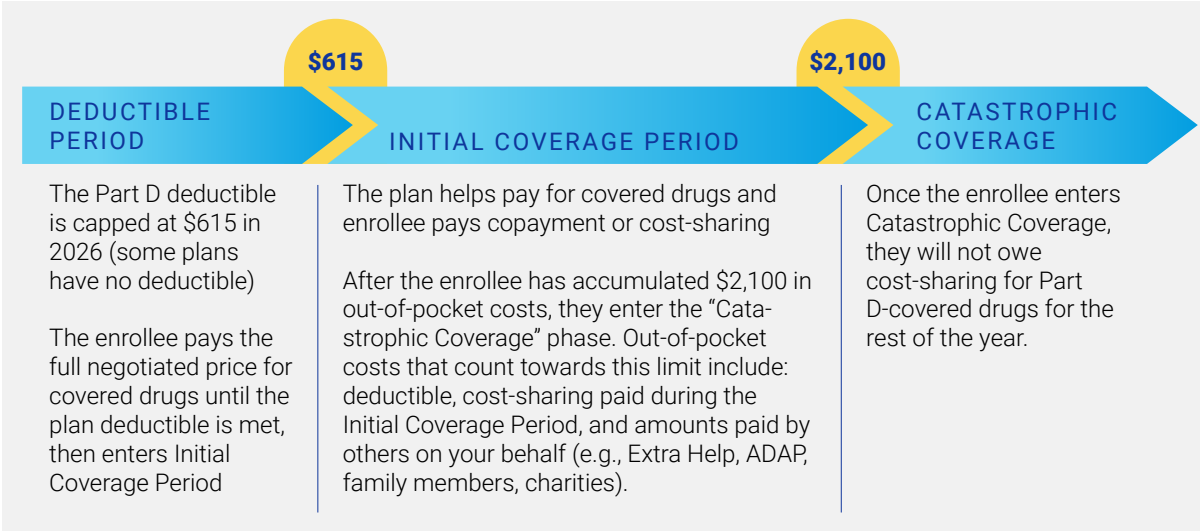
Medicare Prescription Drug (Part D) Cost-Sharing

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. Individuals who have Medicaid, Supplemental Security Income (SSI), or an MSP will automatically qualify for Extra Help regardless of whether they meet Extra Help's income and asset eligibility requirements. Other individuals eligible for Extra Help must enroll through the Social Security Administration. Clients who qualify for Extra Help will not owe a Medicare Part D late enrollment penalty. Extra Help enrollees are eligible 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).

Starting in 2024, full Extra Help is available to individuals with income less than 150% FPL (prior to 2024, individuals from 135-150% FPL were only eligible for partial subsidies). In 2026, those with full Extra Help will pay a low or no premium for their drug plan, a $0 deductible, up to $5.10 copayments for generic drugs, and up to $12.65 copayments for brand-name drugs. Those with full Medicaid pay even lower copays.

The following figure describes the different phases of Medicare prescription drug cost-sharing in 2026.



Enrollees eligible for Extra Help or full Medicaid benefits have no annual deductible, pay no more than a $5.10 copayment for generic drugs and an $12.65 copayment for brand name drugs per fill until 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).[1] This means ADAP cost-sharing payments help clients meet the annual out-of-pocket cost threshold and move into catastrophic coverage, where the client will not owe cost-sharing for Part D-covered drugs for the rest of the year. 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.

[1] In addition to ADAP payments, CMS also includes the following as part of a beneficiary's TrOOP: discounts provided by drug manufacturers under the Medicare coverage gap discount program, Indian Health Service assistance, and most charities providing cost-sharing support (manufacturer copay assistance programs do not meet this definition). A complete list is available here.

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 paid directly to a plan, medical cost-sharing payments are paid 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 ART 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 require 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.
- **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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