A PUBLICATION OF THE NATIONAL ACADEMY FOR STATE HEALTH POLICY July 2018

Targeted Policy Resource Series: State Strategies to Improve Collaboration Between Medicaid and AIDS Drug Assistance Programs

Lyndsay Sanborn

Introduction

HIV is a complex and chronic infectious disease, requiring long-term adherence to medication regimens, care coordination, and access to care not only to treat the disease itself, but for common, co-occurring conditions that can impede HIV treatment, such as mental health and substance use disorders (SUD). State strategies to support people living with HIV (PLWH) can be complicated by the overlapping roles of Medicaid and Ryan White HIV/AIDS programs (RWHAPs), including the overlap in the populations they serve. Eligibility criteria for these programs vary across states, but both programs serve low-income PLWH, provide medical care, prescription drugs, and supportive services, and experience frequent "churn" as PLWH gain and lose eligibility for these programs. While Medicaid is the largest payer of health care services for PLWH,[1] RWHAP AIDS Drug Assistance Programs (ADAPs) provide a critical safety net for PLWH who are not eligible for Medicaid and provide wrap-around services and supports for others.

Increased collaboration between Medicaid and RWHAP ADAPs can help states minimize duplication and fragmentation of services and ensure that scarce resources are used most effectively. To better coordinate Medicaid pharmacy benefits and ADAP services, states have a number of policy levers to consider, such as examining drug formulary design and purchasing strategies (including the use of 340B discounts), and prescribing policies.

About This Series

States, through their Medicaid and Ryan White HIV/AIDS programs, play critical roles in supporting access to care for people living with HIV (PLWH). PLWH can be among the most medically complex individuals covered by state health programs, incurring costs up to five-times greater than the average Medicaid beneficiary.

Research shows that early, comprehensive treatment can significantly improve health outcomes for PLWH and reduce their overall cost of care. Given increasingly constrained state budgets, state policymakers are working to ensure that care to this population is accessible, well-coordinated, and effective.

This series of reports are designed to give Medicaid and RWHAP administrators an understanding of each other's programs, and highlight key opportunities for collaboration.

Overview of Medicaid Outpatient Prescription Drug Coverage

All state Medicaid programs provide outpatient prescription drug coverage to their beneficiaries.[2] States may reimburse pharmacies for drugs dispensed to Medicaid beneficiaries directly or through Medicaid managed care plans. Each state manages its own drug coverage program, using a number of tools and processes to address the needs of its Medicaid population within the context of scarce state resources. Through preferred drug lists (PDLs), states establish which drugs are available to beneficiaries without the need for prior authorization, step therapy approaches, or other processes. PDLs can help direct providers and patients toward lower-cost or generic drugs. States may also use prescription limits, pharmacy benefit managers, and other approaches designed to manage costs while supporting access to necessary medications. States also participate in the Medicaid Drug Rebate Program, a federally-administered program that requires drug manufacturers to negotiate an agreement with the Secretary of Health and Human Services to provide drug rebates to state Medicaid programs. Under the agreement, state Medicaid programs must cover all drugs

made by that manufacturer in their Medicaid drug coverage program.[3] Participating companies must also provide discounted drugs through the 340B Drug Pricing Program.[4]

Overview of AIDS Drug Assistance Program

RWHAP is authorized by Title XXVI of the Public Health Service Act[5] and administered by the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau. RWHAP funds and coordinates with cities, states, and local community-based organizations to provide direct health care and support services to PLWH. A major component of RWHAP is the state ADAP, which provides eligible PLWH with prescription drugs, as well as assistance with health insurance premiums and drug cost-sharing. All US states and territories have an ADAP program, supervised by the state health department or another state government agency. Each state ADAP maintains a formulary of drugs that can be paid for by ADAP funds. Formularies vary by state, but must include drugs from each class of HIV antiretrovirals (ARTs). Other medications may be covered by a state's ADAP formulary, including those for the prevention or treatment of HIV-related opportunistic infections, and those that treat mental health and other co-morbid conditions. ADAP Advisory Committees, typically comprised of clinicians, consumers, and RWHAP program administrators, make recommendations and decisions about changes to a state's ADAP formulary. The 340B Drug Pricing Program, administered by HRSA, allows ADAPs to access discounted outpatient drug pricing through a direct purchase or pharmacy network/rebate model.[6] Title XXVI of the Public Health Service Act designates RWHAPs as payers of last resort, meaning funds may not be used to pay for claims that could be paid by private insurance or through another state or federal benefit, including Medicaid.[7] If an ADAP client becomes eligible for coverage under another payer, the ADAP must retroactively back-bill that payer for services provided to recoup costs.

Both ADAPs and Medicaid or Medicaid managed care plans have the ability to contract out some or all of their pharmacy operations to pharmacy benefit managers (PBM). These organizations provide administrative and pharmacy claims management services, which can include contracting with pharmacy networks, developing and managing formularies, performing drug utilization review, and mail order pharmacy services.[8]

ADAP Drug Purchasing Models

Direct Purchase Model: ADAPs can purchase drugs from manufacturers, wholesalers, or a purchasing agent (e.g., a pharmacy benefits manager). Drugs are dispensed by a pharmacy or contracted pharmacy services provider.

Pharmacy Network/Rebate Model: ADAPs submit claims to drug manufacturers for rebates on drugs purchased through a retail pharmacy network at a higher price than the 340B price.

Source: Health Resources and Services Administration HIV/AIDS Bureau, AIDS Drug Assistance Program (ADAP) Manual (Rockville, MD: Health Resources and Services Administration, 2016)
https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/adapmanual.pdf

Who is payer of last resort?

While Medicaid typically pays a claim only after other liable third parties have made payment, Section 2617(b)(7)(F) of the Public Health Service Act mandates that RWHAP be the payer of last resort -- after Medicaid and other state and federal programs.

Key Policy Issues

Outlined below are opportunities for Medicaid agencies and RWHAPs to identify and address barriers at the intersection of these two programs:

Review alignment of prescription drugs available across Medicaid and ADAP. Specific ARTs and related drugs are critical components in successfully managing HIV, and continuous access to these drugs can lead to better outcomes.[9] Even short-term lapses in an ART regimen can increase the risk of disease progression, and increase viral rebound.[10] When a state's ADAP formulary, Medicaid PDL, and drugs covered by managed care plans are developed independently, the fragmented coverage can create unintentional gaps in drug availability, or disruptions in access for individuals moving between or covered under multiple programs. Key areas for cross-agency alignment include:

- ***Access to consistent ART medications even as eligibility fluctuates between ADAP and Medicaid.*** To support consistent access, some state ADAPS map their drug formularies to that of the Medicaid PDL in their state. This can reduce the risk of disruptions in treatment for beneficiaries as their program eligibility changes. Washington, DC has contracted with a PBM to manage both the Medicaid PDL and ADAP formulary, creating a more seamless experience for individuals who move between the two programs.

- ***Availability of specialty drugs, such as those used to treat SUD and hepatitis C.*** SUD and conditions such as hepatitis C disproportionately affect PLWH posing additional health care and cost challenges.[11] In response, Rhode Island expanded its ADAP formulary to include a range of drugs for the treatment of SUD, including naltrexone. The Illinois Department of Public Health (IDPH) added five hepatitis C drugs to the state's ADAP. The Rhode Island and Illinois health departments work closely with their Medicaid programs to ensure medication alignment across programs.[12,13] The 2018 NASTAD ADAP formulary data indicates that most states offer some SUD drug therapies as part of their ADAP formularies.[14]

Establish systems to prevent duplicate rebates or discounts on prescription drugs. States are prohibited from receiving a rebate for a drug that was already subject to a discount under the federal 340B program.[15] To avoid having a drug manufacturer pay a rebate to the state Medicaid agency (under the Medicaid Drug Rebate Program) and a discount to the state ADAP (a 340B-covered entity) for the same drug, ADAP programs are required to have mechanisms in place to prevent duplicate discounts.[16] Given the range of ADAP drug purchasing models and Medicaid payment structures, and the number of pharmacies that need to coordinate and monitor the status of prescription drug claims, preventing duplicate payment has proven challenging. A 2016 Office of the Inspector General study found that claims-level identifiers could improve accuracy in identifying 340B drug claims, helping states correctly collect rebates on claims submitted by managed care plans.[17] However, this approach is not always used. New Jersey is one of six states that requires Medicaid managed care plans to identify and inform Medicaid of each 340B-purchased drug claim by including a modifier to identify claims purchased at the 340B discount.[18]

Identify common barriers to accessing necessary medications. Supporting evidence-based prescribing practices and facilitating access to medications for PLWH is a critical factor in maintaining health and managing costs.[19] States can review policies and practices regarding:

- ***Prior authorization and other treatment limitations.*** States may have policies that limit the number of prescriptions that beneficiaries can have filled during a specific time period or require prior authorization for name-brand drugs.[20] **Louisiana's** RWHAP works closely with the state's five Medicaid managed care plans to make sure that plans' covered doses of ART align with federal treatment guidelines, eliminating the need for prior authorization for these medications.[21] **Oklahoma** allows

six covered prescriptions per month for eligible adult members. HIV drugs, along with other drug exemptions, are excluded from these limitations and do not count toward the monthly allowable prescription limit.[22]

- ***Medication synchronization and reimbursement for partial refills.*** States such as New York are looking at how medication synchronization–the ability to fill a partial prescription–can help increase adherence and support better outcomes for Medicaid beneficiaries with complex, chronic conditions such as HIV.

Create systems to coordinate verification of eligibility and avoid duplication of services.

ADAPs must verify beneficiary insurance coverage, identify the primary payer, and back-bill for any charges that are the responsibility of other payers.[23] Close coordination and data sharing between Medicaid and ADAP can support compliance with ADAP's payer-of-last-resort status. They can also help eliminate duplication of health care services, such as viral load monitoring, which is covered by both programs. RWHAP and Medicaid programs can improve coordination by:

- ***Leveraging Medicaid systems.*** **Wisconsin's** ADAP uses the state's Medicaid electronic benefits eligibility and management system (ForwardHealth interChange) to process drug claims. In Wisconsin, Medicaid beneficiaries cannot be dually enrolled in ADAP because Wisconsin Medicaid covers all ADAP formulary drugs. When a pharmacy submits an ADAP claim, the system can identify if that client has other insurance that should be billed first or in lieu of ADAP. The system can also identify retroactive Medicaid eligibility, and, if ADAP claims have been paid during that time period, can recoup costs by reducing future payment to the pharmacy.[24]

- ***Streamlining eligibility determinations.*** PLWH often have changes in their eligibility status. Because of this churn, ensuring that PLWH have consistent access to drugs is a continuous and often complex process.[25] To better manage these transitions, **Washington, DC** established the HIV Pharmacy Network through the collaborative work of its health department and Medicaid program. The HIV Pharmacy Network includes a roster of pharmacy providers who dispense ARTs and HIV-related drugs to Medicaid beneficiaries. These pharmacies also participate in the ADAP co-payment assistance program. Washington, DC engaged the services of a PBM to assess and update beneficiaries' eligibility for Medicaid in its Medicaid Management Information System and the ADAP online eligibility file. The PBM also provides claims management. Washington, DC is using this approach to increase access to a broad network of pharmacies for Medicaid and ADAP beneficiaries, streamline program eligibility determinations, and reduce back billing when clients churn between programs.[26]

Conclusion

Medicaid programs and RWHAP ADAPs across the country have worked collaboratively to overcome barriers to providing affordable, effective, and consistently-accessible prescription drugs for PLWH. Overcoming these barriers does not always require a major state policy change or significant investment; rather, states have improved alignment across programs, developed processes to monitor resources more effectively, and/or modified systems in ways that support better care. As states work to balance budgets and manage rising prescription drug costs, it is important that Medicaid programs and RWHAP ADAPs work together to effectively focus their limited financial resources and overcome the complexities and fragmentation of these two programs.

For additional resources detailing how state agencies can improve care for PLWH, explore National Academy for State Health Policy, Toolkit: State Strategies to Improve Health Outcomes for People Living with HIV

Notes

1. "Medicaid and HIV," Kaiser Family Foundation, October 2016, accessed on June 25, 2018, https://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/.
2. "Medicaid Benefits: Prescription Drugs," Kaiser Family Foundation, 2012, accessed on June 21, 2018, https://www.kff.org/medicaid/state-indicator/prescription-drugs/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
3. "Medicaid Drug Rebate Program," Centers for Medicaid and Medicare Services, November 2017, accessed June 12, 2018, https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/index.html.
4. "340B Drug Pricing Program," Health Resources and Services Administration, May 2018, accessed June 25, 2018, https://www.hrsa.gov/opa/index.html.
5. Public Health Service Act, 42 U.S.C. § 2616.
6. Health Resources and Services Administration HIV/AIDS Bureau, AIDS Drug Assistance Program (ADAP) Manual (Rockville, MD: Health Resources and Services Administration, 2016), https://hab.hrsa.gov/sites/default/files/hab/Global/adapmanual.pdf.
7. Public Health Service Act, 42 U.S.C. § 2617(b)(7)(F)
8. National Alliance of State and Territorial AIDS Directors (NASTAD), PBM Toolkit (Washington, DC: NASTAD, 2014), https://www.nastad.org/sites/default/files/PBM-Toolkit-Final.pdf.
9. "HIV Treatment as Prevention," Centers for Disease Control and Prevention, May 2018, accessed June 12, 2018, https://www.cdc.gov/hiv/risk/art/index.html.
10. Christian Holkmann Olsen, et al., "Interruption of Combination Antiretroviral Therapy and Risk of Clinical Disease Progression to AIDS or Death," HIV Medicine 8, no.2 (2007): 96-104.
11. Geetanjali Chander, Seth Himelhoch, and Richard Moore, "Substance Abuse and Psychiatric Disorders in HIV-Positive Patients: Epidemiology and Impact on Antiretroviral Therapy," Drugs 66, no. 6 (2006): 769-789.
12. Personal communication with Paul Loberti, Rhode Island Executive Office of Health and Human Services, February 12, 2018.
13. Eduardo Alvarado, "Financing PrEP: A Cost-Effective Prevention Program" (presentation, PrEP Policy Learning Series Webinar, National Academy for State Health Policy and Health HIV, February 12, 2017).
14. National Alliance for State and Territorial AIDS Directors, "ADAP Formulary Database – Substance Use Treatment Medications," February 2018, accessed June 5, 2018, https://fusiontables.google.com/DataSource?docid=149yw0w-QlJ7MJ9Fpq9wPugkSgboQeEP85dfTsThp#rows:id=1.
15. Social Security Act, 42 U.S.C. §1927.
16. Health Resources and Services Administration, 340B Drug Pricing Program Omnibus Guidance (Washington, DC: Federal Register, August 28, 2015), https://www.federalregister.gov/documents/2015/08/28/2015-21246/340b-drug-pricing-program-omnibus-guidance.
17. Suzanne Murrin, State Efforts to Exclude 340B Drugs from Medicaid Managed Care Rebates (Washington, DC: U.S. Department of Health and Human Services, Office of the Inspector General, 2016), https://oig.hhs.gov/oei/reports/oei-05-14-00430.pdf.
18. State of New Jersey Department of Human Services Division of Medical Assistance and Health Services, Medicaid Managed Care Model Contract, January 2018, accessed June 12, 2018, http://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf.
19. "Guidelines for the Use of Antiretroviral Agents in Adults and Adolescent Living with HIV: Limitations to Treatment Safety and Efficacy," U.S. Department of Health and Human Services, October 2017, accessed June 5, 2018, https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv-guidelines/30/adherence-to-art.
20. Nicola Pinson, et al., Medicaid and Specialty Drugs: Current Policy Options Policy Brief (Portland, OR: Center for Evidence-Based Policy, Oregon Health & Science University, June 2016), http://smart-d.org/wp-content/uploads/2016/09/MED_Medicaid_and_Specialty_Drugs_Current_Policy_Options_Final_Sept-9-2016.pdf.
21. Personal communications with DeAnn Gruber and Debbie Wendell, Louisiana Office of Public Health, February 12 and February 15, 2018.
22. Oklahoma Administrative Code, sec. 317:30-5-72.
23. Health Resources and Services Administration HIV/AIDS Bureau, AIDS Drug Assistance Program (ADAP) Manual (Rockville, MD: Health Resources and Services Administration, 2016), https://hab.hrsa.gov/sites/default/files/hab/Global/adapmanual.pdf.
24. Personal communication with James Vergeront and Michael McFadden, Wisconsin Department of Health Services, July 2, 2018.
25. Health Resources and Services Administration, Impact of Medicaid 1115 Waivers on the Ryan White HIV/AIDS Program: Case Studies on Experiences of RWHAP Providers and Clients (Rockville, MD: US Department of Health and Human Services, April 2015), https://hab.hrsa.gov/sites/default/files/hab/Global/medicaidwaivers.pdf.
26. District of Columbia Department of Health, District of Columbia HIV/AIDS Drug Program, Pharmacy Services Protocol, HIV/AIDS Pharmacy Provider Network Provider Manual (Washington, DC: District of Columbia Departmet of Health, September 2012), https://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/District%20of%20Columbia%20HIV%20AIDS%20Drug%20Program%20Pharmacy%20Services%20Protocol%20(September,%202012).pdf.

Acknowledgements:

The National Academy for State Health Policy (NASHP) wishes to thank the following state Medicaid and health departments for their time and insights that helped make this report possible: Illinois, Louisiana, New Jersey, New York, Oklahoma, Rhode Island, Washington, DC, and Wisconsin.

The author also wishes to thank Trish Riley, Jane Horvath, Kitty Purington, Rachel Donlon, and Natalie Williams for their contributions to this paper. Finally, the author would like to thank her Health Resources and Services Administration (HRSA) project officer, Lynnette Araki, and her HRSA colleagues for their review and input.

This project was supported by the Health Resources and Services Administration (HRSA) of the US. Department of Health and Human Services (HHS) under grant number UD3OA22891, National Organizations of State and Local Officials. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the US Government.