

Ryan White Requirements and the LIHP - Frequently Asked Questions #2

Questions and Requests from Teleconference on 7/27/2011 with Health Resources and Services Administration (HRSA)/ HIV/AIDS Bureau (HAB), Department of Health Care Services (DHCS) Low Income Health Program (LIHP) Division Staff, California Department of Public Health/Office of AIDS (CDPH/OA), California Ryan White Part A and C grantees, local LIHP administrators, and all stakeholders invited to the previous teleconference on 7/21/11.

SET #1: Issues most specific to OA

1. Can the state use Ryan White (RW) funds to pay the Pre-existing Condition Insurance Program (PCIP) premiums for LIHP eligible clients?

Because of the RW payer of last resort statutes, RW funds cannot be used to pay PCIP premiums for clients who are eligible for other health coverage, including LIHP. If a LIHP program is capped, RW funds can be used to pay PCIP premiums during the time that the client is unable to access LIHP. In counties that establish LIHP waiting lists, the RW client would be screened for potential LIHP eligibility and then placed on the waiting list, in order to be eligible for RW payment of PCIP premiums.

2. Is the list of medications in the AIDS Drug Assistance Program (ADAP) formulary available?

The full ADAP formulary is available on the ADAP Pharmacy Benefits Manager (PBM), Ramsell, website at the following links:

http://www.publichealthrx.com/PDF/CA_Alphabetical.pdf

http://www.publichealthrx.com/PDF/CA_DrugClass.pdf

3. When can counties expect guidance on potential requirements for RW grantees to back-bill LIHP for LIHP-covered RW expenditures once LIHP eligibility is determined?

Please refer to this letter from HRSA: [California Waiver Letter from HRSA \(Health Resources and Services Administration\)](#) (posted August 9, 2011). Please note that some issues related to the retroactive period pending contract execution between the LIHP and a RW provider are addressed in item #3 of the August 9 letter.

- 4. Part A and C grantees may be unable to quickly develop and execute contracts required to spend RW funds that become available due to movement of RW clients into LIHP. While there are clear unmet needs that can be addressed with these funds, there are significant concerns regarding the timing. When will guidance be available on this issue?**

The Office of AIDS will ask HRSA about the possibility of carry-forward should we determine that we will have this issue with Part B funds and Part A and C grantees may wish to make similar inquires of HRSA. OA will also ask HRSA about their potential authority to waive the expenditure requirement and penalties during this transition period and OA. Part A and C grantees may also wish to inquire about this issue with HRSA.

- 5. While there is clarity about the payer of last resort statute around Ryan White Parts A, B, and C, is there similar statute around the use of Part D funds?**

HRSA has clarified that the same statute applies to Part D.

[California Waiver Letter from HRSA \(Health Resources and Services Administration\)\(PDF\)](#) 

SET #2: Issues most specific to LIHP or DHCS
--

- 1. Are the LIHPs required to construct their drug formularies according to Medicaid regulations?**

The LIHPs are required to construct their drug formularies according to Medicaid regulations for managed care plans. This means that the LIHP formularies can be limited, must include prior authorization requirements, and are subject to medically necessary determinations by LIHP providers. Practically applied, any prescription drug, regardless of whether it is a brand name drug or a generic drug, that is determined to be medically necessary for the enrollee by a LIHP provider, must be covered by the LIHP even if the drug is subject to limitations, or is not included on the LIHP formulary. This requirement applies to any drug determined medically necessary for a LIHP enrollee and is not restricted to those drugs used to treat HIV.

- 2. If a LIHP is allowed to include limits to their drug formularies regarding the use of generic and brand drugs, please describe how these limits will impact:**
- a. LIHP enrollees who are not being treated for HIV or HIV- related conditions; and,**
 - b. LIHP enrollees who are being treated for HIV or HIV-related conditions but who are not eligible for ADAP.**

All LIHP enrollees will be subject to the limitations applied in the drug formulary constructed by each LIHP. A drug prescribed by the enrollee's LIHP provider which requires

prior authorization and is determined medically necessary for the treatment of the enrollee, regardless of the enrollee's diagnosis of disease or illness, must be provided to the enrollee under the LIHP. If a drug is determined to not be medically necessary for the treatment of a disease or illness, regardless of the disease or illness, that drug will not be provided or covered by the LIHP.

For those LIHP enrollees who are not eligible for ADAP, and are not able to receive a drug under the LIHP because it is not determined medically necessary, they will have to seek coverage through county indigent programs, if eligible for these programs. DHCS anticipates that the majority of the drugs currently being used to treat HIV will be determined medically necessary and covered by LIHP for those enrollees prescribed the drug. In rare situations where an enrollee requests a specific HIV drug from its LIHP provider that is not determined to be medically necessary for the enrollee's treatment, to the extent that the enrollee is co-enrolled in ADAP, the drug can be provided if it is on the ADAP formulary.

DHCS anticipates that every LIHP enrollee diagnosed with HIV will be able to receive a brand name or generic drug that is required for HIV treatment through private health care coverage, as appropriate, LIHP, and in rare situations, through ADAP, pursuant to the payer of last resort requirements in the Ryan White Care Act program.

3. Will LIHPs be using 340B drug pricing in their programs?

The LIHPs have the option to use 340B drug pricing in their programs. Many of the counties and clinics within the LIHP network participate in the 340B drug programs currently, and those counties and eligible providers that do not, may consider enrolling in the federal program to receive discounts on outpatient prescription drugs as an eligible safety net provider.

4. The transition of eligible RW clients into LIHP impacts the LIHPs' utilization and cost projections. Time is required for adequate analysis of any program changes indicated by this transition. Will there be an opportunity, during the Centers for Medicare & Medicaid Services (CMS) contract approval period, to substantively revise the draft LIHP contract as needed by this transition?

DHCS submitted the draft LIHP contracts for the ten legacy counties to CMS for their approval on August 1, 2011. At this point, any changes to these contracts would be handled by contract amendments, after the execution of the LIHP contracts for the ten legacy counties. The other 17, or "new", LIHPs may have time to revise their contracts before submission to CMS for approval. Otherwise, they will also be able to make revisions to their contracts through contract amendments.

Stakeholders are encouraged to submit their LIHP-Ryan White related questions and requests at any time to LIHP@dhcs.ca.gov. LIHP will forward as necessary to the Office of AIDS.

Originally Posted 8.11.2011; UPDATED 10.21.2011

Stakeholders will be updated and provided opportunities to provide input as appropriate during the development of these policy considerations and the implementation plan.