



ADAP Coverage of Treatment & Services for Aging People Living with HIV (PLWH)

July 2017

This fact sheet outlines how the Ryan White HIV/AIDS Program (RWHAP) Part B AIDS Drug Assistance Programs (ADAPs) can support access to medications and related services for the clients they serve who are aging and who experience associated comorbid conditions (e.g., cardiovascular disease, diabetes). It also provides a summary of the Health Resources and Services Administration's (HRSA) HIV/AIDS Bureau (HAB) guidance related to coordination of ADAP and Medicare services for eligible clients.

Treatment and Service Needs among Aging PLWH

Per the [2017 National ADAP Monitoring Project Annual Report](#), the majority (58%) of all ADAP clients served in calendar year 2015 were aged 45 and older. Effective antiretroviral (ARV) regimens have allowed people living with HIV (PLWH) to have longer lifespans and experience fewer HIV-related conditions (e.g., opportunistic infections). Non-HIV-related conditions now account for the [majority of morbidity and mortality among PLWH](#) and occur at higher rates than among persons not living with HIV. These [conditions](#) include cardiovascular disease, lung disease, certain cancers, and liver disease.

Research indicates that HIV may increase the risk of various age-related illnesses by [causing chronic inflammation](#) throughout the body. Chronic inflammation is associated with cardiovascular disease, lymphoma, and type 2 diabetes within the general population and is more common among PLWH. Although ARV treatment helps to reduce the effects of chronic inflammation among PLWH, it [does not fully restore normal immunologic function](#). As PLWH age and are increasingly impacted by comorbid conditions, they are then [at risk of more](#) drug-to-drug interactions and other adverse events associated with taking multiple medications simultaneously (i.e., polypharmacy).

Additionally, long term impact of HIV infection and treatment may uniquely impact PLWH's [cognitive function and overall mental health](#). Although AIDS-related dementia is now rare, HIV-Associated Neurocognitive Disorders (HAND) are [estimated to impact 50% of PLWH](#), resulting in varying degrees of decreases in attention, language, motor skills, memory, and other cognitive functions. If neurocognitive skills decline, PLWH may also experience increased rates of depression, substance use, and social isolation. Taken

together, these issues can affect clients' adherence to ARV treatment and, in turn, their viral suppression.

Many medications necessary to treat aging-related conditions require regular and close monitoring by a prescribing physician, laboratory testing to manage symptoms, dosage, and side-effects, and access to broader support services. RWHAP has over 25 years of experience in providing comprehensive services to PLWH with such complex care needs. To best serve clients as they age and experience increasing rates of aging-related comorbidities, **ADAPs must work in concert with other entities (e.g., RWHAP Part B services, other RWHAP Parts, Medicare, bureaus of aging, and geriatric providers).**

Use of Ryan White HIV/AIDS Program Part B and ADAP Funds to Expand Access to Treatment for Aging-Related Comorbid Conditions

[ADAPs' Support of Treatment Access for Aging PLWH via Formularies](#)

The [Ryan White HIV/AIDS Program Section 2616\(c\)\(6\)](#) of the Public Health Service Act and HRSA policy places the following requirements on ADAP formularies:

- ADAP formularies must include at least one drug from each class of HIV antiretroviral medications
- ADAP funds may only be used to purchase medications approved by the Food and Drug Administration (FDA) or devices needed to administer them
- They must be consistent with the [Department of Health and Human Services' \(HHS\) Adolescent and Adult HIV/AIDS Treatment Guidelines](#)
- All treatments and ancillary devices covered by the ADAP formulary, as well as all ADAP-funded services, must be equitably available to all eligible/enrolled individuals within a given jurisdiction

These requirements enable ADAP formularies to include medications for many comorbid conditions that may impact PLWH, including those associated with aging.

[ADAPs' Coordination with Medicare](#)

As stated in the [HAB ADAP Manual](#), "Medicare is the second largest Federal payer of HIV care costs in the U.S. and a significant payer of HIV prescription costs under the Medicare Part D drug benefit. Similar to Medicaid/ADAP coordination, ADAP and Medicare

coordination is essential for coordinating benefits and controlling costs under the mandate to serve as the “payer of last resort.” Medicare beneficiaries are required to maintain prescription drug coverage that is at least equal to Medicare Part D coverage either via private prescription drug plan (PDPs) or Medicare Advantage plans (MAPs).

ADAPs may assist their Medicare-eligible clients in accessing continuous prescription coverage by paying for Medicare Part D premiums, deductibles, and/or co-payments. ADAPs may also elect to provide clients with medications during the “donut hole” period which begins when total drug costs reach a designated level and ends when expenditures for medications (true out of pocket (TrOOP) expenditures) meet the catastrophic coverage threshold. ADAP expenditures for clients on Medicare Part D [count toward total TrOOP expenditures](#), thereby helping clients to reach the catastrophic coverage threshold faster and more easily at which time Medicare would begin covering the full cost of medications.

As of [January 1, 2015](#), ADAPs assisted their Medicare-enrolled clients in the following ways:

- Premiums:
 - 38 ADAPs reported having covered premiums for clients eligible for the Medicare Part D Standard Benefit (i.e., individuals with incomes >150% of the Federal Poverty Level (FPL))
 - 28 ADAPs covered premiums for clients eligible for a Medicare Part D Partial Subsidy (i.e., individuals with incomes between 136% and 150% of FPL and assets below \$11,990 for individuals and \$23,972 for couples)
- Deductibles:
 - 37 ADAPs covered deductibles for clients eligible for Medicare Part D Standard Benefit
 - 29 covered deductibles for clients eligible for the Partial Subsidy
- Co-payments:
 - 43 ADAPs reported covering co-payments for Standard Benefit- and Partial Subsidy-eligible clients
 - 36 ADAPs covered co-payments for Full Subsidy clients
 - 27 ADAPs covered co-payments for Dually-Eligible (i.e., Medicaid and Medicare) clients
- Donut-hole coverage:
 - 42 ADAPs provided medications to clients within the donut hole

Treatment and Care for Aging-Related Comorbid Conditions: Drug and Service-Specific Information

RWHAP Part B recipients can address a number of aging-related conditions commonly experienced by PLWH and respond to the needs of aging PLWH through ADAP formulary coverage of medications that treat aging-related comorbid conditions and through services that fit under allowable [RWHAP Part B service categories](#). The following are select medication categories and RWHAP Part B services that NASTAD has identified as being particularly beneficial to aging PLWH. These are not exhaustive, however, and should be taken under consideration in the broader context of individual jurisdictions' and clients' needs.

Categories of Treatment Medications for Aging-Related Comorbid Conditions

Alzheimer's Disease Medications: While it is unknown if chronic HIV infection and/or treatment are risk factors for Alzheimer's disease, the high prevalence of HIV-Associated Neurocognitive Disorders (HAND) (estimated between 30 and 50% of PLWH) [may complicate diagnoses of other neurocognitive disorders such as Alzheimer's disease](#). Therefore, there may be under-diagnosis of Alzheimer's disease among PLWH. ADAPs should consider coverage for Alzheimer's disease medications, particularly as increasing numbers of clients reach the typical age of Alzheimer's disease diagnosis (i.e., [65 years and older](#)). A list of Alzheimer's disease medications is available [here](#).

Cardiac Medications: Cardiovascular disease [increasingly impacts PLWH](#) and is higher among PLWH than the general population. In addition to HIV-related chronic inflammation, cardiovascular disease may be more prevalent among PLWH because of [some ARV medications](#). There are several different types of cardiac medications, including [cardioselective beta blockers](#) and [cardiovascular agents](#).

Hepatitis C (HCV) Treatment Medications: An estimated 25%-35% of PLWH in the United States are [co-infected with HCV](#). HIV/HCV co-infection rates are even higher among people who inject drugs, [estimated at 80%](#). As persons co-infected with HIV/HCV age, they are increasingly impacted by progression in their HCV disease (e.g., cirrhosis, end-stage liver disease). A list of HCV treatment medications is available via NASTAD's [National ADAP Formulary Database User's Guide](#).

Mental Health Treatment Medications: PLWHs' overall medical care and treatment adherence may be impacted by [age-related neurocognitive decline and higher rates of depression as well as social isolation](#). A list of the most commonly prescribed mental

health treatment medications among ADAP clients is available via NASTAD's [National ADAP Formulary Database User's Guide](#).

Metabolic Agents: Several metabolic conditions impact PLWH as a result of ARV treatment and HIV itself. For example, long term exposure to ARV treatment is strongly correlated with diabetes among PLWH. Type 2 diabetes is also independently [associated with chronic inflammation](#) caused by HIV. A list of metabolic agents is available [here](#).

Neuropathy Medications: Peripheral neuropathy is one of the [most common neurologic disorders](#) among older PLWH. Neuropathy may be caused [by HIV itself or by ARV toxicity](#) from some nucleoside reverse transcriptase inhibitors (NRTIs). Neuropathy medications include those for [peripheral neuropathy](#) and [diabetic peripheral neuropathy](#).

Pulmonary Medications: Nearly [15% of middle-aged and older adults in the United States](#) suffer from pulmonary disorders (e.g., asthma, chronic obstructive pulmonary disease), while smokers are [acutely vulnerable](#). As they are also [more likely to be smokers](#), PLWH would particularly benefit from access to pulmonary medications as they age. Pulmonary medications include those for [pulmonary hypertension](#) and [pulmonary embolism](#).

Substance Use Treatment Medications: Substance use [may increase as PLWH age](#), particularly in regards to prescriptions drugs used for pain management. A list of substance use treatment medications is available via NASTAD's [National ADAP Formulary Database User's Guide](#).

ADAPs should consider providing access to these treatments with the full complement of related and allowable RWHAP Part B core medical and support services.

RWHAP Part B Core and Support Services that Benefit Aging PLWH

Food Bank/Home-Delivered Meals (Support): According to [HRSA Policy Clarification Notice \(PCN\) 16-02](#), Food Bank/Home-Delivered Meals includes the provision of food items, hot meals, voucher programs to purchase food, and limited and essential non-food items. For aging PLWH with challenged mobility and/or limited financial resources, these delivery services allow for continuous access to food which is [associated with](#) improved rates of viral suppression and other HIV health outcomes.

Home Health Care (Core Medical): Home Health Care includes: administration of prescribed therapeutics (e.g., intravenous and aerosolized treatment, and parenteral feeding), preventive and specialty care, wound care, routine diagnostics testing administered in the home, and other medical therapies. Provision of Home Health Care services is limited to clients who are homebound. As PLWH age, particularly as they reach geriatric age, they may be impacted [by increases in frailty and reduced motion](#). They will increasingly benefit from Home Health Care services as their mobility declines.

Home and Community-Based Health Services (Core Medical): Home and Community-Based Health Services include: appropriate mental health, developmental, and rehabilitation services; day treatment or other partial hospitalization services; durable medical equipment; and home health aide services and personal care services in the home. Aging PLWH will increasingly benefit from Home and Community-Based Health Services as their mobility declines.

Medical Case Management, including Treatment Adherence Services (Core Medical): Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Among aging PLWH, Medical Case Management assists with addressing unique challenges in adherence stemming from polypharmacy to treat multiple aging-related comorbid conditions in addition to HIV itself.

Medical Transportation Services (Support): Medical Transportation is the provision of nonemergency transportation services that enables an eligible client to access or be retained in core medical and support services. In addition to insecure food, [transportation impacts HIV health outcomes](#), including among aging PLWH with neurocognitive impairment.

Non-Medical Case Management Services (Support): Non-Medical Case Management Services provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. Non-Medical Case management services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, including Medicare Part D.

Resources:

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- NASTAD (National Alliance of State & Territorial AIDS Directors) www.NASTAD.org
 - [NASTAD – Health Care Access](#)
 - [National ADAP Monitoring Project Annual Report](#)
 - [National ADAP Monitoring Project Formulary Database](#)
 - [Food and Drug Administration](#)
 - [HRSA HIV/AIDS Bureau](#)
 - [HRSA TARGET Center](#) – technical assistance for the Ryan White community
 - [Ryan White HIV/AIDS Treatment Modernization Act](#) (2009)