DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

HIV/AIDS, Hepatitis, STD and
TB Administration

District of Columbia Department of Health **Pharmacy Benefits Programs** **Policies and Procedures**		**Policies and Procedures** Implementing office: Pharmacy Benefits Program Office Training required: Yes Originally Issued: Revised/Reviewed: 7/2/26
Approved by: **Ademola Are, Pharmacy Benefits Program Chief**	**Approved by:** **Avemaria Smith, Division Chief**	**Effective Date: August 3, 2026** **Valid Through Date: December 31, 2027**

SUBJECT

DC Health Ryan White Part B Pharmacy Benefits Program operation policies and procedures.

PURPOSE

The purpose of these policies and procedures is to delineate the process to determine eligibility for and enrollment in the District of Columbia Department of Health HIV/AIDS, Hepatitis, STD, and TB Administration Pharmacy Benefit Program (DC DOH PBP) while ensuring the appropriate and efficient use of Ryan White Part B (RWPB) funds. The PBP is formally known as the AIDS Medication Assistance Program (ADAP).

Additionally, the policies and procedures provide guidelines for the management of the DC DOH PBP. This policy manual will outline all requirements of the PBP.

HRSA's ADAP operates in the District of Columbia and in all 50 states, Guam, Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands. The program is authorized under Title II of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act and provides HIV-related prescription medications to uninsured and underinsured individuals living with HIV/AIDS. DC PBP only serves eligible residents in Washington, DC.

DC PBP can provide medications by purchasing medicines or health insurance that includes coverage for HIV/AIDS medications.

These Policies and Procedures are provided in accordance with the requirements of the Ryan White HIV/AIDS Program Title XXVI of the Public Health Service Act enacted in 1990 and amended in 2009. It is administered by the Health Resources and Services Administration under the Department of Health and Human Services (DHHS).

POLICY DOH PBP administers the eligibility determination, enrollment management, and comprehensive service delivery components of the Ryan White Part B Grant. Services include individual enrollment, annual recertification, health insurance premium assistance, premium copay assistance, PBP formulary oversight, pharmacy provider network management, and coordination of services through the pharmacy benefit manger (PBM).	
PBP Program	The Ryan White HIV/AIDS Program is a federal program designed for the care, treatment, and provision of support services for people with HIV/AIDS in the U.S. The Ryan White Program is a payor of last resort program for people with HIV/AIDS who have no other source of coverage or face coverage limits. **This designation means that if an individual is eligible for any commercial or public payor, he/she must access its coverage and exhaust all available benefits, before accessing the Ryan White program**. Funding for the Ryan White Program is subject to Congressional appropriations each year. It is the third largest source of federal funding for HIV care in the U.S., after Medicare and Medicaid. HRSA funds states through allocations under Part B of the program and some programs receive additional state funding. Programs in each state provide HIV related prescription medications to low-income individuals with limited or no prescription medication coverage. Eligibility criteria and other program elements vary widely from state to state. ADAPs that participate in the 340B program may purchase medications at or below the statutorily defined 340B ceiling price. DC PBP runs a hybrid medication acquisition system consisting of direct purchase (via 340B program) and rebate model.
Definition of Terms	**Acquired Immunodeficiency Syndrome (AIDS**) - A disease of the immune system due to infection with HIV. HIV destroys the CD4 T lymphocytes (CD4 cells) of the immune system, leaving the body vulnerable to life-threatening infections (including opportunistic infections) and cancer. AIDS is the most advanced stage of HIV infection. **ADAP Data Report (ADR)** - The reporting system through which programs must submit annual reports to HRSA as part of the funding requirements. • Grantee report: provides basic information about the organization, program limits, developments and changes, income eligibility requirements, coordination with Medicaid and Sate Pharmaceutical assistance programs,

	funding and expenditure amounts, and PBP formulary on a semiannual basis. • Customer report: An electronic report of each customer record which contains information on customers enrolled in PBP during the reporting period, regardless of whether or not they received services. Information reported includes demographic status, enrollment and certification information, HIV clinical information, type and cost of PBP services. **Advance Premium Tax Credit** – A federal tax credit that helps lower the monthly cost of insurance premiums for people who buy coverage through the Health Insurance Marketplace. **Affordable Care Act (ACA)** – The ACA was enacted in 2010 through the Customer Protection and Affordable Care Act and the health Caer and Education Reconciliation Act. Following implementation, the ACA has been revised through additional federal legislation, regulatory adjustments, and major judicial decisions. Important changes include the 2017 statutory reduction of the individual mandate penalty to zero and Supreme Court rulings that made Medicaid expansion optional for states and affirmed the availability of marketplace subsidies. These developments should be considered part of ACA's current operational framework. **Antiretroviral (ARV)** - A medication that suppresses retroviruses, like HIV, by interfering with key steps in the viral replication process. **Antiretroviral therapy (ART)** - The use of at least three antiretroviral medications in combination to maximally suppress HIV. **Antiviral therapy** - The use of medication to treat viral infections such as HIV and viral hepatitis. **Authorizing official** - legally bind the covered entity and is responsible for registration, recertification, and profile updates. **CD4 cell** - A type of white blood cell called a lymphocyte. Also known as a T4 cell or T cell. **CD4 count** - A laboratory test that measures the number of CD4 T lymphocytes (CD4 cells) in a sample of blood. The CD4 count is the most important laboratory indicator of immune function and the strongest predictor of HIV progression. The CD4 count is one of the factors used to determine when to start antiretroviral therapy (ART). The CD4 count is also used to monitor response to ART.

	Centers for Medicare and Medicaid Services (CMS) - CMS administers Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). **Consolidated Omnibus Budget Reconciliation Act (COBRA**) - A federal law that may allow individuals to temporarily keep health coverage as a dependent of the covered employee, or another qualifying event. **Contract pharmacy** - An arrangement through which an ADAP contracts with an outside pharmacy to provide comprehensive services. Pharmacy services include dispensing, record keeping, medication utilization review, formulary maintenance, customer profiles, and counseling. **Coordination of Benefits** - Activities that ensure appropriate costs are paid by the responsible payor when multiple payors exist for medications and/or services. Ryan White Program funds are the payor of last resort, making it necessary for all other payors (Medicare Part D, Medicaid, private insurance, etc.) to be utilized first before using Ryan White Program funds. **Co-payment** - The set amount an individual must pay upon receiving medical services or prescriptions. PBP pays the co-payments for PBP formulary medications otherwise paid for under an individual's other source of coverage. **Deductible** - The amount a health insurance beneficiary must pay before a third-party payor begins to provide coverage for health services. PBP pays the cost for eligible beneficiaries. **Dual-eligible** - Individuals who are eligible for both Medicare and Medicaid. **Essential Health Benefits (EHB)** - A set of healthcare service categories that must be covered by certain insurance plans, starting in 2014. **Federal Poverty Level (FPL**) - A measure of income level issued annually by Department of Health and Human Services (DHHS) used to determine eligibility for programs and benefits. Customer income eligibility for the DC PBP is 500 % of the federal poverty level. **HIV/AIDS, Hepatitis, TB, and STD Administration (HAHSTA)** - The mission of HAHSTA is to prevent transmission of the diseases and to ensure management, oversight, planning, and coordination with government and community organizations. HAHSTA plans and coordinates the Health Department's response to HIV/AIDS epidemic; develops strategic and implementation plans for HIV/AIDS programs in the DC in collaboration/cooperation with community-based organizations and private providers; and negotiates and administers HIV/AIDS service contracts. **Hepatitis** - Inflammation of the liver.

	Hepatitis B virus (HBV) - A liver infecting virus that causes the acute and chronic forms of hepatitis B infection. **Hepatitis C virus (HCV)** - A liver infecting virus that causes the acute (new and sometimes short-lived) and/or chronic (long-lasting) forms of hepatitis C infection. **Health Resources and Services Administration (HRSA) and the HIV/AIDS Bureau (HAB)** - The DHHS Health Resources and Services Administration. **HRSA Project Officers** - Scientific and/or technical staff members responsible for ensuring that grantees and grants comply with federal legislative mandates and meet programmatic objectives. **Human Immunodeficiency virus (HIV)** - The virus that causes AIDS. HIV damages a person's body by destroying specific white blood cells, called CD4+ T cells, which are crucial to helping the body fight diseases. **Insurance continuation** – Under HRSA's Health Insurance Premium and Cost-Sharing Assistance (HIPCSA) service category, the DC PBP may pay some or all insurance premiums, co-payments and deductibles for eligible customers when doing so is cost-effective and supports continuous access to HIV care and treatment. This assistance may apply to employer-sponsored insurance, COBRA, Marketplace plans, or other third-party coverage. PBP funds may be used to maintain or obtain such coverage in accordance with HRSA requirements, including ensuring that payor of last resort rules are met and that the coverage option is more cost-effective than direct medication service provision. **Insurance purchasing** - The ability by PBP to purchase insurance coverage through the insurance industry market or state high risk insurance pools on behalf of eligible customers. **Lymphocytes** - Cells that are a part of the body's immune system, which helps to fight viral infections. **Marketplace** - Also known as the Affordable Insurance Exchange, it offers a choice of health plans that meet certain benefits and cost standards. **Medicare Prescription Medication Plan (Medicare part D)** - A program that helps pay for prescription medications for people with Medicare plans that includes Medicare prescription medications coverage. There are two ways to get Medicare prescription medication coverage: through a Medicare Prescription Medication Plan or a Medicare Advantage Plan that includes medication coverage. These plans are offered by insurance companies and other private companies approved by Medicare.

	Office of Pharmacy Affairs (OPA) - The division of HRSA responsible for administering the 340B Medication Pricing Program, which allows eligible healthcare organizations to purchase outpatient medications at discounted prices. **Opportunistic Infection (OI)** - An infection that occurs more frequently or is more severe in people with weakened immune systems such as people with HIV. **Out of pocket maximum** - The maximum that a consumer can expect to pay prior to the insurance paying 100% for covered medical and prescription medication expenses. This limit includes deductibles, co-insurance, and co-payments. **Payor of last resort** - Ryan White Program funds cannot be used to make payments for any item or service if payment has been made or can reasonably be expected to be made with respect to that time or device under a state compensation program, under insurance policy, or under any federal for state health benefits program. **Pharmacy benefit manager (PBM)** - An organization that provides administrative services in processing and adjudicating prescription claims for pharmacy benefit programs. **Pharmacy network** - A group of pharmacies where a PBP customer may have their prescriptions filled. **Premium** - A monthly payment made to the insurer to obtain insurance coverage. Premiums can be paid by employers, unions, employees, or individuals or shared among different payors (i.e., PBP). **Premium tax credit** - A tax credit that is available to eligible individuals and families whose income falls between 100% and 400% of the federal poverty level to help offset the cost of qualified health plan premiums. Individuals can choose to take this tax credit in advance of their tax filing at the time of plan enrollment. If an individual avails themselves of the option to advance the premium tax credit, then they will be directed to engage in a reconciliation to complete their next federal tax filing. **Qualified Health Plan (QHP**) - A private health insurance plan that is certified by a health insurance Marketplace to cover essential health benefits and follow established limits on cost-sharing (like deductibles, copayments and out-of-pocket maximum amounts). Eligible individuals must be enrolled in a QHP to receive any applicable premium tax credits or cost-sharing reductions. **Qualified Medicare Beneficiary** – A state administered Medicare Savings Program that helps individuals with limited income and resources pay for their

	Medicare Part A and Part B out-of-pocket costs, including premiums, deductibles, coinsurance, and copayments. **Rebate** - Amount of money paid by medication manufacturers to eligible programs for medications dispensed to its customers. **The Ryan White HIV/AIDS Treatment Modernization Act of 2009** - The Ryan White Care Act, Title XXVI of the Public Health Service Act (PHSA) as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2009, or Ryan White Program is the single largest federal program designed specifically for people with HIV/AIDS. Part A funds eligible metropolitan areas and transitional grant areas; Part B funds States/Territories and includes ADAPs; Part C funds early intervention services; Part D grants support services for women, infants, children and youth; Part F comprises Special Projects of National Significance, AIDS Education and Training Centers, Dental Programs, and the Minority AIDS initiative. **True out of pocket Expenditures (TrOOP)** - This is the amount of money that Medicare Part D enrolled customers will have to pay to reach the "catastrophic limit" at which point Part D becomes their primary payor for medications. Payments for medications, co-payments, and co-insurance made by the beneficiary, friends, family members, PBP, state pharmacy assistance programs, charities, and the Medicare Low-Income Subsidy (LIS) portion of Medicare Part D count towards TrOOP costs. **Viral load** - The amount of virus presents in an individual's blood. **Wholesaler** - A firm that buys large quantities of medications from various producers or vendors, warehouses them, and resells to retailers. **Wrap-around benefits** - The mechanism PBPs use to assist low-income PBP customers with costs associated with Medicare Part D or other sources of coverage. Paying co-payments for mediations, monthly premium costs, and supporting customers through the Medicare Part D benefit structure are all considered "wrap-around services. Under the updated three-phase Part D model, PBPs may assist with costs in the deductible and initial coverage phases to ensure continued access to medications. Once a customer's true out-of-pocket costs reach $2000, the customer enters a catastrophic phase, during which they pay $0 for all covered Part D medications for the remainder of the year. **340B Medication Pricing Program -** The 340B Medication Pricing Program resulted from enactment of Public Law 102-585, the Veteran's Healthcare Act of 1992, which is codified as Section 340B of the PHSA. 340B limits the cost of

	medications to federal purchasers and to certain grantees of federal agencies. The DC PBP is a covered 340B Program entity and is entitled to the discounted medication prices available to all 340B entities. **340B Prime Vendor Program** - The 340B Program law requires DHHS to create a "prime vendor" program for the entities in the 340B medication discount program. The prime vendor handles price negotiation and medication distribution responsibilities for those entities that choose to join the prime vendor program. Apexus, Inc. is the current HRSA prime vendor.
DC PBP Enrollment and Eligibility Requirements	PBP is a "payor of last resort". Eligibility is based on DC residency, financial eligibility, and medical eligibility. Once enrolled into the program, **PBP customers must recertify** annually. Supporting documents are required to process each application. DC PBP beneficiaries who fail to recertify by their eligibility end date will be dis-enrolled from the program. The following information is required to determine eligibility for all PBP applicants: • **Full name, social security number (if available), and date of birth** are required. If there is another name the customer is known by, that name should be listed on the application in the space provided. • **Proof of residency** can be documented with a copy of one of the following showing name and address of the applicant: current lease or mortgage statement, deed settlement agreement, current driver's license, current voter registration card, current notice of decision from Medicaid, fuel/utility bill (past 60 days), property tax bill or statement, rent receipt (past 60 days), pay stubs or bank statement with the name and address of the applicant (past 30 days), Recipient eligibility confirmation page from DC Medicaid portal, letter from another government agency addressed to applicant (60 days), active (unexpired) homeowner's or renter's insurance policy, DC Healthcare Alliance Proof of DC Residency form, zero income statement (60 days), and if homeless, a written statement from case manager or facility on facility letterhead. • **Living arrangements** should be reported on the application by listing all household members. This includes any dependent of the household, a spouse, or any children under 21 years old. • **Proof of HIV positive status** is required for PBP enrollment. (i.e. written documentation from customer's practitioner). Ryan White legislation states that an individual must have a diagnosis of HIV/AIDS for eligibility of services. New and returning applicants must include a copy of most recent

laboratory reports to include CD4 count and viral load. CD4 count and viral load should be within one (1) year of initiating the application. The lack of an updated laboratory report for recertifying customers shall not impact eligibility determination, yet these customers must be informed to follow up by providing an updated lab.

- **Financial eligibility** is based on 500% of the FPL. The FPL is determined by the household size and is updated annually. The FPL for Ryan White B eligibility determination is updated and effective on April 1st of each calendar year or on the 1st of the month following the release of the guidelines per federal registry. Financial eligibility is calculated on the gross income available to the household excluding Medicare and Social Security withholding and the cost of healthcare coverage paid by the applicant. Income sources should be reported by the applicant and household members for whom applicants have legal responsibility. For each income source the applicant must indicate the gross amount, how often the income is received, and whether it is your income or a household member's.

500% of Federal Poverty Level (2026)		
Family Size	Monthly Allowable Gross Income	Annual Gross Income
1	$6,650	$79,800
2	$9,017	$108,200
3	$11,383	$136,600
4	$13,750	$165,000
5	$16,117	$193,400
6	$18,483	$221,800
7	$20,850	$250,200
8	$23,217	$278,600

	• **For wage earners** income should be documented by copies of pay stubs for the past 30 days. The pay stub must show the year-to-date earnings, hours worked, all deductions, and the dates covered by the paystub. If a paystub is unavailable the applicant must see a letter from their employer showing gross pay for the past 30 days along with a copy of your most recent income tax return. • **Self-employed individuals** must provide business records for 3 months prior to application indicating type of business, gross income, net income, and your most recent year's individual income tax return. A dated and signed statement from the applicant projecting current annual income must be included. • **Rental income** can be documented by a copy of the lease the applicant has with their tenants and a copy of their most recent income tax return. • **All other income** would include copies of SSD/SSI award letters, unemployment checks, social security checks, pension checks, etc. from the past 30 days should be sent as proof of other types of income. • **No income and supported by other** applicants must provide a letter from that friend or family member stating how they support the applicant. A filled zero-income statement form is acceptable. • **Healthcare coverage assistance.** The program can help people who have other health coverage and are having difficulty meeting their deductibles, co-payments, or other out-of-pocket costs. • **Proof of coverage requirements**. A copy of the front and back of all other health coverage cards (i.e., Medicaid, Medicare, Private Health Insurance, Healthcare Exchange, COBRA, and Alliance), proof of address, and HIV information (recent labs and medical history) must be included in the applicant's application packet.
General Application Procedures	Program eligibility specialists shall review all individual applications for accuracy and completeness to ensure all HRSA and DC PBP requirements are obtained prior to determining eligibility. • Applications are received by online portal, mail, or walk-in customers. Application submission via e-fax is only acceptable in the instance when other modes for application submission are not functional. All applications are assigned to a program eligibility specialist for processing.

	• Only completed and signed application forms with required documentation will be processed for eligibility. Supporting documents provided to DC PBP must be clear and legible. • A program eligibility specialist shall utilize available resources for ensuring vigorous pursuit to ensure PBP is the payor of last resort. This protocol ensures a customer is not eligible for services from another source (i.e. Medicaid, PCIP, Healthcare Exchanges). For example, the DC Medicaid eligibility enrollment system (DCAS) can be used to determine if a customer is currently enrolled in Medicaid/ Medicare, or QMB marketplace plans. If the applicant is eligible for healthcare or prescription coverage by another healthcare program, such as the ACA marketplace etc., the applicant and/or case manager must be notified and provided the point of contact to the qualifying healthcare program. **Customers who are beneficiaries of the Veteran Administration or Indian Health Service are exempt from the payor of last resort requirement**. • If a customer is Medicaid eligible, the customer and/or the customer's case manager will be notified of the ineligibility for the PBP and referred to Medicaid. However, qualified Medicare beneficiary (QMB) customers are exempted due to gaps in coverage as QMB only pays Medicare premiums and cost-sharing, not medications. • **Labs**. New customers must submit labs (along with a medical diagnosis form), dated within 12 months of the application submission date. Recertifying customers shall not be denied eligibility based on missing labs. Recertifying customers without updated labs can be referred to the DC Health & Wellness Clinic for updated labs. • Program eligibility specialists shall review and process each complete application within two business days. If more information is needed from a customer/case manager, then the program eligibility specialist shall review and process each application within a week. • **Incomplete applications** shall be denied. • If the program eligibility specialist determines that the customer qualifies for another payor, the customer/case manager will be informed of other *Available Resources* while the customer seeks coverage from the appropriate payor. • Applicants determined PBP eligible will have all supporting documents required by the application and will be uploaded into the electronic

	enrollment system. The program eligibility specialist will categorize the customer by the PBP service approved (i.e. Full PBP/ Copayment/ Insurance Premium or COBRA premium). • Applicants deemed eligible will receive a DC PBP welcome letter, along with a pharmacy benefits card. Customers may also access their benefits card via their member profile on the Ramsell online portal or mobile app. **Recertification notification letters** Customers are required to apply for eligibility at intake and annually thereafter. Customers who elect to receive mail will receive notification of reapplication prior to the expiration of their enrollment. This letter includes a copy of the annual enrollment form.
Health Insurance Assistance Program	The Health Insurance Assistance Program pays for customers' monthly copays and deductibles for medications on the DC PBP medication formulary, and/or insurance premiums, if the customers meet the eligibility criteria and are enrolled in a health insurance plan on their own or as part of an employer plan. All plans must cover all PBP formulary medications.
Premium Assistance	This section outlines some premium assistance requirements and details the processes under the Pharmacy Benefit Program to ensure consistent and compliant beneficiary support. • Customers electing for health insurance premium assistance will have initial payment and scheduled monthly payments entered in the PBM enrollment system. • DC PBP's maximum allowable cost per month for premium payment is **$1300.00**, except for COBRA premiums. • Customers must provide premium statements and documentation of insurance when requested. Start date and end date should be included in documentation. • Program eligibility specialists will verify the applicant's insurance start and end date, and current account status before enrolling into the health insurance assistance program. • After enrolling the applicant into the health insurance assistance program, program eligibility specialists shall set payment schedules through the end of the customer's eligibility expiration date. Premium payment shall not be made into a new calendar year without an updated invoice from the customer.

	• The cost effectiveness of premium payment versus traditional PBP will be calculated monthly by analysis of the monthly and yearly amount expended on medication purchases and premium cost. • Customers with employer-sponsored insurance electing for health insurance premium assistance must provide proof of the insurer's formulary, including coverage of PBP formulary medications. Customers with employer-sponsored plans that do not cover PBP formulary medications will be referred to an ACA plan. **Upon providing proof of vigorous pursuit eligible PBP customers unable to secure an insurance plan may be granted full-pay uninsured PBP medication coverage for up to one (1) year, until the next open enrollment period**. **Customers must secure a plan of their choice once open enrollment begins**. • DC PBP's contracted premium payment vendor will pay customers' premiums directly to the insurance companies weekly for the respective customer's monthly premium payment. • The vendor shall make available custom reports of all premium customers served with cost expended each month. • DC PBP will maintain a premium customer enrollment log and expenditure report, which will be updated monthly, and cross referenced with the Contractor's premium payment report.
Copay/ Deductible Assistance	**The PBM system will process Third Party Liability (TPL) claims and the following rules apply:** • The system will adhere to a $4,600 per claim limit for TPL claims. Any claim over $4,600 will be denied for limits exceeded. • For the insured claims, the system will adhere to $3,000 per claim limit for TPL claims. Any claim over $3000 will be denied for limits exceeded. • The system will pay TPL claims until the member meets or exceeds the $12,000 annual limit. Upon meeting or exceeding the limit, the system will deny the claim for limits exceeded. **For any claims exceeding the per claim limit, prior authorization will be required, and the following criteria apply:**

	• If the maximum allowable limit and deductible are not met, then an override for copay is applied. The primary payor covers the copay, and PBP provides secondary assistance with the copay and deductible. • If the maximum allowable limit is not met but the deductible is met, then an override for the copay is applied. The primary payor covers the medication cost, and PBP assists with the copay. • If both the maximum allowable limit and deductible are met, then the customer is advised to explore a mail-order option. PBP will provide short-term coverage for the gap. If the customer declines mail-order service, an override should be placed and documented in the electronic enrollment system.
Vigorous Pursuit of Other Funding Sources	To ensure compliance with HRSA's requirement for "vigorous pursuit and rigorous documentation" so that Ryan White Part B remains the payor of last resort, all entities funded under the DC DOH PBP—including grantees, sub-grantees, and their contractors are required to actively pursue and document customer enrollment in all available healthcare coverage options. This expectation applies explicitly to all sub-grantees including those funded under Medical Case Management (MCM) and those funded under non-MCM service categories. Sub-grantees providing case-managed services are responsible for conducting vigorous pursuit activities for their assigned PBP customers. For PBP customers who do not have an assigned case manager, HAHSTA will designate an appropriate internal unit or staff resource to ensure that these required activities are completed and documented, as the responsibility to pursue coverage applies uniformly to all customers regardless of case management status. Vigorous pursuit activities must occur at each annual eligibility determination and include, at minimum: • Evaluating the healthcare coverage for which the customer may be eligible (i.e., Medicaid, marketplace, employer based, or private non-marketplace plans). • Discussing available health coverage options with the customer. • Explaining the requirements of additional health coverage and clarifying that Ryan White Part B is not an insurance program. • Rigorously documenting all efforts to support and encourage customer enrollment into appropriate coverage within the electronic enrollment system.

	Determinations of customers' eligibility for healthcare coverage will be supported by DC DOH PBP as follows: • Annual open enrollment notifications will be sent to uninsured customers based on their reported eligibility factors. • PBP customers who appear eligible for another payer and have opted to receive notice will be provided correspondence prior to the annual open enrollment period. This correspondence will include PBP-specific restrictions on marketplace plans listed through the DC Healthcare Exchange, as well as instructions for self-enrollment or obtaining enrollment assistance. **There are no exceptions or exclusions to the vigorous pursuit requirement.**
Payor of Last Resort	To outline the Ryan White Part B (RWPB) expectations regarding payor of last resort procedures, pursuit of enrollment with customers who are eligible for comprehensive healthcare coverage, and the documentation requirements of those activities. These activities are critical in ensuring RW funds are not used for services that could reasonably be paid for by another funding source. The requirements for rigorous documentation and reporting are to show that all reasonable steps have been taken to vigorously pursue enrollment into comprehensive healthcare coverage for all eligible customers. RWPB payor of last resort requirements is standard for all services offered, meaning that funds are to fill gaps in care not covered by other resources. Major payor examples include Medicaid, Medicare, the Children's Health Insurance Program (CHIP), and private health insurance. **Exceptions and exclusions** Veterans Affairs and Indian Health Service programs are designated as payors of last resort, so they do not count as an available third payor when determining RWHAP eligibility.
Vigorous Pursuit of Premium Tax Credit	The Ryan White Part B Program is required to ensure that the program is the payor of last resort for all services it provides. With the implementation of the ACA, a large portion of people have increased access to some form of insurance coverage. Part of the requirements of the ACA is that enrollees must ensure to accurately estimate their income, as well as report any income changes throughout the year to ensure accurate **Advance Premium Tax Credit**

	(APTC) subsidy is assigned. APTC is based on customer's estimated annual income and household size when applying for Marketplace coverage only. Customers who take more APTC than they are qualified for will have to repay the difference at tax time. • Customers must provide DC PBP with any tax refunds associated with premium assistance overpayment immediately, or their enrollment may be impacted. • Customers must submit forms **1095A, 8962, and 1040** to DC PBP annually, by **April 15th.** If they obtain an extension from the IRS, they must send a copy to DC PBP. • Customers must file federal income tax returns for the year in which they receive premium tax credits and not be claimed as a dependent on someone else's tax returns. • Customers must request to take their tax credits throughout the year. • All attempts to pursue premium tax credits for beneficiaries eligible for premium tax credit will be documented and maintained by DC PBP.
Health Insurance Portability and Accountability Act (HIPAA)	Under DC law, HIV related information provided to the DC PBP is kept strictly confidential. Customer information may only be given to those parties necessary for the proper administration of the Programs. These are individuals and organizations with whom the Programs need to discuss customer applications and/or participation to determine eligibility, pay for services or medications covered under the Programs, or properly account for funds spent. Program staffers are aware of customers' need for confidentiality and privacy and will discuss personal information only as strictly necessary for the administration of the Programs. To provide the applicants with an understanding of the issue of confidentiality and the conditions of participation in the Programs, the following examples are provided: • DC PBP will NOT contact the customer's employer, landlord, family, friends, neighbors, or anyone else without direct consent from them, whether directly related to their application or participation in the Programs. • DC PBP can receive, verify, and/or share the customer's demographic, medical, prescription and/or insurance information if it is needed to help them get their prescription and/or premium payments. • DC PBP may share the applicant's information with, but is not limited to, the following: doctor, health department staff, pharmacy staff, clinic,

	case management, insurance company, Medicare, Medicaid, CMS, SSA, SSDI, and other agencies where Ryan White services are provided to the customer. • DC PBP will discuss the application of individuals in prison with authorized employees of Parole or Corrections as needed to enroll in the Programs. **Programming policies and staff responsibilities include but are not limited to:** • Annual security and confidentiality training • Annual Employee Confidentiality Agreement • Personal and collective obligation to comply with data security and confidentiality policies • Challenge unauthorized users and use of data • Report all suspected breaches of security and suspected violations of the policy to supervisor immediately • Exercise good judgment
Audits - Program requirements and Application	A biweekly audit will be performed to determine the accuracy and efficiency of PBP program requirements and application processing. Audit findings will be used to analyze areas of need within the PBP and allow for continued quality improvement outcomes.
Medication Formulary	**PBP Formulary –** Medications on the PBP Formulary are based on recommended treatment regimens approved by the Sub-HADAC and HADAC committee for treating customers with HIV/AIDS. Only medications that have been approved for the PBP formulary are covered.
Medication Purchasing and Delivery	All medications purchased by the PBP at 340B discounted prices are stored and distributed by the PBP Replenishing pharmacies. Any expired, recalled, damaged or otherwise unusable medications will be returned to the Wholesaler for proper disposal after receiving authorization from the PBP Pharmacist. The PBP Pharmacist will request a return authorization (RA) form from the Wholesaler and coordinate with the pharmacy for the Wholesaler to pick up the returned medications. A signed copy of the RA form and other documents included shall be sent to PBP. DC PBP's Wholesaler delivers 340B priced medications weekly, on Thursdays, to the Replenishing pharmacies. The pharmacy orders are generated weekly by PBM claims report data.

Network pharmacies	The pharmacies in the PBP pharmacy provider network are contracted with DC Health Office of Contracts and Procurement to provide medication services for eligible customers. The network is comprised of in-network pharmacies that service uninsured and insured customers; and out-of-network pharmacies, which include chain pharmacies that only service insured customers.
340B Medication Pricing Program	**Section 340B of the Public Health Service Act (1992)** requires medication manufacturers participating in the Medicaid Medication Rebate Program to sign an agreement with the Secretary of HHS. This agreement limits the price manufacturers may charge certain covered entities for covered outpatient medications. The resulting program, called the 340B Program, does the following: • Allows covered entities to stretch scarce federal resources to eligible customers. • Provides a safety net for providers to carry out their mission to serve their communities DC PBP complies with all requirements and restrictions of Section 340B of the Public Health Service Act and any accompanying regulations or guidelines, including, but not limited to, the prohibition against duplicate discounts/rebates under Medicaid, and the prohibition against transferring medications purchased under 340B to anyone other than a customer of the entity. DC PBP uses any savings generated from 340B in accordance with the 340B Program intent. DC PBP has systems/mechanisms and internal controls in place to reasonably ensure compliance with all 340B Program requirements. DC PBP maintains auditable records demonstrating compliance with the 340B Program. 340B entities are facilities/programs listed in the 340B statute as eligible to purchase medications through the 340B Program and appear on the OPA database. **Procedures:** The program's Authorizing Official will update and maintain accurate information in OPA's database.

	1. All addresses, the authorizing official information, and the primary contact information are correct and up to date. 2. DC PBP regularly reviews the 340B database records. 3. DC PBP informs HRSA immediately of any changes to its information by updating the HRSA 340B database/ Medicaid exclusion file within 14 business days. DC PBP ensures only eligible customers receive 340B medications, a Medicaid rebate is not paid on a 340B purchased medication, and all entity eligibility requirements are met. DC PBP has identified the pharmacies contracted to dispense 340B medications to eligible customers. A full list of these contract pharmacy locations is available on the DC PBP website. **Contract Pharmacies.** DC PBP contracts with community pharmacies in DC. Participating contract pharmacies are required to sign a Human Care Agreement with the DC DOH HAHSTA administration. Pharmacies must provide the entity with auditable records of customers utilizing the 340B rebate program annually. DC PBP will register new contract pharmacies during quarter registration periods. Prior to registration DC PBP will ensure that: 1. DC PBP has a signed contract pharmacy services agreement containing the essential compliance elements in the contract pharmacy prior to registration on the HRSA 340B database. 2. DC PBP's leadership team has reviewed the contract and verified that all federal, state, and local requirements have been met. 3. DC PBP has a contract pharmacy oversight and monitoring policy and procedure that has been developed, approved, and implemented. 4. DC PBP's authorizing official of designee completes the online registration during one of four registration windows. Within 15 days from the date of the online registration. The authorizing official certifies online that the contract pharmacy registration request was completed. Contract pharmacy's responsible representative may be the owner, president, CEO, COO, pharmacy manager, or CFO. 5. DC PBP begins using the contract pharmacy services arrangement only on or after the effective date shown on the HRSA 340B database, and after the effective date of the vendor's contract with the district. Registration Dates:

	• January 1-15, effective start date April 1 • April 1-15, effective start date July 1 • July 1-15, effective start date October 1 • October 1-15, effective start date January 1 DC PBP has a 340B hybrid model which is allowed by HRSA for Programs to collect rebates and has a 340B replenishment model using an 11 digit to 11-digit NDC match. **Material Breach.** DC PBP defines a material breach of compliance as a violation that exceeds a threshold of the following: 1. 10% of total 340B purchases or impact to any manufacturer 2. $500.00, based upon total outpatient or 340B spend, or impact to any one manufacturer 3. 5% of total 340B inventory (units) 4. 5% of audit sample 5. 10% of prescription volume/prescription sample 6. Will not self-correct within 3 months DC PBP will take corrective action such as evaluation/ change of software/vendor, changes to policy and procedure manual, contact/action with partners such as vendors, changes to 340B database. Violations identified through internal or external audit that exceed these thresholds and remain – non-correctable will be immediately reported to HRSA and applicable manufacturers. DC PBP's authorizing official and/or PBP pharmacist will oversee this process, review potential violations, perform materiality assessment, and determine if a material breach occurred, and will then identify to whom to self-disclose their breach dependent on that materiality determination and corrective action plan resolution. The authorizing official will review policies to make decisions about the material breach definition and self-disclosure. All records of material breach violations will be maintained by DC PBP. **Program prohibitions include:**

	• Diversion - a medication is provided to an individual who is not a customer of that entity; medication dispensed in an area of a larger facility that is not eligible. • Duplicate discounts - a manufacturer provides a 340B discount and Medicaid rebate on the same Medicaid fee for service medication. **340B Program Site Visits include:** • Auditable records - DC PBP must maintain auditable records that demonstrate compliance with all program requirements. DC PBP will conduct internal monthly audits and annual external audits for its 340B program. Internal audits will comprise of reviewing required data elements for prescription claims processing and inventory data reports specified in the contract pharmacy Human Care Agreement. External audits will be conducted by the DC PBP pharmacist either by onsite visits or desk top audits of pharmacy claims and 340B inventory records. The AO must provide the following information: a) Primary contact b) Medicaid Billing c) Entity Specific type documentation d) Grant number and designation number e) Bill to address f) Ship to address g) Answer prequalification questions For contract pharmacies: a) Pharmacy contact information b) Pharmacy DEA number c) Shipping address • Database records - DC PBP will notify OPA of any changes in eligibility. • **Recertification** - annual recertification is mandatory for the entity. The authorizing official assumes responsibility for accuracy of all information provided for the 340B account. Addresses, phone, point of contact, and

	requested information should be updated accordingly to maintain accuracy. Quality Assurance monitoring shall be conducted in the weekly reports obtained from the PBM and Wholesaler invoices. Site visits will also take place to verify compliance with the 340B medication rebate and DC PBP requirements. These visits will verify medication ownership, inventory lists, and determine if products are segregated in the pharmacy. Best practices for monthly self-audits to ensure HRSA compliance are; validate customer eligibility, review physician reports with NPIs to determine only eligible PBP customers receive 340B dispensed medications, verify referrals for care provided outside the entity, review billing practices for Medicaid and Medicaid managed care to ensure consistency with state policy and the entity's 340B database information, and ensure all information in the 340B database is current.
340B Contract Pharmacy Provider Requirements	**DC PBP Contract Pharmacy Policies and Procedures**: DC PBP's Covered Entity-Contract Pharmacy Agreement is made by and between the **District of Columbia Department of Health HRSA ID RWIID72, RWIIU20002** and the Pharmacy Provider. DC PBP is a covered entity registered under the provisions of Section 340B of the U.S. Public Health Service Act. 340B covered entities are eligible under the 340B Medication Pricing Program to purchase 340B covered medications at reduced prices for use by 340B program customers from medication manufacturers who have signed a medication purchasing agreement with DHHS. Covered entities then contract with pharmacies to dispense 340B covered medications to the covered entities' customers. • Contracted pharmacy providers are duly authorized to provide pharmacy services to people located in the DC, generally, and to customers, specifically. • DC PBP and the pharmacy provider must maintain compliance with the guidelines published by HRSA regarding arrangements between covered entities and their contracted pharmacies. • A pharmacy provider that dispenses 340B covered medications to DC PBP customers at more than one location will be listed in their Human Care Agreement. **Responsibilities of DC PBP**

	Certification and Data. DC PBP will submit data and certifications regarding covered entity's and pharmacy provider's status to the OPA as required for participation in the 340B Medication Pricing Program. **Authorized Prescribers.** All licensed physicians in DC with an NPI, DEA, and controlled substance license. **Customers**. The covered entity will determine who qualifies as a customer. **Customer Choice**. • DC PBP will inform all customers of their freedom to choose a pharmacy provider and that the customer is not required to use the services of a specific pharmacy. **Ownership of DC PBP 340B Covered Medications and Medication Purchase Account.** • DC PBP owns all 340B covered medications. DC PBP has an account with a DC licensed wholesaler and/or manufacturer ("Wholesaler"): a) that requires that covered entity be directly billed and to pay for all 340B covered medications that are purchased to replenish the pharmacy provider's inventory when it dispenses a 340B covered medication to a customer, and b) that requires Wholesaler or manufacturer to ship the replenishment directly to the pharmacy. • DC PBP's PBM orders 340B medications determined by pharmacy claims detail adjudicated by the pharmacy provider in the Ramsell PBM system weekly. • Orders are triggered by package size accumulation placed using the online pharmacy benefits system and communicated to Cencora (formerly Amerisource Bergen) weekly by an EDI connectivity to the Ramsell PBM system. • Medication Invoices are billed to DC PBP. • Contract pharmacies participating in replenishment will receive shipment weekly each Thursday by the Wholesaler's courier service. • Contract pharmacies will notify DC PBP if they do not receive an 11-digit NDC replenishment order within 48 hours of the original order fulfillment request.

	• DC PBP resolves any discrepancies with Wholesaler to ensure 11-digit NDC match. • Unresolved discrepancies due to shortage, slow movers, and other issues are addressed in the pharmacies' Human Care Agreements with the district. **Pricing** • Covered entity shall be responsible for pricing all 340B covered medications. DC PBP receives and reviews invoices for medications shipped to its contract pharmacies. • DC PBP pays invoices to Wholesaler for all 340B medications. • DC PBP has Ramsell adjust the virtual inventory system when variance or discrepancy has occurred. DC PBP uses approved methods with knowledge and agreement of the contract pharmacy regarding reconciliation between inventory and invoices with adjustments as necessary to match changes. **Responsibilities of the Pharmacy Providers** **Prescriptions and Signature Logs**. Pharmacy providers shall maintain records of all prescriptions dispensed pursuant to this Agreement in an electronic or written format specifically approved by the covered entity for each 340B covered medication dispensed to a customer. • The pharmacy provider shall develop and maintain a process to record each customer's acknowledgment that he or she has received a 340B covered medication ("Acknowledgment Process"). The Acknowledgement Process shall be consistent with industry standards, which at a minimum require that each entry include the appropriate prescription number. The Acknowledgement Process also must include the ability for the customer's authorized representative to receive the 340B covered medication. Pharmacy providers must obtain the covered entity's approval for any Acknowledgement Process other than a traditional signature log. **Dispensing** • Pharmacy providers will dispense 340B covered medications only upon presentation of a prescription by an authorized prescriber made for a 340B Program customer.

	Replenishment • Pharmacy providers will not receive 340B medication replenishment for any prescription that has been billed to an excluded governmental program. The pharmacy provider shall review all replenishment orders immediately upon receipt and notify DC PBP and PBM of any discrepancies between the 340B covered medications it dispensed and the replenishment order. • DC PBP has a 340B Hybrid model; therefore, two inventory models have been established to provide medications. • A 340B contracted pharmacy participating as non-340B replenished inventory pharmacy will be dispensing from the inventory purchased by the pharmacy and will be reimbursed by the approved rate ingredient cost and dispensing fee for prescription claims to a PBP customer. • Contract pharmacies dispense prescriptions to eligible customers using contract pharmacy non-340B medications. • A 340B contracted pharmacy participating as a replenishment pharmacy will dispense initial prescription from the pharmacy's inventory and will receive inventory replenishment and will be reimbursed the approved medication dispensing fee. **Pharmacy Services** The Pharmacy Provider will provide pharmacy services to 340B program members up to and including: • Dispensing and recordkeeping • Medication utilization review • Maintaining customer and medication profiles • Counseling and advising consistent with the rules, limitations, and privileges incident to the pharmacy-customer relationship **Reporting** • By contract, the pharmacy provider shall furnish, in a format reasonably requested to DC PBP, reports consistent with customary business practices, including without limitation, reports and claims data to meet any requirements for audit of the covered entity DC PBP by the OPA and/or Office of Inspector General. For the purposes of this section,

	"sufficient claims data" means data sufficient to monitor 340B covered medication purchase orders, 340B covered medication payments, and 340B covered medication inventory of each location. • These reports should be provided to DC PBP. **Tracking and Replenishment of DC PBP Covered Medications** • The pharmacy provider shall establish and maintain a reporting and tracking system, acceptable to the PBM and DC PBP, which is suitable to support 340B contract pharmacy requirements, including prevention of the diversion of 340B covered medications to individuals who are not 340B program customers and prevention of duplicate discounts under Medicaid. Pharmacy providers shall cooperate in good faith to create, maintain, and review this system. • The pharmacy provider will not use 340B medications for Medicaid beneficiaries (carve-out). DC PBP requires all pharmacies to verify customer eligibility with DC Medicaid prior to billing DC PBP. DC PBP also disallows pharmacy claims for all DC Medicaid FFS BIN and PCN numbers. **Inventory Replenishment for 340B Price Claims:** • DC PBP formulary medications shall be dispensed by the pharmacy provider in a virtual inventory model as follows: • The pharmacy provider shall dispense its inventory to 340B program customers pursuant to a prescription for a 340B covered medication. When a pharmacy provider dispenses a medication from its inventory, that medication shall be deemed a 340B covered medication, which DC PBP shall purchase and replenish for the pharmacy provider in accordance with the ship to bill to procedure described below. • The pharmacy provider shall monitor medication inventory and maintain sufficient stock to meet the routine needs of 340B program customers. The PBM and DC PBP will track the dispensing of 340B covered medications, and once 100% of a bottle-or another amount specified by the 340B covered entity-has been dispensed and DC PBP's replenishment threshold is met, the PBM will coordinate with DC PBP to electronically submit a covered entity-approved purchase order to the Wholesaler for shipment to the pharmacy provider and billing to DC PBP. Upon receipt, the pharmacy provider shall promptly review the shipment to verify accuracy. • The pharmacy provider shall promptly acknowledge receipt of all shipments in its tracking system within five (5) business days of receipt of shipment, provide the PBM or its designee with notification of discrepancies in the order received to verify the actual 340B covered medications shipped to and received by the pharmacy provider. In all such cases, 340B covered entity shall be responsible for purchasing DC

	PBP Medications from the Wholesaler, who will bill the DC PBP for the 340B covered medications. **For DC PBP 340B Covered Medications Not Replenished Due to Wholesaler Unavailability:** • If a 340B covered medication that has met the dispensing package size requirements for replenishment as specified in inventory replenishment, is not available for shipment by the Wholesaler, the PBM will identify such applicable medication inventory within ninety (90) days of the initial Wholesaler medication order attempt and pharmacy provider will: (a) adhere to the PBM's requirements for a systematic adjustment to the virtual inventory; and (b) receive reimbursement for the settlement of medication inventory at the price set forth in the pharmacy's Human Care Agreement. **For DC PBP 340B Covered Medications Not Replenished Due to Order or Replenishment Threshold Not being Met:** • If a 340B covered medication has not met the dispensing package size requirements for replenishment as specified in inventory replenishment after a ninety (90) day period or for a period otherwise directed by DC PBP the covered entity, the pharmacy provider will: (a) adhere to the PBM requirements for a systematic adjustment to the virtual inventory; and (b) receive reimbursement for the settlement of medication inventory at the price in the pharmacy's Human Care Agreement. **Prohibition on Duplicate Discounts** • The pharmacy provider and the PBM, on behalf of DC PBP (the 340B covered entity) have agreed not to accept replenishment for, or use 340B covered medications to dispense prescriptions paid for in whole or in part by Medicaid or other covered entity, unless pharmacy provider, referenced 340B covered entity and the applicable State Medicaid Agency or other covered entity have established an arrangement which will prevent duplicate discounts and/or rebates, or as otherwise permitted by law. **Prohibition on Medication Diversion** • The pharmacy provider and the PBM on behalf of the DC PBP (the 340B covered entity), have agreed that they will not resell, or transfer a 340B covered medication, or accept replenishment for a prescription dispensed to an individual who is not a DC PBP 340B program customer. The pharmacy provider has agreed that, in the event of a transfer, diversion, or resale of a 340B covered medication in violation of their

	agreement with the District, it will pay DC PBP an amount equal to (i) the price discount DC PBP received from the Wholesaler for the medication and (ii) any costs incurred by DC PBP, the 340B covered entity and the PBM in connection with correcting such transfer, diversion, or resale. For purposes of this provision, DC PBP's determination of the amount due is conclusive. **Reports and Records** • The PBM will provide DC PBP with its standard reports, which shall include information for the entity to monitor 340B covered medication purchase orders, 340B covered medication payments and 340B covered medication inventory. • DC PBP Reports. If reasonably requested by the PBM or DC PBP, the pharmacy provider will provide the PBM with all reports consistent with customary business practices, which shall include at a minimum dispensing reports that will identify for the 340B covered entity, all prescriptions filled for 340B program customers under this addendum (including the 340B program customer's name, and the 340B covered medication name, strength, quantity dispensed, NDC number and prescription number), 855 files (Medicare provider-enrollment files), and all such other information required by law or reasonably requested by the PBM or DC PBP. • Records. In addition to the Records required under the agreement, parties shall maintain any records required by the 340B medication pricing program for at least seven (7) years (or longer, as required by law). **Audit and Oversight Requirements** • DC PBP routinely conducts internal reviews of each registered contract pharmacy for compliance with 340B program requirements. The following elements are included when conducting audits for contract pharmacies to ensure program requirements: 1. Prescriptions are written for PBP eligible customers only. 2. Prescriber is a licensed physician in the district. 3. An 11-digit NDC match can be documented for accumulation and/or replenishment of a 340B dispensation or administration. 4. DC PBP can document that no prescriptions were billed to Medicaid for eligible PBP customers. 5. DC PBP's pharmacy team will audit 25 claims for a total of 75 customer sample files per year.

	• DC PBP conducts annual independent desk top audits of each registered contract pharmacy for compliance with 340B program requirements. 1. Independent audits will include reviews of: a. 340B eligibility b. 340B registration c. Documentation of policies and procedures d. Inventory, ordering, recordkeeping practices for all 340B accounts. e. Review of the listing in the Medicaid Exclusion File and its reflection in actual practices f. Testing of claims sample to determine any instance of diversion or duplicate discounts in a set period: • Tracking System. The parties will cooperate to establish and maintain a tracking system that will ensure that medications purchased under the 340B Medication Pricing Program are not diverted to individuals who are not eligible customers. Such records can include prescription files, velocity reports, and records of ordering and receipt. Pharmacy provider will permit the covered entity or its duly authorized representatives to have reasonable access to the facilities and records during the term of this agreement to make periodic checks regarding the efficacy of the tracking systems. Covered entity may exercise this right before the pharmacy provider commences furnishing services under this agreement. • The pharmacy provider will make all adjustments to the tracking system that are reasonably necessary to prevent diversion of 340B covered medications to individuals who are not 340B program customers. • Records Retention. Both parties shall retain, during the term of contract plus seven (7) years or as required by state or federal law, whichever is longer, copies of all prescription and transaction records for services provided to 340B program customers under this agreement. For the same period, the pharmacy provider shall also maintain credentialing files for all pharmacists who provide services to customers. For purposes of this agreement, “prescription and transaction records” include, without limitation, prescriptions received, claim forms, signature logs, and invoices prepared by the pharmacy provider. The

	pharmacy provider shall retain the records so that they are available for audit at any reasonable time. • Regulatory Access. Both parties shall make all books, records, invoices, and prescription files related to providing pharmacy services to 340B program customers available to covered entity and applicable state and federal regulatory agencies, as may be necessary to comply with the terms of this agreement. This obligation exists during the term of this agreement plus seven (7) years or as required by state or federal law, whichever is longer. • No Resell or Transfer. Contract pharmacies will not resell or transfer a medication purchased under the 340B Medication Pricing Program to an individual who is not a 340B program customer. The covered entity shall reimburse the manufacturer for any such diverted medications. If the pharmacy provider is found to have violated the medication diversion prohibition contained in Section 340B of the U.S. Public Health Service Act, the pharmacy provider will pay the amount of the discount in question so that the covered entity can reimburse the manufacturer. • Medicaid and Other Excluded Government Programs. Pharmacy providers shall not use medications purchased under the 340B Medication Pricing Program to dispense Medicaid prescriptions or prescriptions for other excluded government programs. **TERMINATION** Termination for Loss of Right to Participate in 340B Medication Pricing Program. If a change in ownership occurs, the pharmacy provider will be required to submit all updated information to DC PBP to complete a new contract pharmacy registration to DPA. The old information from the previous owner will be terminated. If either party becomes ineligible, for any reason, to participate in the 340B Medication Pricing Program; termination under this provision shall be effective immediately.
Contact For more Information	Ademola Are Chief, Pharmacy Benefits Program ademola.are@dc.gov
References	• The Ryan White HIV/AIDS Program: U.S. Congress. (2009). *Ryan White HIV/AIDS Treatment Extension Act of 2009*. *(*Pub. L. 111-87; codified at *42 U.S.C. § 300ff et seq.).*

	• The 340B Medication Pricing Program: U.S. Congress. (1992). *Veterans Health Care Act of 1992* (Pub. L. 102-585; codified at 42 U.S.C. § 256b). • The Affordable Care Act (ACA): U.S. Congress. (2010). *Customer Protection and Affordable Care Act* (Pub. L. 111-148). • The Affordable Care Act (ACA): U.S. Congress. (2010). *Health Care and Education Reconciliation Act* (Pub. L. 111-152). • The Health Insurance Portability and Accountability Act (HIPAA): U.S. Congress. (1996). *Health Insurance Portability and Accountability Act of 1996* (Pub. L. 104-191). • The Consolidated Omnibus Budget Reconciliation Act (COBRA): U.S. Congress. (1986). *Consolidated Omnibus Budget Reconciliation Act of 1985* (Pub. L. 99-272). • CMS/Social Security Act Authorities: U.S. Congress. (1965). *Social Security Act* (Title XVIII and Title XIX).