CAREAssist Policies & Procedures

2023

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APPLICATION PROCESS (Overview)
Effective Date: September 2003; Updated September 2023
Purpose: Provides an overview of the application process.

CAREAssist OAR:
333-022: 1010; 1020; 1030; 1040; 1050

Policy:

An individual may apply for CAREAssist by submitting a complete Program application and providing documentation, as instructed in the application, which verifies:

a. Positive HIV-diagnosis
b. Total family income at or below 550% FPL
c. Oregon residency

CAREAssist accepts applications submitted via mail, email, and fax or those completed on-site at the CAREAssist office. Effective October 1, 2023 CAREAssist will accept electronic signature on the application, CER and proof of residency form.

Complete Applications:

1. Reviewing the application for completeness shall be done within ten (10) calendar days after Program receipt of an application.
2. The effective date of eligibility shall be the date that the application is considered complete by the Program and, if applicable once the applicant has applied for insurance for which they are eligible, as determined by the Program.
3. Clients shall be notified of eligibility within three (3) business days of eligibility determination.
4. If approved, eligibility is for six (6) full months.

Incomplete Applications:

1. If an application is determined to be incomplete or missing required documentation, the applicant and, if applicable, the applicant's Case Manager shall be notified. Notifications shall identify missing documentation or incomplete questions on the application necessary to complete the application and the deadline for doing so.

Incomplete applications shall be closed 45 days from Program receipt. The applicant and, if applicable, the applicants Case Manager shall be notified that the application has been closed and that the applicant may reapply at any time.

Procedure:

Admin staff shall:

1. Print all applications and supporting documents received electronically, including the email to which they were attached
2. Date-stamp all application packets (Application, proof of residency form, HIV confirmation, income, and any miscellaneous packets)
3. Create new client record in database for first-time applicants
4. Enter (or update) all information on Client Info tab.
5. Enter Event Log: “CAREAssist App : Received Initial (1)”
6. Pass to Case Worker for eligibility determination
7. Enter event log notes (how the application was received, such as via mail or electronically, who submitted the application, who it was delivered to and by what method).

Case Workers shall:

1. Review application packet for completeness (all questions on the application answered, signed application, proof of residency completed, proof of HIV completed if new client, proof of income and summary of benefits if client has private or group insurance) and make event log notes throughout the process.
    a. If any pieces are incomplete, send notice to the applicant and, if applicable, the applicant’s Case Manager via email or mail.
    b. If complete, enter Event Log: “CAREAssist App : Complete (2).”

2. Determine eligibility and enter the date this occurred in the Event Log as “CAREAssist App : Eligibility Determined (3).”

3. Enter all pertinent information and application status in electronic record.

4. If eligible, verify applicant enrolled in appropriate coverage and when applicable, a Summary of Coverage has been received, or proof of a complete application for insurance is on file. Assign client to benefit group as follows:
    a. Group 1: Clients who are enrolled in a private, group, or individual policy
    b. Group 2: Clients whose primary prescription benefits are provided by OHP or the Department of Veterans Affairs (VA).

Uninured Persons Program (UPP), if currently ineligible for insurance. (if ineligible for insurance and client is being approved for UPP, see section 9, **UNINSURED PERSONS PROGRAM (UPP)**)

5. Notify client and if applicable, Case Manager of eligibility determination. (Anytime there is a change in eligibility and the client has a Case Manager, the Case Manager must be CC’d on all communication.”
    a. If eligible, notification must include the following:
        i. The eligibility effective date
        ii. The client’s associated benefits
        iii. A list of CAREAssist In-Network Pharmacies
        iv. Recertification date
        v. A program-approved Moda Delta Dental application (if client’s primary insurance is *not* OHP)

b. If ineligible, either because the person didn't qualify or because the application was incomplete for more than 45-days, notification must include:
    i. The reason the application was denied
    ii. Grievance rights information
    iii. A statement that the client may reapply at any time

6. Create a paper file (or update existing file if on-site from a previous eligibility period)

Application Tracking Ensures eligibility is determined within a timely manner, 14-days, after receipt of a complete application	
Event Log	**Description**
(1) CAREAssist App: Received Initial	The original date of receipt
(2) CAREAssist App: Complete *Note: This is the client's 'effective date'*	The date the application form was complete, signed; *and* HIV verification, income and residency is documented.
(3) CAREAssist App: Eligibility Determined	The date the case worker determines the application is complete according to above (2). (The date the application form was complete, signed; *and* HIV verification, income and residency is documented). *or* The 46th day an application has been incomplete

Note: *<u>All</u> clients must have (1) & (3)*

Note: Enrollment in insurance is not a factor when determining (2) App: Complete or (3) App: Eligibility determined.

Lack of Summary of Coverage is a factor when turning on benefits. Client may be eligible, (3) App: Eligibility determined is complete, but if the clients has private or group insurance and we have not received the summary of coverage, we are unable to turn

benefits on and unable to add (2) App: Complete. The program requires the SOC, to confirm that the coverage meets the minimum essential coverage required by the program. *Program requirement: Insurance must cover at least 50% of all RX's.* If this happens and we still receive the SOC within 45 days of receipt of application, Case Worker should retro start the eligibility period to match the same date as Application Tracking, (3) CAREAssist app: Eligibility Determined, add (2) App: Complete with the date the SOC was received, and follow 5A above. If we do not receive the SOC within 45 days of receipt of application, the application would be rejected, and we follow 5B above.

ELIGIBILITY DETERMINATION

Effective Date: September 2003; Updated September 2023
Purpose: Describes the processes used to review applications and determine eligibility.

CAREAssist OAR:
333-022: 1010; 1020; 1030; 1040; 1050

Policy:

All applicants must meet the eligibility standards outlined below. Applicants to CAREAssist must submit a complete application and all supporting documentation, which verifies:

a. Positive HIV diagnosis
b. Total monthly gross income, based on family size, at or below 550% FPL
c. Oregon residency

Applicants to CAREAssist are responsible for providing proof of Program eligibility requirements. In the event that a potential client is unable to provide financial or residency proof, the Program will access State and Federal systems in an attempt to complete the financial and residency eligibility requirements.

Note: Presumptive eligibility is not permitted. Eligibility cannot be initiated until all eligibility requirements have been met and supporting documents have been collected by the Program.

If the client has private or group insurance and has been determined eligible, benefits cannot be initiated until the Summary of Coverage has been received by the Case Worker, reviewed, and verified that the RX component covers 50% or more of RX's. If the RX component does not cover %50 or more of RX's, see CAREAssist leadership.

Procedure:

Case Workers will conduct a thorough review of the application ensuring all questions are answered, all forms requiring a signature are signed and all required documentation, as outlined below, before making a final determination of eligibility. Notes and eligibility determination must be entered in the event log. Effective October 1, 2023, CAREAssist will accept electronic signature on the following forms: application, CER and proof of residency.

Eligibility Determination – HIV Diagnosis Verification

Policy:
Applicant must have a documented HIV-positive diagnosis. Proof of HIV-positive diagnosis must be documented with the program approved CAREAssist HIV/AIDS Confirmation form and received directly from the licensed medical provider or Ryan White Case Manager / Care Coordinator in Oregon trained to interpret HIV labs.

Documentation Required:
HIV confirmation for clients new to CAREAssist:
Acceptable proof of HIV is limited to:

1. A complete Bridge application, signed by the physician; or
2. The CAREAssist HIV/AIDS Confirmation form, signed by the physician or HIV Ryan White Case Manager / Care Coordinator trained to interpret HIV labs. The signing licensed medical provider or Ryan White Case Manager / Care Coordinator must have documentation of HIV positive diagnosis on file. Self-attestation, labs or other documents received from the applicant are not acceptable proof. The CAREAssist HIV/AIDS Confirmation form must be received by the Program directly from the physician or Ryan White Case Manager / Care Coordinator.

Returning Clients:

Proof of HIV may be waived if a potential client has previously been approved for CAREAssist eligibility and approved HIV confirmation was received at that time. If the CAREAssist is unable to verify positive HIV-status, new documentation may be required for a returning client.

Important Note: Once an applicant is an eligible CAREAssist client, Oregon's HIV Surveillance Program may periodically imports CD4/VL data to CAREAssist for confirmed HIV cases only; therefore, an undetectable viral load is adequate proof of positive HIV-status.

Residency Verification

Policy:
Applicant must be a resident of Oregon. Oregon residency means that an individual:

1. Has a physical location to reside in Oregon and a mailing address in Oregon or a mailing address in a state that borders Oregon; and
2. Is in Oregon at least six months out of the year; and
3. Is not absent from Oregon more than three consecutive months: *or*

4. Is living out of state for more than three months due to temporary or seasonal employment outside of Oregon; *or*
5. Is living out of state for more than three months while attending an educational institution full-time (12 or more credit hours in a school term).

If CAREAssist receives information that calls into question a client or applicant's residency, CAREAssist may request additional documentation to verify eligibility. Clients may be required to appear in the CAREAssist office or a local case management agency's office within 24 to 48 hours' notice.

Documentation Required:
Acceptable documents include but are not limited to the items listed below. All documentation provided must be current, meaning it is the most recent document that can reasonably be expected, depending on type. Documentation must also include:

1. The client's full legal name; *and*
2. An address that matches the residential address provided on the application, unless the client does not have a fixed address (in which case a CAREAssist Residency Verification form should be submitted to the program) Approved Documents:

- Unexpired Oregon State driver license
- Unexpired Oregon State ID
- Tribal ID
- Utility Bill
- Lease, rental, mortgage or moorage agreement/document
- Current property tax document
- Current Oregon Voter Registration card
- Letter from lease holder or homeowner that verifies client residential address (must include the lease holder's or homeowners name and phone number)
- Copy of State of Oregon public assistance/benefits (SNAP, OHP, etc.) letter/documentation (current within the past 6 months)
- SSI/SSDI award letter
- Paystubs
- Court Corrections Proof of Identity document
- Homeowner's association fee statement
- Official Military/Veteran's Affairs documents
- Oregon vehicle title or registration card
- Any document issued by a financial institution such as a bank statement, loan statement, credit card bill, mortgage document, a statement for a retirement account, etc.
- Official letter from Oregon State Hospital, homeless shelter, transitional service provider or halfway house
- Letter on company letterhead from an employer certifying that the client lives at a non-business residence address owned by the business or corporation.
- CAREAssist Residency Verification Form **(If not able to provide the above)**

Acceptable Electronic Verification: Pursuant to HRSA PCN 21-02, Case Workers may verify residential address as reported in State systems, including but not limited to: MMIS, ECLM, ENAM, FRANCES wage verification system, SSA Records.

Eligibility Determination – Income Verification

Policy:
Total gross monthly income, based on family size, must be at or below 550% FPL. Applicants must document income from all sources for all household members. See "Determination of Household Size" below for definitions.

Income means the gross monthly average of all monies received on a periodic or predictable basis, which the household relies on to meet personal needs.

Procedure:
To determine income eligibility, the Case Worker shall:

1. Determine household size
2. Calculate total gross monthly income – CAREAssist does not use MAGI (modified adjusted gross income).

1. Determination of Household Size
Household size is determined by counting the individuals related by birth, marriage, adoption, or legally defined dependent relationships who either:

a) Live in the same household as the applicant and for whom the applicant is financially responsible (see i-iv below); or
b) Do not live within the household as the applicant but the following applies:
    i. A legal Spouse; or
    ii. A child 18 years of age or younger who qualifies as a dependent for tax-filing purposes; or
    iii. A child aged 19 to 26 who takes 12 or more credit hours per school term
    iv. An adult for whom the applicant has legal guardianship.

Note: If a child lives with both biological/adoptive parents, they are a family of three regardless of parents' marital status

Clarification on Dependent Status:
Dependent household members are defined as those persons for whom the head of household has a legal responsibility to support. These relationships are defined as legal adoptions and guardianships.

1. Dependent child status shall not extend beyond age 19, except when the dependent child is enrolled as a FT student. In the case of student status, the age at which the dependent child status shall end is age 26. The client must attach documents to show that the child is enrolled as a full-time student in an educational institution and must be submitted with each 6-month re-certification process. A full-time student is defined as being enrollment in classes at 12 credit hours or more per term or semester, or if enrolled in a master's degree program.
2. All dependents claimed must appear on the client's Federal and State Income Tax Return for the most recent year. The program reserves the right to ask for a review from the Oregon Department of Revenue and/or State of Oregon contracted Certified Public Accountant (CPA).
3. Clients may not claim dependent status for individuals who reside outside the United States, unless those persons are listed on his/her most recent Federal Tax Returns filed; and there is a judicial ruling in the United States that defines a legal relationship and dependent status.
4. In cases of joint custody, a child must live with the client 51% of the time in order to be included in the household.
5. All persons over the age of 19 years (who are not covered by the student status extension, and whom the head of household is claiming dependent status) must be named specifically in a legally defined Guardianship Relationship approved by a U.S. Judicial proceeding. Notarized copies of documents must be made available upon request to the program.
6. Adults (i.e. elderly parents, disabled adult child, etc.) are approved dependents if they meet the criteria above.

2. Determination of Income

Gross monthly income is used to calculate the monthly average, except in the case of self-employed clients who file a Schedule C or E.

Documentation Required:

Income Type	Document Type
Work income (wages, tips, commissions, bonuses)	Pay stubs that show YTD gross income, when available (Two most recent consecutive paystubs or earnings statements for all jobs.) *Acceptable Electronic Verification: Recent earnings as reported in State systems (FRANCES wage verification system, SNAP, etc.)*

Self-employment income	1. Most recent year's federal tax return, including Schedule C, if filed, or other applicable schedules; ***and*** 2. Bank statements reflecting deposits for the 6 months prior to application; ***or*** 3. Accounting/business records for 6 consecutive months prior to application.
Rental Real Estate	1. Most recent year's federal tax return, including Schedule E, if filed; or 2. Bank statements reflecting deposits for the 6 months prior to application; or 3. Copy of Tenant/Landlord Agreement, with terms of monthly rent.
Unemployment/Disability Benefits (short term or long term)	Compensation stubs *or* award letter *Acceptable Electronic Verification: Unemployment Benefits as reported in State system ECLM*
Stocks, bonds, cash dividends, trust fund, investment income, royalties	1. Most recent year's federal tax return and related schedules; or 2. Documentation from the appropriate financial institution showing income received, values, terms & conditions.
Pension or retirement income (not Social Security)	Current year annual benefit statement.
Social Security Retirement/Survivor's Benefit	Current year annual benefit statement. *Acceptable Electronic Verification: Current award as reported in State SSA Records*
Veterans Benefits	Current year benefit award letter.
NO INCOME	Self-attestation of zero-income accepted when client completes No-Income Statement in application

Note: *Applicants may be required to complete IRS form 4506-T Request for Transcript of Tax Return, authorizing the IRS to send a transcript of a previous year/s' tax return.*

Procedure:

Using documentation provided and additional verification via State data systems, Case Workers shall:

1. Calculate the total average gross monthly income.
2. If the initial income calculation finds the client over-income for program eligibility, use a second income verification method if applicable and use the most generous calculation.
3. Calculation methodology should be documented in the program database.
4. Enter income from all sources into FPL calculator in Program database, verifying income at or below 550% FPL.

Note: *If income reported by applicant is drastically different from the total monthly average, as calculated by the Program, Case Workers shall contact the client for more information.*

The following are program criteria when determining gross monthly income:

- Employed – Annual gross income, divided by 12 months, is used for clients who have been employed by the same employer for at least 12 months and can provide documentation that "trends" their annual gross income, or by multiple months if there are multiple jobs.

- Self-Employed – Annual gross income from documentation showing the previous year's earnings or the previous 6 month's income annualized over 12 months is used for self-employed clients. The client's ability to document their earning "trend" is important and can be verified by looking at the previous year's federal income tax return.

- Seasonal Employment – Annual income based on documented seasonal trending is used for clients who can prove seasonal employment. Seasonal employment often means income is generated during certain time-periods, which may or may not be over the limit during that time-period, but when annualized over 12 months is within limits. Again, the client's ability to document their earning "trend" is important and can be verified by looking at the client's previous year's federal income tax return.

- Irregular work - Annual income cannot be used for clients who have not been employed for periods throughout the year and cannot establish a seasonal trend in income. For example, a client who had no income for half the year and, mid-year, begins earning over 550% of FPL would not qualify.

- Change in income - Annual income cannot be used for clients who have had a change in income that would make them now eligible for the program. A client who WAS ineligible before might now qualify if they lose their employment or have a reduction in income. When annual income cannot be calculated due to a

recent change in income, like a reduction in hours worked, loss of employment, etc, the Program will determine eligibility based on a client's current and projected income.

- Federal income tax returns will help verify income from multiple part-time jobs and that the family size is accurate.

Specific Income Calculations:

- **EMPLOYED CLIENTS (see current income calculation worksheet)**
  There are:
  - 2080 work hours in a year
  - 52 weeks in a year
  - 26 every-other-week pay periods, or
  - 24 twice-a-month pay periods

If in the same job since the beginning of the year:
Refer to the year-to-date (YTD) total gross income, then divide by the number of pay periods represented on the pay stub.

> Example: Client X has a pay stub showing a pay-date of June 15 and a YTD of $10,000. Divide the YTD amount by the number of pay periods (5.5) since the beginning of the calendar year.
>
> $10,000 divided by 5.5 months equals $1,818.18 per month.

If there is an hourly rate:
Calculate both the monthly income based on the YTD amount listed on their pay stub, described above, and annualize the hourly rate to find the monthly income to the client's best advantage.

> Example: Client Y makes $11 per hour. Calculate BOTH a YTD total AND multiply $11 x 2080 work hours per year, which equals an annual income of $22,880. Then divide the annual income of $22,880 by 12 months, which equals $1,906.67 per month.

If the client receives a one-time, lump sum payment (SSDI back-award, inheritance, etc):
Lump sum payments are not considered income. Monthly disbursements from a living trust for the purposes of living expenses is counted.
If the client is paid twice-a-month OR every-other-week:
Carefully check the pay stub to determine which factor to calculate when determining annual gross income – 24 pay periods per year for twice-a-month and 26 pay periods per year for every-other-week.

If there is a discrepancy between the monthly rate based upon YTD and the monthly rate stated on the pay stub or by client:

The monthly gross rate based upon YTD gross income is calculated by dividing the YTD gross income amount on the pay stub by the number of months in the total pay period. If this gross monthly rate is different from the gross monthly rate stated on the pay stub or if the client stated a different pay rate, further investigation will be warranted. This usually indicates a change in client status. They may have experienced a reduction in hours, began working part-time or were laid off - if the YTD gross monthly is less than the stated gross monthly. They may have worked some extra overtime or had a special circumstance, which is not going to continue - if the YTD gross monthly is more than the stated gross monthly.

- **SELF-EMPLOYED CLIENTS**

1. Self-employed clients must provide a copy of their most recent income tax return, including schedule C, E, and other applicable schedules if filed.
2. Self-employed clients must show documentation of gross monthly receipts. Bank statements that show deposits, accounting records, payable/receivable records **and** a federal income tax return (with Schedule C or E or other applicable schedules if filed) are ways to document gross monthly receipts.
3. A self-employed client must pay for the cost of maintaining their own business and this is considered “overhead.” The Program allows a 50% deduction from gross monthly receipts to cover the cost of maintaining a business provided the client submits a copy of their most recent tax return and all schedules or when the business is new and the client intends to file for the current year. CAREAssist may also allow for the 50% deduction if the client can show a tax extension for the most recent tax year and provide the previous year’s taxes. In all three of these situations, divide a client’s gross monthly receipts in half to determine their monthly income. If the client supplies all taxes and schedules and they are not eligible with the 50% discount, we can use the last 6 months bank statements deposits and offer the same 50% discount – ONLY if we have the current taxes and all accompanying schedules.
4. If a Case Worker determines an applicant or client is over-income for the program, the case worker is required to have another CAREAssist program case worker review the income calculation and both case workers will document their own determinations in the event log, prior to mailing the denial of the application or denial of new eligibility for current client. If both Case Workers agree that the income is over 550% FPL, the assigned Case worker will proceed with notifying the Case Manager, applicant or client of the program decision. If both Case Workers disagree on income calculation, the assigned case worker will forward the application to the Client Services or Program Coordinator with both case workers’ income calculations. The Client Services Coordinator or Program

Coordinator will review the calculations to determine the applicant's household gross income.

Eligibility Determination - Conclusion

1. If a Case Worker determines a client is ineligible, the client and Case Manager shall be notified in accordance with OAR and Program Policies & Procedures, as outlined in Approval or Denial of Application. The client is eligible for a hearing and may also reapply at any time.
    v. If a Case Worker determines a client is eligible, the Case Worker will proceed by identifying a primary payer, discussed in the next section, Insurance Requirements.

INSURANCE REQUIREMENTS

Effective Date: September 2023
Purpose: Describes the Program's vigorous pursuit of insurance for all clients.

CAREAssist OAR:
333-022: 1000, 1060, 1080

Policy:

CAREAssist has determined that purchasing insurance is the most cost-effective means of providing services to clients. This determination was made using NASTAD's Cost-Effectiveness tool.

All clients are expected to enroll in insurance when eligible that meets program requirements. The program requires that insurance coverage must cover 50% or more of RX costs. HIV specific insurance enrollment services are available across the state through -Medical Case Management and in-house services provided by CAREAssist Case Workers. Clients who actively refuse to enroll in insurance must complete an Informed Consent for Individuals Declining Insurance form and are only eligible for assistance with the full cost of medications in 14 classes that include HIV, viral hepatitis, and opportunistic infection, also known as Restricted UPP coverage.

Documentation Required:
Before benefits can be activated, clients must also provide the following:

1. If insured, a copy of the member ID card and the Summary of Coverage or Benefits (SOC or SOB), The SOC or SOB must show the RX benefit covers 50% or more of the RX cost.
2. If uninsured, proof of submitted application to insurance (copies of the application and confirmation of its receipt.)
3. If uninsured and declining insurance, a signed "Informed Consent for Individuals Declining insurance."

Procedure:

1. For insured clients, review the SOC or SOB and verify the plan meets the programs minimum essential coverage (MEC) and covers 50% or more of RX cost. Note in event log that SOC or SOB was received. Update client status and all pertinent information. If the client has new coverage, and has not received the insurance ID card, the case worker will follow up with the client to get a copy of the insurance ID card.

Note: *SOC or SOB's are not required for clients on Oregon Medicaid/Medicare D/Advantage plans.*

A new insurance record is required each year for all clients.

2. Case Workers shall enroll clients and provide guidance if the client is applying on their own. Once proof of application is received, review and verify that a complete application was submitted. Determine the effective date and update client electronic record with all pertinent information. If the CAREAssist Case Worker determines that the client or applicant is not eligible for any available coverage and does not have a SEP to enroll in an off-exchange plan the Case Worker will request the UPP tool form be completed by the Case Manager and submit to CAREAssist for approval. UPP eligibility requires the client to be in Case Management. If the client is not in Case Management, the CAREAssist Case Worker will connect the client with Case Management services. The case worker will approve or deny the UPP tool and notify the applicant and Case Manager of the UPP tool determination. Note all applicable information in the event log.

3. For uninsured clients declining coverage, mail the *Informed Consent for Individuals Declining Insurance* form to the client. The notice must state the deadline for returning the form and the consequences for not doing so. At a minimum, clients must acknowledge:

    a. They are declining insurance for which they are eligible; *and*
    b. They are required to have adequate health insurance under ACA.
    c. They qualify for assistance with the cost of drugs used to treat HIV, viral hepatitis, opportunistic infections and other classes; *and*
    d. Additional Program benefits may be available should they come into compliance and enroll in coverage.

Once received, update client status to Restricted UPP and add all pertinent information including notes in the event log.

BENEFIT GROUPS

Effective Date: September 2023
Purpose: Describes Program Benefit Groups

CAREAssist OAR:
333-022: 1060

Dollars of Last Resort

Ryan White funds are intended to fill gaps in care and serve as the payer of last resort. Ryan White HIV/AIDS Program Legislation, Section 2617(b)(7)(F) states:

The State will ensure that grant funds are not utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to that item or service-

(i) Under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or
(ii) *By an entity that provides health services on a prepaid basis (except for a program administered by or providing the services of the Indian Health Service)*

Policy:

After CAREAssist determines a client is eligible and the applicant is insured or in the process of applying, the clients shall be enrolled in a benefit group based on eligibility for insurance and the primary insurance type. For uninsured applicants see section 9 for additional requirements.

Procedure:

1. Assign approved applicants to a benefit group, as defined below.
2. If insurance changes and the Benefit Group needs updating, the effective date for the new group shall be the effective date for new coverage.

If insurance changes and the client is temporarily dual enrolled, contact the client & determine which insurance should be used for the remainder of the month. Update Benefit Group accordingly.

CAREAssist Benefit Group	Insurance Type
Group 1	Private/Individual/Group Policies & Medicare
Group 2	Medicaid & VA
Uninsured Persons Program (UPP)	Currently ineligible for insurance

Insurance Priorities

Effective Date: January 1, 2014, Updated September 2023
Purpose: Describes the requirement to enroll in cost-effective coverage.

CAREAssist OAR: 333-022: 1000

Policy:

1. Clients eligible for public insurance, such as Medicaid and Medicare or affordable employer-sponsored insurance that meet CAREAssist minimum essential coverage requirements are required to enroll in that coverage. CAREAssist is always funds of last resort.
2. All clients not eligible for Medicaid, Medicare, employer group or those that have VA and choose not to use it will enroll in an off-exchange silver-level plan.
3. Clients who actively refuse to enroll in the most cost-effective coverage identified by the program are ineligible for premium assistance on a private, individual policy. These individuals can:
    a. Pay the premium on the private policy they may have; or
    b. Decline insurance, complete the informed consent for doing so and receive assistance with the cost of medications that treat HIV, viral hepatitis, and opportunistic infections only (***Restricted UPP***)[1].
4. Clients who previously declined coverage shall qualify for additional benefits if they enroll in the cost-effective coverage identified by the program.

Oregon Health Plan Mismatch Report

The CAREAssist Client Services Coordinator (or Program Coordinator as backup) will receive the Mismatch Report monthly, and filter it by Case Worker and distribute to each Case Worker, who in turn will act on the mismatches.

OHP MISMATCH REPORT SHOWS:	**CASE WORKER ACTION / FOLLOW-UP:**	
Client has group coverage and OHP. **CAREAssist is not paying premiums.**	**1.** CW will contact the client and ask which coverage they are using as primary and document response in the Event Log.	**1.** If the client is using the group coverage as primary, the group coverage will be listed as primary and OHP as secondary.

	2. CW should also look at ED to see if we have Rx. and medical claims. If client's response is OHP is primary and Rx's have been dispensed under their private insurance, do not back-date OHP unless the pharmacy can back out claims and bill OHP. Document such events in the Event Log.	**2.** CW or CM should assist clients in updating OHP with TPL or in voluntarily disenrolling from OHP.
Client has group coverage and OHP. **CAREAssist is paying premiums.**	**1.** CW will contact the client and ask which coverage they are using as primary. If the client is income eligible for OHP, they must use OHP. **We can't pay for premiums for group coverage or a private policy if the client has OHP.** Caseworker should also look at ED to see if we have Rx and medical claims. If client's response is OHP is primary and Rx's have been dispensed under their private insurance, do not back-date OHP unless the pharmacy can back out claims and bill OHP. Document such events in the Event Log.	**1.** The CW or CM will help the client report the group coverage, and voluntarily disenroll from OHP[1].
		2. While the OHP is still active we should list both group and OHP coverage in the insurance tab. One primary (paid plan) and one secondary (OHP).
		3. Client will either end the OHP[1] or the Group or private policy depending on what they are income-eligible for.
A different CCO than what we have listed in the insurance tab	CW will verify in MMIS: the CCO and eligibility status.	CW will update the OHP insurance record CCO with the current information found in MMIS.

Note: CAREAssist can never show Oregon Health Plan was primary and active at a time we dispensed medications under Group 1, UPP or Bridge UNLESS we are able to have the pharmacy back those claims out and rebill Oregon Health Plan.

[1]Refer to Section 3 (Insurance Requirements) for Informed Consent instructions.

Insurance Exception Application (Exceptions to ESI Mandate)
Effective Date: March 1, 2022, Updated September 2023
Purpose: Describes the circumstances under which a client may seek prior authorization to decline enrollment in insurance they are eligible for.

OAR: N/A

Policy:

1. Clients eligible for the Oregon Health Plan (OHP) or group insurance through an employer – theirs, a spouse or partner's, or a parent's employer are required to accept that coverage unless they apply for an insurance exception (IEA) and provide documentation, as described below.
2. Insurance Exceptions (IEA) must be approved annually and typically in October. Case Workers need to track their IEA clients to obtain a new form annually.
3. If the client becomes eligible for other insurance throughout the year and still chooses to decline the new coverage, a new IEA must be completed.
4. If exception is approved, Case Worker will refer them to an off-exchange insurance plan and assist them in enrolling in the plan.
5. Document steps, and process in the Event Log.

Reason for Request	Required Documentation
1. Employer will not accept our payment on client's behalf	Letter from employer
2. Employee fears discrimination or loss of job	Signed explanation from client
3. Client has missed employer's open enrollment period	List employer's next **Open Enrollment** period on next page
4. Plan requires using an out-of-network pharmacy	Summary of benefits & coverage or confirmation by CAREAssist in-network pharmacy
5. Person on parent's insurance fears disclosure	Signed explanation from client

6. Plan does not cover HIV, mental health, or transgender services (other exclusions on a case-by-case basis)	Summary of Benefits & Coverage
7. Lack of community providers in the area (within 50 miles)	Letter from provider
8. Interruption of time-limited treatment or current provider treatment would cause harm.	Letter from provider, includes length of treatment.
9. Insurance is of short duration or consistency (job rotation, temporary position, income changes, age).	Signed explanation from client.
10. Employer group health plan exceeds 9.5% of client's gross household income (for client's medical premium only)	Plan documentation from employer
11. Employer doesn't offer group insurance	Letter from employer
12. Client not eligible for employer group insurance	Letter from employer

ENROLLMENT REQUIREMNTS FOR OFF-EXCHANGE PLANS

Effective Date: March 8, 2022 Updated September 2023
Purpose: Describes requirements when clients enroll in off-exchange plans

Policy:

Clients who apply for off-exchange will do the following:

1. Clients are required to enroll in a plan that meets CAREAssist MEC where insurance must cover 50% or more of RX cost.
2. Clients will notify the Program of any changes to insurance eligibility or monthly premium.

Procedure:

Case Workers and Case Management Partners should collect the premium statement and supply it to CAREAssist. CAREAssist must have a statement copy of the current premium being paid on file.

Case Workers will use DDI provided insurance links when enrolling clients on an off-exchange plan. Case Managers may also use DDI.

Note: If the client is eligible for an off-exchange plan and in addition to CAREAssist Case Workers, Case Manager and Insurance Assisters may enroll clients in off-exchange plans. For enrollment with carriers that require a credit card (SPOTS) payment at the time of application, only Case Workers can enroll. SPOTS card information is never handled by anyone other than the card holder.

RECERTIFICATION

Effective Date: March 16, 2022 Updated September 2023
Purpose: Describes the Program's policies and procedures regarding eligibility reviews

CAREAssist OAR:
333-022: 1090

Policy:

Clients of CAREAssist have their eligibility for the program reviewed at least every twelve (12) months, or six (6) months, depending on insurance group. However, the program can request an eligibility review at any time. A completed Client Eligibility Review (CER), proof of income and residency are required of each client who seeks to renew their eligibility in CAREAssist.

CER Requirements:
A complete CER and all documentation must be submitted for the annual CER review. For all clients that receive a short, semi-annual, CER mid-year, self-attestation is allowed.

Effective October 1, 2023 CAREAssist will accept clients electronic signature on the CER, residency form or application.

Procedure:

1. Clients are automatically sent a CER approximately two months before eligibility expires.

2. A list of the clients receiving the CER is sent to the appropriate Case Managers.

3. If we have not received the clients CER, a courtesy reminder is mailed to clients approximately one week before the CER due date.

   (Example: Eligibility expires the last day of June. The CER application is sent the first week of May. The courtesy reminder is sent the last week of May.)

4. An updated list is sent to the appropriate Case Managers, which reflects the clients who still need to return their CER.

5. Upon receipt of the annual (long) CER the Case Worker shall:
   a) Confirm completeness and signature
   b) Verify residential address matches that on residency document

c) Determine household gross monthly income
d) If insurance has changed and it is group or private insurance, a new SOC or SOB is required along with a the new insurance card
e) Update client record accordingly and make Event Log notes
f) When entering the new eligibility, it triggers a new ID card from Ramsell.

6. Upon receipt of the semi-annual (short) CER the Case Worker shall:
   a) Confirm completeness and signature
   b) Update client record accordingly and make Event Log notes
   c) If client checks no on a box and does not attach documentation to justify answer, the Case Worker will reach out to the client to clarify and request any required documentation and include CM if applicable. Document outreach and findings in Event Log
   d) If the missing documentation is not received by the due date, the case worker will mail a restricted letter to the client and email a copy to the case manager if the client is in case management

Entering a new status triggers a new ID card from Ramsell.

Note: Group 2 CER PILOT PROJECT per PCN 21-02. Effective 7/1/23 – 6/30/24 CAREAssist will be piloting a project for all Group 2 clients. The pilot will consist of 1 CER in a 12-month period instead of 2.

UNINSURED PERSONS PROGRAM (UPP)

Effective Date: December 21, 2021, Updated September 2023
Purpose: Describes benefits and requirements related to UPP

CAREAssist OAR:
333-022: 1140; 1080

Policy:
Clients ineligible for public or private insurance or do not accept public insurance qualify for the following:

1. Full-cost coverage for a monthly 30-day supply for any medication on the Bridge/UPP/Restricted formulary. Exceptions may be made with Leadership approval.
2. Full-cost coverage on specific, limited, CPT codes for medical services necessary to treat HIV/HCV listed on the Bridge/UPP CPT code list.

Eligibility:

1. Meet all Program eligibility requirements.
2. Be ineligible for public and private insurance that meets CAREAssist Minimum Essential Coverage (MEC) and covers 50% or more of RX's.
3. Be enrolled in Ryan White Case Management, if the UPP need is going to extend longer than 30 days.

Expectation: The client and/or their Case Manager must notify the Program immediately if and when the client becomes eligible for insurance.

Procedure:

1. CAREAssist case worker, Case Manager or the Enrollment Specialist will screen clients for qualifying life events and Special Enrollment Periods, to confirm the client is ineligible for insurance. If the client or applicant does not have a Case Manager, and UPP is expected to extend more than 30 days, they will need to be referred to the appropriate RW Case Management partner agency to establish care in order to meet the UPP eligibility requirement.

2. CAREAssist case worker, Case Manager or the Enrollment Specialist will inform clients or applicants of which life events grant them a Special Enrollment Period (SEP).

3. If the applicant does not qualify for a SEP, the CAREAssist case worker, Case Manager or the Enrollment Specialist will complete the UPP tool (form OHA8494). If this is a new client, a CAREAssist full application and UPP tool will need to be submitted. If this is an existing client, just that UPP tool will need to be submitted.

4. Once complete, CAREAssist Case Worker shall update client record with all pertinent information, and notify the client, and the Case Manager or Enrollment Specialist if applicable, by phone or in writing.

Note: Lack of UPP Tool is a factor when turning on benefits. Client may be eligible, (3) App: Eligibility determined is complete, but if the Case Worker has not received a complete UPP Tool, we are unable to turn benefits on and unable to add (2) App: Complete. The UPP Tool is a program requirement. If this happens and we still receive the UPP Tool within 45 days of receipt of application, Case Worker should retro start the eligibility period to match the same date as Application Tracking, (3) CAREAssist app: Eligibility Determined, add (2) App: Complete with the date the UPP Tool was received and follow 5A from Section 1, Application Process. If we do not receive the UPP Tool within 45 days of receipt of application, the application would be rejected, and we follow 5B from Section 1, Application Process.

BRIDGE PROGRAM

Effective Date: July 1, 2008; Updated September 2023
Purpose: Describes the requirement to enroll in cost-effective coverage.

CAREAssist OAR:
333-022: 1140; 1080

Policy:

The CAREAssist Bridge Program meets all criteria for Rapid Start.

Individuals who are not yet members of CAREAssist and need emergency coverage for prescription medications related to their HIV care may be eligible for up to a 30-day supply of medications from the Bridge/UPP/Restricted formulary, through the Bridge Program.

This program can also assist with limited medical visits and lab work necessary to determine appropriate HIV treatment regimens. Assistance provided under this program is intended to assist persons in meeting urgent medications access needs while applying for and enrolling in CAREAssist and other long-term medication assistance programs, if eligible.

Bridge Program Benefits

The benefits of the Bridge program apply to dates of service on or after the enrollment date:

- Full cost prescriptions will be paid for up to a one month supply dispensed within the 30-day Bridge period. Only Bridge/UPP/Restricted Formulary drugs are available to a Bridge client and can be dispensed by a CAREAssist in-network pharmacy only. For exceptions, see Covered Costs and Provider Exceptions. Over-the-counter medications are not covered.
- Full cost laboratory and medical visits performed in an outpatient setting and necessary to facilitate access to HIV related medication therapy for up to 30 days. See allowable CPT codes here.

Bridge Program Eligibility

- The applicant must have documented HIV infection confirmed by a medical provider authorized to prescribe ARV's signature on the Bridge application.
- The applicant must reside in Oregon.
- The applicant must have income at or below 550% of the federal poverty level (FPL.)
- The applicant must apply for long-term medication assistance programs such as Medicaid, Medicare, group coverage, private insurance and CAREAssist.

- The applicant must not have received Bridge assistance and/or have not been terminated or restricted from the CAREAssist program within the past 365 days.

Bridge Program Policies

1. Assistance provided under this program is intended to help persons meeting their medication access needs while applying and enrolling in other long-term medication assistance programs. Up to 30 days of assistance can be provided. CAREAssist does not assume any ongoing responsibility to provide Bridge members with medication or medical care, limited medical visits and lab work, beyond the 30-day benefit.

2. Bridge applicants must be available to work with their CAREAssist caseworker to assure progress toward a sustainable means of medication access. Failure to do so may result in cancellation of Bridge enrollment. At a minimum, the client is expected to submit a CAREAssist application within 30 days of Bridge enrollment.

3. The Bridge Program Application must be signed by a medical provider that is a licensed HIV Medication prescribing provider.

4. All prescriptions covered by the Bridge Program must be obtained through a CAREAssist Network Pharmacy except for Multnomah County mutual clients may fill their Bridge medications at the Multnomah County Westside Pharmacy.

5. The Bridge program is not available to persons who have primary health insurance coverage unless an exception has been authorized by CAREAssist leadership. Persons who have primary health insurance should complete a CAREAssist application for ongoing assistance and speak with a caseworker.

Bridge Program Procedures

Bridge Application: A completed Bridge Application *signed by both the client and their medical provider* is required.

1. HIV Verification: Only a licensed, prescribing medical provider is authorized to verify HIV and sign the Bridge application.
2. Income: Applicant must be at or below 550% FPL. Self-attestation accepted.
3. Residency: Applicant must be a resident of Oregon. Self-attestation accepted.
4. The effective date for Bridge coverage shall be the date the complete Bridge application is received by CAREAssist. Bridge applications are a priority and will be approved same day completed Bridge application received.
5. If approved, notification will be sent to the pharmacy and the medical provider/Case Manager.
6. If denied, the medical provider/Case Manager will be informed.

Bridge – Covered Costs and Provider Expectations

1. Bridge clients may fill Bridge medications at Multnomah County's Westside Pharmacy. This is the only exception to the pharmacy network when CAREAssist pays full cost.
2. Bridge coverage is available to medical providers who are assessing a client's urgent or immediate medical need for access to medications.
3. A list of Bridge-approved CPT codes is available on the Program website to help providers order lab tests that will be covered.
4. CAREAssist only pays for the lowest cost, generic equivalent (when available).

Effective October 1, 2010, CAREAssist will reimburse providers at 125 percent of the Oregon DMAP (Medicaid) rate for the authorized CPT codes listed on the CAREAssist web site. When CAREAssist acts as primary, payment shall be accepted in full. Balance-billing is prohibited.

PHARMACY SYSTEM & PROGRAM REQUIREMENTS

Effective Date: May 1, 2013, April 4, 2022, October 20, 2023
Purpose: Describes the pharmacy program used to dispense medications to CAREAssist clients
CAREAssist OAR:
333-022: 1070; 1080

Policy:

1. CAREAssist has a defined network of contracted pharmacies. This network was developed to have the greatest geographic coverage based on historical client use of pharmacy services.

2. The CAREAssist Pharmacy Network will be referred to as In-Network. There are currently 38 contracted pharmacies; the list and their locations can be found on the CAREAssist and Ramsell websites. Two in-network pharmacies can do mail order.

3. Clients of CAREAssist must use an in-network pharmacy for all medications not designated as acute on the formulary if they would like CAREAssist to participate in the claim. All "maintenance medications" taken on an ongoing basis (those that typically have refills authorized by the prescriber) must be filled at an in-network pharmacy for CAREAssist to participate in the claim. These drugs are sometimes referred to as chronic care medications.

4. Exceptions to the network may be made when clients are mandated to use a non-network pharmacy by their primary insurance. Clients are required to supply documentation from their carrier, typically found in their summary of coverage, mandating the use of that pharmacy. Summary of coverage documenting carrier required use of an out of network CAREAssist pharmacy is required yearly and should be tracked by the Case Worker. Some carriers may state that if you use their preferred pharmacy network, they cover a higher amount of the claim. If the carrier allows for lower coverage at a non-preferred pharmacy and that pharmacy is part of the CAREAssist Preferred network and the carrier still covers 50% or more of the claim, a pharmacy exception will not be granted by CAREAssist. An approved exception must be documented in Ramsell and the event log and should always have an end date of 12/31/23. Never use, 'until rescinded.". Even though the pharmacy may not be an in-network pharmacy, the pharmacy may be able to adjudicate through Ramsell. Out-of-network pharmacies unable to adjudicate through Ramsell will need client copays and deductibles paid via a state SPOTS card.

5. Pharmacy Exceptions: Multnomah County Health Department's Westside Pharmacy has a standing exception to program policy in that clients may

continue to use the pharmacies located with the Federally Qualified Health Center-designated county pharmacy system. Multnomah County must adjudicate all claims for CAREAssist clients, for which they will receive a $2 copayment in exchange for the data. Multnomah County Health Department is also paid a $20.00 fee for each Bridge medication they dispense. Clients must be told that they have an option to fill outside the Multnomah County pharmacy system and cannot be instructed to use only the Multnomah County pharmacies.

6. CAREAssist will cover all out-of-pocket expense, which means that a client should not incur any cost when obtaining prescribed medications.

7. CAREAssist does not pay mailing fees for medications. CAREAssist in-network pharmacies do not charge a mailing fee.

8. CAREAssist follows the primary insurance. In most cases, the Program will not permit the dispensing of brand-name drugs to a client when a generic is the preferred option of the health insurance. Likewise, CAREAssist permits its contract pharmacies to dispense brand-name drugs when the insurance permits and does not require the substitution of a generic version.

9. Tadalafil/Sildenafil exception for BPH, benign prostatic hyperplasia and PAH, pulmonary arterial hypertension see, “Process around Cialis for BPH / PAH,” document or Preferred Formulary.

Procedure:

1. CAREAssist will follow the insurance policy regarding medications dispensed. This means that if the insurance allows for a 90-day supply CAREAssist will allow for a 90-day supply. Similarly, if the insurance allows for a 13th fill in a 12-month period CAREAssist will likewise approve that dispensing. Vacation fills, early fills, and replacement fills are approved or denied first by the client’s health insurance. CAREAssist will follow the determination made by their health insurance. Any exception must be approved by the CAREAssist Program Manager, Client Services Manager, Program Coordinator or Client Services Coordinator.

2. CAREAssist follows the DHHS HIV Treatment Guidelines. The CAREAssist Pharmacy Benefits Manager (PBM) assesses medication regimens to assure that the guidelines are followed. In the event a treatment recommendation or guideline is not followed, the PBM will block payment by CAREAssist until the prescriber has submitted a Prior Authorization form to the clinical pharmacist at the PBM. CAREAssist does not approve the appropriateness of a prescriber's order but does have the obligation to assure that program funds are not used to dispense a drug (or combination of drugs) that could be injurious to the client or those that do not conform to published DHHS guidelines.

Pharmacy Services for Bridge, Insurance Gap or approved Full-Cost:

- All medications dispensed during a client's Bridge, Insurance Gap or Full-Cost coverage must be filled at an in-network pharmacy. CAREAssist allows for a 30-day fill when paying full-cost.

- When a Kaiser-insured client fills full-cost medications at a CAREAssist in-network Safeway/Albertson's pharmacy because the medication is not on Kaiser's formulary but is on the CAREAssist formulary, a special override needs to be initiated before the claim can be adjudicated. This override process must be completed each time the Kaiser-insured client fills at a CAREAssist in-network Safeway/Albertson's pharmacy. Case Worker's will reach out to CAREAssist leadership, provide the ID number of the client, the Safeway/Albertson's store location and the medication. Only CAREAssist leadership is able to request the override through the Safeway/Albertson's 340B Team.

- Up to a 30-day supply is available.

Terms and definitions:

- *In-Network*, a pharmacy that has signed a contract with CAREAssist (OHA) and is therefore included in the 340B pharmacy replenishment procedure.

- *Out-of-Network*, a pharmacy that is not under contract with CAREAssist (OHA) but is the designated pharmacy for a client as required by the client's health insurance. If the requirement is defined by the health insurance, medications may be filled by the out-of-network pharmacy.

- *Chronic-care drugs* are those which a client takes on an ongoing basis. All drugs for which there are multiple refills approved by prescribing medical providers are considered chronic-care medications. HIV medications are considered chronic-care drugs. Chronic-care drugs MUST be filled at a CAREAssist in-network pharmacy unless prohibited by the insurance policy.

- *Acute-care drugs* are those medications, which a client takes on a short-term or one-time basis. These medications are typically things such as an antibiotic. These should not be confused with first-time medications.

- *Participating Pharmacy*: An Out-of-Network pharmacy that has signed a billing agreement with the CAREAssist PBM but is not participating in the replenishment model.

FORMULARIES

Effective Date: May, 2016; Updated October, 2016, April 19, 2022, October 20, 2023
Purpose: Describes drugs available through CAREAssist

CAREAssist OAR:
333-022: 1000

Policy:

CAREAssist maintains the following formularies, available on the CAREAssist and Ramsell webpages:

Formulary	Description
Bridge/UPP/Restricted	Limited to Bridge, UPP and Restricted clients only
Preferred Acute	Limited # of meds available at non-preferred pharmacies

1. Each formulary is available online on the Ramsell and CAREAssist websites.
2. Clinical review of the formulary will occur annually, in partnership with Ramsell.
3. CAREAssist maintains an open formulary for clients that are not on Bridge, UPP or are Restricted with the program.
    a. Uninsured clients can get any drug covered at full cost on the Bridge/UPP/Restricted formulary regardless of accepting insurance when eligible.

- Insured clients can get any drug covered at full cost on the Open formulary, as long as the PA was denied by primary insurance as, 'not a covered medication' on the client's insurance formulary list, or not on the CAREAssist drug exclusion list. When a Kaiser-insured client fills full-cost medications at a CAREAssist in-network Safeway/Albertson's pharmacy because the medication is not on Kaiser's formulary but is on CAREAssist formulary, a special override needs to be initiated before the claim can be adjudicated. This override process must be completed each time the Kaiser-insured client fills at a CAREAssist in-network Safeway/Albertson's pharmacy. Case Workers will reach out to CAREAssist leadership, provide the ID number of the client, the Safeway/Albertson's store location and the medication. Only CAREAssist leadership is able to request the override through the Safeway/Albertson's 340B Team.
    b. Drug Exclusion List includes medications prescribed for:
        i. Anorexia, weight loss, weight gain
        ii. Fertility purposes
        iii. Hair growth or cosmetic purposes
        iv. Medications that treat Erectile Dysfunction – *exception when use for BPH or PAH has been documented.* Documentation: Physician

letter from prescribing doctor must indicate client has tried other medications and that the prescriber believes that this is the only medication that will successfully treat BPH or PAH. Send secure email to PSR@ramsellcorp.com and CC tjenness@ramsellcorp.com with the exception request, and make note in the Ramsell portal and in the Event Log.

v. Prescription vitamins and mineral products – *exception includes prenatals, fluoride, niacin, vitamin D analogs and B vitamins*
vi. Non-prescription drugs
vii. Nutritional/Dietary Supplements

Durable Medical Equipment – *exceptions, diabetic supplies are available from the pharmacy and other DME is available through the TPA process.*

MEDICAL SERVICE DEDUCTIBLES, COPAYS & COINSURANCE

Effective Date: July 1, 2003; Revised May 1, 2013, October 20, 2023
Purpose: Identifies policies and procedures specific to the copay and deductible payment components of CAREAssist.

CAREAssist OAR:
333-022-1080

Policy:

1. When possible, CAREAssist payments are made using state-issued warrants. Payments may also be made using State issued (SPOTS) Visa to process payments for co-pays and deductibles.

2. CAREAssist will process payments for co-pays and deductibles only if:
   a. An original invoice is submitted from the service provider that lists the date(s) of service for which the co-pay or deductible payment is being requested,
   b. The invoice(s) also includes the CPT codes for the current billing period, *and*
   c. An insurance "Explanation of Benefits" which matches the original invoice's date of service is attached.

3. CAREAssist will not pay/cover any co-pays or deductibles for services that are not reimbursable by the primary insurance company.

4. CAREAssist can never reimburse a client for any payments the client may have made.

5. CAREAssist is unable to make payment for any request for co-pay or deductible assistance that is received in the office more than one year after the date(s) of service.

6. CAREAssist will not make payment for services occurring during a client's Restriction period.

7. Clients are eligible for an annual maximum on medical claims, to be posted on the CAREAssist website each year.

8. CAREAssist cannot pay collection agencies on clients' behalf. Client or provider billing office can work with the collection agency and request the claim to be released. If the claim is not more than 12 months old and released back to the provider, CAREAssist could then pay the copay or deducible to the provider.

HEALTH INSURANCE PAYMENTS

Effective Date: July 1, 2003; Revised May 1, 2013, October 20, 2023
Purpose: Identifies policies and procedures specific to the health insurance payment components of CAREAssist.

CAREAssist OAR:
333-022-1080

Policy:
CAREAssist shall pay premiums for eligible clients under the following circumstances:

1. The plan meets Minimum Essential Coverage requirements, as outlined in ACA

2. The plan covers at least one drug from each HIV drug class.

3. The plan covers at least 50% or more of medication costs.

4. CAREAssist has received a premium statement or other official documentation from the carrier verifying the premium amount and frequency of pay.

5. Payments are made on a client's behalf. No direct payments shall be made to a client.

6. Clients are required to notify CAREAssist of any premium changes (amount, benefits, etc.) within 30 days of any notice received from their insurance company. Lack of providing premium changes could result in lapse or loss of insurance coverage.

7. CAREAssist may pay retro insurance premiums when they find it is in the best interest of the client and program. All retro insurance premium payments must be approved by the Program or Client Services Manager prior to payment.

Health Insurance Payments for Affected Dependents
Purpose: Describes circumstances under which HIV-affected dependents are eligible for health insurance premium assistance.

Policy:
In rare circumstances when no other public assistance is available, CAREAssist may assist with insurance premiums for the following:

- Dependent children 18 years of age or younger
- Dependent children, ages 18-26 when enrolled as full-time students
- A spouse/partner

1. This is true only when the client's insurance is contingent upon payment in full, for example, and the monthly premium cannot be divided.

Clients are required to separate coverage from other family members at the first available opportunity.

DENTAL PROGRAM
Effective Date: March, 2015, October 20, 2023
Purpose: Describes benefits and requirements related to dental

CAREAssist OAR:
333-022:1147

Policy:

The CAREAssist Dental Program aids with premiums and out-of-pocket dental expenses related to a specific dental plan or plans identified by the Program.

Dental application accompanies the Welcome Letter for all non-Medicaid (OHP) as primary insurance clients. The Welcome Letter event log note will include that a dental application was sent with the letter.

Eligibility:

Clients are eligible for the dental program as long as their primary prescription coverage is not provided by OHP at the time of application. Clients who have CAREAssist dental and transition to OHP are eligible to keep their CAREAssist dental plan. However, if the client is disenrolled from CAREAssist and returns to the program with OHP as primary insurance, the Program will not pay the dental program premium as OHP provides dental coverage. Clients that are disenrolled from the program, and come back after 30 calendar days, will need to re-apply for the dental coverage, as long as they don't have OHP coverage as primary.

Benefits:

1. Premium assistance on a plan specified by the Program
2. Out-of-pocket dental expenses for services allowed under the CAREAssist-sponsored dental plan. If the service is disallowed, it is ineligible for payment through CAREAssist. See current year's Summary of Benefits for specific benefits.

NOTE: See Moda Delta Dental SOP.

RESTRICTED STATUS

Effective Date: October 1, 2005; Revised September 1, 2015. October, 2023
Purpose: Describes the cause and conditions of a restricted benefit status.

CAREAssist OAR:
333-022-1120

Policy: Client benefits will be restricted for up to three months when CAREAssist does not receive a complete CER by the specified deadline.

Duration:

1. Restriction takes effect on the first day of the client's new eligibility period.
2. The restricted period will not exceed 3 months. If at the end of 3 months, CAREAssist still hasn't received a complete CER, the client's restricted benefits expire and reapplication is required. See Disenrollment of Services.
3. If CAREAssist receives a complete CER before the end of the restricted period and determines the client eligible, the client will be approved for six months of unrestricted benefits that take effect on the date of receipt of the complete CER.
4. A CER entered in the CER tracking tool but found to be incomplete by the CAREAssist Case Worker requires manually generated notification in writing that the CER is incomplete and if documentation is not received by the due date, the client will be on Restricted status.
5. The restriction cannot end prior to the date of receipt of a complete CER.
6. For circumstances under which a restriction status extension may be approved, see Exceptions Process section.
7. Anytime a client is restricted and has a case manager, the case manager must be notified.

Benefits:

Restricted clients are eligible for assistance with:

1. The cost of health insurance premiums, if applicable.
2. Copays, coinsurance and deductibles on prescription drugs that treat HIV, viral hepatitis, some opportunistic infections and mental health medications, if insured.
3. The full cost of formulary medications that treat HIV, viral hepatitis and some opportunistic infections and mental health medications.
    a. When enrolled in the Uninsured Persons Program; or
    b. When such medications are not covered by the client's health insurance.

4.The cost of the CAREAssist-sponsored Delta Dental premium and eligible coinsurance.

5.The Restricted, Bridge and UPP combined formulary is available on the Ramsell website.

Restricted clients are not eligible for TPA benefits.

Note: Group 2 CER PILOT PROJECT per PCN 21-02. Effective 7/1/23 – 6/30/24 CAREAssist will be piloting a project for all Group 2 clients. The pilot will consist of 1 CER in a 12-month period instead of 2. These clients will not be eligible for a 3-month restriction if CER is not received and instead will be disenrolled at the end of their eligibility.

INSURANCE GAP COVERAGE
Effective Date: May 1, 2013, October 26, 2023
Purpose: Describes prescription drug coverage for clients who have been approved for CAREAssist and are pending enrollment in insurance.

CAREAssist OAR:
No OAR on GAP

Policy:

1. The intent of Insurance Gap Coverage is to prevent a lapse in treatment when the client has been determined eligible for CAREAssist and the CAREAssist case worker has verified the insurance provider received a complete application for enrollment and the client's need for medication has been verified.
2. Clients are eligible for a 30-day supply of any medication covered under the Open Formulary.
3. Meds must be filled at a CAREAssist In-Network pharmacy.
4. Medical care is not a covered service under Gap.

Procedure:

The CAREAssist Case Worker:

1. Receives a complete application and determines the client will be eligible for ongoing benefits once insurance is approved.

2. Verifies that the insurance provider received a complete application. (A copy of the submitted application will be requested by CAREAssist.)

3. Confirms the start date for the client's insurance.

4. Updates the client's eligibility, placing the client in ‘Gap’ in the database.

5. Notifies the pharmacy of any changes to Group number.

6. Notifies the client and Case Manager, if applicable, that refills are authorized.

7. For employer insurance (group coverage) summary of coverage is required. CAREAssist caseworker will verify that group coverage meets MEC.

8. Documents steps in Event Log.

Note: GAP VS UPP – Gap is used when an individual that has applied for insurance and CAREAssist has proof of application. UPP is used when an individual is not eligible for public or private insurance.

TERMINATION OF SERVICES

Effective Date: July 1, 2003; Revised May 1, 2013, October 26, 2023
Purpose: Describes the activities that will result in termination from CAREAssist and the procedures used by the program to terminate a client from the program.

CAREAssist OAR:
333-033-1160

Policy:

1. The following activities will result in termination (or "disenrollment") of all or some services provided by CAREAssist:

- The client no longer lives in Oregon.

- The client is deceased.

- The client has been determined to have deliberately reported false information and/or failed to report income or insurance benefits at the time of application, or on their 6-month Client Eligibility Review (CER). Persons who are found to have provided false, fraudulent, or misleading information can be barred from the program for a period of six (6) months and could be asked to repay the program for the costs of services provided.

- A client is determined to be over-income.

- The client is placed in a custodial institution, state, or federal prison, or hospitalized while incarcerated (see Incarceration Policy for information about city and county jails.)

- Failure to notify the program of changes in accordance with OAR 333-022-1100. A CAREAssist client is required to notify the Authority within 15 calendar days of the following: Changes in contact information including address and phone number; or Changes in eligibility for group or individual insurance coverage, whether private or public. CAREAssist staff will make reasonable attempts to determine the client's current address by other means, including phone calls.

- The client fails to provide any requested documentation necessary to determine eligibility by the deadline given.

- Group 1 clients that fail to complete and submit a Client Eligibility Review, (CER), within the required time while restricted.

- Group 2 clients, under the pilot project, that fail to submit a CER by the end of their current eligibility period.

Procedure:

1. The date of termination and reason for termination is documented in the Event Log.

2. Before disenrolling a possibly deceased client, Case Worker will confirm with Surveillance (Lea Bush) and document findings in Event Log.

3. Clients will be notified that benefits have ended and why. (Anytime there is a change in eligibility and the client has a Case Manager, the Case Manager must be CC'd on all communication.)

INCARCERATION

Effective Date: July 1, 2003; Revised November 1, 2012, October 26, 2023
Purpose: Policy for incarcerated clients.

CAREAssist OAR:
333-022-1130

Policy:

1. Persons incarcerated in a state or federal prison are ineligible for CAREAssist and CAREAssist clients will be disenrolled immediately.

2. CAREAssist clients housed in a city or county correctional facility will remain enrolled in the program for 60 days from their booking date as long as primary insurance is maintained. This is true regardless of the expected release date. An additional 30 days may be negotiated if the client will be released within those 30 days. Clients who are incarcerated at the time of recertification are still responsible for completing a CER and are subject to restriction or termination for failure to recertify.

Pre-release Application to CAREAssist

A new application will be processed and a pre-release authorization will be issued for clients whose release date is within 30 days. The starting date for services will be the date their insurance is effective or the date they are released from incarceration, if the release date is after the insurance effective date.

Probation, Parole or Work Release

Persons who are on probation, parole or work release are eligible for CAREAssist services because they are living in the community and are not in the full-time care or custody of a jail or prison system, although they may be reporting to a parole or probation officer or are required to spend their nights in jail/prison. Persons who are under “House Arrest” are not considered incarcerated.

EXCEPTIONS PROCESS

Effective Date: April 13, 2004; Revised May 1, 2013, November 9, 2023
Purpose: Describes the circumstances under which the Program will consider an exception to policy.

CAREAssist OAR:
N/A

Policy:

Exceptions to CAREAssist policy can be considered under the following circumstances, documentation is required:

Cause	Example	Documentation Required
Medical	Client was in the hospital or inpatient treatment and couldn't complete CER	Letter from Doctor or treatment facility
Case Manager Error	Client received misinformation or CM didn't follow through	Letter from Case Manager's Supervisor
Force Majeure	Client's house burnt down, natural disaster	Varies, e.g. Police Report, Declared Emergency

Procedure:

1. The CAREAssist case worker receives a request from either a client or the client's case manager or other healthcare provider and receives supporting documentation. The CAREAssist case worker may request additional documentation or may speak with verifying physicians or other health care professionals. All conversations are documented fully in the client's event log.

2. The CAREAssist case worker meets with CAREAssist Client Services Manager or Program Manager within three (3) working days from the receipt of all documentation requested. CAREAssist managers have the final authority to grant or deny final approval.

3. In the case where there may be dire consequences, such as loss of insurance coverage, staff is authorized to start, or continue payments for up to 30 days from the date of the request for exception, with a clear understanding that final approval is pending review by a CAREAssist manager.

4. The CAREAssist case worker who initiated the request for exception is responsible for notifying the client and the client's HIV Case Manager (where appropriate), in writing, of the final decision within three (3) working days from the

meeting with CAREAssist Leadership. Notes of the decision are made in client's event log.

5. All supporting documents are filed in client record.

Note: Exceptions may me made when the error is deemed a CAREAssist error. In the event of a CAREAssist error, the CAREAssist case worker notifies and meets with the CAREAssist Client Services Manager or Program Manager within 2 business days from discovering error. When applicable, the Case Worker should apply steps 3, 4 and 5 above.

CAREAssist Case workers should track all pharmacy and insurance exceptions in their caseloads on a spreadsheet. This spreadsheet should be accessible to program staff. Pharmacy expectations require a yearly review by the case worker. SOC must be requested, reviewed, and documented in CAREAssist database yearly. If applicable, a new pharmacy exception is required in Ramsell or if the exception no longer applies, rescind existing exception.

RIGHTS & RESPONSIBILITIES

Effective Date: December 1, 2012; Revised: November 9, 2023
Purpose: Describes policies related to client and CAREAssist Case Worker rights and responsibilities.

CAREAssist OAR:
333-022-1150

Clients will:

1. Be treated with respect, dignity, consideration and compassion.
2. Receive CAREAssist services free of discrimination on the basis of race, color, sex/gender, ethnicity, national origin, religion, age, class, sexual orientation, physical and or mental ability.
3. Be informed about services and options available in the CAREAssist program for which they may be eligible.
4. Have their CAREAssist records be treated confidentially.
5. Have information released only in the following circumstances:
    a. When the client signs the CAREAssist Application/Recertification Application and for the purposes of coordinating care.
    b. When there is a medical emergency.
    c. When a clear and immediate danger to the client or to others exists.
    d. When there is possible child or elder abuse.
    e. When ordered by a court of law.
6. Have access to a written grievance process.
7. Not be subjected to physical, sexual, verbal and/or emotional abuse or threats.
8. Let their CAREAssist caseworker know of any changes in any information (address, phone number, income, pharmacy, insurance, physician, case manager, emergency contact information, etc.) submitted to the program.
9. Respond to CAREAssist staff calls, emails or letters within the timeframe requested.
10. Provide accurate information and not omit or misrepresent key information required by the program.
11. Not subject any CAREAssist staff or other clients to physical, sexual, and/or verbal abuse or threats.

Caseworkers will:

1. Treat clients with respect, dignity, consideration and compassion.
2. Be treated by clients with respect, dignity and understanding.
3. Provide CAREAssist services free of discrimination on the basis of race, color, sex/gender, ethnicity, national origin, religion, age, class, sexual orientation, physical and or mental ability.
4. Inform clients about the services and options available in the CAREAssist program for which a client may be eligible.

5. Treat CAREAssist records confidentially.
6. Release information only in the following circumstances:
    a. When the client signs the CAREAssist Application/Recertification Application and for the purposes of coordinating care.
    b. When there is a medical emergency.
    c. When a clear and immediate danger to the client or to others exists.
    d. When there is possible child or elder abuse.
    e. When ordered by a court of law.
7. Not be subjected to physical, sexual, and/or verbal abuse or threats.
8. Not subject clients to physical, sexual and/or verbal abuse or threats.
9. Respond to client calls, emails or letters within two business days.
10. Record all communications in the Event Log. Event Log notes should include, when applicable, who, what, why, how, email threads and resolution.

All possible privacy breaches or grievances must be reported via email, written or verbal, with all details immediately to CAREAssist Client Services Manager or Program Manager.

Note: The CAREAssist database does not have the capability to reassign individual clients to another Case Worker. Our Alpha-split is made to ensure that caseloads are comparable, equitable and that one Case Worker is not staffed with just clients with higher barriers, health issues and concerns. If you experience challenges/barriers working with a client, reach out to the CAREAssist Client Services Manager.