APPLICATION PROCESS (Overview)
Effective Date: September 2003; Updated August 2024
Purpose: Provides an overview of the application process.

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

Policy:

All applicants must meet the eligibility standards outlined below. Applicants 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

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. Case Workers will review an application received for completeness within 1-2 business days. If application is complete, Case Worker will process application within seven (7) business days from the date of receipt. If application received is not complete, Case Worker will follow up with client and / or Case Manager within seven (7) business days from the date of receipt.
2. The effective start 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 health insurance for which they are eligible, as determined by the Program.
3. Clients shall be notified of eligibility determination 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 information 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 applicant's Case Manager shall be notified by mail that the application has been rejected and that the applicant may re-apply at any time.

Notification of rejected application must include Notice of Rights informing the applicant to their right to a hearing.

Procedure:

Administrative staff shall:

1. Print application and all documents received electronically including the email to which they were attached.
2. Date stamp all application packets (including the application, proof of residency or Residency Verification Form, HIV Confirmation Form, proof of income, and any miscellaneous documents the applicant submitted).
3. Create a 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. Forward to the Case Worker for eligibility determination.
7. Enter Event Log including how the application packet was received (ie via mail, email, fax), who submitted the application, which Case Worker it was forwarded to and how it was forwarded (ie via email, mail).

Case Workers shall:

If the Case Worker receives the application packet directly, Case Worker will complete administrative staff procedure above.

1. Review application packet for completeness (all questions on the application answered, signature present, proof of residency completed, HIV Confirmation Form completed if they are a first-time applicant, proof of income completed, and Summary of Benefits completed if client has private or employer group health insurance) and enter Event Log throughout the process.
    a. If application packet is incomplete, notify the applicant and, if applicable, the applicant’s Case Manager via email or mail.
    b. If application packet iscomplete, 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 database.
4. If eligible, verify applicant enrolled in appropriate health insurance and, if applicable, a Summary of Benefits has been received, or proof of a complete application for health insurance is on file. Assign client to benefit group as follows:
    a. Group 1: Clients who are enrolled in private, employer group, or individual health insurance plan.
    b. Group 2: Clients whose primary prescription benefits are provided by OHP or the Department of Veterans Affairs (VA).
    c. UPP: Clients who are not currently eligible for health insurance. See Section 9: Uninsured Persons Program (UPP)

5. Notify the client and, if applicable, Case Manager of eligibility determination. Note: If there is a change in a client's eligibility and the client has a Case Manager, they must be cc:d on all communication.
    a. If eligible, notification of eligibility determination must include:
        i. The eligibility effective start date
        ii. The client's associated benefits
        iii. The CAREAssist In-Network Pharmacy List
        iv. The deadline to re-certify
        v. The Moda / Delta Dental application approved by the Program if the client's primary health insurance is not OHP.
        vi. The CAREAssist Client Handbook.

    b. If ineligible, either because the applicant does not qualify for the Program or the application was incomplete for more than 45 days, notification of eligibility determination or rejection must include:
        i. The reason the applicant was determined ineligible or the application was rejected
        ii. Notice of Rights
        iii. A statement that the client may re-apply to the Program at any time
6. Create a paper file or update existing file if it is still on-site from a previous eligibility period.

Application Tracking Ensures eligibility is determined within seen (7) business 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 start date".*	The date the application packet 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); or, rhe 46th day an application has been incomplete.

Note: All clients must have (1) & (3)

Note: Enrollment in health insurance is not a factor when determining (2) App: Complete or (3) App: Eligibility determined. Lack of Summary of Benefits (SOB) is a factor when turning on benefits. A client may be eligible for the Program, (3) App: Eligibility determined is complete, but if the client has private or employer group health insurance and the Program has not received the SOB, the Case Worker cannot turn benefits on and do not add (2) App: Complete. The Program requires the SOB to confirm that the coverage meets Minimum Essential Coverage required by the Program and must cover at least 50% of the cost for all prescription medications. If the Case Worker receives the SOB within 45 days of receipt of the application, Case Worker may retro start the eligibility period to match the date for (3) CAREAssist App: Eligibility Determined, enter (2) App: Complete with the date the SOB was received, and follow 5A above. If the Case Worker does not receive the SOB within 45 days of receipt of the application, the application is rejected, and follow 5B above.

HRSA PCN 21-02 encourages the use of other state sources when determining eligibility. For CAREAssist, this would include income reported in FRANCES.

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 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. If an applicant is unable to provide proof of income or proof of residency, the Program will access state and federal systems in an attempt to complete the income 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 received by the Program.

Note: If the client has group health insurance and has been determined eligible, benefits cannot be initiated until the Summary of Benefits has been received by the Case Worker, reviewed, and verified that the insurance covers at least 50% of the cost for all prescription medications. If the insurance does not cover at least 50% of the cost for all prescription medications, see Section 6: Insurance Exception Application.

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, is received 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 application, CER, and Proof of Residency Form.

Eligibility Determination – HIV Diagnosis Verification

Policy:
Applicant must have a documented HIV-positive diagnosis. Proof of HIV-positive diagnosis must be documented with the HIV Confirmation Form and received directly from a licensed medical provider or Ryan White Case Manager / Care Coordinator in Oregon. The licensed medical provider may be an out-of-state provider.

Documentation Required:
HIV-positive diagnosis for new applicants to CAREAssist:
Acceptable documentation of HIV-positive diagnosis is limited to:

1. A complete Rapid ART / Bridge application, signed by a licensed medical provider pr Ryan White Case Manager / Care Coordinator trained to interpret HI labs; or,
2. The HIV Confirmation Form, signed by a licensed medical provider or Ryan White Case Manager / Care Coordinator trained to interpret HIV labs. The 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 are not acceptable documentation of HIV-positive diagnosis. The HIV Confirmation Form must be received by the Program directly from the licensed medical provider or Ryan White Case Manager / Care Coordinator.

Returning Clients:

Documentation of HIV-positive diagnosis may be waived if the applicant has previously been approved for CAREAssist eligibility and documentation of HIV-positive diagnosis was received at that time. If the Program is unable to verify HIV-positive diagnosis, new documentation may be required for a returning applicant.

Note: Once an applicant is an eligible CAREAssist client, Oregon's HIV Surveillance Program may periodically import 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 (for Program communication only); 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's 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 Residency Verification Form should be submitted to the Program.

<u>Approved Documents</u>:

- Unexpired Oregon State driver's license
- Unexpired Oregon State ID
- Tribal ID
- Utility Bill in client or applicant's name
- 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 homeowner's 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 showing the applicant's home address
- 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, retirement account statement, etc.
- Official letter from Oregon State Hospital, homeless shelter, transitional service provider, residential treatment facility, 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 the client is unable to provide any of the above documentation.

Note: 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, 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 who are not dependents under the age of 19. 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. Determine total gross monthly income

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.

Note: 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 full-time student. In the case of student status, the age at which the dependent child status ends is 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 re-certification. 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 their 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 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.*

Determination of Total Gross Monthly 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)	Paystubs that show YTD gross income, when available (most recent, one month consecutive paystubs or earnings statements for all jobs.) *Note: Recent earnings as reported in State systems (FRANCES, SNAP, etc.)*
Self-employment income	1. Most recent year's federal tax return, including Schedule C, if filed, or other applicable schedules (S-Corps income requires 1120-S which may be discounted 50%; K-1 not allowed since it does not indicate gross receipts or sales); ***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 *Note: Unemployment Insurance Benefits as reported in ECLM State system.*
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. *Note: Current gross award amount as reported in SSA Records State system.*
Veterans Benefits	Current year benefit award letter.
No Income	Self-attestation of zero-income accepted when client completes No-Income Statement on 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.

Note: CAREAssist does not use MAGI (Modified Adjusted Gross Income) the way Medicaid does. MAGI is based on federal tax rules that change frequently. CAREAssist staff are not tax experts. Keeping up with frequently changing income rules, required when calculating income with MAGI, would create unnecessary barriers for clients and partners.

Note: As a general policy, CAREAssist income calculations should include any income that is considered reported, taxable income by the IRS. Below are some noted exceptions and clarifications to this policy:

- *Educational assistance programs offered by employers to their employees are a tax-free benefit up to $5,250 per employee per year. Assistance provided above that level is taxable as wages. (https://www.irs.gov/newsroom/reminder-educational-assistance-programs-can-help-pay-workers-student-loans#:~:text=By%20law%2C%20tax%2Dfree%20benefits,Tax%20Guide%20to%20Fringe%20Benefits.)*

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 the Program, use a second income verification method if applicable and use the most generous calculation.
3. Calculation methodology will 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
Refer to 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 and divide by the number of pay periods represented on the paystub.

> *Example: Client has a paystub 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 paystub, 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 bi-weekly:
Carefully check the paystub to determine the frequency of pay and determine the annual gross income – 24 pay periods per year for twice-a-month and 26 pay periods per year for bi-weekly.

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

The monthly gross rate based upon YTD gross income is calculated by dividing the YTD gross income amount on the paystub 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 paystub 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. S-Corps income requires 1120-S which may be discounted 50%; K-1 not allowed since it does not indicate gross receipts or sales.
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 is considered "overhead." The Program allows a 50% deduction from gross monthly receipts as overhead 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 statement's deposits and apply the same 50% discount – only if the current taxes and all accompanying schedules have been received by the Program. Form 1120-S shows gross receipts for a S-Corp and can be treated like a Schedule C (50% deduction is applied); Schedule K-1 is a breakdown of a S-Corp partner that does not include gross receipts (50% deduction is not applied).
4. If a Case Worker determines an applicant or client is over-income for the program, the Case Worker is required to have another Case Worker review the income calculation and both Case Workers will document their own determinations in the Event Log. If both Case Workers agree that the income is over 550% FPL, the assigned Case Worker will proceed with eligibility determination. 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 or applicant and Case Manager shall be notified by mail in accordance with OAR and Program Policies & Procedures, as outlined in Approval or Denial of Application. The Hearing Rights notice must be included with letter of denial.
2. 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 health 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 health insurance for which they are eligible and which meets Program requirements. The Program requires health insurance that covers at least 50% of the cost for all prescription medications. HIV-specific health insurance enrollment services are funded by the Program and are available across the state through regional Medical Case Management providers as well as Case Workers at CAREAssist. Clients who decline to enroll in health insurance must complete the Informed Consent to Decline Insurance Form and are only eligible for assistance with the full cost of prescription medications in 14 specific medication classes that include HIV, viral hepatitis, and opportunistic infection, also known as Restricted UPP coverage.

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

1. If insured, a copy of the client's primary health insurance ID Card and the Summary of Benefits (SOB) if primary health insurance is employer group health insurance. The SOB must confirm that the employer group health insurance covers at least 50% of the cost for all prescription medications. If the client has Medicare as primary health insurance, the Program requires a copy of the member's Part D Drug Plan or Medicare Advantage Plan ID Card and the Medicare Beneficiary ID Card. If the client has OHP as primary health insurance, the Program does not require an ID Card since eligibility can be verified via MMIS.
2. If uninsured, proof of health insurance application submitted to carrier and confirmation of its receipt will qualify the applicant for Gap coverage; if the applicant needs UPP coverage, an UPP Tool is required.
3. If uninsured and declining to enroll in health insurance, client must complete the Informed Consent to Decline Insurance Form.

Procedure:

1. For insured clients, review the SOB and verify the plan meets Minimum Essential Coverage (MEC) and covers at least 50% of the cost for all prescription medications. Enter Event Log that SOB was received, reviewed, and meets Program requirements. Update client status and all required health insurance information in the Insurance tab. If the client has new coverage and has not received the health insurance ID Card, the Case Worker will follow up with the client to submit a copy of the health insurance ID Card when they receive it.

Note: SOC or SOB's are not required for clients on private health insurance, Oregon Medicaid (OHP), Part D Drug Plans / Medicare Advantage Plans.

Note: A new health insurance record in the Insurance tab is required each calendar year for all clients.

2. Case Workers shall enroll clients and provide guidance if the client is applying for health insurance on their own. Once proof of application is received by the Program, review and verify that a complete application was submitted. Determine the effective start date and add or update the health insurance record in the Insurance tab with all required health insurance information. If the Case Worker determines that the client or applicant is not eligible for any health insurance and does not have a Special Enrollment Period (SEP) to enroll in an off-exchange plan, the Case Worker will complete the UPP Tool or request the completed UPP Tool from the Case Manager. Eligibility for UPP requires the client to be enrolled in Case Management. If the client is not in Case Management, the 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. Enter all pertinent information in the Event Log.

3. If uninsured and declining to enroll in health insurance, send the Informed Consent to Decline Insurance Form and Hearing Rights Notice to the client's mailing address. By completing the Informed Consent to Decline Insurance Form, at a minimum, clients acknowledge that:
    a. They are declining to enroll in the health insurance or prescription drug coverage for which they are eligible; and
    b. They are required to maintain coverage for the most cost-effective health insurance they are eligible for per the Affordable Care Act and CAREAssist policy; and
    c. They will only qualify for assistance with the cost of prescription drugs on the CAREAssist UPP Bridge Restricted Formulary; and
    d. They may qualify for additional benefits through CAREAssist if they choose to enroll in the health insurance or prescription drug coverage for which they are eligible, or if their eligibility for health insurance or prescription drug coverage changes; and
    e. If CAREAssist does not receive the completed Informed Consent to Decline Insurance Form within 30 days, the Program will assume consent as described above.

Upon receipt of the Informed Consent to Decline Insurance Form or after 30 days, update client’s status to Restricted UPP and enter information and 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)*

Additionally, as a federally funded program, CAREAssist clients are required to acquire drugs "in the most economical manner feasible" (42 CFR part 50, subpart E). The 340B Drug Pricing Program (340B Program) is a federal drug pricing program, administered by HRSA's Office of Pharmacy Affairs, that provides federally designated entities (including ADAPs and other federal grant recipients) with access to discounted medications.

Policy:
After CAREAssist determines a client is eligible and has enrolled in health insurance or is in the process of applying for health insurance, the client shall be enrolled in a benefit group based on eligibility for health insurance and the primary health insurance type. For additional requirements for uninsured clients, see Section 9: Uninsured Persons Program (UPP).

Procedure:
1. Assign approved clients to a benefit group, as defined below.
2. If health insurance changes and the benefit group needs updating, the effective start date for the new benefit group shall be the effective start date for the new health insurance.
3. If health insurance changes and the client is temporarily dual enrolled, private health insurance should be used and never retro-terminated to coincide with the effective start date for the new health insurance. The effective start date for the new health insurance shall never be prior to the termination date of private health insurance since there may be prescription drug or medical services co-pays to be processed.

CAREAssist Benefit Group	Insurance Type
Group 1	Private / Employer Group & Medicare
Group 2	OHP & 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 Medicaid, Medicare, or employer group health insurance that meets 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 health insurance, or those who have VA and choose not to use it for prescription drug benefits, will enroll in an off-exchange, silver-level plan.
3. Clients who decline to enroll in the most cost-effective coverage identified by the Program are ineligible for premium assistance on a off-exchange plan. These clients may:
    a. Pay the premium on the health insurance plan they choose to have; or
    b. Complete the Informed Consent to Decline Health Insurance Form. Clients are eligible to receive assistance with the cost of prescription drugs on the CAREAssist UPP Bridge Restricted Formulary. See Section 3 – Insurance Requirements.
4. Clients who previously declined to enroll in the most cost-effective coverage identified by the Program shall qualify for additional benefits through CAREAssist if choose to do so at a later date.

Oregon Health Plan Mismatch Report:

The Client Services Manager or Client Services Coordinator will designate a staff person who will receive the OHP Mismatch Report monthly and filter it by Case Worker to distribute to each Case Worker. The Case Worker will make any appropriate updates based on the mismatched information indicated on the OHP Mismatch Report.

OHP Mismatch	**Case Worker Action / Follow-Up**	
Client has group coverage and OHP. **CAREAssist is not paying premiums.**	**1.** Case Worker 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 EGHP as primary, the EGHP will be listed as primary and OHP as secondary.

	2. Case Worker should check ED to see if prescription medication and medical claims are on file. If client's response is OHP is primary and prescription medications have been dispensed under their private insurance, do not back-date OHP unless the pharmacy can reverse claims and bill OHP. Document such events in the Event Log.	**2.** Case Worker or Case Manager should assist client to report TPL to OHP or voluntarily term OHP.
Client has EGHP and OHP. **CAREAssist is paying premiums.**	**1.** Case Worker 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. **CAREAssist can't pay premiums for EGHP or a private health insurance if the client has OHP.** Case Worker should check ED to see if prescription medication and medical claims are on file. If client's response is OHP is primary and prescription medications have been dispensed under their private insurance, do not back-date OHP unless the pharmacy can reverse claims and bill OHP. Document such events in the Event Log.	**1.** Case Worker or Case Manager should assist client to report TPL to OHP or voluntarily term OHP. **2.** While OHP is active, insurance records should indicate EGHP and OHP coverage in the Insurance tab - one primary (paid plan) and one secondary (OHP). **3.** Client will voluntarily term OHP or the EGHP or private health insurance plan depending on what they are eligible for based on income calculated by CAREAssist.
A different CCO than what we have listed in the Insurance tab	Case Worker will verify OHP eligibility and CCO on MMIS.	Case Worker will update the insurance record in the Insurance tab with the current CCO assignment indicated on MMIS.

Note: CAREAssist can never show OHP as active primary health insurance at a time we paid prescription medication co-pays under Group 1, UPP, or Bridge unless the Case Worker can verify that the pharmacy will reverse the claims and bill the OHP.

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 employer group health plan – a client's, their spouse or partner's, or a parent's employer – are required to enroll in that health insurance unless they complete an Insurance Exception Application (IEA) and submit necessary documentation, as described below.
2. An IEA must be approved annually and typically prior to Open Enrollment. Case Workers must track their clients with an approved IEA on the shared spreadsheet and request a new IEA annually.
3. If the client becomes eligible for other health insurance during the year and still chooses to decline the new health insurance, a new IEA must be completed and approved.
4. If an IEA is approved, Case Worker will refer them to an off-exchange plan and assist them in enrolling in that off-exchange 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 and employer will not allow us to pay (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 health insurance that meets CAREAssist Minimum Essential Coverage (MEC) and the health insurance must cover 50% or more of the prescription drug cost.
2. Clients will notify the Program of any changes to health insurance eligibility or monthly premium.

Procedure:

Case Workers and Community Partners should request the premium statement and provide it to CAREAssist. CAREAssist must have a copy of the premium statement on file.

Case Workers will use CAREAssist vetted DDI-provided health insurance applications when enrolling clients in an off-exchange plan. Case Managers may also use DDI.

Note: If the client is eligible to enroll in an off-exchange plan, Case Workers, Case Managers, or Community Partners may assist the client with enrollment. For off-exchange applications that require a binder payment paid via credit card (SPOTS) upon completion of the off-exchange application, only Case Workers may enroll the client. SPOTS credit card information is never handled by anyone other than the assigned cardholder.

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:

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

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

Effective October 1, 2023 CAREAssist will accept a client's electronic signature on the CER, Residency Verification Form and 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 the Program has not received the client's CER, a courtesy reminder is mailed to the client approximately one week before the CER requested due date.

   (Example: Eligibility expires the last day of June. The CER is sent the first week of May. The courtesy reminder is sent approximately 10 days prior to the end of May.)

4. An updated list is sent to the appropriate Case Managers, which indicates the clients who still need to return their CER and may have or have missed the requested due date. (The original requested due date for the CER is not the eligibility end date.)

5. Upon receipt of the annual eligibility review CER the Case Worker shall:
    a) Confirm completeness and client signature
    b) Verify residential address matches that on document submitted as proof of residency
    c) Determine household gross monthly income. If documentation is not provided, the Case Worker will check state income screens that program staff have access to in an attempt to verify employer indicated on the CER and determine income eligibility. Case Worker will request necessary documentation if the Case Worker cannot verify the employer or determine income eligibility from the most recently completed quarter using state screens.
    d) If health insurance has changed and it is an employer group health plan or private health insurance, a new SOC or SOB is required along with the new insurance ID Card
    e) Update client record accordingly to what the client is reporting on the current CER and make Event Log notes. (For example – If the client has had a case manager but did not list a case manager on the current CER, the case manager would need to be removed. This applies to all information. If you have questions regarding what has been submitted or removed on the CER, reach out to the client.)
    f) When entering the new eligibility, it triggers a new ID card from Ramsell.

6. Upon receipt of the semi-annual eligibility review CER, the Case Worker shall:
    a) Confirm completeness and client 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 or if missing documentation is income related and can't be verified using state screens, 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, may extend. 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 listed on the Bridge/UPP CPT code list.

Eligibility:

1. Meet all Program eligibility requirements.
2. Be ineligible for public and private insurance or employer group health 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 community partner application assister 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 community partner application assister 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.

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.

RAPID ART 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:

HRSA does not require ADAPs to provide rapid delivery of services prior to eligibility determination. However, the CAREAssist Rapid ART Bridge Program meets all criteria for Rapid Start and HRSA best practice for ADAPs.

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 Rapid ART Bridge Program.

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

Rapid ART Bridge Program Benefits

The benefits of the Rapid ART Bridge program apply to dates of service on or after the enrollment date which may be up to 14 days prior to the date of application receipt if indicated by Provider or Ryan White Medical Case Manager:

- Full cost prescriptions will be paid for up to a one month supply dispensed within the 30-day Rapid ART Bridge period. Only Bridge/UPP/Restricted Formulary drugs are available to a Bridge client and must be dispensed by a CAREAssist in-network pharmacy.. 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 to facilitate access to HIV related medication therapy for up to 30 days. See allowable CPT codes here.

Rapid ART Bridge Program Eligibility

- The applicant must have documented HIV infection confirmed by a medical provider or a Ryan White Medical Case Manager on the Bridge application.
- The applicant must self-attest that they reside in Oregon.
- The applicant must self-attest that they 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, employer group health insurance, or private health 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.

Rapid ART 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 Rapid ART Bridge members with medication or medical care, limited medical visits and lab work, beyond the 30-day benefit period.

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

3. The Rapid ART Bridge Application must be signed by a medical provider or Ryan White Medical Case Manager..

4. The Bridge effective date is the date of the provider's signature, not the date CAREAssist receives the Bridge application. The Provider or Ryan White Medical Case Manager may backdate the Bridge application 14 days from the date CAREAssist receives it.

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

6. The Rapid ART Bridge program is not available to persons who have primary health insurance coverage. Persons who have primary health insurance should complete a CAREAssist application for ongoing assistance and speak with a Caseworker.

Rapid ART Bridge Program Procedures

Rapid ART Bridge Application: A completed Bridge Application *signed by both the client and their medical provider or RW Case Manager* is required.

1. HIV Verification: Only a medical provider or Ryan White Case Manager is authorized to verify HIV and sign the Rapid ART 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.
7. The Rapid ART Bridge effective date is the date of the provider's signature, not the date CAREAssist receives the Bridge application. The Provider may backdate the Bridge application 14 days from the date CAREAssist receives it.
4. Rapid ART Bridge applications are a priority and will be approved within 2 hours from when the completed Rapid ART Bridge application is received.
5. If approved, notification will be sent to the pharmacy and the medical provider/Ryan White Case Manager.
6. If denied, the medical provider/Ryan White Case Manager or other Case Manager / Navigator will be informed.

Rapid ART Bridge – Covered Costs and Provider Expectations

1. Rapid ART 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. Rapid ART 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 Benefits or Summary of Coverage indicating the carrier requires use of an out-of-network 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. Pharmacy exception authorizations are voided when there is a change in insurance.

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.

10. Request to mail out of the state of Oregon must follow the Exception Process (see Section 20). CAREAssist does not cover any fees or charges incurred if the pharmacy mails medications out-of-state. Clients may pay the medication co-pay and any fees or charges incurred in order to mail medications out-of-state. (Maybe we need to state medications where CAREAssist participates in the claim are not able to be mailed out of the state.)

Procedure:

1. CAREAssist will follow the primary insurance policy regarding medications dispensed. This means that if the insurance allows for a 90-day supply CAREAssist will pay the copay or deductible . Similarly, if the insurance allows for a 13th fill in a 12-month period CAREAssist will likewise pay the copay or deductible. 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 to following the determination of the client's health insurance must be approved by the CAREAssist Program Manager, Client Services Manager, Program Coordinator or Client Services Coordinator.

2. The CAREAssist Pharmacy Benefits Manager (PBM) assesses medication regimens to assure that the DHHS HIV Treatment 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 to assure that program funds are not used to dispense a drug (or combination of drugs) that could be harmful or those that do not conform to published DHHS guidelines.

Full-Cost Pharmacy Services for Bridge, Insurance Gap and UPP:

- All medications dispensed during a client's Bridge, Insurance Gap or UPP coverage must be filled at an in-network pharmacy. CAREAssist allows for a 30-day fill when paying full-cost. The exception to this rule is the Multnomah County Health Department pharmacies (frequently Westside Pharmacy). CAREAssist will pay full cost for mutual clients' Bridge medications dispensed at Westside Pharmacy. CAREAssist will pay copays and deductibles for mutual clients' medications dispensed at Westside pharmacy.

- 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 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 can 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 model.

- *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* > medications 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* > 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.

Note: The Oregon Health Authority grants Multnomah County Health Department an exemption to Oregon Administrative Rule 333-022-1070. The exemption allows clients of the CAREAssist program, and of the Ryan White Part C funded HIV Health Services Center to remain enrolled in CAREAssist and utilize the Multnomah County HIV Health Services Center pharmacy if they choose. CAREAssist does not seek insurance reimbursement or rebate on the medications dispensed by the Multnomah County HIV Health Services Center pharmacy through its 340B program. It is understood that the CAREAssist program will maintain all benefits for clients that choose to utilize the Multnomah County HIV Health Services Center pharmacy. CAREAssist agrees to pay for insurance premiums, medical deductibles, copays and coinsurance, and other eligible costs for joint clients without receiving the 340B cost saving benefit directly. It is further understood that the CAREAssist program may rescind this exemption at any point due to financial inability to maintain this agreement.

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	Bridge, UPP and Restricted clients only
Non-preferred	Limited # of acute meds available at non-preferred pharmacies
Preferred	All medications available at 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 who are not on Bridge, UPP or are Restricted with the program.
    a. Uninsured clients can get a 30-day fill of any drug covered at full cost on the Bridge/UPP/Restricted formulary..

- 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, 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 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 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 can 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 a 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.*

Note: CAREAssist drug exclusion list is referenced above. Always check the Preferred Formulary for the most up-to-date list of CAREAssist excluded medications.

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 a 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 medical service(s) occurring during a client's Restricted or Gap eligibility period.

7. Clients are eligible for an annual maximum on medical claims of $20,000. Updates to the annual maximum will be posted on the CAREAssist website and Welcome Letters sent to new clients.

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.

8. CAREAssist pays in-network rate.

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 health insurance premiums that have an RX component 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. CAREAssist will only pay the medical portion of a client's EGHP; CAREAssist cannot pay the premium for an EGHP that includes vision, dental, or other benefits not included in their medical benefits.

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~~ -19-26 ~~when~~ with proof that they are enrolled as a full-time student.
- 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 identified by the Program.

A dental application accompanies the Welcome Letter sent to all clients for whom Medicaid (OHP) is not the primary insurance. 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 will expire, disenrollment status is added and to reestablish benefits, a new application is required. See Termination 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 (medical co-payment) benefits.

Note: Group 2 CER PILOT PROJECT per PCN 21-02. Effective 7/1/23 – 12/31/24 (may be extended) 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 period.

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 Caseworker has verified the insurance provider received a complete application for enrollment ,there is a start date for the new insurance on the 1st of the following month or sooner, 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. (Insurance must be starting on the 1st of the following month or sooner).

4. Updates the client's eligibility, placing the client in ‘Gap’ status 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), a 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 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 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. Clients are required to notify CAREAssist 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 who fail to complete and submit a Client Eligibility Review, (CER), within the required time while restricted.

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

Procedure:

1. The date of disenrollment and reason for disenrollment 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. Disenrollments should be completed at the last possible moment to avoid having to reverse a disenrollment. When a disenrollment is reversed and the client had dental insurance, the dental insurance must be reopened.

4. Clients will be notified by mail 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.) Clients must also receive a Hearing Rights notice when disenrolled.

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 may be submitted within 45 days of the client's release date. .If application is complete and the client has been determined eligible,the start date for services will be the date they are released from incarceration.

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 CER 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 Caseworker receives a written or email request from either a client or the client's case manager or other healthcare provider and receives supporting documentation. The CAREAssist Caseworker 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 Caseworker 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 a 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 Caseworker 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 management. Notes of the decision are made in client's event log.

5. All supporting documents are filed in client record.

Note: Exceptions may also be made when the error is deemed a CAREAssist error. In the event of a CAREAssist error, the CAREAssist Caseworker notifies the CAREAssist Client Services Manager or Program Manager within 2 business days from discovering the error. When applicable, the Caseworker should apply steps 3, 4 and 5 above.

CAREAssist Caseworkers should track all pharmacy and insurance exceptions in their caseloads on a spreadsheet. This spreadsheet should be accessible to program staff. Ongoing pharmacy expectations require a yearly review by the Caseworker. 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 and hearing rights 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 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.
11. Communicate with the client's case manager.

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 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.