CAREAssist Policies & Procedures

Updated 2022

Oregon Health Authority

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APPLICATION PROCESS (Overview)
Effective Date: July, 2003; Updated 2021
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.

Complete Applications:

1. Eligibility shall be determined within fourteen (14) calendar-days after receipt of a complete application.
2. The effective date for services shall be the date of receipt of a complete application to the Program, once the applicant has applied for insurance, if applicable.
3. Clients shall be notified of eligibility within seven (7) calendar days of 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 or applicant's Case Manager shall be notified. Notifications shall identify missing documentation necessary to complete the application and the deadline for doing so.
2. Incomplete applications shall be closed 45-days from receipt. Applicants shall be notified that the application has been closed and that they may reapply at any time.

Procedure:

Processing 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
3. Create new client record in database for first-time applicants
4. Enter demographic and contact information, Case Manager and Medical Provider
5. Enter Event Log: “CAREAssist App : Received Initial (1)”
6. Pass to Case Worker for eligibility determination
7. Enter event log notes.

Case Workers shall:

1. Review application packet for completeness and make event log notes throughout the process.
    a. If incomplete, send notice to client and/or 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).
    c. Uninured Persons Program (UPP), if ineligible for insurance.

5. Notify client and Case Manager of eligibility determination.
    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
    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

Application Tracking Ensures eligibility is determined within 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: *All clients must have (1) & (3)*

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

ELIGIBILITY DETERMINATION

Effective Date: July, 2003; Updated October, 2016
Purpose: Describes the processes used to review applications and determine eligibility.

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

Policy:

All applicants are consistently held to 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 eligibility and when possible, the Program will utilize access to State and Federal systems to complete eligibility requirements.

Note: Presumptive eligibility is not permitted. Payment for services cannot be activated until all eligibility requirements have been met and supporting documents have been collected

Procedure:

Case Workers will conduct a thorough review of the application 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.

Eligibility Determination - HIV Diagnosis Verification

Policy:
Applicant must have a documented HIV-positive diagnosis. Proof of positive HIV-status must be received on the program approved CAREAssist HIV/AIDS Confirmation form directly from the medical provider/Case Manager.

Documentation Required:

New Applications:
Acceptable proof of HIV for new applicants 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 Case Manager. The signing physician or HIV Case Manager must have documentation of positive HIV status on file. Self-attestation or documents received from the applicant are not acceptable proof. Instead, documentation must be received directly by the physician or HIV case management agency from the originating medical practice or lab.

Returning Clients:
Proof of HIV may be waived when the electronic record already contains a CD4/VL import from the Surveillance Program.

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

If the Program is unable to verify positive HIV-status, new documentation may be required (see New Applications, 1 & 2).

HIV-Confirmatory Testing:
HIV confirmatory testing is an allowable expense under the Bridge Program. If no documentation is available, physicians can submit a complete Bridge application to the program. However, if the results indicate the applicant is HIV-negative, only the cost of the confirmatory test is eligible for payment. For more information, see Bridge Program Policies and Procedures.

Eligibility Determination - 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 provider's office within 24-48 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.

<u>Approved Documents</u>:

- 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 showing the employees 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 that includes your residence address, 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: Residential address as reported in State systems, including but not limited to; MMIS, ECLM, ENAM, WAGE, 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 family members. Monthly income means the gross monthly average of any and all monies received on a periodic or predictable basis, which the family relies on to meet personal needs.

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

1. Determine family size
2. Calculate total gross monthly income – CAREAssist does not use MAGI, modified adjusted gross income.

1. Determination of Family Size
Family 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; 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 marital status

Clarification on Dependent Status:
Dependent family 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 months current, consecutive paystubs or earnings statements for all jobs.) *Acceptable Electronic Verification: Recent earnings as reported in State systems WAGE, SNAP*

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.
Alimony/child support/foster care payments	Benefit award letter *or* Official document showing amount received regularly.
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.
Social Security income (SSI/SSDI)	Current year award letter. *Acceptable Electronic Verification: Current award as reported in State SSA Records*

Worker's Compensation or Sick 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 using at least two methods. Select the most generous calculation; and
2. 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. Within reason, the program attempts to look at current 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 months, and percent of partial months, 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 5.5 months:
>
> $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):
This is considered income in the month in which it was received only. After that, it converts to a resource and CAREAssist doesn't have an asset test. Lump sum payments only threaten eligibility when payment is received the month the client applies or recertifies.

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, or 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. In this case, divide a client’s gross monthly receipts in half to determine their monthly income. Deposits may be halved “in good faith” when the business is new and the client intends to file for the current year.
4. In the event when the overhead is higher than 50%, the Program will use the federal income tax return (with Schedule C or E or other applicable schedules if filed) and the Determining Self-Employment Income Form to determine the business overhead when it is higher than 50%. (OAR461-145-0920)

5. 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, 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 Program Lead or Program Coordinator with both case workers income calculations. The Program Lead or Program Coordinator will review the calculations to determine the applicant 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: January 1, 2014
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.

As a result, all clients are expected to enroll in insurance that meets minimum program requirements, when eligible. HIV-specific enrollment services are available across the state through CAREAssist-funded assister contracts and in-house services provided by case workers. Clients who actively refuse to enroll in insurance are eligible for assistance with the full cost of medications used to treat HIV, viral hepatitis, and opportunistic infections only.

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 Benefits & Coverage (SBC). SBC must show the RX benefit covers 50% or more of the RX cost.
2. If uninsured, proof of application to insurance, including a Federally Facilitated Marketplace enrollment summary or 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 SBC and verify the plan meets Minimum Essential Coverage (MEC) and covers 50% or more of RX cost. Note in event log that SBC was received.Update client status and all pertinent information. ***Note:*** *SBCs are not required for clients on Oregon Medicaid/Medicare D/Advantage plans or private policies sold on and off the Marketplace. These plans are reviewed annually to ensure they conform to Program Requirements. Copies of SBCs on file.* A new insurance record is required each year.

2. Case Workers shall enroll clients themselves and may refer uninsured clients to CAREAssist-contracted assisters for help enrolling in the appropriate coverage or 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-contracted assisters determines that the client or applicant is not eligible for any available coverage and does not have a SEP to enroll in a plan through the marketplace or off the exchange the assister will complete the UPP tool form and submit to CAREAssist for approval. The case worker will approve or deny the UPP tool and notify the applicant, contracted assister or case manager of the UPP tool determination. All clients that have an approved UPP tool form will be required to be enrolled in case management. Note all applicable information in the event log.

3. For uninsured clients declining coverage, mail the Informed Consent for Individuals Declining Insurance 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 and may be assessed a penalty by the IRS for being uninsured; *and*
    c. They qualify for assistance with the cost of drugs used to treat HIV, viral hepatitis and opportunistic infections only; *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. Proceed to Approval or Denial of Application.

BENEFIT GROUPS
Effective Date: January 1, 2014
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 has applied for insurance and provided documentation to CAREAssist of insurance application, client shall be enrolled in a benefit group based on eligibility for insurance and the primary insurance type or uninsured. 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 insurance coverage.
3. 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 and make event log notes.

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

Insurance Priorities

Effective Date: January 1, 2014
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 requirements are required to enroll in that coverage.

2. Clients whose household income is over 400% of the Federal Poverty Level (FPL), owe CAREAssist overpaid APTC, have not filed their current federal taxes, have previously been approved for a CAREAssist Insurance Exception or have a temporary immigration status will enroll in an off-exchange silver plan.

3. Clients for whom the above criteria does not apply or who have not been identified as transitioning during open enrollment to off-exchange may apply for an off-exchange silver plan or a Federally Facilitated Marketplace (FFM) silver plan. Clients who enroll on an FFM plan must reconcile their taxes.

4. 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 and still receive assistance with out-of-pocket medical expenses, as outlined in Group Benefits; 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].

5. Clients who previously declined coverage shall qualify for additional benefits if they enroll in the cost-effective coverage identified by the program.

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

Insurance Exception Application (Exceptions to ESI Mandate)
Effective Date: March 1, 2022
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 – or if they qualify for a Qualified Health Plan (QHP), through the **Federally Facilitated Marketplace** (FFM) 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.
3. If exception is approved, Case Worker will refer them to an off-exchange insurance plan.
4. 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. Child 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 70 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. Client does not file Federal Income Taxes	

ENROLLMENT REQUIREMNTS WHEN USING FFM

Effective Date: March 8, 2022
Purpose: Describes requirements when clients enroll through the Federally-Facilitated Marketplace (FFM) and related polices.

CAREAssist OAR:
333-022: 1000

Policy:

Clients who apply through the Federally-Facilitated Marketplace (FFM) must be eligible for APTC and will do the following:

1. Clients will enroll in a silver-level plan, as required by the program.

2. Clients are required to take the full amount in advance, referred to as the Advanced Premium Tax Credit (APTC).

3. Clients will notify the Program of any changes to insurance eligibility or monthly premium as a resulting from a reported change to FFM, within 15-days of the event.

4. Clients on Healthcare.gov plans receive APTC and will file taxes (jointly, if married) as required under ACA. Some exceptions apply to the joint-filing requirement.

Procedure:

Case Workers and enrollment specialists will collect the FFM Eligibility Summary, which documents:

1. Plan selection and metal level
2. Eligibility status showing APTC amount.
3. Acceptance of APTC and Cost-Sharing Reductions

If client on Federally-Facilitated Marketplace (FFM) plan becomes ineligible for APTC during the year, they may remain on the plan until they are able to move to an off-exchange plan or other insurance.

TAX RECONCILIATION

Effective Date: July 1, 2016. *Applies to CAREAssist-supported plans in 2017*
Purpose: Describes the annual process by which eligible clients document the reconciliation of premium tax credits; the pursuit of premium refunds; and payment of premium-related tax liabilities.
Updated 3/15/22

CAREAssist OAR:
333-022: 1080

Policy:

Clients who apply for a FFM plan must be eligible for tax credits and accept Advanced Premium Tax Credits (APTC). These clients are required to file taxes and reconcile those payments in accordance with the Affordable Care Act (ACA). Upon reconciliation:

Beginning in January of each year, Fiscal operations staff will compile a report of clients with a QHP (http://wpdhssqll42/Reports/report/HIV/ADAP/QHP%20Client%20Report/QHPers) for the prior calendar year to identify:

- Clients whose reconciliation balances, and therefore no payment or refund is owed.
- Clients who owe the IRS for excess APTC that should be paid by CAREAssist on behalf of the client.
- Clients who owe CAREAssist for net PTC that should be paid to CAREAssist by the client.

Fiscal operations staff will mail notifications to clients requesting tax documents a total of three times the week of February 1, March 1 and April 15 to verify APTC liability or refund. Documents must be accurate and complete in order for staff to process.

By February 1, the program will issue letters to clients who had a QHP in the previous year, requesting copies of Form 1040, Form 8962, and Form 1095-A by deadline identified in the correspondence in order to make payment to IRS by the tax deadline. Other forms might be needed as well depending on situations unique to each tax year (ie Schedules 1-3, etc).

Fiscal operations staff will:

A. Enter IRS documents received from the client into the event log and the Tax Reconciliation master tracking sheet.
B. Validate accuracy and completeness of tax documents received by clients.
C. Request any missing documents by email or mail, entering actions to resolve missing documentation in the event log.
D. In the event the documents have errors and/or data mismatches that you are unable to resolve, mark the documents as 'unable to validate', notify the client and make an event log.

Excess APTC Liability to IRS

- If review of the documents shows that client owes the IRS for Excess APTC, and documents are received from the client by the CAREAssist program deadline, fiscal staff will process payment to the IRS for excess APTC prior to the IRS deadline.
- Send notice, a copy of the check and a copy of the form 1040-v to the client that payment has been made.
- Enter the payment on behalf of the client equal to the excess APTC owed to the IRS during the months enrolled in both QHP and the CAREAssist program. Payments should be allocated to the associated months in the CAREAssist database under Ledger/Insurance Premiums. Use drop-down to choose client and Insurance Carrier for associated time period. Add a "payment" paid to the IRS (see Supporting Procedures folder F:\Policy & Procedures\CareAssist Fiscal\Supporting Procedures).
- Include client's name, SSN, address, phone #, and the tax year on a label on the top of the check to the IRS. Complete IRS form 1040-V to accompany the payment. Mail these items to the client using certified mail tracking to verify delivery/receipt. If the address on client's tax forms differ from that shown in the CAREAssist database, verify which is current (and update the database if necessary).

CAREAssist will retain documents by tax year per state retention policy.

PTC Owed to CAREAssist

If review of the documents shows that the client received a net PTC refund, that amount is owed back to CAREAssist. The CAREAssist Program will invoice clients for net PTC with bill dates as soon as received. Clients may make payments quarterly or pay in full at any time.

A. A hardship form will be provided to all clients upon initial request for payment. If the client submits a hardship form the fiscal operations staff will verify the hardship. The hardship request will be 1) Denied; or 2) Approved. If approved, the invoice will be adjusted to zero owed.

B. CAREAssist will receive and receipt payments from clients (see Supporting Procedures folder F:\Policy & Procedures\CareAssist Fiscal\Supporting Procedures).
C. CAREAssist will maintain documentation of attempts, communications, and payments owed and received.
D. If payment is made by direct check, fiscal operations staff will:
    a. Look up the original expense in RStars (86 screen) and print the backup showing the expense.
    b. Write “ROX” and the current deposit coding on the backup document.
    c. Make two copies of the check and back-up documentation, one for the cashier’s office and one to the general file.
    d. Enter the amount of the refund into the CAREAssist database.

    (see Supporting Procedures folder F:\Policy & Procedures\CareAssist Fiscal\Supporting Procedures).
E. Fiscal operations staff should enter the refund from the client equal to the net PTC that was overpaid allocated to the associated months into the CAREAssist database. Under Ledger/Insurance Premiums/use drop down to choose client and drop down to choose Insurance Carrier for associated time period. Add a “refund” payment received.
F. Per HRSA policy, clients may not be removed from the CAREAssist Program if payment is not made.
G. After four quarterly outreach attempts, the CAREAssist Program will close the issue and document non-payment in the event log.

RECERTIFICATION

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

CAREAssist OAR:
333-022: 1090

Policy:

At a minimum, every client in CAREAssist must have their eligibility for the program reviewed every six (6) months. However, the program can request an eligibility review at any time. A completed Client Eligibility Review (CER) application and 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. Self-attestation is allowed on the semi-annual CER review.

Procedure:

1. Clients are automatically sent a CER two months before eligibility expires. Response is requested by the last business day of the month that the client receives the CER.

2. A list of clients receiving the CER application is sent to the HIV case managers.

3. A courtesy reminder is mailed to clients a week before the CER due date to clients who have not responded. *(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 emailed to HIV 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) Verify residential address matches that on residency document
    b) Determine total monthly income average
    c) Update client record accordingly and make Event Log notes
    d) When entering the new status it triggers a new ID card from Ramsell.

6. Upon receipt of the semi-annual (short) CER the Case Worker shall:
   a) Update client record accordingly and make Event Log notes
   b) 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.

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

UNINSURED PERSONS PROGRAM (UPP)

Effective Date: December 21, 2021, (Updated March 22,2022)
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 or UPP formulary. Exceptions can 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 or UPP CPT code list.

Eligibility:

1. Meet all Program eligibility requirements.
2. Be ineligible for public and private insurance that meets Minimum Essential Coverage (MEC) in accordance with the ACA.
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. Medical Case Manager, CAREAssist case worker, 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 Medical 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. Medical Case Manager, CAREAssist case worker, 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 Case Manager, CAREAssist case worker, 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.

BRIDGE PROGRAM

Effective Date: July 1, 2008; Revised January 1, 2014, April 11, 2022
Purpose: Describes the requirement to enroll in cost-effective coverage.

CAREAssist OAR:
333-022: 1140; 1080

Policy:

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 formulary, through the Medication 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 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 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 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 Medication Bridge Program Application must be signed by a physician that is a licensed HIV Medication prescribing provider. All prescriptions covered by the Bridge Program must be obtained through a CAREAssist Network Pharmacy, .

4. 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 program application for ongoing assistance and speak with a caseworker. Bridge members who do not have health insurance with pharmacy benefits are also required to apply for health insurance at the direction of CAREAssist staff.

Bridge Program Procedures

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

1. HIV Verification: Only a licensed, prescribing 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. Clients may fill medications at Multnomah County's Westside Pharmacy under Bridge. This is the only exception to the pharmacy network when paying full cost.
2. Bridge coverage is available to primary care 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
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. There are 37 physical locations known as "Brick-and-Mortar" sites and one that is just mail-order.. Some brick-and-mortar locations also mail medications.

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 drugs 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 called 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 mandating the use of that pharmacy. It must be documented in Ramsell and the event log.

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, replacement fills are approved or denied first by the health insurance. CAREAssist will follow the determination made by the health insurance. Any exception must be approved by the CAREAssist Program Manager, Program Coordinator or Program Analyst 2.

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.

- 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 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 the 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
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	Limited to Bridge and UPP clients only
Preferred (Acute)	Limited # of meds available at non-preferred pharmacies
Restricted (status)	Limited to HIV, viral hepatitis & OI treatments
Open	Some exceptions apply.

1. Each formulary is available online on the Ramsell and CAREAssist websites.
2. Clinical review of the formulary will occur annually, in partnership with either the AIDS Education & Training Centers or Ramsell
3. CAREAssist maintains an open formulary for members that are not on Bridge, UPP or restricted with the program.
    a. Uninsured clients can get any drug covered at full cost on the Bridge/UPP 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, denied as not a covered medication on the client's insurance formulary list or isn't 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 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.
    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*:* PA 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. Make note in Ramsell portal and in the Event Log.
v. Prescription vitamins and mineral product – *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
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 shall use a State issued (SPOTS) Visa to process payments for co-pays and deductibles. Payments may also be made using state-issued warrants.

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 reimburse any co-pays or deductibles for services that are not reimbursable by the primary insurance company.

4. 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 of services.

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

6. CAREAssist cannot reimburse clients directly if they pay copays on their own.

7. CAREAssist cannot pay collection agencies on clients' behalf.

HEALTH INSURANCE PAYMENTS

Effective Date: July 1, 2003; Revised May 1, 2013
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. CAREAssist has received a premium statement or other official documentation from the carrier verifying the premium amount and frequency of pay.

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

5. Clients are required to notify CAREAssist of any premium changes (amount, benefits, etc.) within 30 days of any notice received from their insurance company.

Health Insurance Payments for Affected Dependents

Purpose: Describes under what circumstances 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 18-24 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, the monthly premium cannot by divided.

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

DENTAL PROGRAM

Effective Date: March, 2015
Purpose: Describes benefits and requirements related to dental

CAREAssist OAR:
333-022:1147

Policy:

The CAREAssist Dental Program provides assistance with 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) clients. The Welcome Letter event log note will include that a MODA Delta 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 Medicaid (OHP) at the time of application. Clients who have CAREAssist dental and transition to OHP are eligible to keep their CAREAssist dental plan.

Benefits:

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

CHANGE NOTIFICATION LETTERS

Effective Date: July 1, 2003; Revised May 1, 2013
Purpose: Requires a written notification to the client of any fundamental changes in the client's support by the program.

CAREAssist OAR:
333-022-1150, 1160

Policy:

1. Clients will be notified in writing by CAREAssist of any fundamental changes in their benefits provided by CAREAssist.

2. The client's HIV case manager, if there is one, will be notified via letter or email of any fundamental changes in the client's benefits.

3. Fundamental changes may include:
    - Ending CAREAssist premium payments of an insurance policy outside the normal life of the policy.
    - Cessation of payments made on behalf of a client, including pharmacy and medical service costs. This includes notice of restriction or disenrollment.
    - When other insurance is available and the client is resisting moving to the other insurance.

Procedure:

1. The change notification letters include pertinent discussion of the reason for the change.

2. Letters will be mailed as soon as CAREAssist identifies a fundamental change. Clients will be given as much notice as possible - typically one month before the change.

3. A copy of the change notification letter is sent to the client's HIV case manager, if there is one.

A copy of the change notification letter is placed in the client file and Event Log notes are made.

RESTRICTED STATUS

Effective Date: October 1, 2005; Revised September 1, 2015
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.

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 and some opportunistic infections, if insured.
3. The full cost of formulary medications that treat HIV, viral hepatitis and some opportunistic infections.
    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 formulary is available on the Ramsell website.

Restricted clients are not eligible for TPA benefits.

INSURANCE GAP COVERAGE

Effective Date: May 1, 2013
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 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. Documents steps in Event Log.

TERMINATION OF SERVICES

Effective Date: July 1, 2003; Revised May 1, 2013
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.

- The client fails to complete and submit a Client Eligibility Review (CER) within the required time while restricted.

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. The notice will also include hearing rights and a statement that the client may reapply at any time.

INCARCERATION

Effective Date: July 1, 2003; Revised November 1, 2012
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
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 Leadership within five working days from the receipt of all documentation requested. CAREAssist Leadership has 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 CAREAssist Leadership.

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 five (5) 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.

RIGHTS & RESPONSIBILITIES

Effective Date: December 1, 2012
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 (wet signature) the CAREAssist Application/Recertification Application with the written release of information.
    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 (wet signature) the CAREAssist Application/Recertification Application with the written release of information.
    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 Leadership (Program Manager Program Coordinator or Program Analyst 2).