CAREAssist Advisory Group Meeting Notes

December 10, 2025

Announcements

In 2026:

- Kris will provide support to the CAREAssist Advisory Group (CAG).
- Instead of checks for $157, eligible members will receive $150 gift cards. Some paperwork will continue to be required. If you are eligible for a stipend, please let CAREAssist know if you have a preferred gift card. If you have a store you'd like to suggest for gift cards, please let Kris or Joanna know.
- Existing meeting invitations will be canceled and resent by Kris. All meetings will continue to be online and will be using the Teams application.

Program Income & Cost Containment

Program Income

As a part of the development of Oregon's integrated plan for 2027-2031, a statewide financial services inventory must be completed. The purpose of the inventory is to help guide HIV prevention and care planning over the next five years. It's also an opportunity to identify any duplication of services and identify ways to work together more effectively. Many OSPG members will help with this assessment. We recognize that there is uncertainty related to funding; this will serve as a point-in-time assessment.

An HIV Funding Inventory will be included in the five-year plan. Many agencies will be involved in this process, including Part A and Part B.

<u>What will OHA include in the financial services inventory?</u>

- OHA federal grants from:
    - HRSA, which funds 1) Ryan White Part B (services for PLWH in 31 counties) and 2) the statewide AIDS Drug Assistance Program
    - CDC, which funds 1) HIV Prevention and Surveillance, 2) the Medical Monitoring Project (a statewide needs assessment related to PLWH care and treatment), and 3) National HIV Behavioral Health Surveillance (NHBS, an assessment of prevention needs in the Portland metropolitan area, known locally as Chime In). It is uncertain whether NHBS funding will continue.
    - Housing and Urban Development (HUD), which funds statewide Housing Opportunities for Persons With AIDS (HOPWA) programs Oregon Carceral Engagement & Access Network (OCEAN), OSSCR (Oregon Statewide Supportive Community Reentry Project), and OHBHI (Oregon Housing and Behavioral Health Initiative).

- OHA State General Funds, which support:
    - HIV Prevention (statewide testing, condom distribution, harm reduction and disease investigation in counties that have transferred their public health statutory authority to the state)
    - HIV care (Part B jurisdiction. Full cost OTC, eye care and medical care expenses not covered)
- Ryan White Part B Program income, which supports:
    - Oregon's AIDS Drug Assistance Program (CAREAssist)
    - HIV case management/support services in Part B jurisdiction (31 counties)
    - Enhanced statewide Ryan White services (since 2017), including HIV Early Intervention and Outreach (HIV/STI Statewide Services)
    - HIV Supportive Housing and Behavioral Health, other Ryan White services
    - Communications/Awareness activities
    - Provider education

What is OHA program income? OHA's AIDS Drug Assistance Program (CAREAssist) is eligible for the federal 340B Drug Pricing Program that requires manufacturers to provide discounted medications. The 340B Program enables covered entities to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services. Many hospitals, health centers, and federal grantees across Oregon are also 340B covered entities (e.g., federally qualified health centers, specialized clinics, Ryan White, reproductive health, STI and TB clinics, hospitals).

Program income plays a substantial role in funding CAREAssist and other services. Over 80% of the CAREAssist budget relies on annual 340B reimbursements to fund the program.

Federal rules state that:

- Program income is additive and must be used for the purposes for which the award was made. OHA must deliver services as outlined in the grant award and per HRSA guidance.
- Funds from program income must be used for Ryan White Part B allowable costs, with a priority for ADAP.
- Program income may not be shared with other entities including, but not limited to, other Ryan White recipients, marketplace plans, Medicaid, or any other state or federal program. However, OHA can issue contracts for enhanced Ryan White Part B services.

Funding for enhanced services

Due to the variability of OHA program income and associated risks, OHA must have received funds before issuing a contract. The OHA fiscal team forecasts approximately $12 million/year for enhanced services (sometimes lower/sometimes higher) after Ryan White Part B grant close-out. Multi-year contracts are issued to assist with the flux in reimbursements—which provides more time to earn the resources needed to maintain

contracts, protects contractors from any fiscal volatility, and allows both OHA and contractors to plan ahead if changes are needed.

In 2026, OHA Program Income will be used to continue the following contracts:

- Statewide HIV Early Intervention and Outreach ($8.2 million annually)
    - HIV/STI Statewide Services (HSSS, previously known as EISO)
    - Money issued through an Intergovernmental Agreement with all Local Public Health Authorities
    - Conference of Local Health Officials (CLHO) approved funding formula
- Statewide HIV Housing and Behavioral Health Services ($7.3 million annually)
    - Intergovernmental Agreement with Multnomah County to serve the Part A jurisdiction
    - Direct OHA contracts with HIV Alliance and EOCIL (the Eastern Oregon Center for Independent Living) to serve the Part B jurisdiction
    - The HOPWA OCEAN (housing) project leveraging required by the grant and serves clients statewide

Key planning dates:

- November 2025 - January 2026: Financial Services Inventory
- January - March 2026: OHA will schedule two town halls for providers and two town halls for clients (one in English, one in Spanish). Additional data collection will be conducted as needed.
- April 8: OSPG meeting
- May 1 - 22: Oregon's draft integrated plan for 2027-2031 will be available for review and comment.
- May 25 - 29: Integrate suggested revisions and document decisions.
- June 3: At this OSPG meeting, we will review final changes to Oregon's new integrated plan for 2027-2031. Voting members of the OSPG submit votes of concurrence, non-concurrence, or concurrence with reservations.
- June 24: Deadline for letters of concurrence from the OSPG and Part A Planning Council.
- June 30: Integrated plan due to CDC and HRSA

Cost Containment

The National Association of State and Territorial AIDS Directors (NASTAD) released a brief encouraging state AIDS Drug Assistance Programs (ADAPs) to identify cost-saving and cost-cutting measures. The publication was supported by HRSA under their cooperative agreement. ADAPs facing budget shortfalls have two main options: they can identify **cost-saving opportunities** to maximize the use of available resources and/or they can identify **cost-cutting measures** to reduce expenditures. These two paths are not mutually exclusive and should be considered together. ADAPs face a number of challenges, including:

- Changes to Medicaid, Medicare, and commercial insurance enrollment and coverage, which may increase the number of people with HIV who become or remain uninsured
- Rising costs of antiretrovirals and other drugs
- The growing complexity of the 340B program, which offers revenue generation opportunities for ADAP but also comes with important compliance requirements and complex partnership dynamics

NASTAD recommended the following cost-saving measures to ADAPs:

- Develop more sophisticated budget projection methodologies
- Consider federal and state funding options
- Maximize health care coverage outreach and enrollment
- Institute or reinstitute more frequent eligibility determinations
- Conduct robust plan assessments
- Develop enhanced rebate monitoring and reconciliation procedures

Due to the CAREAssist robust Program Income (PI) model, ADAP Emergency Relief Funds are not an option or necessary currently. CAREAssist does not utilize Oregon general fund. Some state ADAPs receive allocations from RWHAP – Part A, B or C to bolster the ADAP program. Because there hasn't been a hardship and let me repeat that - CAREAssist is not experiencing a hardship now - this has never been explored or tapped.

Under federal law, the RWHAP, including ADAP, is a "payer of last resort," and as such, federal funds may not be used for any item or service to the extent that payment has been made, or can reasonably be expected to be made under any State compensation program, under an insurance policy, or under any Federal or State health benefits program, or by an entity that provides health services on a pre-paid basis. Reminder – Under HRSA's payor of last resort policy, CAREAssist requires clients to apply for insurance for which they are eligible.

HRSA also requires recipients, including ADAPs, to "vigorously pursue" public and private health care coverage, including aiding individuals to ensure they are aware of and enrolling in comprehensive coverage sources for which they may be eligible. HRSA mentions that maximizing health care coverage enrollment may require implementing a more robust screening protocol for eligibility for other coverage when clients apply to ADAP, as well as more intensive outreach and enrollment resources to help clients enroll and stay enrolled in coverage. Reminder - CAREAssist has maintained 2 recertifications annually for clients that CAREAssist is paying costs for to meet the recommended, more robust, screening protocols suggested.

CAREAssist continuously assesses why their full-pay, UPP, clients are not enrolled in other coverage sources. Note: ADAPs are also encouraged to implement strategies for more thorough screening for Medicaid eligibility.

CAREAssist recognizes that while longer periods between confirmations of eligibility may reduce burden, it can also keep clients who are no longer eligible for ADAP or who are eligible for other coverage that would be no cost or reduced cost to ADAP. Maintaining the more frequent eligibility recerts for clients on insurance other than OHP or VA has allowed CAREAssist to prioritize coverage and funds for those who have no other coverage options.

CAREAssist continues to assess insurance plans that will provide the best coverage for clients and the most sustainable financing options for the program. To date, CAREAssist has not had to restrict insurance plans like many other state ADAPs have. CAREAssist recognizes that this is a cost-savings measure recommendation that should be and is on the radar should the financial landscape of the program significantly change in the future.

Rebate monitoring is ongoing, and part of that process is the utilization of a comprehensive benefits manager. Among many things - The PBM, Ramsell, partnership assists CAREAssist in addressing potential disputed 340B claims, partial-pay rebates, and manufacturer disputes, and ensures that CAREAssist is generating supplemental rebates on claims. CAREAssist also contracts with a vendor(s) for a 340B independent annual audit.

NASTAD recommended the following cost-cutting measures to ADAPs:

- ADAP formulary management
- Lower ADAP income eligibility threshold
- Prioritize ADAP services
- Initiate an ADAP waiting list

CAREAssist follows the primary insurance formulary. CAREAssist currently has no plans to make changes to any of the program formularies and formularies are reviewed annually. Recommendations and what some other ADAP's are doing are removing some medications that have limited 340B discounting or rebate opportunities, implementing robust prior authorization requirements for high-cost medications that have narrow indications or therapeutically equivalent alternatives and spending caps – either monthly or annually on what an ADAP will spend on a client's medications. Again, let me repeat – These are recommendations, some other ADAP's are already doing these things, CAREAssist is not there.

CAREAssist is unique due to our PI model. PI is generated when a client in the program is insured with coverage other than Medicaid or VA and is using a CAREAssist in-network pharmacy. Lowering the CAREAssist FPL would significantly impact CAREAssist PI in a negative way unlike many ADAP's that just use a rebate model. Lowering the CAREAssist FPL would result in a loss of individuals that boost PI.
We continue to prioritize ADAP services collectively as a program, community and state and this is ongoing as HRSA policies and needs change for ADAP.

CAREAssist has no need to explore a waiting list currently.

The brief encourages ADAPs to explore support systems - It is recommended that to prevent gaps in treatment, ADAPs should consider implementing pathways for short-term medication access. This could include providing a 30-day emergency supply of medication for clients who are transitioning on the program that are uninsured or underinsured, giving them a critical window to enroll in insurance without interrupting their antiretroviral therapy. CAREAssist is doing this and continues to do this with the Bridge and Uninsured Person program.

In addition, to help prevent gaps in treatment, CAREAssist allows for a 3-month restricted period for when someone misses recertification – They have an additional 3 months of CAREAssist coverage that offers benefits like health insurance premium assistance, dental insurance premium assistance and copay assistance for medications on the UPP/Bridge/Restricted formulary which includes 14 classes of medications.

Discussion

- Q: Are there cost savings or reductions in program income when generic medications are prescribed?
    - A: While generic medications reduce program income, this is not a topic that CAREAssist has explored because CAREAssist follows primary insurance, and primary insurance determines whether or not generic medications are covered. In addition, many medications don't have generic options.
- This was really informative. I'm glad to hear that we're doing relatively well during these uncertain times.
- It's great to hear that CAREAssist is ahead of the other states and is stable. Big thanks to all the CAREAssist staff for the great service that they provide to consumers!
- Q: Are there PLWH who might potentially lose Medicaid? Would they become fully insured under CAREAssist?
    - A: If a client is eligible for the program and has a denial from Medicaid, CAREAssist can help them enroll in other coverage. CAREAssist loses PI when clients transition to Medicaid and gains PI when clients return to CAREAssist on private insurance.
- Q: How many people would lose Medicaid with potential cuts or work requirements?
    - A: CAREAssist does not have a way to determine how many people might become newly eligible for CAREAssist unless or until they reach out to the program.

Open Enrollment Status

CAREAssist has sent letters to all clients with instructions for Open Enrollment. This year, CAREAssist is focusing on enrolling clients who were previously approved for an insurance exception and clients who have had an off-exchange plan but appear to be eligible for OHP/OHP Bridge or an employer group health plan. The goal is to ensure clients enroll in the health insurance for which they are eligible.

If a client has an off-exchange plan, the letter shares what they need to do to keep an off-exchange plan or to transition to OHP or an employer plan if appropriate. If a client has been unresponsive, they are informed that their CAREAssist benefits may be reduced if they do not respond, as well as steps to remedy the situation (e.g., applying for health insurance before January 15).

Not all clients will be able to transition during Open Enrollment. CAREAssist will continue to conduct outreach to clients during 2026 to help them transition to the health insurance for which they are eligible so that CAREAssist can continue to be the payer of last resort.

Many other clients remain eligible for OHP/OHP Bridge; their insurance records are being updated without any documentation required from clients. Unless CAREAssist is notified otherwise, clients enrolled in Medicare will have their insurance records updated using plans and premium amounts provided by the Division of Financial Regulation, Senior Health Insurance Benefits Assistance, and health insurance carriers. Clients who are eligible for OHP can enroll any time (year-round). Clients who continue to be eligible for an off-exchange plan should submit the auto re-enrollment letter they receive from their health insurance carrier indicating the premium amount for 2026.

Discussion

- Q: What does the reduction in benefits look like for clients?
    - A: With restricted UPP, CAREAssist will pay for medications on the UPP formulary, including antiretroviral (ARV) medications, medications for mental health, and medications for opportunistic medications (Includes 14 classes of medications). Clients with Restricted UPP will not have access to other medications and will not get third-party administrator (TPA) benefits that cover lab visits and outpatient medical services. This is how restriction has always worked; this is not new.
- Q: Would continuation of HCV medications be covered in the restricted benefit?
    - A: Yes, per the UPP/Bridge/Restricted formulary.
- HRSA requires CAREAssist to be the payer of last resort. If a client has access to insurance through the Oregon Health Plan (OHP), Medicare or through their employer, that should be their first option. If denied, CAREAssist needs documentation of the denial and can explore other options. Per HRSA, CAREAssist can make exceptions for a limited number of reasons:

    - Missed Employer Open Enrollment: The client missed the employer's Open Enrollment period to enroll in employer insurance. Documentation of the open enrollment dates will be required, and the client will need to apply during the employer's next Open Enrollment period.
    - Currently Covered on Parent Plan: The client is on a parent's insurance, is over 18 years of age, and has concerns that their private health information might be disclosed to their parent(s) and the client is not eligible for any other coverage. Statement from client is required.
    - No Employer Insurance Available: The client's employer does not offer health insurance. A letter or other official documentation from the employer will be required.
    - Not eligible For Employer Insurance: The client is not eligible for employer insurance. A letter from the employer or other official documentation will be required.
    - Employer Insurance does not cover at least 50% of the cost of medications. The Summary of Benefits for the employer insurance including pharmacy benefits is required.
    - Employer Insurance does not cover ART. The Summary of Benefits or Formulary for the employer insurance indicating that ART is non-covered is required. [KH1]
- Q: Do we know how the work requirement for Medicaid will impact CAREAssist enrollment (e.g. If people don't have 80 work hours the month prior to Medicaid renewal, will restricted UPP/Bridge be available)?
    - A: CAREAssist policy is: if they are ineligible for Medicaid (based on program requirements but not for not re-certifying eligibility), CAREAssist can help determine their eligibility for other health insurance including private health insurance. Documentation of denial for OHP may be required if CAREAssist eligibility indicates they should also be eligible for OHP.
- Q: What is the rationale for possibly excluding HIV visits and labs with restricted UPP? How will people get medication if they cannot get labs or see providers?
    - A: ADAP's core mission is to provide access to medications. Everything beyond that is not required of ADAPs. Restricted UPP is for clients who have insurance available to them but choose to not enroll. Reminder - Under federal law, the RWHAP, including ADAP, is a "payer of last resort," and as such, federal funds may not be used for any item or service to the extent that payment has been made, or can reasonably be expected to be made under any State program or under an insurance policy.
- CAREAssist can't pay, but even if they could, CAREAssist's TPA vendor, PAI, does not have staff to examine claims that come through and assess which ones are labs and can be paid. Nor does CAREAssist have staff that are medically trained to interpret HICF forms to partially pay claims. This would be a long and costly change to state and vendor technology systems and staffing. Community partners are encouraged to explore financial assistance programs and other local systems that support access to health care (for all people, not just PLWH). HRSA requires

ADAP to be the payor of last resort; other resources should be used first. CAREAssist, per HRSA, encourages clients to apply for the insurance that they are eligible for.
    - If clients need labs and provider visits to access medication, but they cannot get those labs or see a provider, then they do not have access to medication.
- Financial assistance programs do not always work. Some patients still receive large bills and then stop receiving care as a result.
- Some employer plans are really expensive and some cannot accept CAREAssist.
- If funding is in jeopardy for core HIV services, perhaps we should discuss whether dental coverage should remain a priority.
    - CAREAssist encourages clients to apply for the insurance they are eligible for. Paying for dental plans does not limit the program's ability to pay for other services. Not paying for dental plans does not change HRSA's policy around covering clients that have insurance available to them and choose not to enroll. Dental services are a HRSA-approved expense. At the same time, CAREAssist is exploring ways to be more cost effective with dental benefits.
- While higher income CAREAssist clients might help provide more program income, lower income folks might be struggling the most with accessing care and medication. We have to consider the barriers they face.
- Q: If folks get kicked off of Medicaid, what is CAREAssist's role?
    - A: CAREAssist policy is if they are ineligible for Medicaid (based on program requirements but not for not re-certifying eligibility), CAREAssist can help determine their eligibility for other health insurance, including private health insurance. Documentation of denial for OHP may be required if CAREAssist eligibility indicates they should also be eligible for OHP.
- We might be entering a time when health care systems have smaller operating budgets and fewer resources to offer assistance, especially in rural Oregon. This is important to monitor. In addition to the impact on clients, how might these changes impact staff and turnover (e.g., increased workloads)?
- OHP eligibility is based on income and household status. OHP Bridge also considers citizenship status. If CAREAssist gets a denial from OHP Bridge due to citizenship status, they do not meet the program requirements and should be screened for eligibility for other health insurance.
- Q: Can CAREAssist work with state medical providers and ask them to write prescriptions for clients who providers are unable to see?
    - A: No, this is not a part of the job description of a public health physician. The state does not accept liability for public health physicians to provide direct patient care.
- Q: Does UPP cover appointments?
    - A: UPP is for individuals not currently eligible for health insurance, but will have access to health insurance during open enrollment or if they experience a QLE (Qualifying Life Event) that provides an SEP (Special

Enrollment Period). UPP covers medications on the UPP/Bridge/Restricted Formulary and limited laboratory and medical services. UPP is different from Restricted UPP. Restricted UPP is for individuals who have insurance available to them but choose not to enroll. Restricted UPP covers medications on the UPP/Bridge/Restricted Formulary.

- I lived through a "No ADAP " period. It was horrible. We are fortunate to have what CAREAssist is providing now. Granted, there will always be a few people who still face challenges accessing services.
- Q: There are some folks that are not in case management; will they be connected?
    - A: Yes, if clients are interested, CAREAssist can help with and refer them to case management.

2026 Client Experience Survey

It is time for CAREAssist to survey clients. The questions will focus on clients' CAREAssist benefits.

CAREAssist's last client survey was in 2023. It featured 27 questions (some with a sub-set of questions) and addressed a range of topics, including health and wellbeing, social support, mental health, health literacy, U=U, oral/dental health, vision, health insurance, and demographics.
Of the 400 clients who received the survey (randomly selected), 124 (31%) completed it. Results from the 2023 survey are available on the CAREAssist website.

Discussion

- When thinking of the services provided by CAREAssist, what question(s) do you feel should be asked?
    - Perhaps ask if they have a case manager. Some clients do not have one.
    - It's great to use many of the same questions to make comparisons over time.
    - "Have you heard that CAREAssist has been building a new database that will enable you to recertify online? How beneficial is this change for you?"
- Q: Are you going to ask any qualitative questions?
    - A: CAREAssist is very early in the planning process and encourages suggestions for possible qualitative questions. Please send them our way.

340B Updates

The 340B Rebate Model Pilot Program: HRSA announced on July 31, 2025 the availability of a voluntary (by drug manufacturer) 340B Rebate Model Pilot Program for drugs on the CMS Medicare Drug Price Negotiation Selected Drug List for year 2026 from qualifying manufacturers meeting specific criteria. Note - This is the first fundamental change to the program since 1992. The pilot targets ten drugs currently subject to Medicare drug price negotiations under the Inflation Reduction Act. These include some of the highest-cost

pharmaceuticals in outpatient settings: Eliquis, Jardiance, Xarelto, Januvia, Farxiga, Enbrel, Imbruvica, Stelara, Entresto, and Novolog/Fiasp.

What does this mean for covered entities? Starting in just a few weeks, select high-cost medications will no longer be eligible for upfront pricing discounts. Instead, covered entities must pay full Wholesale Acquisition Cost and wait for manufacturer rebates, potentially creating immediate cash-flow pressure that could reach millions of dollars for many organizations. Covered entities have just 45 days from the date of dispense to submit those claims through HRSA's new Beacon platform. Participating manufacturers must process rebate claims within 10 business days of submission. While currently limited to ten drugs, HRSA has explicitly indicated the model could expand based on pilot results and stakeholder feedback throughout 2026. (I do understand already that they are adding another drug in April).

Again, the shift from up-front discounts to back-end rebates creates an immediate, severe cash flow challenge that many covered entities are unprepared to handle.

CAREAssist with our PBM Ramsell's support adjudicated approximately 1,000 claims from the proposed drug list this year for CAREAssist clients. Anticipating around the same number of claims in 2026, CAREAssist unlike many other covered entities, does not anticipate a significant impact to cashflow due to the project but with the support of Ramsell, our 340B Committee, and our fiscal folks, will continue to monitor potential impacts and any additional changes to the 340B Program and Pilot Project.

CAREAssist works with the Oregon Department of Justice to correspond with manufacturers regarding the carve out (HB 2385). So far, these communications have resulted in minimal pushback.

The Role of the CAREAssist Advisory Group

The Ryan White HIV/AIDS Program legislation does not mandate an AIDS Drug Assistance Program (ADAP) advisory committee; however, the Oregon ADAP, CAREAssist, convenes an advisory group meeting quarterly. The CAREAssist Advisory Group is an open meeting composed of clinicians, pharmacists, service providers, people with HIV, representatives from other RWHAP Parts, health department staff, contractors, and other state program staff. The advisory group convenes to address needs of the ADAP, which may include program policy, benefits, utilization, quality management, and formulary. The advisory group is a venue to share informed perspectives, advice, and recommendations. It is not a decision-making body.