OREGON ADMINISTRATIVE RULES
OREGON HEALTH AUTHORITY, PUBLIC HEALTH DIVISION
CHAPTER 333

DIVISION 22

HUMAN IMMUNODEFICIENCY VIRUS

CAREAssist

333-022-1000
Purpose and Description of Program

(1) The CAREAssist program is Oregon's AIDS Drug Assistance Program (ADAP). The core purpose of CAREAssist is to ensure access to HIV-related prescription drugs to underinsured and uninsured individuals living with HIV/AIDS. CAREAssist also helps people living with HIV or AIDS pay for medical care expenses, including but not limited to medication, insurance premiums and medical services. The program is funded through Part B of the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87), which provides grants to states and territories.
(2) The Oregon Health Authority (Authority) shall make funds available for the CAREAssist program as long as it continues to receive grant funds from the federal government.
(3) If insufficient funds are available for the CAREAssist program the Authority may:
(a) Modify group benefits for approved clients; and
(b) Institute a waiting list in lieu of accepting applications.
(4) Ryan White funds may not be used for any item or service if payment has been made, or can reasonably be expected to be made by another payment source. ADAP is a last-resort payment source. As such, the Authority may require the applicant or client to enroll in the most cost-effective insurance available, as determined by the Authority. If the client or applicant refuses to enroll in health insurance that the Authority has identified as the most cost-effective plan for which he or she is eligible, the Authority shall only provide assistance with the cost of HIV antiretroviral, Hepatitis antiviral and opportunistic infection-related medications as identified in the formulary.
Stat. Auth.: ORS 413.042, 431.250, 431.830
Stats. Implemented: ORS 431.250, 431.830

333-022-1010
Definitions

(1) "AIDS" means acquired immunodeficiency syndrome.
(2) "Authority" means the CAREAssist program, administered by the Oregon Health Authority.
(3) "CAREAssist" includes benefits provided to clients under Bridge, UPP, Group 1 or Group 2 as those terms are used in OAR 333-022-1000 through 333-022-1170.
(4) "CAREAssist formulary" or "formulary" means a list of medications available to enrolled clients of CAREAssist when the same drug or a therapeutically comparable medication is not available through the client's primary health insurance.

(5) "Federal Poverty Level" or "FPL" means the annual poverty income guidelines, published by the United States Department of Health and Human Services.
(6) "Family" means all individuals counted by the Authority in determining the applicant's or client's family size.
(7) "Monthly income" means the monthly average of any and all monies received on a periodic or predictable basis, which the family relies on to meet personal needs.
(8) "Gross monthly income" means income before taxes or other withholdings.
(9) "HIV" means the human immunodeficiency virus, the causative agent of AIDS.
(10) "OHP" means the Oregon Health Plan.
(11) "Oregon residency" means that an individual:
(a) Has a physical location to reside in Oregon; and
(b) Is in Oregon at least six months out of the year; and
(c) Is not absent from Oregon more than three consecutive months; or
(d) Is living out of state for more than three months due to temporary or seasonal employment outside of Oregon; or
(e) Is living out of state for more than three months while attending an education institution full time.
(12) "Refuses" means a client or applicant actively declines enrollment in the insurance identified by the Authority.
(13) "Seasonal worker" means the applicant performs work cyclically during the year and most often the work is defined by seasons and typically defined by the calendar year.
(14) "Special enrollment period" means a time period outside of open enrollment in which a client is eligible to apply for private insurance because they experienced a qualifying event as defined by the Affordable Care Act.
(15) "UPP" means the CAREAssist Uninsured Persons Program.
Stat. Auth.: ORS 413.042, 431.250, 431.830
Stats. Implemented: ORS 431.250, 431.830

333-022-1020
Eligibility
To qualify for the CAREAssist program an individual must:
(1) Be HIV positive or have AIDS; and
(2) Reside in Oregon; and
(3) Have a monthly income based on family size which is at or below 500 percent of the FPL.
Stat. Auth.: ORS 413.042, 431.250, 431.830
Stats. Implemented: ORS 431.250, 431.830

333-022-1030
Application Process
(1) An individual may apply for CAREAssist benefits by completing a form prescribed by the Authority and providing the documentation as instructed in the application so that the Authority can verify that the applicant:
(a) Has tested positive for HIV or has AIDS; and
(b) Has a monthly income based on family size at or below 500 percent of the FPL; and
(c) Is a resident of Oregon.

(2) An applicant must sign an authorization that permits the Authority to contact and exchange information with the applicant's health care providers, insurers, and any other individual or entity necessary to determine the applicant's eligibility for CAREAssist, process payments and facilitate care coordination for the client.
Stat. Auth.: ORS 413.042, 431.250, 431.830
Stats. Implemented: ORS 431.250, 431.830

333-022-1050
Approval or Denial of Application
(1) If the Authority determines that an applicant is eligible for CAREAssist benefits the applicant shall be notified in writing within 14 calendar days of the Authority's determination and be assigned to a benefit group as follows:
(a) Group 1: Clients who are enrolled in a private, group or individual insurance policy.
(b) Group 2: Clients whose primary prescription benefits are provided by OHP or the Department of Veterans Affairs (VA).
(2) A client's notification must describe:
(a) The eligibility effective date and end date;
(b) Group number and benefits associated with that group;
(c) A list of CAREAssist in-network pharmacies;
(d) Recertification date and process; and
(e) The repercussions of not recertifying.
(3) CAREAssist eligibility is for six months.
(4) If the Authority determines that an applicant is not eligible for CAREAssist benefits an applicant shall be notified in writing in accordance with ORS 183.415.
(5) An applicant who has been denied may reapply at any time.
Stat. Auth.: ORS 413.042, 431.250, 431.830
Stats. Implemented: ORS 431.250, 431.830

333-022-1080
Payments and Cost Coverage
(1) The Authority may only make insurance premium payments directly to the insurance carrier or benefits administrator. No direct payments may be made to a client.
(2) When no other payer for health coverage (public assistance or private) is available, CAREAssist may pay insurance premiums for a limited time for a client's insurance plan that covers his or her family members if the monthly premium cannot by divided, until the Authority determines that the client's family members can obtain their own policies.
(3) The Authority may not use CAREAssist funds to pay for any administrative costs, which are in addition to the premium payment.
(4) Authority payments for prescriptions follow the health insurance pharmacy benefits defined within the policy and may not pay for the cost to dispense a brand-name drug when a generic equivalent is the preferred option of the health insurance.
(5) The Authority shall only cover the costs of medications that are covered by the client's health insurance or those specifically listed on the CAREAssist formulary as additional benefits to the client, and prior to any payments being made by the Authority must receive a determination by the prescriber that no acceptable therapeutic equivalent is available through the primary insurance.

(6) The Authority may only pay for HIV medications or a combination of HIV drugs as approved in the federal Department of Health and Human Services (DHHS) Treatment Guidelines, which can be found at http://aidsinfo.nih.gov/guidelines.
(a) The CAREAssist Pharmacy Benefits Manager (PBM) clinical pharmacist team (team) assesses each client's medication regimen to ensure that it conforms to current DHHS guidelines. In the event that a treatment recommendation or guideline is not followed, the clinical pharmacist at the PBM shall notify the Authority that payment may not be made until the prescriber submits a prior authorization form to the PBM's clinical pharmacist.
(b) The Authority may deny payment for medications that are determined to be clinically inappropriate pursuant to the DHHS Treatment Guidelines.
(7) Medical Services.
(a) The Authority shall identify and inform clients of an amount to be provided within the calendar year for medical service copays and deductible. The annual financial amount shall be posted on the CAREAssist website at the beginning of each calendar year. All costs exceeding the published amount are the client's responsibility.
(b) The Authority may pay for a client's out-of-pocket medical service expense for an insurance-covered medical service or durable medical equipment, up to an annual maximum amount. The client's primary insurance must cover the service or device before CAREAssist assumes any financial cost unless the client is pre-approved for limited full-cost coverage under UPP or Bridge, as allowed under OARs 333-022-1140 and 333-022-1145.
(8) When the Authority acts as primary payer:
(a) Reimbursement to providers shall be 125 percent of the current Oregon Medicaid Fee for Service rate for the allowable Current Procedural Terminology (CPT) Code unless the provider bills for less. A list of allowable CPT Codes is posted on the CAREAssist website.
(b) Payments made by the Authority on behalf of clients must be accepted by the provider as payment in-full. Balance billing is prohibited.
(9) Clients who receive refunds for services paid by the Authority on the client's behalf must reimburse the program or develop a repayment plan within 60-days of receiving the refund. This includes but is not limited to refunds issued by pharmacies, medical providers, insurance carriers and the Internal Revenue Service.
Stat. Auth.: ORS 413.042, 431.250, 431.830
Stats. Implemented: ORS 431.250, 431.830

333-022-1090
Client Eligibility Review
(1) The Authority must verify a client's eligibility every six months, but may conduct an eligibility review at any time and as many times as necessary within an eligibility period.
(2) The Authority must provide CAREAssist clients with a Client Eligibility Review (CER) form and instructions within 60 days of the expiration of their current eligibility period.
(3) A client must submit the CER and any other required documentation within the timeframe established by the Authority in the instructions. A deadline for submitting the CER or requested documentation may be extended at the discretion of the Authority.

(4) The Authority shall review a client's application and supporting documentation and verify the information in accordance with OAR 333-022-1040.
(5) The Authority must notify a client in writing whether his or her benefits continue and whether there are any changes. Notification shall include the effective date for the client's new enrollment status. If a client is not found eligible for continued benefits the client shall have a right to a hearing in accordance with ORS 183.415.
(6) A CAREAssist client who fails to submit the required renewal documents by the requested deadline shall be placed on a restricted status in accordance with OAR 333-022-1120. If the Authority has not received a complete CER at the end of three months, the client is no longer eligible to receive benefits. The Authority must inform the client that he or she is no longer eligible for benefits because the required information was not submitted, eligibility could not be verified and explain that benefits shall end effective the first day of the following month. An individual may reapply for benefits at any time under OAR 333-022-1030.
Stat. Auth.: ORS 413.042, 431.250, 431.830
Stats. Implemented: ORS 431.250, 431.830

333-022-1120
Restricted Status
(1) The Authority may place a client on restriction if the client fails to return a complete Client Eligibility Review (CER) by the requested deadline.
(2) The effective date and duration of the restriction shall be as follows:
(a) Restriction takes effect on the first day of the client's new eligibility period.
(b) The restricted period shall not exceed three consecutive months. If the Authority has not received a complete CER at the end of three months, the client is no longer eligible for benefits and the client will be notified in accordance with OAR 333-022-1090.
(3) Ending restriction:
(a) Six full months of unrestricted benefits shall be approved if the Authority receives a complete CER before the end of the restricted period and determines the client eligible.
(b) The effective date for full benefits shall be the date of receipt of the complete CER.
(4)The Authority shall notify a client of the restricted status. The notice must comply with ORS 183.415 and explain:
(a) How long the restriction is in effect;
(b) How the client can come into compliance and have the restriction lifted; and
(c) The consequences of not coming into compliance within the specified time period.
(5) If a client is placed on restricted status the Authority may only provide the following benefits to the client:
(a) Payment of insurance premiums; and
(b) Payment of medications that treat HIV, viral hepatitis and opportunistic infections, as those are described in the CAREAssist restricted formulary, available on the CAREAssist website.
(6) Restricted clients are ineligible for assistance with the cost of:
(a) Prescriptions not listed on the Restricted Formulary; and
(b) All medical services, even when that service continues to be paid by the client's primary insurance.
(7) Restricted clients are required to recertify, as indicated in OAR 333-022-1090.

Stat. Auth.: ORS 413.042, 431.250, 431.830
Stats. Implemented: ORS 431.250, 431.830

333-022-1140
Bridge Program
(1) The Bridge Program provides limited benefits to an individual whose medical provider has applied for the program on the patient's behalf. The program provides payment for basic services and medications for an individual who is in the process of applying for CAREAssist and insurance.
(2) Bridge Program eligibility. In order to be eligible for the Bridge Program an individual must:
(a) Be HIV positive or have AIDS;
(b) Reside in Oregon;
(c) Have income at or below 500 percent of the FPL;
(d) Be in the process of applying for long-term medication assistance programs such as Medicaid, Medicare, or applying to CAREAssist; and
(e) Have not previously received Bridge Program benefits or have not been terminated from the CAREAssist program within the past 365 days.
(3) To apply for Bridge Program benefits a patient's medical provider must, on behalf of the patient, submit a form prescribed by the Authority and sign the form attesting that the individual is HIV positive or has AIDS. If the health care provider is licensed outside of Oregon, the Authority may request a copy of the applicant's most current laboratory results.
(4) The Authority must notify an applicant whether the patient's application has been approved or denied, in accordance with ORS 183.415.
(5) An individual enrolled in the Bridge Program is not guaranteed to be determined eligible for CAREAssist benefits.
(6) The Bridge Program benefits include:
(a) Assistance with the cost of a 30-day supply of prescription drugs listed on the CAREAssist formulary and designated as available to Bridge Program participants, only if dispensed by a CAREAssist contract in-network pharmacy.
(b) Payment of the costs of medical services and laboratory tests as defined by the list of approved Current Procedural Terminology (CPT) codes noted on the Bridge Program instructions and application forms.
(7) The Authority may only pay for an individual's medical visits or laboratory tests for dates of service that are on or after the individual's enrollment in the Bridge Program.
(8) Individuals enrolled in the Bridge Program must actively participate with an assigned CAREAssist caseworker to assure progress toward a sustainable means of medication access. Failure to do so may result in cancellation of enrollment. At a minimum, the client is expected to submit a full application for ongoing assistance with CAREAssist within the 30 days of Bridge Program enrollment.
(9) The Bridge Program is not available to an individual who has primary health insurance coverage.
Stat. Auth.: ORS 413.042, 431.250, 431.830

Stats. Implemented: ORS 431.250, 431.830

333-022-1145
Uninsured Persons Program
(1) The Uninsured Persons Program (UPP) provides full-cost coverage for a limited number of medications and medical services for clients who are ineligible for insurance.
(2) In order to be eligible for UPP an individual must:
(a) Meet all eligibility requirements outlined in OAR 333-022-1020; and
(b) Be ineligible for public and private insurance that meets minimum essential coverage under the federal Affordable Care Act, Public Law 111 - 148; and
(c) Be enrolled in Ryan White community-based HIV Case Management Services.
(3) To apply for UPP an individual must comply with OAR 333-022-1030 and an application shall be reviewed by the Authority in accordance with OAR 333-022-1040, as applicable.
(4) If the Authority determines that an applicant is eligible for CAREAssist benefits the applicant shall be notified in writing within 10 business days of the Authority's determination. A client's notification must describe:
(a) The eligibility effective date and end date;
(b) Group number and benefits associated with that group;
(c) A list of CAREAssist in-network pharmacies;
(d) Recertification date and process; and
(e) The repercussions of not recertifying.
(5) UPP eligibility is for six months.
(6) If the Authority determines that an applicant is not eligible for UPP benefits an applicant will be notified in writing in accordance with ORS 183.415.
(7) An applicant who is denied may reapply at any time.
(8) UPP benefits include:
(a) Assistance with the cost of prescription drugs listed on the CAREAssist formulary, when dispensed by a CAREAssist contract in-network pharmacy;
(b) Full-cost laboratory and medical visits performed in an out-patient setting. Coverage is limited to allowable CPT codes, as designated by the program. The program may cover the cost of each allowable CPT code up to four times a year. Any additional coverage requires prior authorization initiated by the client's prescribing physician.
(c) Medication therapy management; and
(d) Tobacco cessation services.
(9) An UPP client must notify the Authority immediately if he or she becomes eligible for insurance or obtains insurance.
Stat. Auth.: ORS 413.042, 431.250, 431.830
Stats. Implemented: ORS 431.250, 431.830

333-022-1147
Dental Benefits
(1) The CAREAssist Dental Program provides assistance with out-of-pocket dental expenses related to a specific dental plan or plans identified by the Authority.

(2) Clients are eligible for the CAREAssist Dental Program as long as their primary prescription coverage is not provided by the Oregon Health Plan at the time of application.
(3) The Dental Program provides assistance with the cost of:
(a) The monthly premium on a dental plan identified by the Authority, paid directly to the insurance carrier or benefits administrator.
(b) Out-of-pocket dental expenses for services approved by the identified plan. The plan must cover a portion of the specific procedure before CAREAssist assumes any financial cost.
(4) The Dental Program cannot provide assistance with the cost of:
(a) Out-of-pocket dental expenses related to any dental plan other than the plan or plans specified by the Authority.
(b) Dental services for which the CAREAssist-sponsored dental plan will not pay, either because the service is disallowed or the client has maximized the annual dental benefit, as determined by the dental plan administrator.
Stat. Auth.: ORS 413.042, 431.250, 431.830
Stats. Implemented: ORS 431.250, 431.830