LA HAP 2.0: the Sequel!

This webinar will cover…

- Maximizing HIP benefits
- Maximizing LDAP benefits
- Serving special populations
- Client rights and responsibilities

Why is LA HAP so complicated?

Typical ADAP model pre-ACA

- One-page formulary (HIV medications only)
- Single, central pharmacy

LA HAP model today

- Comprehensive medical, dental, vision benefits
  - HIP pays premiums to over 250 distinct insurance plans and employers
- Network of almost 600 pharmacies
- Over 3,100 HIP clients have access to an open network of over 30,000 potential providers
  - Over 350 individual providers bill HIP each month

Maximizing HIP benefits

Utilizing HIP

What can clients do?

- Inform a provider's office about HIP BEFORE visit
- Report any difficulties to HIP staff
- Bring a copy of the HIP Provider Packet to the visit
- Remember that even if they have to incur a copay, other bills can be sent to HIP

The phrase "**secondary payer**" is your friend!

What can providers do?

- Make sure front desk staff are familiar with HIP and their billing procedures
- If you have specialists to whom you commonly refer patients, ensure they are familiar with and agree to work with HIP

What can HIP do?

- Call a provider on a client's behalf to explain HIP
- Send the Provider Packet or other details to provider if requested
- Name providers in a client's area who have worked with HIP

HIP and LA HAP communicate with providers as often as possible and are happy to assist clients; however, LA HAP members are ultimately responsible for managing their own care.

Vision coverage

Vision coverage (like dental coverage) is not regulated by the Affordable Care Act, so out-of-pocket costs for clients may apply

- As with health insurance, HIP shares cost with the insurer via deductibles, copays, coinsurance
- HIP CANNOT cover anything in excess of maximum dollar amounts set by the insurer

EXAMPLE: Client visits in-network provider for annual exam, purchases bifocal lenses and $150 frames

- HIP pays: $15 exam co-pay + $20 materials co-pay (if any) + $120 maximum on frames = $155
- Client pays: Difference between $150 frames and $120 maximum = $30

SERVICES (IN-NETWORK)		OUT-OF-NETWORK ALLOWANCE
Co-Pays Exam (Once per 12 months) Materials	 $15 $20	 Up to $35 See below
Standard Plastic Lenses (Once per 12 months)		
Single Vision Bifocal Trifocal Lenticular Progressive	Covered by Co-pay Covered by Co-pay Covered by Co-pay $80 Allowance $70 Allowance	Up to $25 Up to $40 Up to $50 Up to $50 Up to $40
Frames (Once per 12 months) Choose any frame available at provider locations	$120 retail frame	Up to $50
Contact Lenses (Once per 12 months) (Includes fit, follow-up and materials) In lieu of eyeglass lenses & frames • Elective • Medically necessary	$20 co-pay Up to $120 retail Up to $210 retail	 Up to $100 retail Up to $210 retail

Sample Summary of Benefits

Dental coverage

Service Type	Guardian	Other types of coverage
Premium	$7.10 monthly	Client portion of premium
Deductible	n/a- $0	Insurer-imposed deductible
Copay/coinsurance	n/a- $0/0%	Insurer-imposed cost-share
Covered service, inside waiting period	n/a- no waiting period	Not covered
Covered service, received out-of-network	Covered up to 95th percentile of usual, customary and reasonable (UCR) charges for area	Not covered (but insurer may choose to cover much of the cost)
Covered service, above annual max	Not covered (annual max set at $5,000)	Covered at insurer's negotiated rate up to $5,000
Covered service, above service limit	Not covered (generous service limits)	Covered at insurer's negotiated rate up to $5,000
Non-covered service	Not covered	Not covered

Billing HIP

- Claims must be submitted within 180 days of when the primary insurer paid
  - Provider, client, or assister may submit claim
- An Explanation of Benefits must be included
  - If not available, submit any correspondence/bill/etc. that clearly shows the amount that the insurance company has paid
- What can't be billed:
  - Full cost of services excluded from insurer's Schedule of Benefits
  - Costs associated with an inpatient hospital stay

These are decisions made at the federal level; LA HAP does not have control over these policies.

Provider Resources

- https://www.lahap.org/provider-resources
- Medical, Dental versions of Provider Packet
- Please print! Please use! Please provide feedback on use!

Louisiana Health Access Program

Welcome to the
Louisiana Health Access Program

Home | Apply for LA HAP | Using your Benefits | Provider Resources | Contact

Resources for Medical/Dental Providers

The Louisiana Health Access Program is administered by the Louisiana Office of Public Health. It acts as a **secondary payer** for insured Louisiana residents who meet specified financial and medical criteria.

LA HAP subcontracts with a Baton Rouge-based social services organization called HAART to review and pay claims for clients through the Health Insurance Program (HIP).

Member enrollment and eligibility can be verified by calling LA HAP at 504-568-7474. Claims status and payment authorizations can be verified by calling HIP at 225-424-1799.

Medical, dental and vision claims can be sent via fax to:
225-927-1267

Or mailed to:
Attn: Health Insurance Program
PO Box 66913
Baton Rouge, LA 70896

HIP maintains an **open provider network**-- they accept claims from any medical, dental or vision provider who bills HIP on behalf of their members. The member's primary insurer should be billed first for services. With the exception of costs associated with an inpatient hospital stay, which is outside HIP's scope of coverage, **any co-pay, coinsurance, or deductible may be billed to HIP**. Please be advised that HIP cannot reimburse its members for any payments they make directly to providers. If you have questions related to the HIP billing process or require payment upfront before rendering services, please contact the Health Insurance Program at 225-424-1799.

LA HAP
Enrollment Card

Member Name: JOHN DOE
Identification No: 12345678900
SAMPLE
Rx BIN: 004519
Rx PCN: LA01AP
Group No: 12345
Card Expiration Date : MM/DD/YYYY

Approved Services
Vision Premiums
Vision Copays Deductibles
Health Premiums
Health Copays Deductibles
Drug Copays Deductibles
Dental Premiums
Dental Copays Deductibles

Members are encouraged to present their LA HAP card at the time of their appointment along with their primary insurance card.

For more information, please refer to:

HIP Medical Provider Packet
HIP Dental Provider Packet

Maximizing LDAP benefits

LA HAP Pharmacy limitations

Uninsured	Insured
13 fills per year	Follows primary insurer policy
Lost fill: up to 30-day supply	
Vacation fill: up to 30-day supply	
Retail: Max 30 day supply per month	
Mail order: Max 30 day supply per month	Follows primary up to 90 days

Medication access (1)

- Ask: what is the exact error message preventing the fill?
- Ask: who is denying the claim: the insurer, LA HAP, or the pharmacy?
  - This will help you follow up with the appropriate entity
- Obtain contact information of specific pharmacist in case LA HAP/Ramsell need to follow up

Medication access (2)

Reason for denial	Resolution
Non-formulary	Contact physician to request script for covered medicine. If physician finds no suitable substitute, **consider filing an appeal to insurer.**
Step Therapy restriction	Contact physician to check status of PA. If still denied, **consider filing an appeal to insurer.**
Pharmacy is out of LA HAP and/or insurer network	Contact LA HAP or insurer (whichever is appropriate) or visit website to locate alternate pharmacy.

Medication access (3)

Reason for denial	Resolution
Maximum fills per year reached	Ask pharmacist about appropriate fill date.
Filling too early	Ask pharmacist about appropriate fill date; if needed for vacation fill/to replace lost fill, contact LA HAP or Ramsell to override.
Contraindicated regimen or duplicate ingredient	Contact LA HAP or Ramsell to request override.
LA HAP eligibility has lapsed	If LA HAP is active, ensure claim date is within eligibility period. If LA HAP is expired, recertify!

Serving special populations

Special populations: non-citizen (1)

- Regardless of insurance status, non-citizen clients should complete or attempt to complete a Medicaid application if their income is 138% FPL or below as they may be eligible for benefits depending on their citizenship status
  - **However,** LAHAP will not require any undocumented client to apply for Medicaid if they do not feel comfortable applying for federal assistance due to their citizenship status

Special populations: non-citizen (2)

- If a note is included on a LAHAP application that client will not qualify for Medicaid based on citizenship status, that is sufficient confirmation that the client won't qualify and LAHAP wouldn't require that client to apply for Medicaid
  - LAHAP does not determine eligibility based on citizenship status but on Medicaid eligibility
  - If confirmed that client doesn't qualify for Medicaid based on citizenship status, the client's income can be anywhere between 0-500% FPL to be eligible for LAHAP
  - If a LAHAP application notes that a client is not a US citizen but mentions nothing about their Medicaid eligibility and their income qualifies them for Medicaid, the LAHAP application may be denied

Special populations: justice-involved

- There are some exceptions to LAHAP's Medicaid eligibility policies for clients who are either in or recently exited the correctional system:
  - Clients who have recently exited the correctional system can apply for temporary LAHAP benefits while their Medicaid application is processed. LAHAP should be notified by client or Case Manager when Medicaid is approved. If Medicaid is denied, denial should be forwarded for LAHAP for further review.
  - Clients in Transitional Work Programs, Pre-Trial detainees, and some halfway houses are not eligible for Medicaid. These clients can apply for LAHAP assistance. Clients in TWP's will be approved on the regular 12 month approval intervals (or release date if earlier). Pre-trial detainees will be extended month to month if they haven't been transferred to a facility that will provide medications.
  - Clients that are incarcerated in a parish facility that is unable to provide medications can apply for LAHAP assistance.
    - If you have questions about whether a client is incarcerated in a state or parish facility please contact Office of Public Health Corrections staff at 225-342-2120

Special populations: Medicaid-eligible (1)

Refers to clients who have been denied for LA HAP based on Medicaid eligibility

- After Medicaid expansion, LA HAP adopted the policy that all clients who are deemed Medicaid eligible will be disenrolled at the time their LA HAP application is reviewed
- However, we do realize that Medicaid applications take time to process by Medicaid staff so LA HAP created an appeals process

Special populations: Medicaid-eligible (2)

- If a client's LA HAP application is denied due to Medicaid eligibility but the client is in need of LA HAP assistance, the client or Case Manager can call LA HAP staff to appeal the denial
  - Requirements for appeal process: reason for appeal, Medicaid application submission date
  - Appeal will not be approved until **after** client has applied for Medicaid
- After required information is provided the LA HAP application will be provisionally approved (with shortened eligibility period) by the CSS Supervisor
  - Client or CM **must** follow up with LAHAP staff when Medicaid is approved
  - If client's Medicaid application is denied, Medicaid denial letter must be forwarded to LA HAP for further review

Special populations: Medicaid "churn" (1)

Refers to clients whose Medicaid is terminating in the future and will need LAHAP assistance after Medicaid termination date

- Clients needing assistance with a future insurance plan after Medicaid terminates:
  - Submit a LAHAP application with no assistance requested (note that client currently has Medicaid and provide Medicaid termination letter) **AND** an insurance add/change form requesting assistance with the future insurance plan
    - If premium assistance is requested: the application and insurance add/change form will be processed together when received complete. The client will be approved for premium assistance ONLY until Medicaid termination date. After Medicaid terminates the clients profile will be 'churned' and approved for all assistance requested.
    - If no premium assistance is requested: the application and add/change form will be processed together the first business day after Medicaid termination date.

Special populations: Medicaid "churn" (2)

- For clients needing uninsured medication assistance only after Medicaid terminates:

  Submit a LAHAP application requesting assistance with uninsured medication only and the Medicaid termination letter. The application will be reviewed and approved after Medicaid terminates.

As always, detailed notes about clients insurance situation are helpful so if you have a client in either of these situations please notate this on the application.

- Example: "Client's Medicaid is terminating 8/31/22. Planning to enroll in a marketplace insurance plan beginning 10/1/22. Will send add/change form once insurance information is received, for the mean time client will need uninsured medication assistance after Medicaid terminates."

Insurance Add/Change Forms (1)

- **Policy start date:**
  - If left blank it is difficult and sometimes impossible to tell if the plan is already active or if the plan will become active in the future
  - Often clients with group insurance may not remember the exact policy start date due to being in the policy for a long time. In this case it is acceptable to use the date the policy renewed or amended
    - *Example: a client states they've been in a policy for the last 10 years but states it renewed or amended in 2022. A policy start date of 1/1/22 is acceptable.*
- **Street address of insurance company, employer, or third party administrator:**
  - These fields indicate where a premium payment should be sent. This information should absolutely be provided whenever premium assistance is being requested. HIP needs this information to ensure the premium payment is being sent to the correct address. If no address or an incorrect address is provided the premium payment HIP may not be able to issue a payment. **Client can obtain this information by calling their insurance company.**

Insurance Add/Change Forms (2)

- **Next payment due date:**
  - This field is often left blank when submitted but is very important. LAHAP & HIP staff need to know when the next premium payment is due.
    - Example: if other funds (such as client payments, HIA, or other agency funds) were used to pay previous months premiums LAHAP needs to know that information. Please include as much detail as possible on fax cover sheet if applicable and provide a correct 'next payment due date' to ensure payments are made correctly

Is your client switching insurance plans? Make sure they have taken all necessary steps to cancel their old policy! HIP CANNOT cancel a policy on a client's behalf.

Client Rights & Responsibilities

LA HAP Client Rights

All LA HAP clients have the right to:

- Have their personal records kept confidential. Records will not be released to a 3rd party without client consent except when required by law.
- Revoke at any time their consent to have their information shared with particular entities.
- Be treated in a courteous and respectful manner and to have any questions answered in a clear and accessible manner.
- File a grievance with LA HAP without fear of retribution, harassment, or loss of eligible services.

These rights can be found in the LA HAP Policy & Procedure Manual at www.lahap.org

LA HAP Client Responsibilities

All LA HAP clients have the responsibility to:

- Provide truthful information to LA HAP when applying for services or upon request regarding personal information, income, and existing insurance coverage.
- Inform LA HAP of any change in their personal information which is relevant to their LA HAP services, such as premium rate increases, new contact information, or a change in insurance status.
- Return to LA HAP any refund received from the insurer, the IRS or another source for services for which LA HAP originally paid, such as a premium tax credit overpayment or insurer refund.
- To the best of their ability, be proactive about learning how LA HAP coverage works with their existing health insurance coverage.

These responsibilities can be found in the LA HAP Policy & Procedure Manual at www.lahap.org

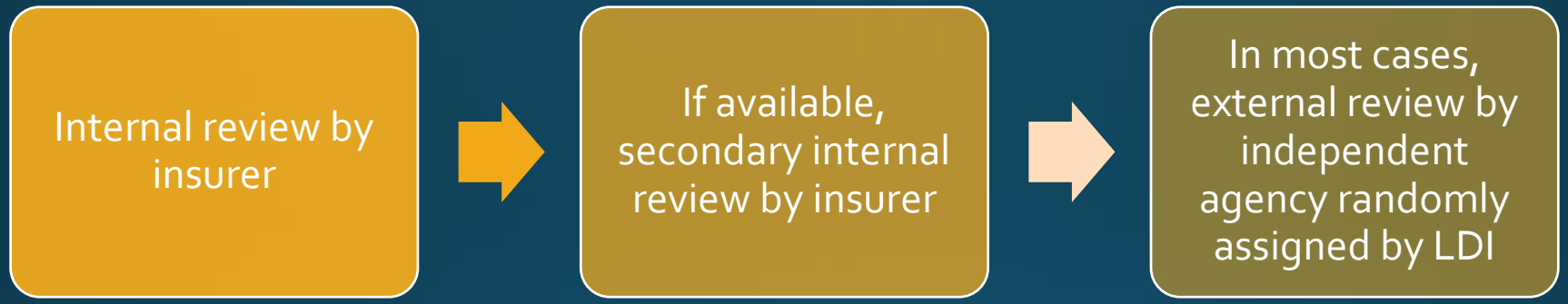
Complaints, Grievances, Appeals (1)

Complaint	Grievance	Appeal
An oral expression of dissatisfaction with us or provider services. A quality of care concern addresses the appropriateness of care given to you. A quality of service concern addresses our services, access, availability or attitude of our network providers.	*A written expression of dissatisfaction with us or provider services. If you do not feel your complaint was adequately resolved over the phone or you wish to file a formal grievance, you must submit this in writing. If necessary, our Customer Service Department will assist you.*	*An appeal is a written request to change a prior decision that we have made. Examples of issues that qualify as appeals include denied authorizations, denied claims, and medical necessity determinations.*

Definitions vary by insurer; these definitions come from BCBSLA.

BCBSLA Appeal Request Form located here

Complaints, Grievances, Appeals (2)



Medicare (A&B) has its own 5-stage appeals process: Medicare appeal → independent appeal → Office of Medicare Hearings and Appeals → Medicare Appeals Council → Federal District Court

- Parts C and D appeals follow same basic procedure as other private plans: internal review → external review

For assistance filing Medicare appeals, contact the local Senior Health Insurance Information Program

Complaints, Grievances, Appeals (3)

- **Tips for successful appeals:**
  - Informal appeals can often preface formalized ones (e.g. in the case of administrative errors)
  - Proceed slowly: quality is better than speed
  - Save all correspondence from the insurance company related to denials, as this will include instructions for next steps in the appeal process
  - Stay optimistic
    - Pre-ACA, between 39-50% of formal internal reviews successfully resulted in a decision reversal. Approximately 40% of external appeals were successful.
    - ACA strengthened and standardized the insurance appeals processes (no recent data on effectiveness are available)

If an insurer denies a claim and no one files an appeal, how will anything every change?

Mark your calendars!

- Open Enrollment coming soon!
  - Medicare Parts C & D: **October 15th- December 7th**
  - Marketplace: **November 1st- January 15th**

Questions?

Erin.Jensen@la.gov; 504-568-3623

Tranisha.Walker@la.gov ; 504-877-3790

lahap@la.gov ; 504-568-7474