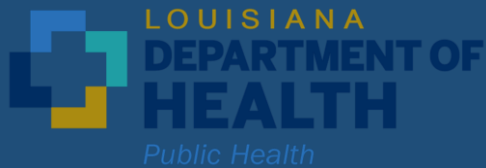




LOUISIANA HEALTH ACCESS PROGRAM POLICY & PROCEDURE MANUAL

Revised 5/4/18



STD/HIV PROGRAM
1450 POYDRAS ST SUITE 2136
NEW ORLEANS, LA 70112

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1. HRSA & Legislative Guidelines for State AIDS Drug Assistance Programs

1.1. Use of Funds

The Louisiana Health Access Program (LA HAP) receives its funding under Part B of the Ryan White HIV/AIDS Program (RWHAP), administered at the federal level by the Health Resources and Services Administration (HRSA). Per the current legislation, “A State shall use a portion of the amounts provided under a grant awarded under section 2611 to establish a program under section 2612(b)(3)(B) to provide therapeutics to treat HIV/AIDS or prevent the serious deterioration of health arising from HIV/AIDS in eligible individuals, including measures for the prevention and treatment of opportunistic infections.” In essence, the program exists to provide assistance for the purchase of medications for HIV and related opportunistic infections, hence each Part B-funded medication program is known as an “AIDS Drug Assistance Program (ADAP)”. Each state ADAP also has the option to assist with the costs of insurance coverage for its clients. Louisiana is one of the states that has opted to cover insurance costs.

A defining feature of an ADAP is its role as a payer of last resort. From Policy Clarification Notice 13-03: “Grantees must assure that funded service providers make reasonable efforts to secure non-RWHAP funds whenever possible for services to individual clients. Grantees and their contractors are expected to vigorously pursue enrollment into health care coverage for which their clients may be eligible (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or other private health insurance) to extend finite RWHAP grant resources to new clients and/or needed services.”

Although LA HAP sets much of its own policy on scope of coverage, HRSA also places several distinct limitations on how funds can be used:

For uninsured, medication-only clients:

- Each state must maintain a formulary which includes, at a minimum, the list of classes of core antiretroviral therapeutics established by the DHS Secretary
- An ADAP formulary must include at least one drug from each class of HIV antiretroviral medications
- RWHAP funds may only be used to purchase medications approved by the FDA and the devices needed to administer them
- An ADAP formulary must be consistent with the most recent Adolescent and Adult HIV/AIDS Treatment Guidelines published by the Department of Health and Human Services
- All therapeutic treatment and ancillary devices included on the ADAP formulary and all ADAP-funded services must be equally and consistently available to all eligible enrolled individuals throughout the State/Territory

For insured clients:

A state ADAP must:

- ensure they are buying health insurance that at a minimum, includes at least one drug in each class of core antiretroviral therapeutics from the HHS Clinical Guidelines for the Treatment of HIV/AIDS as well as appropriate primary care services; and
- assess and compare the aggregate cost of paying for the health insurance option versus paying for the full cost for medications and other appropriate primary care services.

HRSA funds may not in any circumstances be used to pay the following:

- The Individual Shared Responsibility payment (fee for not having health insurance, per the Patient Protection and Affordable Care Act)
- Late-enrollment penalty for Medicare Part D plans

1.2. Client Eligibility

Per the legislation, to be eligible to be served by the ADAP and individual must:

- 1) have a medical diagnosis of HIV/AIDS; and
- 2) be a low-income individual as defined by the state.

Accordingly, the ADAP is required to collect proof of an applicant's HIV positivity (whether provided directly by the applicant or by another source), and to determine the applicant's financial eligibility for the program.

Every ADAP must determine initial eligibility for new clients and conduct 6-month recertification for all enrolled clients.

Clients may NOT receive presumptive eligibility: that is, an applicant may not receive any ADAP services until they have successfully completed the certification process.

Similarly, grace periods are not allowed: if a client fails to recertify by the 6-month deadline for their eligibility, they may not continue to receive ADAP services until their recertification is complete.

2. LA HAP Structure

2.1. Program Eligibility

LA HAP is available to applicants who:

- Are HIV positive
- Live in Louisiana
- Have an income below 400% of the Federal Poverty Guideline (FPL)
- Do not have full Medicaid benefits nor are eligible for full Medicaid

LA HAP does not accept applicants who are eligible for Medicaid benefits because Medicaid is considered comprehensive coverage and LA HAP is federally mandated to be a payor of last resort. On July 1st 2016, Medicaid was expanded in Louisiana and became available to Louisiana residents fitting all of the following criteria:

- U.S. citizen or lawful permanent resident of 5 years
- Between the ages of 19-64
- Not receiving Medicare
- Income at or below 138% FPL

There are three exceptions to this policy for applicants who meet the criteria for Medicaid eligibility:

- If an individual reports income to LA HAP that places them between 0-138% FPL but they can provide a letter that proves they applied for Medicaid and were denied within the past 6 months, they can receive LA HAP services. This situation usually arises from a discrepancy between what income information has been provided to LA HAP and what has been provided or is available to Medicaid. As Medicaid has access to third party income verification systems, LA HAP generally defers to Medicaid data when there is a discrepancy in reported income.
- If an individual is a pre-trial detainee or a recently incarcerated person in a work release program, they may only utilize their Medicaid benefits for inpatient care or services. Therefore, a client who is determined to be in this situation is eligible for LA HAP services.
- If an individual is co-infected with HIV and Hepatitis C, has full Medicaid, they may be eligible for LA HAP assistance with the purchase of Hepatitis C medications only. In some instances they will be required to submit documentation from their Medicaid managed care provider demonstrating they been denied coverage of Hepatitis C treatment by Medicaid in the past 6 months.

2.2. Income Eligibility

LA HAP assesses income based on household [Modified Adjusted Gross Income \(MAGI\)](#). MAGI is equivalent to one's Adjusted Gross Income with certain forms of income added back. LA HAP aligns with Medicaid rules for counting MAGI, meaning that additional forms of income are further excluded. MAGI is a tax-based calculation, but applicants do not need to file taxes in order to be eligible for LA HAP. However, they must follow

MAGI-based income and household calculation rules as directed on the LA HAP application.

The definition and composition of household under MAGI rules is as follows:

	Tax filer	Tax dependent	Non-filer
Definition	Files taxes as single, married/jointly, or married/separately/head of household	Is claimed on someone else's taxes	Doesn't file taxes, or is tax dependent who meets one of 3 exceptions*
Household composition- Clients 19 and older	Client, spouse if living w/client, any dependents claimed by client	Client, spouse if living w/client, tax filer who claims client, tax filer's spouse, any other tax dependents of filer	Client, spouse if living w/client, (step)children aged 18 or younger
Household composition- Clients 18 and younger			Client, spouse if living w/client, (step)parents, (step)siblings aged 18 or younger, (step)children aged 18 or younger

- *1) Client is claimed as a dependent by someone other than (step)parent or spouse
- 2) Client is under age 19 and claimed as a dependent by a non-custodial parent
- 3) Client is under age 19 and living with two (step)parents who do not expect to file joint tax return

The definition of household income under MAGI (per Medicaid rules) includes the following forms of income:

- | | |
|---|--|
| <ul style="list-style-type: none"> • Salary/Wages/Commission/Tips • Self-Employment Income • Any foreign earnings • Interest (including both taxable and non-taxable) • Unemployment benefits • Pension/annuity/IRA distributions (taxable amount only) • Social Security (Retirement/Survivor's/Disability) (including non-taxable part of benefits) • Retirement accounts | <ul style="list-style-type: none"> • Alimony received • Net farming/fishing • Net rental/royalty • Net capital gain • Scholarships/grants (only count as income if used for living expenses, not tuition and fees) • Business income/capital gain • Rental real estate, royalties, partnerships, S corporations, trusts • Taxable refunds, credits, or offsets of state and local income taxes |
|---|--|

The following forms of income are excluded:

- | | |
|--|--|
| <ul style="list-style-type: none"> • Certain self-employed expenses • Student loan interest • IRA deduction (traditional IRAs) • Moving expenses | <ul style="list-style-type: none"> • Penalty on early withdrawal of savings • Health savings account deduction |
|--|--|

- Alimony paid
- Domestic production activities deduction
- Certain business expenses of reservists, performing artists, and fee-basis government officials
- Scholarships/grants (only the portion used for tuition/fees can be deducted, not living expenses)
- Certain American Indian and Alaska Native income derived from distributions, payments, ownership interests, real property usage rights and student financial assistance

Income is assessed on behalf of the entire household, with one exception. Income is NOT included for children (age 18 and younger) in the household of a parent, or for a tax dependent in the household of the tax filer, if the income of the child or dependent meets the tax filing threshold and the child or dependent is required to file a tax return.

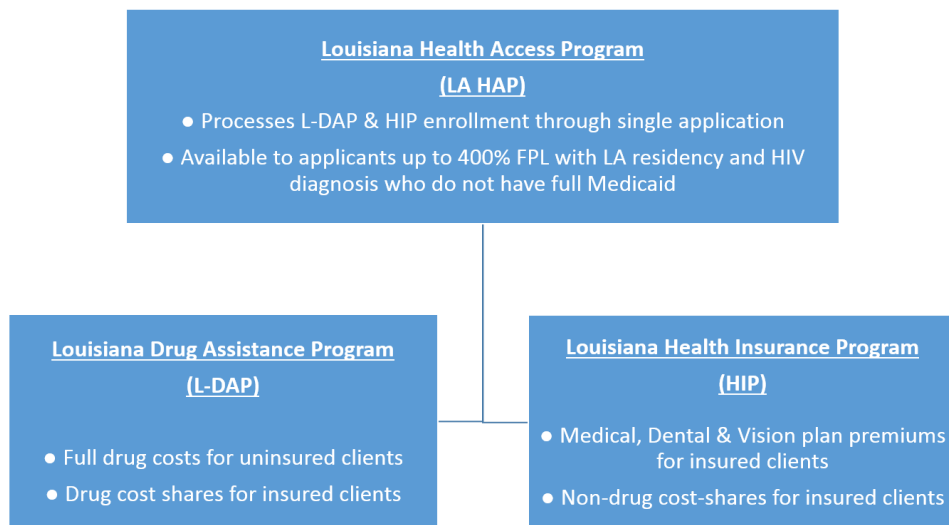
This threshold is any of the following:

- Unearned income over \$1000
- Earned income over \$6100
- Combined unearned/earned income is more than the larger of: \$1000, or earned income + \$350 (up to \$6100)

Social Security benefits or other non-taxable income do not count toward this threshold.

2.3. Program Organization

LA HAP is divided into two components, the Health Insurance Program (HIP) and the Louisiana Drug Assistance Program (LDAP, pronounced “EL-dap”). Eligibility for both programs is assessed via a single application, the LA HAP application, which clients complete every 6 months.



Although staff at the central LA HAP office at the Office of Public Health STD/HIV program (SHP) process enrollment for all clients, two contractors manage the payment logistics of each component of LA HAP. HAART, a Baton Rouge-based HIV service organization, manages payments for health insurance premiums and cost-shares related to medical visits. Ramsell, a California-based pharmacy benefits manager (PBM), manages LDAP benefits and access to medications for insured and uninsured program participants.

2.4. Health Insurance Program

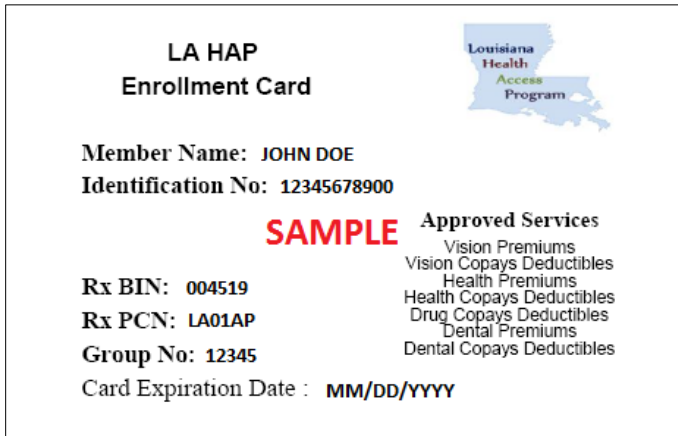
LA HAP staff (at SHP) process enrollment for HIP via the LA HAP application. All insured client services with the exception of drug cost-shares are paid through HIP. HAART staff run daily reports to identify clients newly eligible for or newly disenrolled from LA HAP with HIP-approved services. Based on this report, they adjust their schedule for client insurance premium payments. Clients do not need to re-submit premium information to HIP or LA HAP every month in order for payments to be made, unless this information changes.

HIP pays cost-shares related to medical visits when a bill with an accompanying Explanation of Benefits (EOB) is received at their office for a service or product that is (1) covered by the primary insurer, (2) allowable under HIP (see Section 3), and (3) received at HIP within 180 days of the date of claims adjudication by the insurance company (when the insurance company paid on the claim). Bills may be sent to HIP directly by the client or by a provider on a client's behalf. Bills sent directly from providers are typically sent as a HFCA 1500 Claim Form, but clients may also submit bills directly in whichever format they receive them from their provider.

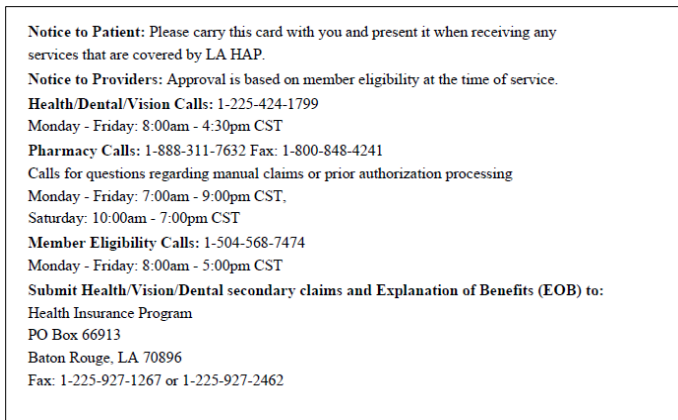
2.5. Ramsell Pharmacy Benefits Manager

2.5.1. Overview

Ramsell has been the Pharmacy Benefits Manager (PBM) for LA HAP since 2014. Ramsell's primary duty is to process pharmaceutical claims for clients at the point of sale. All clients enrolled in LA HAP receive a "LA HAP card," sometimes known as a "Ramsell card," in the mail from Ramsell upon being certified for LA HAP. When presented to the pharmacy, this card is used to charge LA HAP for pharmacy co-payments (for insured clients) and full-cost medications (for uninsured clients). No follow-up or additional action is required from the client.



The front of each card lists identifying information, expiration date, and list of Approved Services (these data are drawn from the Ramsell User Interface (UI)). BIN and PCN are the same for all LA HAP clients.



The back of each card lists contact information for claims and eligibility services.

2.5.2. The Ramsell User Interface (UI)

Ramsell also maintains an online eligibility database of LA HAP clients. LA HAP staff manually enter information from the LA HAP application into the Ramsell UI for each applicant. Upon approving a client's application, a client's approved services and eligibility dates are updated in the UI. This triggers a LA HAP card to be sent to the client's mailing address.

A client may select up to 2 case management agencies to have view-only access to their Ramsell record. While the client may select additional agencies to have full access to the information in the record, the Ramsell UI is designed to only provide viewing access to 2 agencies per record. Case managers may use this database to view client information, track eligibility, and access archived documents submitted on a client's behalf.

2.5.3. Access to the User Interface

All LA HAP staff and case managers have a unique Ramsell User ID which is used to access the system. Each case manager account is tied to an Agency ID.

- New LA HAP staff/new case managers at established agencies obtain a User ID by completing the Ramsell User Request Form and submitting to LA HAP.
- Case managers at new-to-LA HAP agencies must first register their agency with LA HAP in order to receive an Agency ID. Once they have an Agency ID, they may complete and submit the Ramsell User Request Form. An Agency ID may be granted to any agency which:
 - Receives Ryan White funding to conduct case management, OR
 - Has an existing caseload of 50 or more LA HAP clients.

All LA HAP staff have editing access to all client records.

HIP staff have view-only access to all client records.

Case managers may be granted view-only access to limited records. While a specific case manager may be listed on a given record, access to records is granted at the agency level and not the individual level. Therefore a case manager will have access to the records of their own clients as well as all clients of a case manager who shares their Agency ID.

Pharmacists and benefits verification specialists (such as front-desk staff) may be granted limited view-only access to the Ramsell UI allowing them to see claims and eligibility information only.

Clients and medical providers typically do not have access to the Ramsell UI. Exceptions are made for:

- Clinicians such as nurses who also provide case management as part of their job duties;
- Non-case management staff at established agencies with reasonable need to access client records, with approval of their supervisor (as indicated on the Ramsell User Request Form)

3. LA HAP Coverage

3.1. Uninsured Clients

For uninsured clients, LA HAP covers the full cost of drugs on the [LA HAP Uninsured Formulary](#). This formulary is limited to drugs for the treatment of HIV, the prevention and treatment of opportunistic infections (OIs), and Hepatitis C. Prior Authorization from Ramsell is required to obtain Hepatitis C medications, and this sub-program covers up to 45 participants at a time. [Providers may initiate the process here.](#)

LA HAP covers no medical, equipment, or supply costs for uninsured clients. Exceptions can but will not always be made in instances when a client receives a bill for the full cost of services rendered during a time when they had unknowingly lost insurance.

3.2. Insured Clients

3.2.1. Overview

In general, LA HAP covers premiums and/or copayments/coinsurance/deductibles ("cost-shares") for insured clients. Typically, for LA HAP to cover a service the insurer must first adjudicate the claim. LA HAP cannot cover costs associated with any service which the insurer does NOT cover (for example, if a client visits an out-of-network provider).

LA HAP will generally cover any service or product that the primary insurer covers. This includes diabetic supplies and equipment (as long as they can be adjudicated through the insurer) and Durable Medical Equipment (covered up to \$5000 per client per calendar year).

The only excluded service is inpatient hospital admission, for which LA HAP can NOT cover any associated cost-shares for any insurance types. Some overnight services, such as residential rehabilitation programs, can be covered by LA HAP provided the client is not formally admitted as "inpatient." This distinction of inpatient vs. residential is a determination made by the insurance company, not LA HAP, and is typically based on the ICD code assigned to a service. Clients dependent on LA HAP financial assistance should contact their insurer and provider to determine whether a program or procedure is considered inpatient before deciding on a course of treatment.

LA HAP will cover any cost-shares associated with a drug on the primary insurer's formulary provided it does not fall into one of four excluded categories below:

- over-the-counter (OTC) medication;
- nutritional supplements;
- Erectile Dysfunction (ED) medication;

- drugs used for cosmetic purposes.

3.2.2. *Private Medical Insurance*

Premiums: LA HAP will only cover *premium* assistance for insurance plans deemed to have “adequate coverage;” that is, a plan with a formulary that includes at least one drug in each class of core antiretroviral therapeutics from the HHS Clinical Guidelines for the Treatment of HIV/AIDS as well as appropriate primary care services. This may include but is not limited to:

- Private insurance from the Health Insurance Marketplace
 - LA HAP assists with the costs of Bronze, Silver, Gold, and Platinum plans. Basic/Catastrophic plans are not covered.
 - LA HAP will not assist with the costs of Marketplace plans for Medicare-eligible clients.
 - All clients requesting premium assistance from LA HAP and eligible for a premium tax credit from the Marketplace must take the full amount of the tax credit in advance.
- Private insurance purchased directly from the carrier
- Employer-based group coverage
 - In order for premiums to be paid by LA HAP, the employer must agree to accept payment from LA HAP on behalf of the client's portion.
- COBRA
 - LA HAP applications for COBRA coverage are often very time-sensitive. Enrollees **MUST** observe the deadline set by their insurer to make their initial COBRA payment—there is absolutely no grace period.

LA HAP cannot cover any premium portions or cost-shares for a non-client family member. For example: if a client has an employer-based insurance policy for themselves and their child, LA HAP may pay the client's portion of the premium to the employer but the child's portion must continue to be paid by the client.

Cost-shares: covered

3.2.3. *Dental Insurance*

Premiums: covered

Cost-shares: covered

Additional coverage: Unlike health insurance plans, dental plans are not subject to the same standards to which medical plans must adhere under the Patient Protection and Affordable Care Act (PPACA) and therefore dental coverage is typically more limited

than medical coverage. LA HAP accordingly covers the following additional services associated with dental plans, provided the service itself is on the insurer's Schedule of Benefits:

- Services provided after a client has reached their annual benefit maximum
 - Example: the insurer has paid \$2,000 on a client's behalf throughout the year and will pay no more. LA HAP can cover costs incurred above this maximum until the plan year resets.
- Services provided above the maximum annual number set by the insurer
 - Example: the insurer allows one crown replacement per year. LA HAP can cover additional necessary replacements at full cost until the plan year resets.
- Charges billed back to a client because the provider's charge exceeded the amount allowed by the insurer (balance billing)
 - Example: an insurer pays \$40 on a provider's \$100 claim. LA HAP can cover the remaining \$60 if this amount is balance billed to the client.
- Services provided inside of a waiting period imposed by the insurer
 - Example: an insurer only covers root canal procedures after a client has been insured for 12 months. LA HAP can cover the cost of a procedure before these 12 months have passed.
- Services provided by an out-of-network provider when no in-network provider was available within reasonable distance of the client

On a case-by-case basis, LA HAP can also cover the cost of a service not on the insurer's Schedule of Benefits. The service must be deemed medically necessary per the client's dental care plan and the client must consult with LA HAP prior to receiving services if they intend to bill HIP.

3.2.4. Vision Insurance

Premiums: covered

Cost-shares: covered. Unlike dental coverage, LA HAP adheres strictly to the insurer's Summary of Benefits and does not cover overages associated with vision insurance. Example: an insurance company has a maximum allowed amount on a pair of frames of \$100. A client who selects a \$150 pair of frames will have to pay out-of-pocket \$150-\$100=\$50.

3.2.5. Medicare

3.2.5.1. Part A

As inpatient care is LA HAP's only excluded service, LA HAP does not cover any costs associated with Medicare Part A.

3.2.5.2. *Part B*

Premiums: can only be covered if the client is able to obtain an invoice for the premium amount and provide this invoice to HIP. As the vast majority of Medicare beneficiaries have Part B premium amounts taken directly from their Social Security check, LA HAP rarely covers Part B premiums in practice. Late enrollment penalties cannot be covered. Clients must pay the insurer or HIP directly for any penalty. For more information see Section 5.7: Billing.

Cost-shares: covered

3.2.5.3. *Part C (Medicare Advantage)*

Premiums: covered, including for partially dual eligible Medicare/Medicaid beneficiaries.

Cost-shares: covered ONLY for Medicare beneficiaries who are not fully dual eligible Medicare/Medicaid beneficiaries.

For more information on Part C coverage, see Section 3.2.6.2: Medicare Savings Programs.

3.2.5.4. *Part D*

Premiums: covered. Late enrollment penalties cannot be covered. Clients must pay the insurer or HIP directly for any penalty. For more information see Section 5.7: Billing.

Cost-shares: covered

All LA HAP Medicare beneficiaries must enroll in a Part D plan (or a Part C plan with prescription drug coverage). Clients who do not have a Part D plan at the time of application will be required to apply for Low Income Subsidy (LIS) which, if granted, will prompt a Special Enrollment Period for Part D. Clients not eligible for LIS will be required to enroll in a Part D plan during annual Open Enrollment, October 15th – December 7th.

3.2.5.5. *Medigap (Medicare Supplement)*

Premiums: covered, with the exception of clients enrolled in a Part C plan. Anyone with a Part C plan is NOT allowed by law to be sold a Medigap plan.

Cost-shares: covered, with the exception of clients enrolled in a Part C plan.

3.2.6. Medicaid

3.2.6.1. Healthy Louisiana

Clients with full Medicaid benefits are not eligible for LA HAP in most circumstances.

Healthy Louisiana expanded Medicaid benefits were offered to new groups in July 2016. Anyone who fits all the criteria below is eligible for Medicaid and thus ineligible for LA HAP:

- Louisiana resident
- Meets citizenship requirements (citizenship not necessary but must be lawfully present)
- Income below 138% FPL
- Between ages of 19-64
- Not eligible for Medicare

The only people with full Healthy Louisiana benefits that are eligible for LA HAP are those who are co-infected with HIV and Hepatitis C. The only service these clients are eligible for is access to the HCV medications on the [LA HAP Uninsured Formulary](#). In some cases, the applicant must have been denied HCV treatment by Medicaid within the past 6 months. The Hepatitis C sub-program is capped at 45 participants at a time. For more information on this program see 4.2: Application for HCV Treatment Regimens.

3.2.6.2. Medicare Savings Programs

Participants in Medicare Savings Programs are both Medicare and Medicaid clients.

There are two categories of MSP clients:

- *Full dual eligible*: Client is fully covered by both Medicare and Medicaid. Medicare is primary payer and Medicaid pays Medicare cost-shares. Medicaid will additionally cover some other services that Medicare does not cover.
 - If a client is fully dual eligible (their Medicaid Eligibility Verification record says they are “Eligible for Medicaid” on current date), LA HAP can cover only cover limited services: premiums and co-pays for a standalone dental and/or vision plan and premiums for a Part C plan.
- *Partial dual eligible*: Client is fully covered by Medicare and partially covered by Medicaid. Medicare is primary payer and Medicaid pays Medicare cost-shares. Medicaid will not cover any services not covered by Medicare.
 - If a client is partially dual eligible (a Medicaid Eligibility record exists for the client but says they are “Not eligible for Medicaid” on current date), LA HAP can cover all applicable premiums and cost-shares.

4. Applying for Services

4.1. The LA HAP Application

4.1.1. Overview

All applicants to LA HAP with the exception of Medicaid enrollees applying for Hepatitis C coverage complete the LA HAP Application. A blank copy of this application is mailed to each client approximately 6 weeks before their 6-month eligibility period expires. This application is the same for both new and existing clients.

Medicare beneficiaries must additionally apply for Low Income Subsidy (LIS) before submitting the LA HAP application, unless they are a dual eligible beneficiary. Dual eligible beneficiaries automatically receive LIS.

The application is available in English and Spanish versions and can be accessed on the "Forms and Applications" tab of www.lahap.org. Detailed instructions for completing the application can also be found on the website.

4.1.2. Required Documentation/Attachments

- Proof of income for each source of income an applicant or a member of their family claims. Detailed information on types of income accepted for each income source are available at the "Forms and Applications" tab of www.lahap.org.
- (For Medicare beneficiaries only) Proof of Low-Income Subsidy status
 - If applicant is already receiving LIS, no documentation is needed (although LA HAP may need to contact client if they are unable to verify LIS status with Medicare)
 - If applicant has been denied LIS within the past 12 months, attach a copy of the LIS denial letter
 - If applicant was denied LIS more than 12 months ago or has never applied, apply for LIS and attach a printout of the LIS online application submission page dated within the current calendar year
- (For applicants requesting premium assistance for a plan LA HAP has not previously covered only) Copy of invoice from insurance company indicating premium amount
- (For non-Medicare applicants between 0-138% FPL only) Proof of application and denial for Louisiana Medicaid coverage dated within the past 6 months
- (For applicants enrolling in a new insurance plan only) The LA HAP Insurance Add/Change Form

4.1.3. Submitting an application

Applications must be signed and dated before they can be accepted at LA HAP. Applications must be faxed, mailed or delivered in person. They cannot be emailed.

Fax:
504-568-3157

Mailing Address:
1450 Poydras St Suite 2136
New Orleans, LA 70112

If a client wishes for a case manager to have access to their Ramsell record, it is imperative that they indicate this in Section 15 of the application. Access to the client record will be granted for a period of 12 months past the date of the client's signature on the application.

If no case manager is indicated in Section 15, the client will be treated as a "Self-Referral" and LA HAP staff will not be able to discuss the client with their case manager unless a separate Release of Information (ROI) form is on file with LA HAP. Additionally, the case manager will not have electronic access to the client's Ramsell record in order to track their application process and eligibility.

4.2. Application for HCV Treatment Regimens

A separate application exists for full Medicaid enrollees who are applying for LA HAP assistance with Hepatitis C (HCV) medications only. The application for this sub-program is divided into two parts.

- The APPLICANT should complete the [LA HCV application](#). The two-page application will require applicants to:
 - Attest to the fact that they fit all program criteria as listed above.
 - State their approximate income. Separate documentation/proof of income is NOT required.
 - [In some cases] Attach a letter from their Medicaid provider indicating that they have been denied coverage of an HCV treatment regimen. This letter must be dated within 6 months of receipt at LA HAP.
 - This letter is ONLY required if clients have a FibroSure test result indicating a fibrosis stage of F3-F4.
 - This letter is NOT required If the stage is F0-F1, as LA HAP will presume them to be denied treatment coverage by Medicaid.

Documentation of Medicaid enrollment and HIV diagnosis are NOT required as this information can be verified independently by LA HAP staff.

- The applicant's MEDICAL PROVIDER should complete the [Supplemental Form for HCV Treatment Regimens](#). Providers must include documentation of the following:
 - Hepatitis C genotype
 - CD4 count within the last 6 months
 - Hepatitis C RNA viral load within the last 3 months
 - HIV viral load within the last 6 months
 - Fibrosis staging, if needed:
 - If the Fibrosis stage is F0-F1, documentation will be required in order to waive the requirement that the applicant provide a letter of treatment denial from Medicaid.
 - Staging of F3-F4 does not require documentation as the letter of treatment denial from Medicaid is required regardless.

These two applications can be submitted independently of each other: a client does not need to wait on the completion of the Supplemental Form before submitting the Application, and vice versa.

4.3. Application Tracking

If a client has granted them permission (via Section 15 on the LA HAP application or via submission of the Release of Information Form), case managers are able to track the application process and eligibility determination via the Ramsell UI (access granted via the Ramsell User Request Form).

- *Follow-up:* If a case manager is linked to a client record, they will be the first point of contact for LA HAP staff in the event that an application is incomplete and requires further follow-up. LA HAP will proactively follow up with the case manager, and then (if the case manager is not available) with the client regarding incomplete applications. Phone contact will be attempted first. If LA HAP staff cannot make phone contact, the case worker will be informed of missing information by fax.
- *Denial:* If an application is denied, the applicant's case manager will be informed via fax. Applicants who do not have a case manager will be informed via mail.
- *Approval:* If an application is approved, the client's eligibility information will be updated in the Ramsell UI and visible to the case manager. The client will receive a LA HAP card in the mail showing current eligibility dates and approved services.

4.4. Additional Forms

4.4.1. *Certificate of No Income/Cash-Only Income*

- Certify that a client has either ZERO income or CASH income as part of their income eligibility verification on the LA HAP application. This form cannot be used to certify any other form of income, such as SSDI benefits or salary.
- Note that applicants in the New Orleans region may also submit the "Self-Attestation for Eligibility" form from the Ryan White Part A Eligibility Packet for this purpose.

4.4.2. *Disenrollment*

- Request disenrollment at any time if a client is deceased, has left Louisiana, or for any other reason no longer requires LA HAP services. They will be disenrolled from LA HAP.

4.4.3. *Employer Human Resources*

- Request permission from a client's employer to pay insurance premiums on their behalf, and to request premium payment information. This form is typically initiated by HIP post-application approval but may be proactively submitted by a client along with their LA HAP application or Insurance Add/Change Form if they feel comfortable obtaining this information from their employer.

4.4.4. *Insurance Add/Change*

- Request LA HAP assistance with a new insurance plan, add new services to existing LA HAP coverage, or report a change in insurance. This form should not be used to report loss of insurance coverage (please see the Information Change Form).
- Insurance Add/Change Forms requesting premium assistance are due to LA HAP 10 days before the premium payment is due (for Marketplace plans, payment is due by the first of the month of effectuation). Forms submitted after this date will still be addressed but LA HAP cannot guarantee timely processing.

4.4.5. *Information Change*

- Inform LA HAP at any time of a change to client's personal information. This includes a loss of insurance coverage (and an accompanying request for LA HAP assistance with full-pay medications, if applicable), change of legal name or gender, change of address, etc.

4.4.6. *Proof of Positivity*

- Verify proof of HIV positivity. This form is never required but is helpful to submit alongside a LA HAP application for clients who are newly diagnosed or who have moved to Louisiana from another state, for whom HIV status may not already be on file in Louisiana.

4.4.7. *Release of Information*

- Grant permission to an agency to access and release client information to/from LA HAP. This form MUST be initiated and signed by the client. This form is not necessary if a client uses Section 15 of the LA HAP application to grant an agency access to their LA HAP client record.

5. Using LA HAP Benefits

5.1. Accessing Medical Services

HIP clients may visit any provider they choose as long as (1) the provider is in the primary insurer's network, and (2) the provider agrees to bill HIP for any cost-shares incurred. Exceptions are made for out-of-network providers if the primary insurer agrees to cover a portion of costs for these visits. For a claim to be paid by HIP, the insurance company must first adjudicate and, if appropriate, make payment on the claim. In most instances, HIP cannot cover the total cost of a medical bill outright.

HIP cannot directly reimburse clients for any payments made to a provider or insurance company. Therefore, it is important for the client to communicate this fact to their provider in order to avoid being billed before their visit. Clients willing and able to cover their own co-pay for a visit may of course do so and forward any other bills received after their visit to HIP.

See Section 5.7: Billing for information about billing procedures.

5.2. Accessing Medication

Both uninsured and insured clients must ensure that they are visiting a pharmacy in the [LA HAP pharmacy network](#). The uninsured pharmacy network is a subset of the insured network. Additionally, insured clients must ensure that their chosen LA HAP network pharmacy is also in their primary insurer's network.

When presented to the pharmacy, the client's LA HAP card is used to bill LA HAP at the point-of-sale for pharmacy co-pays (for insured clients) and full-cost medications (for uninsured clients). No additional action is required from the client.

LA HAP authorizes 6 fills per prescription. Additionally, uninsured clients can only access 13 fills a year and a 30-day supply at a time. Insured clients are not subject to the 13 fill/30-day supply rules but may be subject to other dispensing limits set by their insurance carrier. See Section 5.3: Prior Authorization for information about overriding these policies in special circumstances.

5.3. Prior Authorization

LA HAP staff can approve prior authorizations for clients to fill a prescription if the client has lost their last fill, is going on vacation, or is receiving a message at the pharmacy about a duplicate component or contraindicated therapy in their ARV regimen.

Lost fills/vacation fills: LA HAP staff can authorize an early fill of a 30-day supply of medication for uninsured clients. For insured clients, LA HAP will follow the guidelines of the primary insurer. Clients seeking an early fill must contact LA HAP to initiate this process.

5.4. Receiving Care out of State

Medical care: Insured clients may receive medical care out of state only if it is allowed by their insurance company. HIP can cover associated cost-shares as long as the primary insurer first renders payment on the claim.

Medication: Ramsell does not authorize medications to be shipped from the pharmacy out of state except in a state or federal emergency. Clients who plan to be out of Louisiana for an extended amount of time may arrange for a family member, friend or case manager to pick up their medication in Louisiana on their behalf and ship it to their out-of-state location. If they will not have a regular out-of-state location, they may be able to arrange with a post office in the general vicinity of where they will be to accept the delivery.

5.5. Emergency Access

In personal emergencies, such as theft or sudden displacement, uninsured clients may access an early 30-day supply of medication. Insured clients may access an early supply of medication to the extent and in the amount allowed by their primary insurer. Clients should contact LA HAP to initiate this process.

In official state or federal emergency situations, such as a hurricane or flood, LA HAP will initiate an emergency protocol specific to the situation at hand. In most cases, this involves identifying all clients residing in affected parishes (those officially designated as being in a state of emergency by the state or the federal government) and providing a general override for all these clients to access an early fill of any of their medications. Insurance companies typically respond to emergency situations by adopting similar policies.

Clients who have been displaced to a location outside of Louisiana can work with Reliant Healthcare in Monroe, Avita Pharmacy in Baton Rouge, or Avita Pharmacy in New Orleans to coordinate the temporary shipment of medications to their current address. These are the only pharmacies authorized to ship medications out of Louisiana on behalf of LA HAP and this permission is only applicable during official emergencies.

In the event that a client's regular pharmacy has been damaged or is inaccessible:

- Clients who visit the same pharmacy chain but in a different location (such as Walgreens or Avita) should inform the pharmacist of their situation and provide

the information of their regular pharmacy so the prescription can be appropriately transferred

- Clients who normally patronize a local, non-chain pharmacy will likely need to contact their physician in order to initiate a fill of their prescription at a new pharmacy. Often, this transfer can be done over the phone.

5.6. Refunds/Overpayments

Per federal law, any individual who took an Advance Premium Tax Credit (APTC) on a Marketplace health insurance plan in a given year must reconcile their federal taxes in order to assess whether they may have overpaid or underpaid their health insurance premiums (relative to their true income and household size) throughout the year. LA HAP clients who took an APTC, and for whom HIP paid at least one premium in a given year, are responsible for forwarding to HIP any applicable refund attributable to premium overpayment. The amount owed HIP is pro-rated based on the number of premium payments made by HIP throughout the year. For example: if a client's tax statement indicates that they overpaid \$18 for each of the 12 months they had insurance one year and HIP paid 4 months of premiums on their behalf, the total amount owed to HIP is $\$18 \times 4 \text{ months} = \72 .

Payment should be returned to HIP via money order (preferred), check, or cash. Checks and money orders should be made payable to HIP. If cash is sent, it should include a letter indicating the amount enclosed and that it is in reference to a premium refund. All payment must include a copy of the client's federal 1040, 1040A or 8962 (Premium Tax Credit) form.

If a client receiving LA HAP assistance has received other refunds from their insurance company, they should first ascertain what services (medical cost-share, medical/dental/drug premium, or drug cost-share) the refund refers to.

- A refund for a medical/dental cost-share (copay, coinsurance, deductible) or a premium may be returned to the HIP office in Baton Rouge.
- A refund for a drug cost-share may be returned to the LA HAP office in New Orleans.

If the nature of the refund is unclear, follow up with their insurer in order to correctly route the check. The client should sign the back of the check if they are able and include any accompanying explanation/correspondence from the insurance company when they return the check.

5.7. Billing

Claims may be sent to HIP directly by the client or by a provider on a client's behalf. The HFCA-1500 form may be used but is not mandatory.

Bills may be sent to HP by fax at 225-927-1267. Alternatively, they may be mailed to:

Attn: HIP
P.O. Box 66913
Baton Rouge, LA
70896

HIP pays cost-shares when a claim/invoice with an accompanying Explanation of Benefits (EOB) is received at their office for a service or product that is (1) covered by the primary insurer, (2) an allowable charge under HIP (see Section III), and (3) received at HIP within 180 days of the date of claims adjudication by the insurance company (date when the insurance company paid on the claim).

HIP cannot directly reimburse clients for any payments made to a provider or insurance company.

Any other inquiries about billing, including all questions related to specific client situations, should be referred to the HIP Customer Affairs Coordinator, at 225-424-1799.

6. Confidentiality

6.1. Overview

LA HAP staff take client confidentiality very seriously and complete annual Health Insurance Portability and Accountability Act (HIPAA) training.

All client information is stored electronically on secure network drives at the LA HAP office. Fax is the primary way in which client information is received at LA HAP. The LA HAP fax line is a secure connection and incoming faxes are sent automatically to a secure network drive. Paper files are housed in a locked storage room when not in immediate use. Files of immediate use to LA HAP staff are kept in locked cabinets when staff are not present.

Visitors are not admitted to staff offices unless accompanied by LA HAP staff. Client information is not discussed or visible in the presence of non-STD/HIV Program visitors unless the visitor has been specifically authorized by the client to access such information.

6.2. Electronic (Ramsell) access to client records

Agency access to client records in Ramsell can ONLY be granted in 2 ways:

- *A client lists an agency on their signed LA HAP application*
 - A case worker must be listed in Section 15 of a client's LA HAP application in order to gain access to their Ramsell record. The application allows up to 2 agencies to be selected. If the client wishes an additional agency to gain access, they must do so via a signed ROI form (see below).
 - The client must attest to the fact that they are authorizing any case worker/agencies named on their LA HAP application to access their record. Therefore, any case worker/agencies must be notated on the application BEFORE the client signs.
- *The case worker, agency or client submits a client-signed Release of information (ROI) form to LA HAP specifying that the client agrees for the case worker's agency to exchange protected health information (PHI) with LA HAP.*
 - A release specifying that the case worker's agency can release information to LA HAP but does not specify that the case worker's agency can receive information from LA HAP is not sufficient.
 - There is an ROI form on lahap.org which may be used for this purpose or as a template to create an agency-specific form. This form is NOT required to replace any agency-specific form, as long as the agency-specific form suitably mentions LA HAP or a broader state entity such as LDH/OPH.

Electronic access to client records is limited to 2 agencies at any time. If a client has submitted an ROI to add more than 2 agencies to their record, case workers at the 3rd agency will not be able to view the electronic Ramsell record. However, they will be able to call LA HAP to obtain information about the client's record.

Agency permission to access a client's record shall remain valid for 1 year from the date of signature of the LA HAP application or ROI form.

Clients may contact LA HAP at any time to revoke an agency's access to their record.

6.3. Phone communication

A *client* calling for information on their LA HAP record must verify their identity by correctly providing the client's name and at least TWO of the following from their Ramsell record:

- Last 4 digits of SSN
- DOB
- Ramsell ID
- Home address

A *case worker* calling for information pertaining to a client's LA HAP record MUST EITHER have their agency listed on that client's record OR have a valid ROI on file in the client's record in order to access information. Additionally, they must verify their identity by providing BOTH of the following:

- Last 4 digits of client's SSN OR Client's Ramsell ID
- The name of the agency where they work AND their full name as listed in their Ramsell record
 - If a case worker is not able to access Ramsell but the client has still authorized their agency to have access to their client record, the case worker must give the full name of both their own agency and verify the identity of the client.

A *provider's office* (including clinic manager, billing specialist, administrative specialist, etc.) who does not have electronic access to a client's record may obtain limited information about a client record by providing the client's name and at least TWO of the following from the client's Ramsell record:

- Last 4 digits of a client's SSN
- DOB
- Ramsell ID

With this information, providers may access information about a client's record limited to:

- Current eligibility
- Approved services

A client's representative (including friend, family member, or authorized representative) may access client information in certain circumstances.

- A client may designate a representative in Section 2 Question 25 of the LA HAP application with whom LA HAP can discuss information regarding eligibility only.
- While on the phone with LA HAP, a client may verbally authorize a family member or other representative to discuss their record with LA HAP after verifying their identity per the method outlined above. This consent remains in effect only for the duration of the client/representative's call to LA HAP.

In instances where a client is non-verbal or otherwise unable to communicate with LA HAP directly (for example they are unconscious, incarcerated etc.; NOT that they are currently away from the phone):

- An authorized representative with full power of attorney to act on a client's behalf must submit documentation of such to LA HAP. LA HAP can then discuss information with the representative as though they are the client.
- A parent, spouse, or other non-official representative may access information about a client's record on a limited, case-by-case basis, per approval by the CSS Supervisor.

LA HAP staff cannot confirm or deny the existence of any client record in LA HAP without the above information. This includes having an eligibility history with LA HAP, record, having a pending application on file, receipt of application, receipt of services, HIV status, etc.

6.4. Email communication

At this time, LA HAP does not have a secure email connection with which to discuss client information. Email topics must be limited to general inquiries or must exclude all Protected Health Information (PHI) including but not limited to name, date of birth, Social Security Number, Ramsell ID, diagnosis information, and health policy information.

Example of acceptable email communication: "I have just faxed follow-up paperwork for the client we discussed this afternoon."

Example of unacceptable email communication: "I have just faxed follow-up paperwork for John Doe, SSN 123-45-6789."

7. Clients Rights and Responsibilities

All individuals applying to or receiving services through LA HAP are protected against discrimination based on race, national origin, religion, sex, gender, age, or disability.

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.

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 rebate
- To the best of their ability, be proactive about learning how LA HAP coverage works with their existing health insurance coverage

8. Grievances and Appeals

Clients have the right to contact LA HAP with any grievances related to LA HAP staff or services. Appeals of coverage determinations are also appropriate in some circumstances as described below.

Grievances related to LA HAP staff or eligibility determination should be directed to the CSS Supervisor. Grievances related to LA HAP services should be directed to the Health Insurance Program Coordinator.

To appeal an eligibility determination:

- If client was denied because their submitted income was less than 138% FPL or greater than 400% FPL, they may submit updated or additional income documentation to show they are truly eligible for LA HAP. If the same type of documentation is being re-submitted (for example, additional paystubs), the re-submitted income documentation must be dated more recently than the original.

Example #1: Client worked a considerable amount of overtime 1 week and submitted that weeks' paycheck as income so LA HAP calculated income was considerably greater than client's actual income. Client can submit updated paycheck and follow-up will be processed in a timely manner so client can access services.

Example #2: Client is a truck driver and their gross income includes the cost the client is paying towards buying their truck. Client can submit a recent tax return for the same job to show actual yearly income and follow-up will be processed in a timely manner so client can access services.

- If client was denied based on income showing client is eligible for Medicaid, the client can appeal the LA HAP denial for provisional approval but must complete the following steps before being given approximately 1 month of additional LAHAP eligibility:
 1. Client must apply for Medicaid and follow up with Medicaid about their application status
 2. Client must state reason for appeal (for example: "in need of medications"), Medicaid application date, and Medicaid's response to follow up on application status
 3. Client must provide Medicaid denial letter in order for eligibility to be extended beyond provisional approval

4. CSS Supervisor determines if appeal is accepted or denied with direction from Services Manager if needed
5. If appeal is accepted provisional approval will be granted in a timely manner so client can access services

9. Resources

9.1. LA HAP

There are 2 websites devoted to information about LA HAP.

- [The Louisiana Department of Health site](#) (LDH) contains basic information about program structure and eligibility.
- www.lahap.org is the most frequently updated source of information about LA HAP. It differs from the LDH site in that it contains links to all forms required by LA HAP as well as technical assistance resources for providers and clients.

9.2. Health Insurance Marketplace

Clients can sign up for health insurance or Medicaid through www.healthcare.gov.

- The site also allows you to search FAQs on Marketplace coverage.
- You can also browse plans without setting up an account by going to Getting Answers → "Where Can I Find 2017 Plans and Prices?" or at www.healthcare.gov/see-plans

9.3. Social Security Administration

The Social Security Administration administers retirement and disability benefits for many LA HAP clients, as well as the Low Income Subsidy program for Medicare beneficiaries.

- Clients can set up an account that allows them to track their benefits and download benefit award letters at www.ssa.gov/myaccount/.
- Medicare clients can apply for LIS through www.ssa.gov/medicare/prescriptionhelp.

9.4. Medicare

Medicare beneficiaries can access their own plan information at www.mymedicare.gov.

- Navigating to Sign Up/Change Plans → Check Your Enrollment is the easiest way to access plan information. Creating an account is not necessary, but users must have their Medicare number, Part A effective date, zip code and date of birth.
- 1-800-Medicare is potentially useful for beneficiaries but doesn't always assist with state-specific answers. A good referral for Louisiana Medicare questions is the state Senior Health Insurance Information Program (SHIIP) at 1-800-259-5300.

9.5. Medicaid

Clients can apply for Medicaid through the state directly, or by completing an application on www.healthcare.gov.

- The state website is www.healthy.la.gov. Although the site also has some basic information and FAQs, the best way to obtain up-to-date information about program structure or enrollment (not specific MCOs) is by calling 1-888-342-6207.
- Questions about coverage specific to the clients' Managed Care Organization (MCO) can be directed to 1-855-229-6848. Clients can also browse plans at www.myplan.healthy.la.gov.

9.6. Ramsell

Case managers may most frequently access Ramsell's secure portal to track client application and enrollment, but providers and clients may also visit the public website to obtain more information about the Pharmacy Benefits Manager in general.

- <http://www.ramsellcorp.com/> has separate sections for providers, pharmacies and individuals. It houses the most up-to-date versions of the LA HAP formulary and pharmacy networks.

9.7. HIP

HIP is the primary point of contact for questions about claims and billing.

- The HIP Customer Affairs Coordinator is the initial point of contact for directing all inquiries: 225-424-1799
- Website: <http://www.haartinc.org/health-insurance-program/>