



LA HAP Beyond the Basics

This webinar will cover...

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

But first...

Why is LA HAP so complicated?

Typical ADAP model pre-ACA

- One-page formulary (HIV medications only)
- Single, central pharmacy
- ~25% percent of ADAP population had access to insurance

LA HAP model today

- Almost ALL ADAP clients have access to insurance
- Comprehensive medical, dental, vision benefits
 - HIP pays premiums to over 250 distinct insurance plans and employers
- Network of almost 600 pharmacies
- Over 3,500 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
- Provide a client with the names of providers in their 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 navigating their own care.

Vision coverage (1)

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	Covered by Co-pay	Up to \$25
Bifocal	Covered by Co-pay	Up to \$40
Trifocal	Covered by Co-pay	Up to \$50
Lenticular	\$80 Allowance	Up to \$50
Progressive	\$70 Allowance	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 <ul style="list-style-type: none">• 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

Vision coverage (2)

Can HIP cover premiums for standalone vision plans?

- HIP can cover premiums provided they can get an invoice and an address to pay by check
- HIP CANNOT set up a bank draft or make monthly credit card payments
- Vision insurers are extremely unlikely to accept HIP payment via check
 - Exceptions: employer-sponsored vision plans, Medicare add-ons
- Benefits under health insurance plans
 - Some private health plans provide basic vision benefits (e.g. Vantage)
 - Medicare Part B covers certain services such as cataract surgery, glaucoma screenings for those considered at high risk
 - Medicare Part C often provides more comprehensive benefits

Dental coverage: overview

- HIP covers premiums/cost-shares associated with:
 - The LA HAP/Guardian Dental Plan
 - Medicare Part B, C and dental/vision riders
 - Group (i.e. retiree, employer-sponsored) plans
- HIP does NOT cover costs associated with:
 - Standalone, individual market dental plans
 - Clients with these plans may be referred to the LA HAP/Guardian Dental Plan

The LA HAP/Guardian dental plan

- All LA HAP eligible clients are eligible to enroll in the LA HAP Guardian dental plan
 - BUT clients already enrolled in an employer-sponsored dental plan or clients enrolled in a Medicare dental rider must choose between their current plan and the Guardian plan (not both)
- Dual eligible (Medicare plus Medicaid) clients
 - These clients can enroll and are eligible for assistance with LA HAP Guardian dental plan

See www.lahap.org/dental and slides from our "Navigating Dental Benefits" webinar for more information on this plan.

Dental coverage under LA HAP


Service Type	Guardian	Other types of coverage
Premium	\$7 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 95 th 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 adjudication (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:
 - 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/case-managers>
- Separate sections explaining LA HAP for medical providers, pharmacists
- Includes “Provider Packet” for distribution to providers new to HIP— print! Use! Provide feedback!

[Home](#) [Apply for LA HAP](#) [Using Your Benefits](#) [Provider Resources](#) [Contact](#)

Resources for Case Managers

LA HAP Program Resources

[LA HAP Policy & Procedure Manual](#) (updated 10/21/19)

[Release of Information \(ROI\) Form](#)
Use this form if you want to grant permission to an agency to access and release client information to/from LA HAP. Form MUST be initiated and signed by client.

[2019 Federal Poverty Income Guidelines for Ryan White eligibility](#) (updated 3/8/19; LA HAP uses 2019 FPIG until March 2020)

[2020 Marketplace and Medicare plan information](#)

Recent LA HAP Bulletins

01/02/2020
New in 2020: documentation grace period, Marketplace documentation due, Naloxone added to uninsured formulary, Medicare General Enrollment

10/07/2019
LA HAP Policy Change on Low Income Subsidy for Medicare Beneficiaries

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[ACCESS FULL BULLETIN ARCHIVE](#)

Webinar Archive

LA HAP hosts a webinar on the first Thursday of every month at 10 am. Topics vary. To subscribe to our invitation list or to suggest a webinar topic, please email lahap@la.gov.

[Open Enrollment 2020: A Guide for LA HAP Assistors](#)
This webinar was presented in October 2019. It reviews the basics of Open Enrollment and action steps which must be taken by LA HAP clients.

[Navigating Dental Benefits](#)
This webinar was presented in August 2019. It reviews how LA HAP clients can enroll in and use dental benefits.

[2019 Open Enrollment Debrief & Tax Filing Considerations for the 2018 Filing Year](#)
This webinar was presented in March 2019. It reviews responsibilities that LA HAP clients have toward HIP and toward the Marketplace at this time.

[LA HAP 2.0!](#)
This webinar goes into more specific detail regarding HIP and LDAP utilization, serving special populations, and client rights and responsibilities.

[Orientation to the Louisiana Health Access Program](#)
This webinar introduces LA HAP coverage and utilization.

Ramsell User Resources

[Ramsell User Request Form](#)
For the purposes of tracking client eligibility, LA HAP grants Ramsell User Interface access to agencies who receive Ryan White funding to conduct case management and/or who manage caseloads of at least 50 Ryan White-eligible clients. Do NOT use this form if you are receiving an error message that your Ramsell web access has expired. Instead, contact Ramsell Technical Support at 1-888-311-7632.)

[Instructions for running reports in Ramsell](#)

[Ramsell Plan and Group Key](#)

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
6 fills per prescription (original + 5 refills)	

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
Ramsell Plan or Group mismatch	Call LA HAP to request correction to plan/group
Non-formulary medication	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.
Maximum fills (6) per prescription reached	Contact physician to obtain new prescription.

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 0-400% 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 6 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 8/31/18. Planning to enroll in a marketplace insurance plan beginning 10/1/18. 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 2018. A policy start date of 1/1/18 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

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.

Grievance

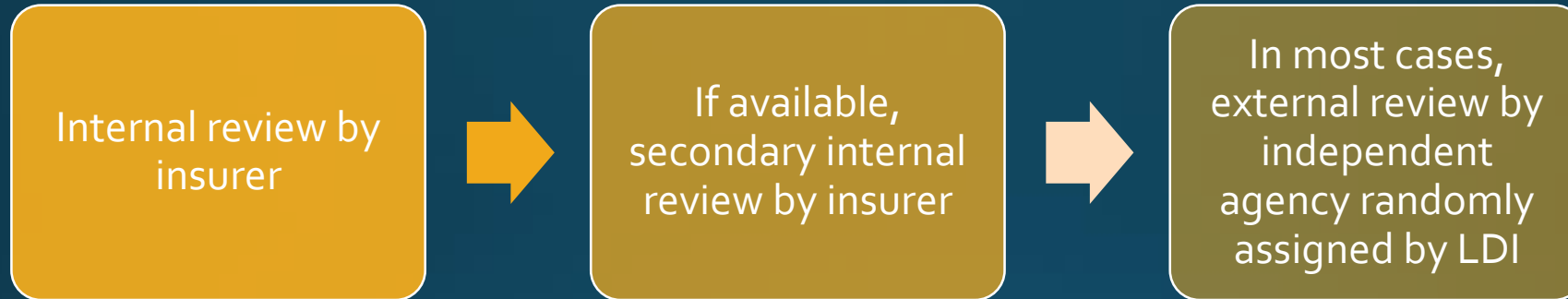
A written expression of dissatisfaction with us or provider services. If you do not feel your complaint was adequately resolved over the phone or you wish to file a formal grievance, you must submit this in writing. If necessary, our Customer Service Department will assist you.

Appeal

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 ever change?

Questions?

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