TEXAS
Health and Human Services

Hemophilia Assistance Program

Provider Manual

November 2023

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Introduction

Welcome to the Hemophilia Assistance Program (HAP), administered by the Texas Health and Human Services Commission (HHSC). The Hemophilia Assistance Program Provider Manual is designed to answer questions you might have about the program.

We recognize there might be times when you cannot find the answer you need. Please feel free to call our helpline at 800-222-3986 from 8 a.m. to 5 p.m. Central Standard Time, Monday through Friday. You can also email us with questions at hemophilia@hhs.texas.gov.

Thank you for enrolling in our program and for the care and services you extend to our clients.

Program Overview

The Hemophilia Assistance Program (HAP) improves access to health care by helping clients with hemophilia pay for their blood factor products or by providing reimbursement for health insurance premiums.

A HAP client may be eligible for both blood factor products and health insurance premium assistance; however, a client may not receive both blood factor and health insurance premium assistance at the same time.

HAP operates under the rules found in Texas Administrative Code (TAC) Title 26, Part 1, Chapter 354.

HAP Contact Information

Mailing address

Texas Health and Human Services Commission
Hemophilia Assistance Program
P. O. Box 149030
Mail Code 1938
Austin, TX 78714-9947

Physical address for courier service

Texas Health and Human Services Commission
Hemophilia Assistance Program
701 W 51st Street
Mail Code 1938
Austin, TX 78751

Helpline

800-222-3986

Fax number

512-206-3982

Email

hemophilia@hhs.texas.gov

Website

hhs.texas.gov/services/health/hemophilia-assistance-program

Provider Enrollment

Any pharmacy, hospital, or blood bank doing business in Texas may request to become a HAP provider. However, HAP may make binding agreements or contractual arrangements with a limited number of providers for purposes of cost containment and quality assurance.

To enroll with HAP, a provider must:

- Be a current Texas Medicaid Provider; and
- Complete and return a HAP enrollment packet.
- The packet includes:
  - HAP Enrollment Form
  - Child Support Certification Form
  - Provider Agreement
  - Direct Deposit Form (recommended)
  - Application for Texas Identification Number (if applicable)

Call 800-222-3986 to get an enrollment packet. You can also send a fax to 512-206-3982 or email hemophilia@hhs.texas.gov.

Change of Ownership (CHOW)

Any enrolled provider that changes ownership must notify HAP in writing within 30 calendar days and submit a new enrollment packet as defined above. HAP must also be notified if the new owner will assume liability for outstanding balances in effect or incurred by the previous owner.

Suspension or Termination of Enrollment

HAP may suspend or terminate a provider's enrollment for any reason, including:

- Submission of false or fraudulent claims;
- Failure to provide and maintain quality services;
- Failure to adhere to medically acceptable standards;

- Breach of the provider agreement;
- Disenrollment as a Texas Medicaid Program provider; and
- Violation of HAP rules.

Provider Rights

HAP providers have the right to:

- Apply and enroll as a provider;
- Be notified of the program's decision relating to denials, suspensions, or terminations;
- Have confidentiality of information in the manner and to the extent authorized by law;
- Appeal program decisions in the event HAP denies a prior authorization request, claim, or suspends or terminates provider enrollment and request a fair hearing if the provider disagrees with the outcome of the administrative review; and
- Reapply for the program if eligibility for the program is denied or terminated.

Provider Responsibilities

HAP providers have the responsibility to:

- Abide by federal and state laws, HAP rules, and regulations;
- Comply with the terms and conditions set forth in the provider agreement and provisions of the most current HAP Provider Manual;
- Not discriminate against applicants or clients based on source of payment;
- Notify HAP of any lawsuits contemplated or filed concerning the cause of the medical condition for which HAP has made payment;
- Report changes in ownership, business name, address, phone number, status of Medicaid, or other required license and certifications to HAP in writing within 30 calendar days of the change;
- Request prior authorization before providing services;

- File claims within filing deadlines;
- Accept the HAP established reimbursement rates as payment in full for authorized services; and
- Reimburse HAP for any overpayments within 30 calendar days of the notice.

Client Eligibility

HAP clients must meet the following criteria:

- Have a diagnosis of hemophilia certified by a licensed physician;
- Be 18 or older;
- Be a legal Texas resident;
- Not be incarcerated in a city, county, state or federal jail or prison, nor be a ward of the state;
- Have an income level at or below 200 percent of the federal poverty level guidelines;
- Be ineligible for Medicaid, or the Children's Health Insurance Program (CHIP). The applicant may be required by the program to apply for Medicaid, Medicare, CHIP, or the Children with Special Health Care Needs (CSHCN) Services Program when the applicant's age, income, or medical disability determination meets the eligibility criteria for participation in one of those programs; and
- Renew their eligibility annually.

Client Benefits, Limitations, and Prior Authorization

Benefits

HAP provides two different benefits. The HAP program helps with reimbursement for blood factor replacement products *or* insurance premium payment assistance.

Clients are only eligible for one benefit type at a time but can switch during the fiscal year with approval by the HAP program.

Blood Factor Replacement Products

Eligible clients may receive covered blood factor replacement products. Payments will not exceed $55,000, per client, per state fiscal year (September 1 through August 31) and are subject to funds availability. No reimbursement shall be made for supplies.

Insurance Premium Reimbursement

Instead of receiving blood factor replacement products, HAP will issue insurance premium reimbursement directly to eligible clients. Proof of premium payment is required.

Benefit Limitations

- All benefits are based on availability of program funds;
- HAP is the payor of last resort; and
- Clients eligible for drug coverage under a private/group health insurance plan are not eligible to receive blood factor replacement benefits until drug coverage under the private/group health insurance plan has been exhausted.

Prior Authorization

Prior authorization is required for all covered products. A list of covered products may be viewed on the program website. Under the title, "HAP Forms," download the HAP Allowable Product and Fee List (PDF).

Providers must ask for and receive a prior-authorization number before each issuance of a blood factor product. If the client has other insurance, documentation must be submitted showing the amount paid, if any, that the client has reached their maximum allowable amount, or that the service is not a covered benefit.

Requests must be within the client's maximum allowable amount per year ($55,000 cap per client, per state fiscal year) and is dependent on available program funds. You may request prior authorization by calling 800-222-3986, Monday through Friday between 8 a.m. and 5 p.m., Central Standard Time. Authorization decisions will be made within three (3) business days of the date the request is received, with written notification to follow.

Prior authorization is not a guarantee of payment. Services provided to ineligible clients will not be reimbursed.

Claims Filing and Reimbursement

Claims Filing

Claims must be received by HAP within 95 calendar days from the last day of the month of the date of service. The CMS-1500 claim form (sample CMS-1500) must be used to request reimbursement of prior authorized services. Providers will receive an explanation of benefits (EOB) for paid and denied claims.

A claim may be denied when it is submitted incomplete, on the wrong form, for uncovered benefits or with inaccurate information. A denied claim may be reconsidered for payment if the claim is corrected and resubmitted to HAP within 30 calendar days after the date of the program notice of denial or within the initial 95-day filing deadline, whichever is later. Corrections must be made to the original CMS-1500 along with documentation evidencing timely filing, eligibility, a copy of the HAP EOB and the third-party EOB, as applicable.

Additional purchases will not be considered for payment on a resubmitted claim.

When a HAP client has other health insurance:

- HAP is the payor of last resort; and
- Claims must be received by HAP within 95 calendar days from the last day of the month of the date of service. If a disposition from the other health insurance is not received with the claim, HAP will deny the claim. Claims must be resubmitted within 30 calendar days of the disposition date from the insurance company including copies of EOBs.

Providers must submit claims by mail to:

Texas Health and Human Services Commission
Hemophilia Assistance Program Claims
P. O. Box 149030
Mail Code 1938
Austin, TX 78714-9947

Reimbursement

HAP does not reimburse for services above the prior-authorized amount. Reimbursement rates for allowable products are determined annually and are based on Texas Medicaid's Vendor Drug Program rates. HAP rates are published on the program website under the "HAP Allowable Product and Fee List".

Payment may be made only after the allowable product has been dispensed and the claim has been approved.

For claims that involve partial payments pursuant to a primary payer, the reimbursable amount by HAP will be based on the difference in the other insurance paid amount and the HAP allowable amount.

Overpayments

A provider who has been overpaid may have future payments adjusted to satisfy the overpayment. If no additional claims are submitted, the provider is directed to reimburse HAP directly for any overpayment within 30 calendar days of receipt of the notice.

Right of Appeal

An applicant, provider, client, or legally authorized representative may appeal a program decision regarding eligibility or benefits.

A provider, client, or legally authorized representative may appeal a program denial of a prior authorization request for program services.

Requests for an appeal may be denied for prior authorization decisions or for reimbursement amounts for claims that are paid in accordance with the reimbursement rate as determined by the agency and benefits and limitations authorized by TAC §354.7.

Requests for an administrative review must be in writing and received by the program within 30 calendar days from the date on the EOB or adverse notice. If no request for an administrative review is received, the requestor waives their right to an administrative review and the program action will become final.

Mail or email supporting documentation and requests for administrative review to:

Texas Health and Human Services Commission
Hemophilia Assistance Program Administrative Review
P. O. Box 149030
Mail Code 1938
Austin, TX 78714-9947
Email: hemophilia@hhs.texas.gov

Administrative Review Process

The administrative review process Title 26, Part 1, Chapter 354.17 Right of Appeal is as follows:

- Program notifies the affected party (the applicant, client, or provider) of his or her right to request an administrative review on the Notice of Eligibility, Explanation of Benefits, or the termination letter.
- The appellant has 30 calendar days from the date of the notice to request an administrative review and include supporting documentation.

- Program accepts a request for an administrative review in writing via fax, email or mail from a client, social worker or any agent acting on behalf of the appellant. Providers and clients can also call program at 800-222-3986 and a customer service representative will assist them in requesting the administrative review.
- Program conducts a comprehensive review of all available documentation related to the adverse decision.
- Within 30 days of receipt of the request, program sends the appellant an administrative review response letter with the decision to uphold, partially overturn or completely rescind program's prior decision. Program may send an extension notice by the 30th calendar day informing the appellant that more time is required. Extension determination is at program's discretion.
- The administrative review response letter will include:
  - the action program intends to take, and
  - supporting reasons for the action.

If the appellant is dissatisfied with the program's decision following the administrative review, a request for a fair hearing must be submitted within 20 calendar days of the date of the administrative review decision notice.

Fair Hearing Process

The fair hearing is the final appeal process and is described in TAC, Title 25, Part 1, Chapter 1, Subchapter C §§1.51-1.55, Fair Hearings Procedures. The fair hearing process is conducted by the Office of General Counsel at DSHS.

Fair hearing requests must be submitted in writing to the program within 20 days of the date of the administrative review notice. The request should state the reasons for the disagreement and include any documents or other proof that help support those reasons. Failure to submit a timely request will result in the waiver of the appellant's right to a fair hearing and the program action will become final.

Mail or email requests for fair hearings to:

Texas Health and Human Services Commission
Hemophilia Assistance Program Fair Hearing
P. O. Box 149030
Mail Code 1938
Austin, TX 78714-9947
Email: hemophilia@hhs.texas.gov

Summary of Changes

23-7, This version of the HAP Provider Manual is restructured to conform with current rule language and HHSC handbook standards. The following sections were added or revised in the manual:

Section Title	Change
Table of Contents	Adds organized provider manual content.
Introduction	Adds the policy manual introduction for program providers.
Program Overview	Adds program overview and corrects contact information.
Provider Enrollment	Expands the description and conditions for provider eligibility, enrollment, rights, and responsibilities in the program
Client Eligibility	Adds description for client eligibility.
Client Benefits, Limitations, and Prior Authorization	Expands description for client benefits and limitation to include client eligibility and the prior authorization requirement.
Claims Filing and Reimbursement	Expands the description for the claims process and adds a timeline for reimbursing overpayments.
Right of Appeal	Corrects rule references regarding right of appeal.