Hemophilia Assistance Program (HAP) Client Handbook

Texas Health and Human Services

November 2022

Table of Contents

Welcome to the Hemophilia Assistance Program (HAP) **3**
What is the Hemophilia Assistance Program? 3

Eligibility **4**
Effective Date of Eligibility 4
HAP Identification Number 5

Program Benefits **6**
Blood Factor Replacement Products 6
Insurance Reimbursement 7

Claims and Reimbursements **8**
Insurance Premium Payment Assistance Claims 8

Termination of Benefits **9**
Client Actions 9

Reconsideration and Fair Hearing **10**
How to Request an Administrative Review 10

Client Rights and Responsibilities **11**
Client Rights 11
Client Responsibilities 11

HAP Policy Information **12**
Other Coverage 12

Contact the Hemophilia Assistance Program **13**
Phone 13
Fax Number 13
Email Address 13
Mailing Address 13

Welcome to the Hemophilia Assistance Program (HAP)

This booklet was developed to introduce newly approved clients to the Hemophilia Assistance Program (HAP), which is administered by the Texas Health and Human Services Commission (HHSC). It includes information on the benefits covered by HAP, how to submit claims, and relevant policy information.

You can learn more about the program at:

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

For additional assistance, call 800-222-3986 or email hemophilia@hhs.texas.gov.

What is the Hemophilia Assistance Program?

The Hemophilia Assistance Program (HAP) helps Texans diagnosed with hemophilia cover specific medical bills. An eligible client may receive blood factor replacement products or insurance premium payment assistance in the same fiscal year, but not at the same time.

Eligibility

The program is available to anyone who:

- lives in Texas;
- is 18 years of age or older;
- has an income at or below 200% of the federal poverty guidelines (povertylevelcalculator.com);
- has a diagnosis of hemophilia;
- is not incarcerated or a ward of the state; and
- is not eligible for Medicaid or the Children's Health Insurance Program (CHIP) and 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.

Effective Date of Eligibility

If an application is approved, the HAP client's effective date of eligibility is the date the complete HAP application was received by HHSC.

The eligibility period is determined based on when the application was received and the end of August (end of the HHSC fiscal year). For example, if a complete HAP application is received in January and approved, the applicant's benefits will be determined from January to the end of August (end of the HHSC fiscal year).

Clients are required to submit changes to HHSC within 30 days. Some changes can include household members, income, insurance, etc.

The client must provide a renewal application on or before August 31 and be determined eligible for benefits to begin September 1 (start of the HHSC fiscal year).

Annual Eligibility Renewal Process:

- The HHSC central office mails current HAP client renewal notices by July 31.
- Current clients submit renewal applications on or before August 31.
- If determined eligible, client benefits begin on September 1 through August 31 of the following year.

HAP Identification Number

This is a unique five-digit number beginning with a zero that is issued to identify HAP clients and is on the HAP Notice of Eligibility. Clients should use this number when inquiring about benefits or submitting claims.

Program Benefits

Benefits available to qualified clients include limited reimbursement to program providers for blood factor replacement products indicated for the treatment of hemophilia and prescribed to eligible clients for use in medical or dental facilities, or in the home. The program may reimburse eligible clients with insurance premium payment assistance and copays and drug deductibles associated with a primary insurance.

Eligible clients may receive either blood factor replacement products or approved insurance premium/copay reimbursement, but not during the same month. Payments won't exceed $55,000, per client, per annual eligibility period and are subject to program fund availability.

Blood Factor Replacement Products

Program benefits for allowable products are limited to those prescribed by a physician and dispensed by a program provider.

The program will pay for allowable products based upon:

- available funds;
- established limits for allowable products by type or category; and
- the reimbursement rates established by the department.

Prior authorization is a condition for reimbursement and is not a guarantee of payment. Services provided to ineligible clients or clients not enrolled in HAP will not be reimbursed.

Note: Eligible clients with private or group health insurance, for which the program does not provide insurance premium payment assistance, must exhaust all benefits prior to receiving program benefits for allowable products.

Insurance Reimbursement

Insurance Premium Payment Assistance (IPPA)

The program may assist eligible clients in obtaining public or private health insurance by providing Insurance Premium Payment Assistance if paying for such health insurance can reasonably be expected to be cost effective for the program.

Claims and Reimbursements

Complete claims or reimbursement requests must be received by the program within 95 calendar days from the end of the month for which the service was received or 95 calendar days from the end of the month for which the insurance premium was paid. Incomplete and ineligible submissions will be denied. Denied submissions may be considered for payment if the submission is corrected and resubmitted within 30 days following the date of the program notice of denial or within the initial 95-day filing deadline, whichever is later.

Insurance Premium Payment Assistance Claims

The program reimburses eligible clients for insurance premium payments made to program-approved health plans. Reimbursements may be made after the program receives valid proof of the insurance premium payment.

Completed reimbursement requests must be received by the program within 95 calendar days from the end of the month for which the service was received or 95 calendar days from the end of the month for which the premium was paid.

Reimbursement requests must be submitted to the program at hemophilia@hhs.texas.gov. They must include proof of the insurance premium that indicates the month of coverage payment. Reimbursement payments are made directly to the enrolled client, or to whoever made the payment, as documented on the receipt.

Termination of Benefits

Client Actions

HAP benefits may be terminated for any of the following reasons, which include but are not limited to:

- the application or other requested information is erroneous or falsified;
- financial eligibility requirements are not met;
- failure to establish or maintain Texas residency;
- financial or residency documentation is not provided as required or requested;
- failure to provide information when requested;
- the client is or becomes incarcerated in a city, county, state, or federal jail, or prison;
- the client is or becomes a ward of the state;
- failure to receive allowable products through a program provider;
- failure to reimburse the department, as requested, for overpayments made to the client; or
- failure to continue insurance premium payments on individual or group insurance or prepaid medical plans, where such plans provide benefits for the care and treatment of persons who have hemophilia and whose eligibility for benefits under the plan(s) was effective prior to eligibility for the program; and failure to provide a statement on the application form outlining the reason(s) why such insurance cannot be maintained.

  Note: If the client had private insurance when eligibility was approved for HAP and they lose coverage during the approval period, the client must write a letter explaining why coverage was lost.

Reconsideration and Fair Hearing

HAP clients have the right to request an Administrative Review and Fair Hearing for any decision HAP has made regarding benefits, eligibility, and claims.

How to Request an Administrative Review

If for any reason a client's benefits have been modified or terminated by the Hemophilia Assistance Program (see Termination of Benefits above), the client will receive a letter of termination. The letter of termination will include an explanation of the reasons for the action and an explanation of the client's right to request an Administrative Review.

The notice will also include the procedure by which a client may request an Administrative Review, the email and mailing address where written requests should be submitted, and the phone number to call to request assistance for an Administrative Review. The notice will also state that the request for an Administrative Review must be made within 30 days of the date of the notice and that failure to do so will mean that the right to an Administrative Review and Fair Hearing will be waived, and the action will become final.

When an Administrative Review has been requested within the allowed time, HAP will have 30 days to review the action and make a decision. If it is decided that the request for an Administrative Review is not approved and that an action will be taken, the client will be notified of their right to a Fair Hearing.

Client Rights and Responsibilities

Client Rights

The applicant, client, or legally authorized representative has the right to:

- apply for eligibility determination;
- choose providers subject to program limitations;
- choose a health plan, if applicable, subject to program limitations;
- be notified of program decisions relating to modifications, suspensions, denials, or terminations;
- have all client files and other information maintained in a confidential manner to the extent authorized by law;
- appeal program decisions and receive a response within the deadline; and
- reapply for the program when eligibility for the program is denied or terminated.

Client Responsibilities

The applicant, client, or legally authorized representative has the responsibility to:

- provide accurate medical information to providers and notify providers of program eligibility prior to delivery of services;
- provide the program with accurate information regarding any change of circumstance which might affect eligibility and benefits within 30 days following such change; and
- notify the program of any lawsuit(s) contemplated or filed concerning the cause of the medical condition for which the program has made payment.

HAP Policy Information

Other Coverage

Benefits available to HAP clients are dependent on hemophilia status and eligibility for benefits from other programs such as Medicare, Medicaid, or private insurance. HAP is the payer of last resort. HAP benefits are paid only after all other third-party payers have met their liability.

Contact the Hemophilia Assistance Program

Phone

800-222-3986

8 a.m. to 5 p.m. Central Time

Monday through Friday

Fax Number

512-206-3982

Email Address

hemophilia@hhs.texas.gov

Mailing Address

Hemophilia Assistance Program

MC 1938

P.O. Box 149030

Austin, TX 78714-9947