Patient Protection and Affordable Care Act (ACA)
Frequently Asked Questions for Providers

1. **What is a Qualified Health Plan?**
   A Qualified Health Plan (QHP) provides the required Essential Health Benefits, follows established limits on cost sharing and meets other state and/or federal requirements. Essential Health Benefits include:

   - Emergency services
   - Hospitalizations
   - Laboratory services
   - Maternity care
   - Mental health and substance use treatment
   - Outpatient or ambulatory care
   - Pediatric care
   - Prescription drugs
   - Preventive care
   - Rehabilitative and habilitative care
   - Vision and dental care for children

   HAP has 70 Qualified Health Plans — all compliant with the ACA. These plans have a variety of cost-sharing and coverage options available for individuals as well as groups with two or more eligible employees.

2. **Where are QHPs purchased?**

Option	Individual Consumers	Small Employers
Directly from insurers like HAP	√	√
Through private exchanges	√	√
Through the Health Insurance Marketplace at **healthcare.gov** or by phone	√	
Through an agent	√	√
Through the Small Business Health Option (SHOP) Marketplace		√

3. **What is the difference between on- versus off-Marketplace?**
   QHPs purchased from the Health Insurance Marketplace are considered on-Marketplace (also known as on-Exchange). All other options are considered off-Marketplace.

   Some consumers purchasing on the Health Insurance Marketplace may be eligible for lower costs. For those making less than 400% of the Federal Poverty Level (FPL), the government will provide premium subsidies known as Advance Premium Tax Credits (APTC). Cost-sharing reductions, which lower the amount eligible consumers have to pay for out-of-pocket costs, are also available for those making less than 250% FPL. These lower costs are only available for plans purchased on-Marketplace.

   You may want to note that delinquency rules are different for on-Marketplace consumers receiving APTC and that not all on-Marketplace consumers receive APTC.

4. **How will I know if the patient has a HAP Qualified Health Plan?**
   According to your contract with HAP, you must verify eligibility of your HAP patients at each visit prior to rendering services. Failure to obtain verification may result in denial of claims payment, and you cannot balance-bill the member. The most efficient, accurate method to verify eligibility is by one of these methods:

   - Online at **hap.org** via the Member Eligibility Application (MEA). Remember to use your NPI or vendor number to log in. If you cannot find the patient using his/her ID number, try searching by last name using the magnifying glass icon.
   - Call the Provider Automated Service (PAS) line at (800) 801-1766 (24/7)
   - Call the Provider Verification line at (313) 664-8995, Monday through Friday, 8 a.m. to 4 p.m.

   While it is not a verification of eligibility, you can quickly identify HAP patients in these plans when you look at the RxPCN field on the patient's ID card and note:

   - HAPQHP1ON: Refers to Both Individual and Group HMO on-Marketplace
   - HAPQHP4ON: Refers to Both Individual and Group AHL on-Marketplace

   - HAPQCOFF: Refers to Both Individual and Group HMO off-Marketplace
   - HAPQAOFF: Refers to Both Individual and Group AHL off-Marketplace

5. **Does the HAP ID card look different for patients in a Qualified Health Plan?**
   No. They look the same as the HAP ID cards you see today.

6. **Do I have to be credentialed for these new plans?**
   No. You are already credentialed for these plans.

7. **Can I opt out of these plans? (#219)**
   No. If you are already a HAP provider then you are included in our network for Qualified Health Plans (on- and off-Marketplace) for 2014.

8. **What is the fee schedule for these new plans? (#87)**
   Same as current HAP fee schedules. You can find fee schedules when you log in at **hap.org.**

9. **What is the three month grace period? (#67)**
The ACA provides for a three month grace period for members receiving Advance Premium Tax Credits through the Health Insurance Marketplace. This grace period begins immediately upon a current member's first missed or partial premium payment, with the following reimbursement implications:

IF:	THEN:
Medical and pharmacy claims incurred during 1st month	HAP pays all appropriate claims
Medical claims incurred during 2nd and 3rd months	HAP pends all medical claims and determines whether member paid outstanding premium *
Pharmacy claims incurred during 2nd and 3rd months	HAP denies all pharmacy claims
Member makes a full payment of their outstanding premium prior to termination of contract	HAP pays outstanding claims
Member does **not** make full payment of their outstanding premium	Member is terminated back to day 31. Claims for the second and third months would be denied and the provider can seek reimbursement from the member
Note: An individual must have paid at least one month's premium before this grace period goes into effect.	

***** The Michigan Department of Insurance and Financial Services has indicated that claims submitted for services rendered to these members are not considered clean claims for which HAP would be responsible for payment. Therefore providers may directly bill these members, who are in the second and third month of the grace period, for services rendered.

10. **How will I know if a HAP patient is in a delinquent status?**
When you verify eligibility via our online Member Eligibility Application (MEA), you will see a warning message indicating the member is in delinquency and what month (e.g., Warning: member is in the first month of delinquency). You will also be able to mouse over the warning message to obtain more details.

11. **Can I pay my patients' premium obligation to satisfy their delinquent status?**
The Federal government has issued a warning to medical providers that they should not make payments on behalf of patients to meet their premium payment obligations.

12. **Can I deny services while a patient is in a delinquent status during the grace period? (#171)** No. Patients are still considered active during this time period.

13. **If the patient is terminated at the end of three months due to nonpayment of premium, will you take back the claims you paid for services rendered in the first month?**
No

14. Can a provider make a patient sign a waiver or pay for services up front?

Yes, if at least one of the criteria below is met, per HAP's Member Hold Harmless policy:

- Patient requested services that are not covered by his/her subscriber contract
- Patient has been advised that a referral is required for the service and the referral has not been obtained and/or authorized
- Patient has been advised that he/she is not assigned to the physician rendering service yet the member is requesting to be seen by provider

Note: For patients receiving Advance Premium Tax Credits through the Health Insurance Marketplace and in the second or third month of the three month grace period, The Michigan Department of Insurance and Financial Services has indicated that claims submitted for services rendered to these members are not considered clean claims for which HAP would be responsible for payment. Therefore providers may directly bill these patients, who are in the second and third month of the grace period, for services rendered. (Please refer to question 9).

15. **Will HAP be authorizing services during the delinquency grace period for members receiving premium tax credits through the Health Insurance Marketplace? (#171)**

Yes. Members are still considered active during this time period.

16. What is an Essential Community Provider (ECP)? (#89)

ECP refers to those providers who serve a predominantly low-income, medically underserved population. ACA requires issuers to meet specific contracting requirements, which HAP agreed to in its certification agreement with CMS. Many ECPs currently provide health care to individuals who have enrolled in Marketplace plans. It will be important to include ECPs in the plan provider networks so that patients can continue to receive care from them.

Types of ECP providers according to CMS

ECP Category	ECP Provider Types
Federally Qualified Health Center (FQHC)	FQHC and FQHC "Look-Alike" Clinics, Outpatient health programs/facilities operated by Indian tribes, tribal organizations, programs operated by Urban Indian Organizations
Ryan White Providers	Ryan White HIV/AIDS Providers
Family Planning Provider	Title X Family Planning Clinics and Title X "Look-Alike" Family Planning Clinics
Indian Health Providers	Indian tribes, Tribal and Urban Indian Organization Providers
Hospitals	Disproportionate Share Hospital (DSH) and DSH-eligible Hospitals, Children's Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers, Critical Access Hospitals
Other ECP Providers	STD Clinics, TB Clinics, Hemophilia Treatment Centers, Black Lung Clinics, and other entities that serve predominantly low-income, medically underserved individuals.

17. How do I become an ECP? (#90)

HAP contacted every ECP within the HAP service area to extend an invitation to become a participating HAP provider. Several providers have already responded by signing a contract. If you have questions or would like to become a HAP contracted ECP provider, please contact the HAP Provider Contracting team at (313) 664-8465.