DIVISION OF
Health Care
Finance and Policy

Health Safety Net Eligibility Processes: A Report by the Executive Office of Health and Human Services Division of Health Care Finance and Policy

Submitted in compliance with Section 35 of Chapter 118G

December 2010

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Commonwealth of Massachusetts

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Introduction

The Division of Health Care Finance and Policy (the Division) hereby submits this report to the Massachusetts legislature in compliance with Section 35 of M.G.L. Chapter 118G. Section 35 requires the Division to provide an annual report evaluating the processes used to determine eligibility for reimbursable health services. Specifically, Section 35 calls for:

- An analysis of the effectiveness of these processes in enforcing eligibility requirements for publicly-funded health programs and in enrolling uninsured residents into programs of health insurance offered by public and private sources;
- An assessment of the impact of these processes on the level of reimbursable health services by providers; and
- Recommendations for ongoing improvements that will enhance the performance of eligibility determination systems and reduce hospital administrative costs.

This report provides the required evaluation and illustrates that service utilization has declined since the implementation of health care reform. Through continued coordination and collaboration with MassHealth, the Division will continue to realize improvements to the eligibility determination system that supports the Health Safety Net.

Health Safety Net Eligibility Background

The Health Safety Net (HSN) was created by Chapter 58 of the Acts of 2006 as the successor to the Uncompensated Care Pool (UCP). The HSN, like its predecessor, serves as a safety net for uninsured and underinsured Massachusetts residents by reimbursing acute care hospitals and community health centers (CHCs) for allowable services. Some of the Health Safety Net's key eligibility policies include:

- Individuals may be eligible for the HSN if they are uninsured or underinsured and document family income between 0% and 400% of the federal poverty level (FPL).
- Uninsured and underinsured individuals with family income up to 200% of the FPL may be eligible for full HSN.
- Uninsured and underinsured individuals with family income between 201% and 400% of the FPL may be eligible for partial HSN, which includes a deductible based on the patient's income.
- Individuals with incomes between 0% and 400% of the FPL who are enrolled in insurance programs with limited benefits (such as MassHealth Limited) may be eligible for HSN secondary.

- HSN secondary eligibility is available for dental services for Commonwealth Care patients whose plans do not cover dental services, and for vision and dental services for Commonwealth Care Bridge patients.
- The HSN provides temporary eligibility to individuals during enrollment "gap" periods; 10 days prior to a patient's application for certain MassHealth programs or Commonwealth Care, and for a period of time after the application; in order to allow sufficient time to complete the enrollment process.
- The HSN may pay for emergency room bad debt (ERBD) at acute hospitals or urgent care bad debt (UCBD) at CHCs in cases where a provider is unable to collect payment from a patient after pursuing collection activity for a specified time period. ERBD and UCBD payments are only made for individuals who are uninsured and not eligible for MassHealth or Commonwealth Care.
- Individuals enrolled in MassHealth programs that provide comprehensive benefits, such as MassHealth Standard, Basic or Essential, are not eligible for the HSN.

Enforcement of Eligibility Requirements

The eligibility determination process for publicly funded health programs in Massachusetts relies on a single integrated eligibility system. The process begins when an individual fills out a form called a Medical Benefit Request (MBR). The MBR is a consolidated application used to determine patient eligibility for MassHealth, Commonwealth Care, and the HSN, respectively. Patients may either complete a paper MBR or an electronic MBR through the Virtual Gateway[1] with the assistance of a provider or outreach worker.

MassHealth processes the MBR and confirms patient eligibility using the MA-21 eligibility determination system. The system first assesses whether the applicant is eligible for MassHealth. If the applicant is not eligible for MassHealth, eligibility for Commonwealth Care is evaluated, followed by the HSN. As part of the eligibility determination process, MassHealth may initiate data matches with other agencies in order to verify income and determine program eligibility. These sources include, but are not limited to, the HSN, the Commonwealth Health Insurance Connector Authority, the Department of Unemployment Assistance, and the Department of Revenue.

Once an eligibility determination is made, the information in the MA-21 system is transferred to the New Medicaid Management Information System (NewMMIS). NewMMIS contains the Eligibility Verification System (EVS), the subsystem that providers use to obtain MassHealth, Commonwealth Care, and HSN eligibility information.

[1] The Virtual Gateway is an internet portal designed by the Executive Office of Health and Human Services that may be used to apply electronically for a number of human service programs. For more information, visit www.mass.gov/vg.

Individuals found eligible for the HSN undergo an annual redetermination process to maintain their eligibility. The redetermination process requires HSN households to complete and return an Eligibility Review Verification form within 45 days of receipt. If a household does not return the form within the specified timeframe, MassHealth will terminate the household's HSN eligibility.

With the exception of ERBD claims, all HSN claims must be for services provided to patients with HSN eligibility. Beginning in Health Safety Net fiscal year 2008 (HSN08), the claims adjudication system matches all non-ERBD HSN claims to an HSN-eligible patient prior to payment, leaving no paid claims unmatched. The HSN claims adjudication system receives a daily feed of eligibility data from NewMMIS, allowing it to immediately reject claims which cannot be matched to an HSN-eligible patient. The eligibility feed also allows the claims system to properly adjudicate ERBD, as claims for insured or HSN-eligible patients do not qualify for ERBD reimbursement. See Appendix A for a patient eligibility information data flow diagram.

The HSN serves as a payer of last resort for patients who are unable to obtain affordable health coverage through other sources. As such, the HSN does not make payments to providers if another payment source is available or if the individual is determined to have access to affordable insurance. To ensure compliance with these principles, the Division:

- Utilizes a common application and maintains the MA-21 system to ensure that eligibility policies are coordinated and applied consistently between the HSN, MassHealth, and Commonwealth Care;
- Utilizes provider messaging that communicates HSN eligibility and cost sharing policies;
- Provides incentives for patients to enroll in affordable and comprehensive insurance plans by precluding HSN primary coverage if the patient is eligible for affordable insurance coverage through an alternative source such as MassHealth, Commonwealth Care, or an employer; and
- Performs routine audit reviews to ensure that all other payer sources have been exhausted when payment is made from the HSN.

Encouraging Enrollment of Uninsured Residents in Public and Private Health Insurance

In keeping with the HSN's role as a payer of last resort, the Division is required by Chapter 58 of the Acts of 2006 to "develop programs and guidelines to encourage maximum enrollment of uninsured individuals who receive health services reimbursed by the fund into health care plans and programs of health insurance offered by public and private sources." Since 2006, the Division has undertaken several initiatives to encourage patients to enroll in available affordable insurance plans.

In October 2007, when the HSN replaced the UCP, approximately 48,000 Commonwealth Care-eligible individuals had not yet enrolled in Commonwealth Care. Between October and December of 2007, these individuals were informed that their HSN eligibility would end after a period of time sufficient to complete the Commonwealth Care enrollment process. All Commonwealth Care-eligible individuals were subsequently removed from the HSN between December 2007 and February 2008. The Division is currently studying the outcomes of this transition process.

The current HSN eligibility regulation allows Commonwealth Care-eligible individuals to receive time-limited HSN eligibility in order to allow them time to enroll in Commonwealth Care. Individuals applying for a Commonwealth Care determination may receive up to 90 days of HSN eligibility from their date of application. Commonwealth Care-eligible individuals may also receive HSN eligibility between the time they enroll and the time that plan coverage begins if this period falls outside of the initial 90 days. These eligibility requirements are programmed into the HSN claims system and communicated to providers through EVS.

During HSN09, approximately 26,000 legal immigrants were transitioned from the Commonwealth Care program to the Commonwealth Care Bridge (Bridge) program as the result of legislation. MassHealth, the Connector, and the HSN coordinated during this time to ensure a smooth transition and that patients remained eligible for the HSN as they were moved from one program to the other. EVS provider messaging was updated in response to Bridge program implementation to allow providers to distinguish Commonwealth Care and Bridge patients. The Health Safety Net Office collaborated with the Connector and with MassHealth to develop and implement these provider messages.

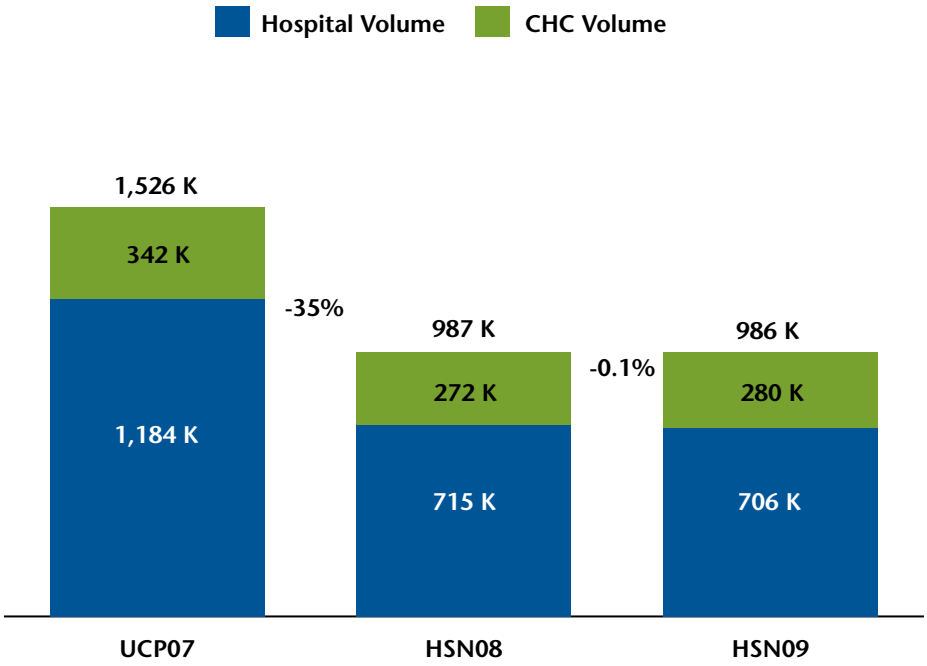
Currently, the HSN is working to expand the eligibility determination system capabilities to screen for access to affordable employer-sponsored insurance to promote individuals enrolling in alternative, affordable insurance. The current regulation allows individuals with access to affordable insurance that enroll in a plan to retain HSN secondary eligibility, in which the HSN acts as a secondary payer to their primary insurance plan for eligible services. On the other hand, individuals with access to affordable insurance who fail to enroll may lose HSN eligibility. The Division is also pursuing changes to the MBR that will capture information related to access to other types of potentially affordable insurance such as student health insurance, Tricare, and young adult plans. When implemented, these initiatives will further encourage enrollment of uninsured residents into appropriate health insurance.

The Impact of HSN Eligibility Policies on the Level of Reimbursable Health Services by Providers

The effects of HSN eligibility requirements and other changes related to health care reform are reflected in UCP/HSN visit and discharge volume statistics (see Figure 1). UCP/HSN volume declined

by 35 percent between UCP07, the last year of the UCP, and HSN08, the first year of the HSN, and has begun to stabilize under the new HSN structure.

Figure 1: UCP/HSN Total Service Volume Trends UCP07-HSN09



Notes: Hospital volume is the sum of inpatient discharges and outpatient visits for which payments were made to hospital providers in the periods shown. Community health center volume is the sum of visits for which payments were made to community health center providers in the periods shown.

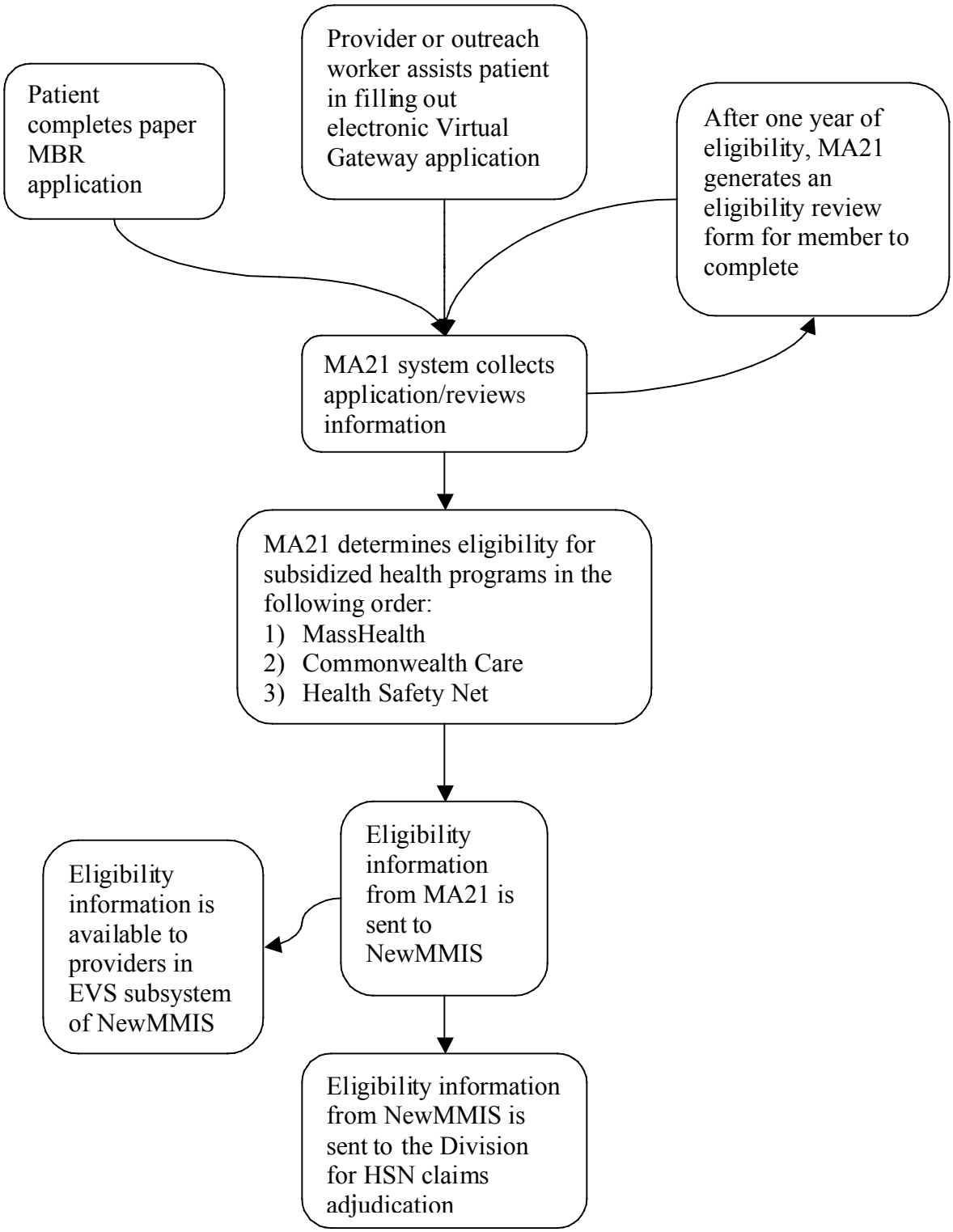
Recommendations for Ongoing Improvements

The Division will continue to monitor processes related to the MBR application to ensure continued coordination between MassHealth, the Connector, and the HSN in the eligibility determination process. Through on-going review of messaging in systems such as EVS, the Division will identify any issues and work with MassHealth to implement updates as needed to improve the quality and accuracy of patient eligibility information available to providers.

The Division will also continue work on a number of program integrity initiatives. The HSN is in the process of developing contracts that will monitor patient access to and enrollment in other sources of health insurance. Post audit reviews will maintain provider incentives to enroll patients in health insurance when it is available. Compliance review audits will also ensure that providers bill the HSN in accordance with regulatory requirements.

In sum, the Division has initiated a number of on-going program integrity measures and has systems in place to ensure the continued review and identification of new areas to be explored.

Appendix A: Map of Eligibility Determination Process



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