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**COMMONWEALTH OF MASSACHUSETTS**
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May 6, 2024

Chair Michael J. Rodrigues
Senate Committee on Ways and Means
State House, Room 212
Boston, MA 02133

Chair Aaron Michlewitz
House Committee on Ways and Means
State House, Room 243
Boston, MA 02133

Chair Cindy F. Friedman
Senate Chair, Joint Committee on Health Care Financing
State House, Room 313
Boston, MA 02133

Chair John H. Lawn, Jr.
House Chair, Joint Committee on Health Care Financing
State House, Room 236
Boston, MA 02133

Dear Chairs Rodrigues, Michlewitz, Friedman, and Lawn,

Section 65 of M.G.L. Chapter 118E as established by Section 131 of Chapter 224 of the Acts of 2012 requires Executive Office of Health and Human Services (EOHHS) to provide an annual report evaluating the processes used to determine eligibility for Health Safety Net reimbursable health services.

Specifically, Section 65 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. Please find attached a report which provides the required evaluation and illustrates service utilization trends.

I hope you find this report useful and informative. If you have any questions, please feel free to contact Sarah Nordberg at Sarah.Nordberg@mass.gov.

Sincerely,

Mike Levine

cc: Kathleen E. Walsh

**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) to reimburse Acute Care Hospitals and Community Health Centers (CHCs) for health services provided to uninsured and underinsured Massachusetts residents.

An overview of HSN eligibility is as follows:

- All HSN-eligible individuals must be uninsured or underinsured. Once determined eligible, the costs incurred by individuals are reimbursed through Primary or Secondary HSN, and individuals may be required to pay a deductible (HSN Partial).
    - HSN Primary is for patients who have no other health coverage and HSN is their primary payer for eligible medical services.
    - HSN Secondary is for patients who have other health insurance coverage. The HSN pays for HSN reimbursable health services that are not covered by the patient's primary insurance coverage.
- Massachusetts residents may be determined for different HSN eligibility based on their income level.
    - Uninsured and underinsured individuals with incomes up to 150% of the FPL may be eligible for HSN Primary or HSN Secondary, without a deductible.
    - Uninsured and underinsured individuals with incomes between 150% and 300% of the FPL may be eligible for HSN Primary Partial or Secondary Partial, which includes a deductible based on the patient's income.
- The HSN provides temporary medical and dental reimbursement to individuals determined eligible for ConnectorCare coverage, which includes the 10 days prior to a patient's application date and 90 days after the submission of their application. This allows sufficient time to complete the ConnectorCare enrollment process.
    - HSN Secondary is available to individuals who are eligible for ConnectorCare after the above period of time. HSN provides reimbursement for allowable dental services not covered by their health plan.
- The HSN may also reimburse providers for reimbursable health services provided to members of other Qualified Health Plans (QHPs) offered by the Connector that are not covered by their primary insurance, as long as the member is otherwise HSN eligible.
- For HSN eligible recipients enrolled in MassHealth Limited which provides emergency services only, the HSN reimburses providers for allowable reimbursable health services not covered by their MassHealth plan.

- The HSN reimburses providers for emergency or urgent care bad debt at HSN authorized Acute Care Hospitals, Hospital Licensed Health Centers or Community Health Centers (CHCs) in cases where a provider is unable to collect payment from an uninsured patient after pursuing collection activity for a specified time period. Bad debt payments are only made for individuals who were uninsured and had no HSN eligibility at the time the services were provided.
- Some individuals may qualify for other types of HSN eligibility under certain special circumstances. These patients make up a very small percentage of the HSN caseload.
    - The HSN Medical Hardship program reimburses allowable medical expenses from HSN authorized providers for services provided to patients who have medical bills that exceed a specified proportion of their income. This is a retrospective eligibility type for services delivered up to 12 months prior to the application date. Individuals are only eligible to submit an application for this coverage two times within a 12-month period. A financial contribution from the patient may be required based on the patient's income level.
    - HSN Confidential is a program that reimburses providers for services confidentially provided to minors seeking treatment for sexually transmitted diseases and/or family planning services, as well as services provided to survivors of domestic violence who have a reasonable fear of domestic violence. Providers may only submit claims for confidential services when no other source of funding is available to pay for the services confidentially. This eligibility type must be renewed annually with the assistance of a provider.
    - Uninsured individuals who meet the eligibility criteria for HSN and are unable to complete a full application for health coverage at the time they receive medical treatment can have their provider submit an application for temporary HSN coverage on their behalf through a presumptive determination process. The HSN reimburses for eligible services until the end of the month after their determination date or at the time a determination is made on a full application, whichever comes earlier. Individuals can only apply for temporary HSN once annually.

**Enforcement of Eligibility Requirements**

Eligibility Determinations

The HSN uses the same application and determination systems as MassHealth for all types of coverage mentioned above, except emergency or urgent care bad debt and those coverages listed under special circumstances. As with MassHealth, all applications submitted for the HSN have income, residency, access to other health insurance, and identity verified at the time of application. Those applicants whose information cannot be verified through state and federal data sources at the time of application are asked to provide that information within 90 days. Similar to MassHealth, the HSN re-determines eligibility on an annual basis.

Claims Processing

With the exception of bad debt claims, all HSN claims must be for services provided to patients with HSN eligibility. The HSN's claims adjudication system matches all non-emergency bad debt HSN claims to an HSN-eligible patient prior to payment, leaving no paid claims unmatched.

All claims are checked for HSN eligibility when they come in through either the Medicaid Management Information System (MMIS), the Pharmacy Online Processing Center (POPs), or the DentaQuest Dental Processing Center. This allows the claims adjudication system to immediately deny claims that cannot be matched to an HSN-eligible patient. An ongoing eligibility feed from MMIS is used to allow the HSN claims processing system to properly adjudicate bad debt claims, as claims for insured or HSN-eligible patients do not qualify for bad debt reimbursement.

Since July 15, 2012, all HSN medical claims have been received for processing through the MMIS system. HSN claims pass through the full range of claims editing available in MMIS, including edits to capture duplicate claims, medically unnecessary services, medically unlikely services, and correct coding initiative edits incorporated. However, MMIS is currently unable to run full HSN claim edits or price HSN claims. Therefore, certain eligibility and claims editing continues to occur outside of MMIS. Pricing also continues to occur outside of MMIS due to differences in HSN and MassHealth pricing methodologies.

HSN pharmacy claims are processed and priced using MassHealth's Pharmacy Online Processing System (POPS). POPS processes HSN pharmacy claims as the HSN pays for prescription drugs using the same rates as MassHealth.

As of January 1, 2017, MassHealth's dental vendor, DentaQuest, began processing and pricing HSN dental claims. Prior to that date, HSN dental claims were being processed directly by the HSN. DentaQuest adjudicates and prices dental claims for the HSN using MassHealth edits and pricing logic that already existed in the system, reducing the need for manual processes and increasing overall claims processing efficiency.

Identifying Other Available Insurers

The HSN serves as a payer of last resort for services provided at Acute Care Hospitals, Hospital Licensed Health Centers, and Community Health Centers to low-income patients who are unable to obtain comprehensive or affordable health insurance coverage through other sources. As such, the HSN does not make payments to providers if another payment source is available. To ensure compliance with these principles, the HSN has implemented the following program integrity measures:

- The HSN uses a common application and eligibility system to ensure that eligibility policies are applied consistently between the HSN, MassHealth, and the Connector.
- The eligibility systems HSN providers access communicates HSN eligibility and cost sharing policies.
- The HSN contracts with a vendor that reviews HSN paid claims to determine whether another payer was available on the date of service, and to recommend the recovery of payment in cases where the provider did not appropriately bill the primary payer prior to billing the HSN.
- The HSN continues to work with MassHealth on a standardized reporting practice for all HSN Secondary claims in order to deny any claims where the primary payer's adjudication information is not reported accurately. This will further enhance the specificity and accuracy of any payments to providers that submit claims to HSN as a secondary payer.

- The HSN works with MassHealth and the Connector to deny medical claims for patients that are enrolled in medical plans through The Health Connector. This ensures that HSN is only paying on claims that are truly HSN's responsibility.

Verification of Income and Eligibility

Income is verified by MassHealth during the eligibility determination process. Income verification may be in the form of a match to federal and state data hubs. If an applicant reports income that does not reasonably match those sources, verification of income is requested within 90 days. Individuals that submit their verification of income within this period receive their HSN eligibility begin date 10 days prior to their application date. MassHealth also performs regular data matches for HSN individuals with the Department of Revenue and other data sources on all eligible individuals with a Social Security Number in order to verify wage information.

As explained above, eligibility is also verified for each HSN claim before it is paid. HSN Primary and Secondary claims are run through eligibility logic during the adjudication process to ensure that the HSN eligible individual is known to the MMIS system and has HSN eligibility on the date of service. For bad debt claims, the system ensures that no eligibility is present on the date of service before allowing the claim to pass.

The HSN also has a grievance process in place for patients who believe they received an inaccurate eligibility determination or would like to dispute an action taken by the HSN or a provider. HSN staff promptly responds to patients with most grievances resolved promptly. For more complicated cases, collaboration with other state offices and agencies may be required, but patients receive regular updates until a resolution is reached.

Encouraging Enrollment in Other Available Insurance Programs

Section 65 of MGL Chapter 118E requires the HSN 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 the implementation of this requirement in 2006, the HSN has undertaken various initiatives to encourage patients to enroll in available, affordable insurance plans. For instance, in March 2020, the HSN awarded grant funds to six Awardees to enhance the ability of low-income individuals to complete and maintain enrollment in comprehensive health coverage, particularly through the range of options provided by MassHealth and the Health Connector. Additionally, the HSN awards grant funding to the Massachusetts Fishing Partnership who employs Massachusetts Health Connector Navigators who are certified application counselor's, performs substance abuse disorder initiatives, and safety programs with the overall goal of assisting and maintaining health insurance enrollment among the fishing community while also reducing the HSN's liability with its SUD and safety programs.

As a result of the Affordable Care Act (ACA), many patients who previously were eligible only for the HSN have become eligible for other programs. Under the ACA, a new coverage type called MassHealth CarePlus was created to cover certain patients with incomes up to 133% of the FPL who were not previously eligible for Medicaid. MassHealth Standard also became available to certain HSN patients between 19 and 20 years of age in this income range. On January 1, 2014, approximately 30,000 HSN patients were transitioned into MassHealth

Standard and CarePlus coverage. The ACA also expanded subsidies to individuals that fall within 300-400% of the FPL through advanced premium tax credits (APTCs). APTCs can be applied to the cost of Qualified Health Plans offered by the Connector to reduce the premium amounts paid by members who may have only been eligible for HSN in the past.

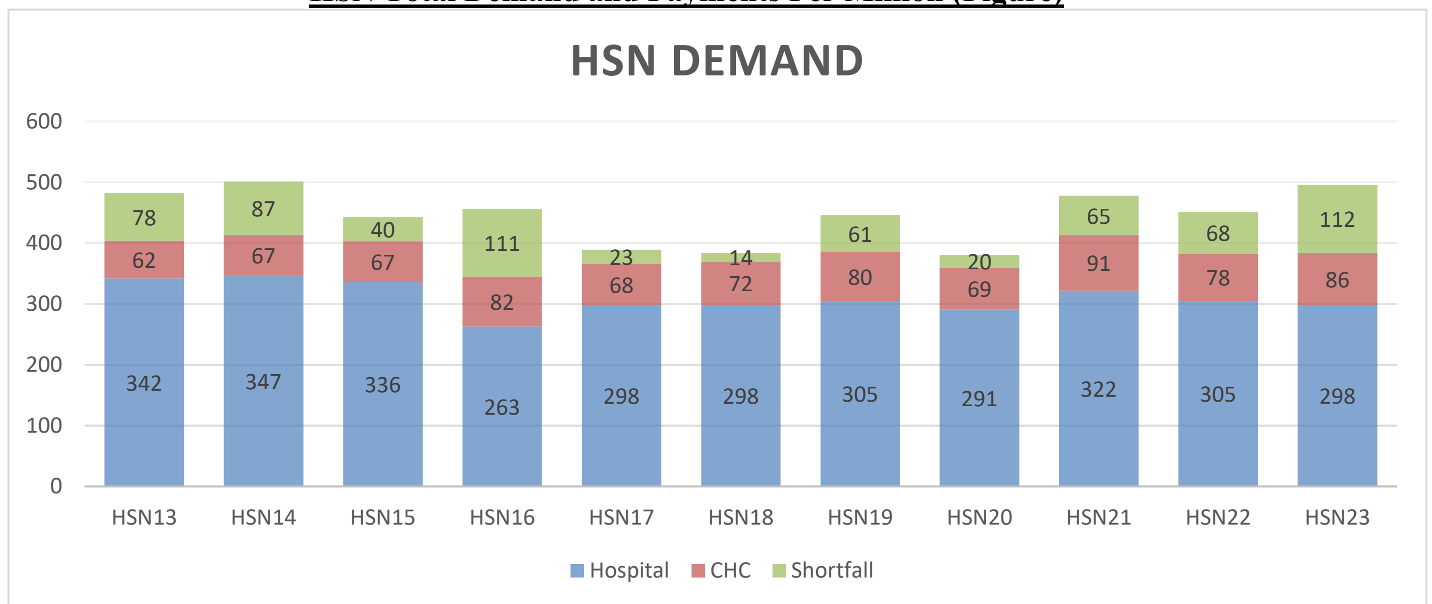
The HSN continues to actively work with MassHealth, the Health Connector, and other community stakeholders on efforts to encourage the uptake in comprehensive coverage for those who qualify.

**Impact of HSN Eligibility Policies on the Level of Total HSN Demand from Providers**

The effects of HSN eligibility requirements and other changes related to health care reform are reflected in HSN payment and demand statistics. Demand from hospitals and Community Health Centers (CHCs) reflects the impact of policies on overall utilization of HSN reimbursable services.

As seen in Figure 1, UCP/HSN Spending has returned to pre-pandemic levels as utilization shifted to pre-COVID-19 levels.

**HSN Total Demand and Payments Per Million (Figure)**




**Recommendations for Ongoing Improvement**

The Health Safety Net works collaboratively with MassHealth, the Connector, and other state agencies to streamline eligibility systems and determination processes and ensure program integrity. The Health Safety Net will continue to collaborate with state agencies on enhancements to the new eligibility system and determination processes. The HSN plans to prioritize the following improvements:

- Enhance claims processing systems to improve overall HSN claims processing and program integrity, ensure accurate payments are made to providers in a timely fashion and further reduce hospital administrative burden.