

Health Safety Net Annual Report

December 2014



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Introduction

The Executive Office of Health and Human Services (EOHHS) hereby submits this report to the Massachusetts Legislature in compliance with Chapter 165 of the Acts of 2014, Line Item 4000-0300, which calls for EOHHS to report on the utilization of the Health Safety Net Trust Fund, including:

- The number of persons whose medical expenses were billed to the Health Safety Net Trust Fund in fiscal year 2014,
- The total dollar amount billed to the Health Safety Net Trust Fund in fiscal year 2014,
- The demographics of the population using the Health Safety Net Trust Fund,
- The types of services paid for out of the Health Safety Net Trust Fund in fiscal year 2014, and
- An analysis on hospitals' responsiveness to enrolling eligible individuals into the MassHealth program upon the date of service rather than charging those individuals to the Health Safety Net Trust Fund.

This report reflects Health Safety Net (HSN) utilization during HSN fiscal year 2014 (HSN14), which ran from October 2013 through September 2014.



HSN Overview

- The Health Safety Net (HSN), created by Chapter 58 of the Acts of 2006, makes payments to hospitals and community health centers for health care services provided to low-income Massachusetts residents who are uninsured or underinsured.
- Massachusetts residents who are uninsured or underinsured and have income up to 200% of the Federal Poverty Level (FPL) are eligible for full HSN primary or full HSN secondary coverage. If residents have income above 200% and up to 400% of the FPL, they are eligible for partial HSN or partial HSN secondary, which includes a sliding scale deductible. Low income residents who are enrolled MassHealth, Commonwealth Care, ConnectorCare, or other insurance may be eligible for HSN secondary for certain services not covered by their primary insurance.
- Implementation of the Affordable Care Act began to affect HSN utilization in HSN14, as many HSN members have become eligible for other programs. The impact of the Affordable Care Act is reflected in this report.
- The HSN pays hospitals based on claims, which are adjudicated to verify that the patient is eligible and the services are covered. HSN payment rates for most services are based on Medicare payment principles.
- HSN14 funding included the following sources: An assessment on acute hospitals' private sector charges (\$164.7 million); a surcharge on payments made to hospitals and ambulatory surgical centers by HMOs, insurers, third party administrators, and individuals (\$164.7 million); an annual appropriation from the Commonwealth's General Fund (\$30 million); and offset funding for uncompensated care from the Medical Assistance Trust Fund (\$70 million).

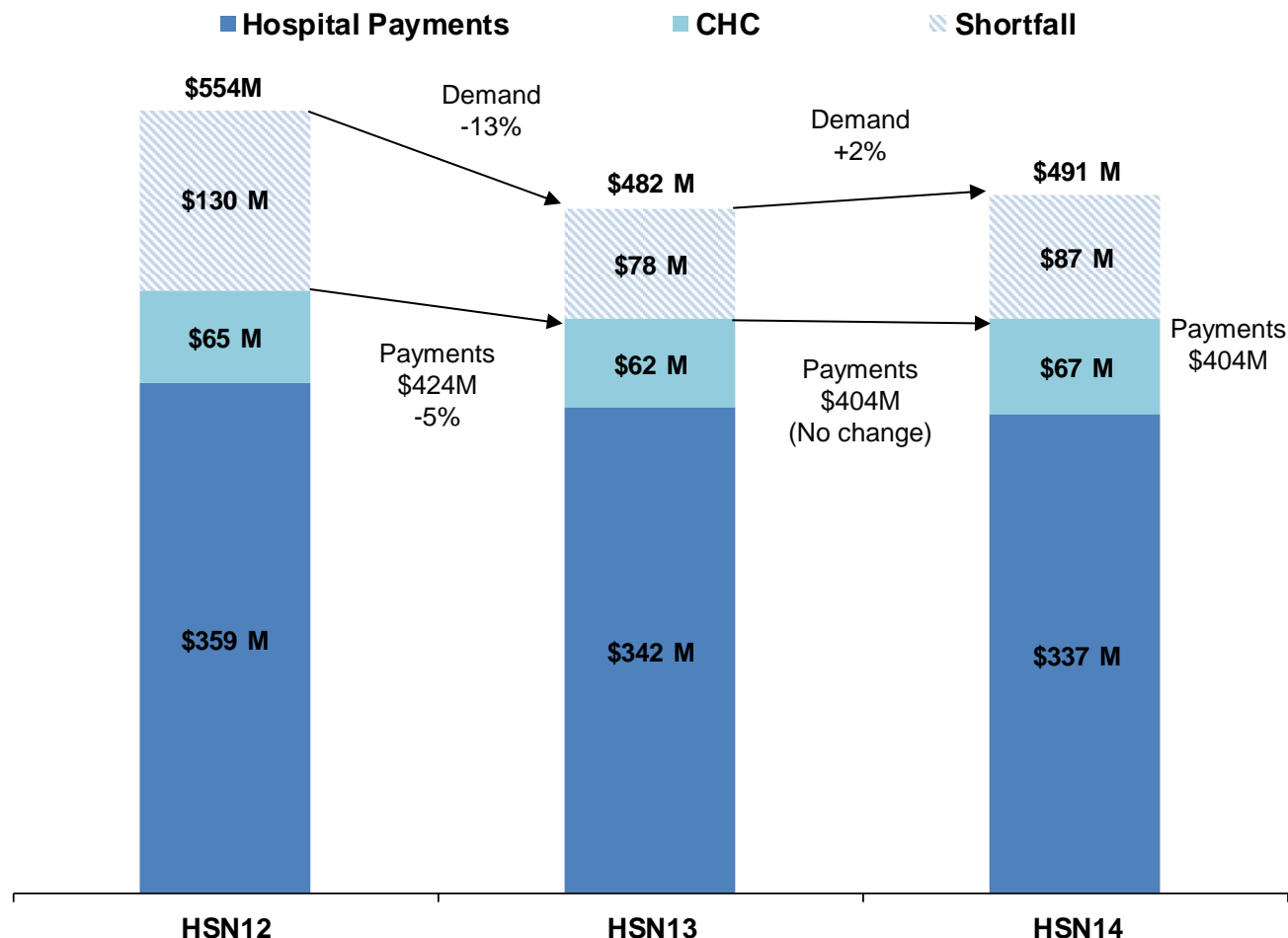


HSN Data Notes

- As required by Chapter 68 of the Acts of 2011, HSN medical claims processing transitioned from the Health Safety Net Office's claims adjudication system to MassHealth's Medicaid Management Information System (MMIS) in July of 2012.
- In order to prepare for the transition, the Health Safety Net Office stopped accepting medical claims as of May 1, 2012. The first payments based on claims submitted to MMIS were made in January 2013. During this transition period, providers received interim payments based on their historical claim volume.
- After the transition, interim payments were recovered and providers were paid for claims from the transition period, many of which would have been paid during HSN12 under normal circumstances.
- HSN reports prior to HSN13 have reported data based on the month in which claims were paid. However, applying this methodology to data from the transition period would misrepresent claim volume and demand. Therefore, unless otherwise specified, data in this report is reported by date of service.
- Data from prior periods may differ from data previously reported due to this change in methodology, and data for the periods included in this report is subject to change as additional claims are processed.



HSN Total Demand and Payment Trends



Demand represents the amount that providers would have been paid in the absence of a funding shortfall. Because in Health Safety Net fiscal year 2014 (HSN14) demand exceeded HSN14 funding, hospital providers experienced an \$87 million shortfall during HSN14.

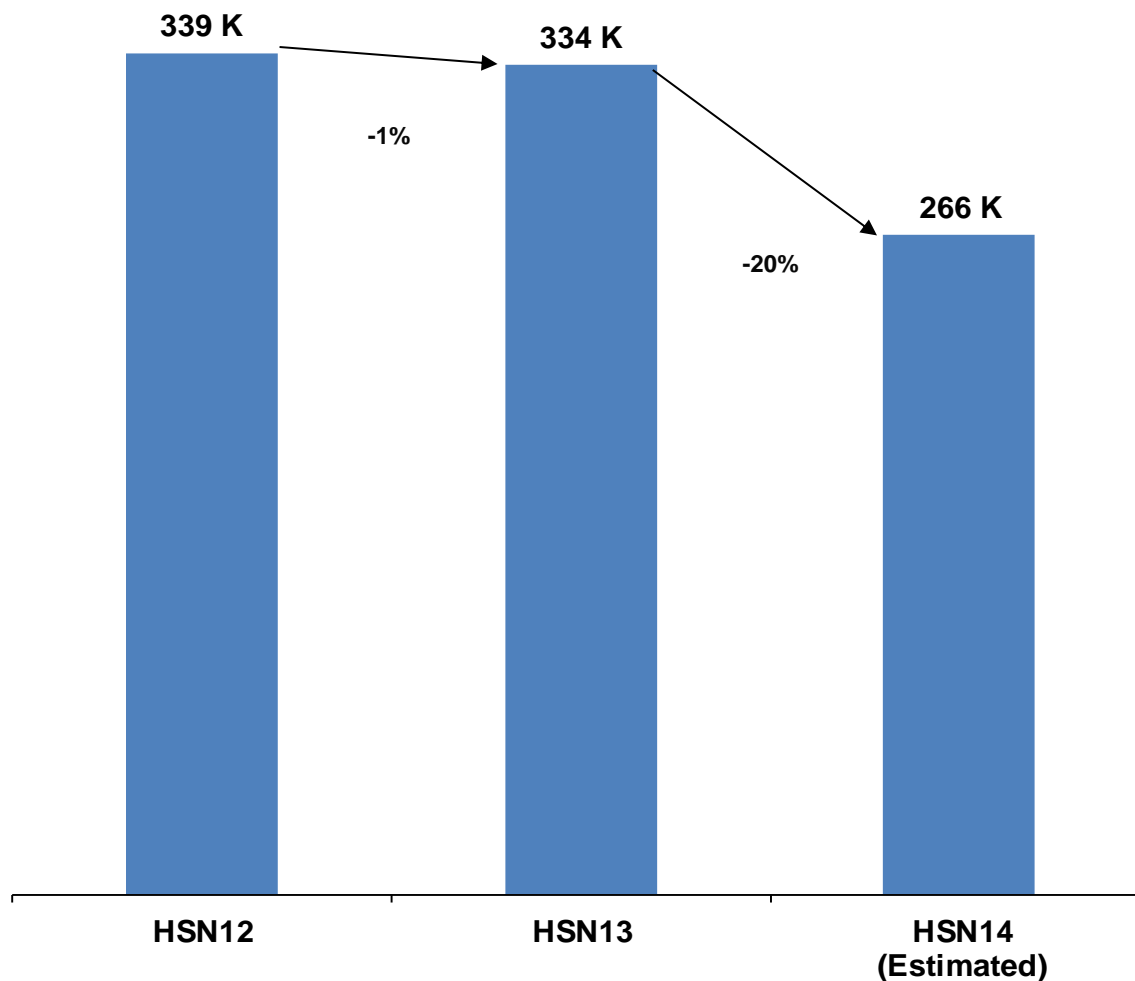
Total Health Safety Net (HSN) demand decreased in HSN13 compared to the prior fiscal year. However, it is important to note that this was driven by claims processing adjustments, rather than by a decrease in actual demand for services.

Due to a financial adjustment made during HSN12, October and November 2011 CHC payments were made using HSN11 funding. These payments account for \$10.2 million of the \$65 million HSN12 CHC payment reported to the left.

Notes: The Health Safety Net fiscal year runs from October 1 through September 30 of the following year. Hospital and community health center payments are reported in the month in which payment was made. HSN12 hospital payments include an HSN12 payment adjustment transacted in October 2012. Due to the transition of HSN claims processing to MMIS, providers received interim payments based on historical claims data from July through December 2012. The shortfall amount is based on spending assumptions in place during the fiscal year and may differ from year-end shortfall estimates reported elsewhere. Numbers are rounded to the nearest million and may not sum due to rounding; percent changes are calculated prior to rounding.

Source: Health Safety Net Payment Calculation.

HSN Total User Trends



The Health Safety Net (HSN) Office estimates that medical services provided to 266,000 individuals in HSN14 will be billed to the HSN.

A portion of claims for HSN14 dates of service have not yet been submitted. These claims may represent unique users that are not yet accounted for in the existing claims data. Therefore, the total number of HSN14 users is estimated based on current claims data and historical claims experience.

The overall decrease in HSN users from HSN13 to HSN14 is likely due to HSN-eligible individuals being placed into new coverage types as a result of the Affordable Care Act (ACA).

Notes: The Health Safety Net fiscal year runs from October 1 through September 30 of the following year. Users who receive a service in more than one setting (hospital, community health center or emergency room bad debt) are counted only once. Users are reported on claims for which payments were made to hospital and community health center providers based on date of service. Total users in HSN12 reflect updated claims activity and may differ from data previously reported. Total users in HSN14 are based on current claims submitted and may change based on updated data. Numbers are rounded to the nearest thousand; percent changes are calculated prior to rounding.

Source: Health Safety Net Data Warehouse as of 11/6/2014.



Top Ten Inpatient Major Diagnostic Categories

Inpatient Major Diagnostic Categories (MDC) for HSN14	Percent Inpatient Discharges	Percent Inpatient Payments
Diseases of the Circulatory System	15%	15%
Diseases of the Digestive System	12%	11%
Diseases of the Musculoskeletal System and Connective Tissue	8%	9%
Diseases of the Respiratory System	11%	8%
Diseases of the Nervous System	7%	7%
Infectious and Parasitic Diseases	5%	7%
Mental Illness	9%	7%
Diseases of the Hepatobiliary System and Pancreas	5%	7%
Endocrine, Nutritional, and Metabolic Diseases	5%	4%
Alcohol and Drug Use Treatment	5%	4%
Total for Top Ten	82%	79%

In Health Safety Net fiscal year 2014 (HSN14), the top ten diagnostic categories accounted for 82% of inpatient discharges and 79% of inpatient payments.

Circulatory, digestive, musculoskeletal system and respiratory diseases and were the top four diagnostic categories among inpatient claims.

These four diagnostic categories comprised 46% of inpatient discharges and 43% of inpatient payments.

Notes: The Health Safety Net fiscal year runs from October 1 through September 30 of the following year. Inpatient claims are grouped into major diagnostic categories (MDCs) using version 31 of the MS-DRG grouper, depending on the date of service on the claim. Hospital inpatient volume is inpatient discharges reported in the month in which the service was provided. Hospital inpatient volume excludes pharmacy claims. Hospital inpatient payments are reported in the month in which the service was provided. Hospital inpatient payments exclude pharmacy payments. Numbers are rounded to the nearest percent.

Source: Health Safety Net Data Warehouse as of 11/6/2014.



Top Ten Outpatient Clinical Classification Diagnosis Categories

Outpatient CCS Diagnosis Categories for HSN14	Percent Outpatient Claims	Percent Outpatient Payments
Symptoms; signs; and ill-defined conditions and factors influencing health status	15%	16%
Diseases of the musculoskeletal system and connective tissue	11%	10%
Diseases of the nervous system and sense organs	8%	9%
Diseases of the genitourinary system	8%	8%
Neoplasms	6%	8%
Diseases of the circulatory system	8%	7%
Endocrine; nutritional; and metabolic diseases and immunity disorders	8%	7%
Injury and poisoning	6%	7%
Diseases of the respiratory system	6%	6%
Diseases of the digestive system	5%	5%
Total for Top Ten	81%	83%

In Health Safety Net fiscal year 2014 (HSN14), the top ten clinical classification (CCS) diagnosis categories accounted for 81% of outpatient claims and 83% of outpatient payments.

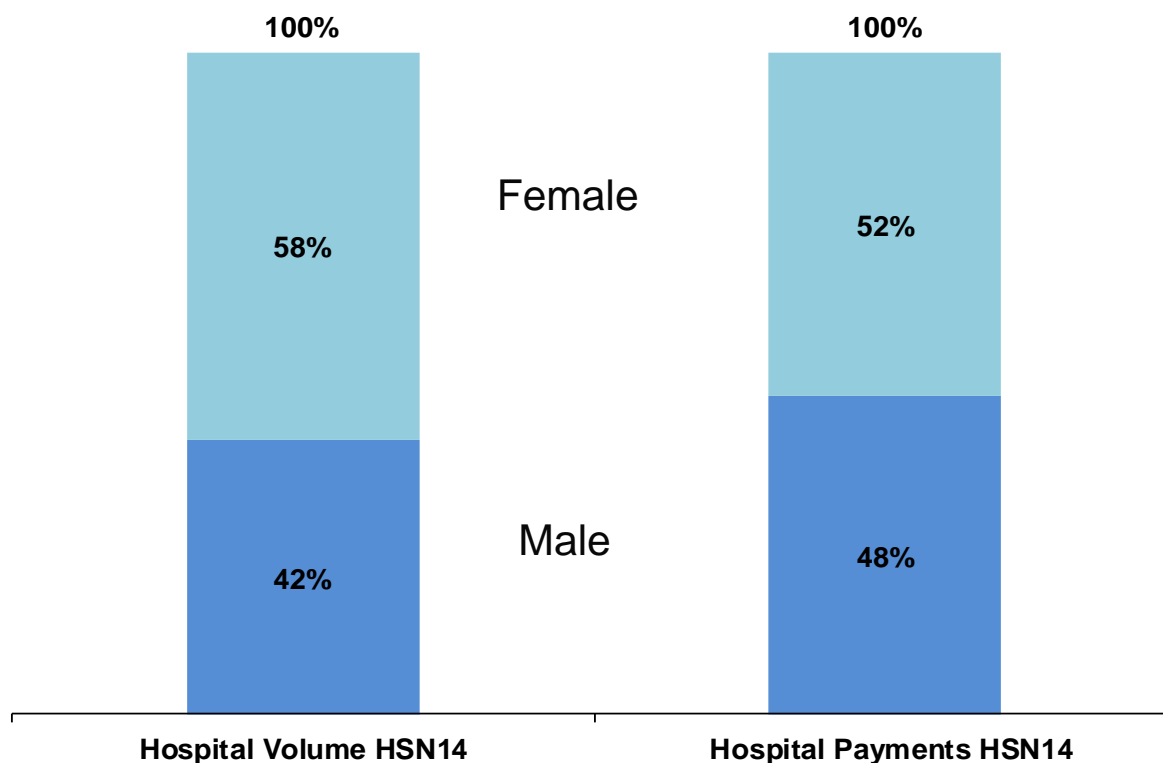
Symptoms, signs, and ill-defined conditions and factors influencing health status; musculoskeletal system and connective tissue diseases; and diseases of the nervous system and sense organs were the top three CCS diagnosis categories among outpatient claims.

These three CCS diagnosis categories comprised 34% of outpatient claims and 35% of outpatient payments.

Notes: The Health Safety Net fiscal year runs from October 1 through September 30 of the following year. Outpatient 837I claims are grouped using the Clinical Classification Software (CCS) from the Agency for Healthcare Research and Quality (AHRQ). Hospital outpatient claims are claims reported in the month in which the service was provided. Hospital outpatient claims exclude pharmacy claims. Hospital outpatient payments are reported in the month in which the service was provided. Hospital outpatient payments exclude pharmacy payments. Numbers are rounded to the nearest percent. Source: Health Safety Net Data Warehouse as of 11/6/2014.



Hospital Utilization and Payments by Gender



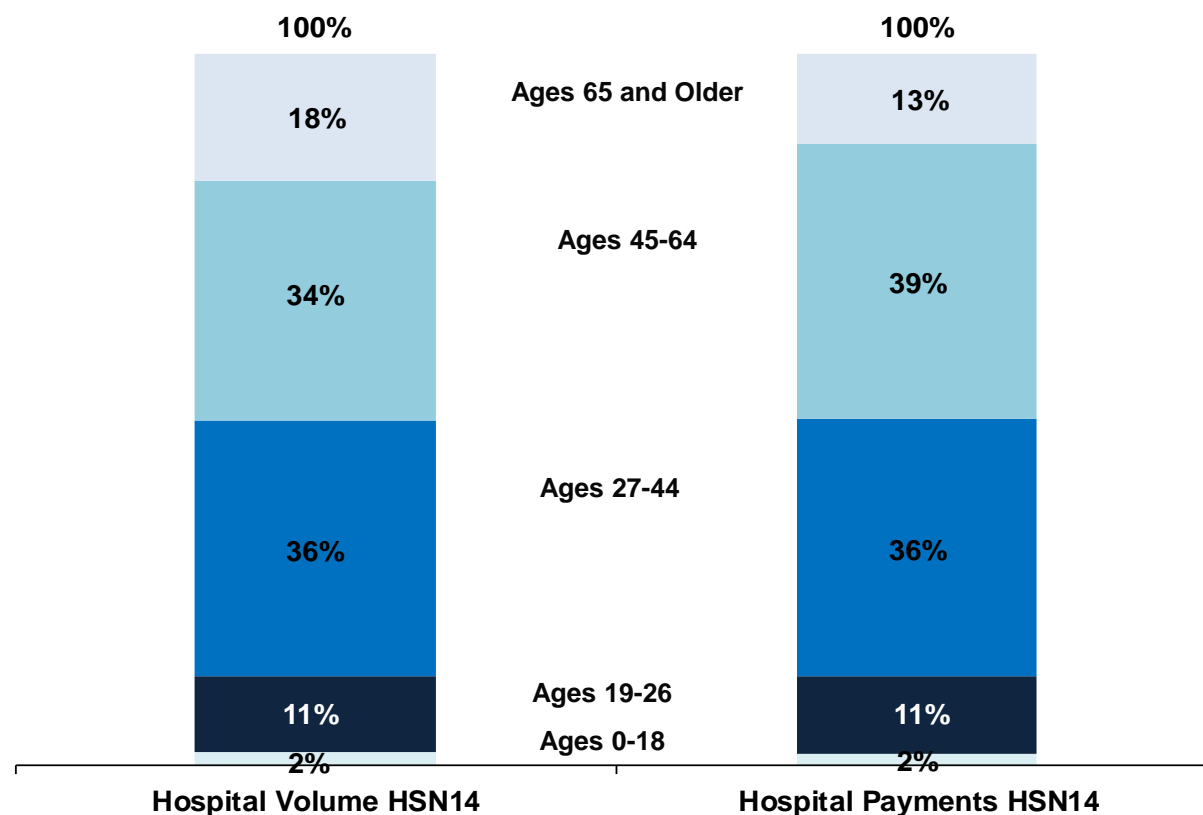
In Health Safety Net fiscal year 2014 (HSN14), men used fewer services than women yet payments for men's services were higher than payments made for women's services.

During this period, men accounted for 42% of volume and 48% of payments.

Notes: The Health Safety Net fiscal year runs from October 1 through September 30 of the following year. Hospital volume is the sum of inpatient discharges and outpatient visits reported in the month in which the service was provided. Hospital volume excludes pharmacy claims. Hospital payments are reported in the month in which the service was provided. Hospital payments exclude pharmacy payments. Numbers are rounded to the nearest percent and may not sum to 100% due to rounding.
Source: Health Safety Net Data Warehouse as of 11/6/2014.



Hospital Utilization and Payments by Age



In Health Safety Net fiscal year 2014 (HSN14), the non-elderly adult population (ages 19 to 64) accounted for 81% of hospital volume and 86% of hospital payments.

Because the Health Safety Net (HSN) is a secondary payer for low-income Medicare patients, adults ages 65 and older accounted for 18% of hospital volume but only 13% of hospital payments.

Notes: The Health Safety Net fiscal year runs from October 1 through September 30 of the following year. Hospital volume is the sum of inpatient discharges and outpatient visits reported in the month in which the service was provided. Hospital volume excludes pharmacy claims. Hospital payments are reported in the month in which the service was provided. Hospital payments exclude pharmacy payments. Numbers are rounded to the nearest percent and may not sum to 100% due to rounding.
Source: Health Safety Net Data Warehouse as of 11/6/2014.

Hospital Responsiveness to Enrolling Patients in MassHealth

Chapter 165 of the Acts of 2014 requests an analysis on hospitals' responsiveness to enrolling eligible individuals into the MassHealth program upon the date of service rather than charging those individuals to the Health Safety Net Trust Fund.

At the beginning of HSN14, the eligibility determination process for most publicly funded health programs began when an individual filled out a form called a Medical Benefit Request (MBR). The MBR was a consolidated application used to determine patient eligibility for MassHealth, Commonwealth Care, and the HSN. MassHealth processed the MBR and confirmed patient eligibility using the MA-21 eligibility determination system. The system first assessed whether the applicant was eligible for MassHealth. If the applicant was not eligible for MassHealth, eligibility for Commonwealth Care was evaluated, followed by HSN eligibility. Therefore, an applicant could not be determined eligible for the HSN without first having their eligibility for MassHealth and Commonwealth Care considered.

Due to systems issues at the beginning of 2014 related to ACA implementation, the Commonwealth was unable to determine many applicants' eligibility for ACA coverage types. These systems issues impacted eligibility determinations for MassHealth, Health Connector programs, and the Health Safety Net. In order to provide coverage at this time, the Commonwealth temporarily extended Commonwealth Care and the Medical Security Plan (MSP) for enrolled members, and enrolled new applicants who did not have other coverage into temporary MassHealth coverage types. Thus, during this time period, many applicants who may have otherwise been determined eligible for the HSN were determined into one of the temporary coverage types. During HSN14, over 300,000 individuals have been enrolled in temporary MassHealth coverage, which indicates that hospitals are taking active steps to enroll patients in appropriate subsidized coverage. These systems issues have been resolved in time for the 2015 open enrollment period in November 2014. All individuals currently in temporary coverage, Commonwealth Care, and MSP will be asked to submit new applications.

