

# Health Safety Net Annual Report

February 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 38 of the Acts of 2013, 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 2013,
- The total dollar amount billed to the Health Safety Net Trust Fund in fiscal year 2013,
- 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 2013, 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 2013 (HSN13), which ran from October 2012 through September 2013.



# 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.
- The Division of Health Care Finance and Policy was responsible for administering the HSN until November 2012, when Chapter 224 of the Acts of 2012 transferred this authority to the Office of Medicaid within EOHHS.
- 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 between 201% and 400% of the FPL, they are eligible for partial HSN or partial HSN secondary coverage, which includes a sliding scale deductible. Low income residents who are enrolled MassHealth, Commonwealth Care, or other insurance may be eligible for HSN secondary for certain services not covered by their primary insurance.
- Implementation of the Affordable Care Act is expected to affect HSN utilization beginning in HSN14, as many HSN members may become eligible for other programs. The impact of the Affordable Care Act will be reflected in future reports.
- 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.
- HSN13 funding included the following sources: An assessment on acute hospitals' private sector charges (\$160 million); a surcharge on payments made to hospitals and ambulatory surgical centers by HMOs, insurers, third party administrators, and individuals (\$160 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).

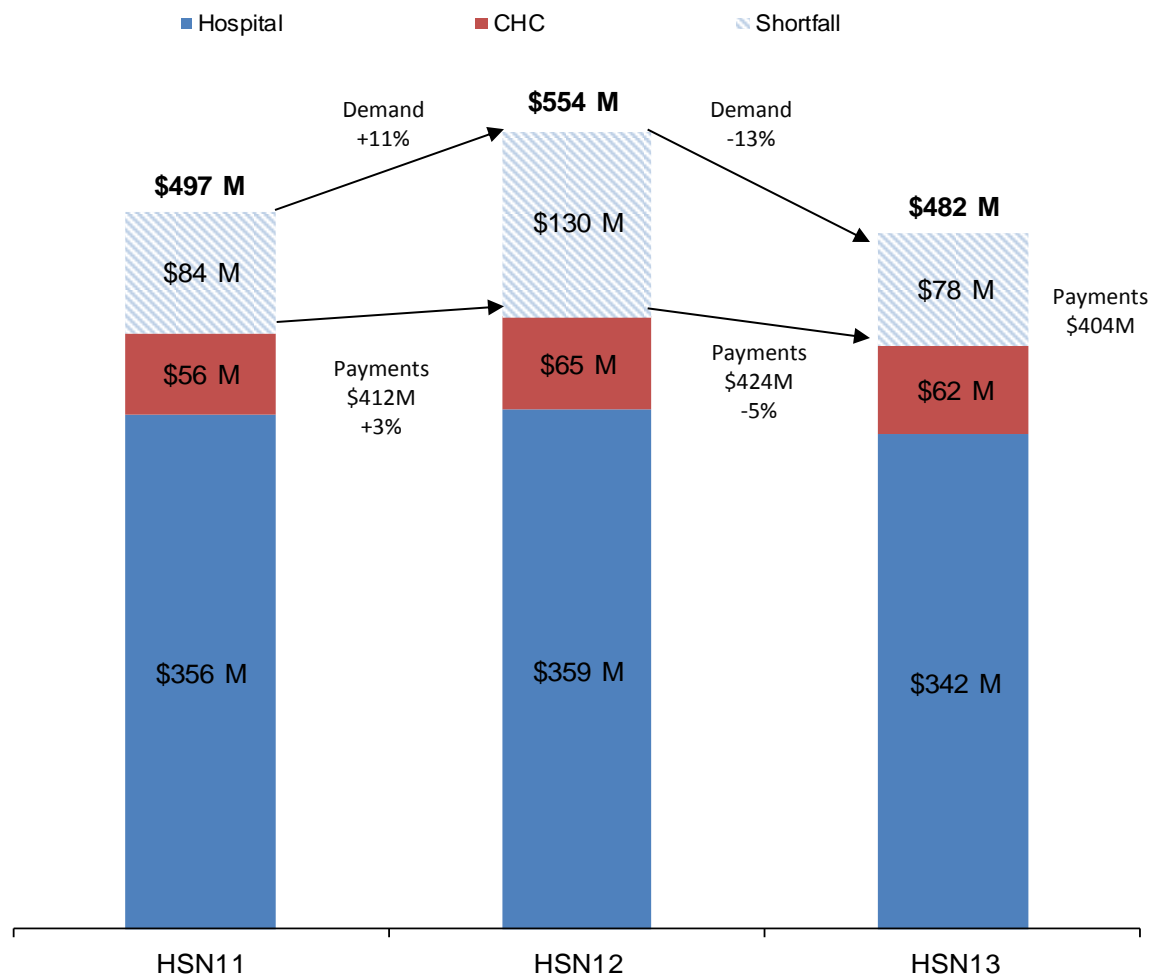


# HSN13 Data Notes

- 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 historically have reported data based on the month in which claims were paid. However, applying this methodology to HSN13 claims data would overstate HSN13 claim volume. 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 2013 (HSN13) demand exceeded HSN13 funding, hospital providers experienced a \$78 million shortfall during HSN13.

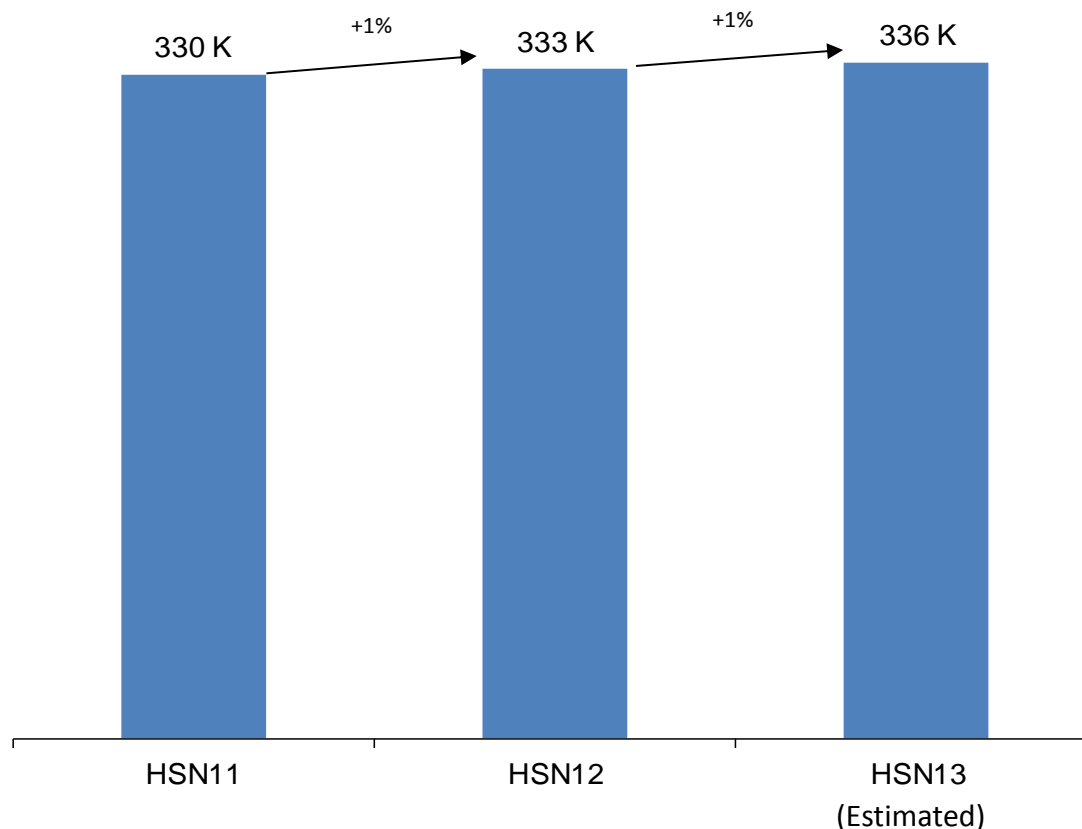
Total Health Safety Net (HSN) demand decreased in HSN13 compared to the prior fiscal year. However, it is important to note that this was driven by claims processing adjustments, rather than by a decrease in actual demand for services.

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 as of 12/5/2013.



## HSN Total User Trends



The Health Safety Net (HSN) Office estimates that medical services provided to 336,000 individuals in HSN13 will be billed to the HSN.

A portion of claims for HSN13 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 HSN13 users is estimated based on current claims data and historical claims experience.

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 HSN11 and HSN12 reflect updated claims activity and may differ from data previously reported. Total users in HSN13 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 12/5/2013.



## Top Ten Inpatient Major Diagnostic Categories

Inpatient Major Diagnostic Categories (MDC) for HSN13	Percent Inpatient Discharges	Percent Inpatient Payments
Diseases of the Circulatory System	13%	17%
Diseases of the Digestive System	11%	11%
Diseases of the Nervous System	6%	10%
Diseases of the Respiratory System	10%	8%
Diseases of the Musculoskeletal System and Connective Tissue	7%	8%
Mental Illness	12%	7%
Diseases of the Hepatobiliary System and Pancreas	6%	6%
Infectious and Parasitic Diseases	4%	6%
Endocrine, Nutritional, and Metabolic Diseases	4%	4%
Diseases of the Kidney and Urinary Tract	4%	3%
<b>Total for Top Ten</b>	<b>77%</b>	<b>80%</b>

In Health Safety Net fiscal year 2013 (HSN13), the top ten diagnostic categories accounted for 77% of inpatient discharges and 80% of inpatient payments.

Circulatory, digestive, and nervous system diseases and disorders were the top three diagnostic categories among inpatient claims.

These three diagnostic categories comprised 30% of inpatient discharges and 38% 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 30 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 12/5/2013.



## Top Ten Outpatient Clinical Classification Diagnosis Categories

Outpatient CCS Diagnosis Categories for HSN13	Percent Outpatient Claims	Percent Outpatient Payments
Symptoms; signs; and ill-defined conditions and factors influencing health status	14%	16%
Diseases of the musculoskeletal system and connective tissue	10%	10%
Diseases of the genitourinary system	8%	8%
Diseases of the nervous system and sense organs	7%	8%
Diseases of the circulatory system	8%	7%
Injury and poisoning	6%	7%
Endocrine; nutritional; and metabolic diseases and immunity disorders	7%	7%
Diseases of the respiratory system	6%	6%
Neoplasms	5%	6%
Mental Illness	6%	6%
<b>Total for Top Ten</b>	<b>77%</b>	<b>81%</b>

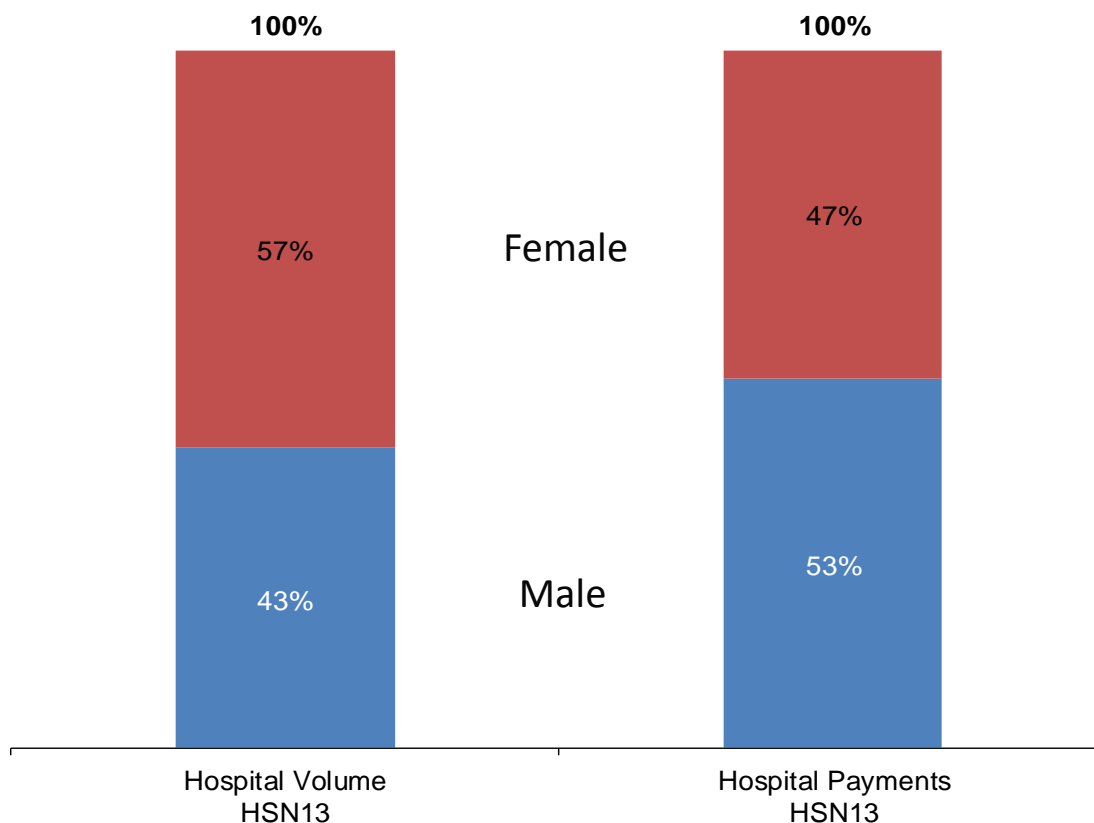
In Health Safety Net fiscal year 2013 (HSN13), the top ten clinical classification (CCS) diagnosis categories accounted for 77% of outpatient claims and 81% of outpatient payments.

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

These three CCS diagnosis categories comprised 32% of outpatient claims and 34% 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 12/5/2013.

## Hospital Utilization and Payments by Gender



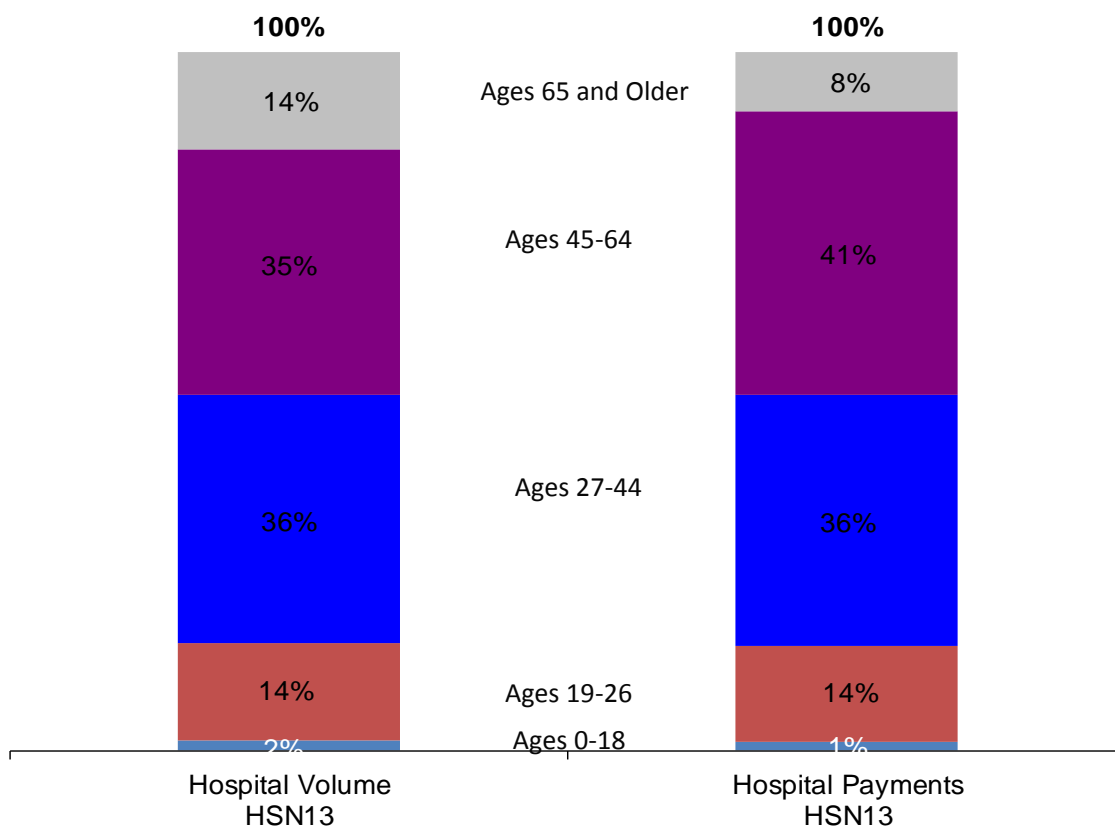
In Health Safety Net fiscal year 2013 (HSN13), men used fewer services than women, but had higher payments for their care.

During this period, men accounted for 43% of volume and 53% 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. Numbers less than 1% are not displayed.  
Source: Health Safety Net Data Warehouse as of 12/5/2013.



# Hospital Utilization and Payments by Age



In Health Safety Net fiscal year 2013 (HSN13), the non-elderly adult population (ages 19 to 64) accounted for 85% of hospital volume and 91% 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 14% of hospital volume but only 8% 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. Numbers less than 1% are not displayed.  
Source: Health Safety Net Data Warehouse as of 12/5/2013.



# Hospital Responsiveness to Enrolling Patients in MassHealth

Chapter 38 of the Acts of 2013 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.

The eligibility determination process for most 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. Patients may either complete a paper MBR or an electronic MBR through the Virtual Gateway 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 HSN eligibility. Therefore, an applicant cannot be determined eligible for the HSN without first having their eligibility for MassHealth and Commonwealth Care considered.

All Massachusetts hospitals that are HSN providers are registered to use the Virtual Gateway to assist members in applying for subsidized insurance. Hospital application data indicates that hospitals are taking active steps to enroll patients in MassHealth.

