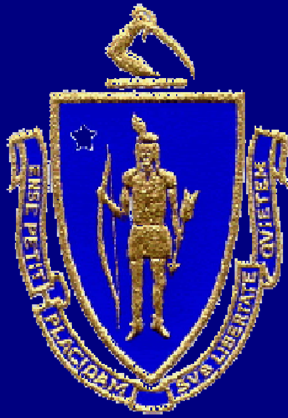

Office of the Inspector General

Commonwealth of Massachusetts

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Ongoing Analysis of the Health Safety Net Trust Fund

March 2010

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Introduction

Since 2004, the Office of the Inspector General ("Office") has been monitoring the practices of the Uncompensated Care Pool fund, now known as the Health Safety Net ("HSN"), for payment of services for eligible uninsured individuals seeking care at hospitals and community health centers in the Commonwealth. This Office has promulgated a number of analyses, reports, and recommendations regarding oversight of the Uncompensated Care Pool, systems and practices involving eligibility and enrollment of the uninsured in Commonwealth Care, health care reform implementation and other topics.

Chapter 113 of the Acts of 2009 directed the Office of the Inspector General to maintain a pool audit unit to oversee and examine the practices in all Massachusetts' hospitals, including the care of the uninsured and the resulting free care charges. This report is in accordance with the requirements of Chapter 113, in concert with the Inspector General's ongoing review and examination of the HSN.

The Legislature established the HSN in the Division of Health Care Finance and Policy ("DHCFP") to comply with federal funding agreements. DHCFP was tasked with establishing a new reimbursement system for acute hospitals and community health centers ("CHCs") for covered health services provided to uninsured and underinsured patients. The claims submission and eligibility systems are now in place. This Office's analysis tracks utilization, internal claims monitoring, and payments from the HSN.

For this report, the Office examined payment and utilization data for the HSN. According to DHCFP's 2009 Health Safety Net Annual Report, a 1% increase occurred in expenditures from Health Safety Net Fiscal Year 2008 ("HSN08") to Health Safety Net Fiscal Year 2009 ("HSN09"), from $409 million in HSN08 to $414 million in HSN09. A decrease of 0.1% in utilization also occurred during this time period, from 987,000 to 986,000. Putting the HSN08 and HSN09 figures in context, the Uncompensated Care Pool expenditures in Pool Fiscal Year 2007 ("PFY07") were $661 million and utilization was near 1.5 million patients. In comparing the new payment methodology to the prior

Uncompensated Care Pool methodology, from PFY07 to HSN08, both expenditures and utilization dropped by 35%.

Background

Chapter 58 and the Transition to a New Payment System for the Uninsured and Underinsured

On April 12, 2006, the governor signed Chapter 58 of the Acts of 2006 into law, instituting far-reaching changes in the provision of and payment for health care in the Commonwealth. As part of that reform, Section 30 of Chapter 58 required that, beginning on October 1, 2007, a new office would be responsible for the reimbursement of payments to Massachusetts hospitals that treat uninsured or underinsured patients. This new agency, the HSN, would operate differently from its predecessor.

The goal of this legislation was to move the HSN reimbursement model to be more Medicare-like. The reform required HSN payments to be made on a claims basis, using Medicare-like payment principles modified to reflect the level of appropriation and expanded mix of services (beyond those covered by Medicare). Similar to a true payer, these payments were required to be adjudicated on a claims-based and fee-for-service basis, adjustable for individual hospitals. The law proposed a model to achieve the goals outlined in Chapter 58 by incorporating Medicare payment principles, which would help ensure more appropriate payment for services.

Also included in this reform was the restriction on emergency room bad debt ("ERBD") payments. ERBD payments are calculated using the appropriate methodology for either inpatient or outpatient services. The HSN was directed by its enabling statute to increase monitoring of eligibility, charges, and volume of ERBD claims. Depending on volume, a hospital's claims may be denied by the HSN because the HSN may limit the number of discharges and visits recognized as ERBD. In response to its mandate, DCHFP established rules that limited access to payment. Providers seeking reimbursement must demonstrate that they attempted to collect payment from either the patient or the person fiscally responsible for the patient for a period of 120 days. After that period has lapsed, and the provider attempted to acquire payment, which it can document upon request, the provider may submit a claim in the 837 Electronic Data

Interchange format for payment. This format ensures that the eligibility, billing, and diagnosis information will be submitted with every claim.

Funding for the Health Safety Net Trust Fund ("Trust") comes from several sources including hospital assessments, a surcharge on private payments made to hospitals and ambulatory surgical centers, and funds from the state general fund.

The Standard Payment System

The standard payment system is similar to the payment model of the MassHealth Program, but features pricing and payment rates similar to Medicare pricing principles, grouping, and claims editing systems. This system makes payments per discharge for inpatient services, and per visit for outpatient services, but the system is based on actual claims submitted by the hospitals and CHCs. These claims are edited through the appropriate Medicare claim specifications in order to identify type of payment (allowable inpatient discharges and allowable outpatient services).

Because Medicare recognizes many different payment levels for inpatient and outpatient services provided to individuals, and because Chapter 58 mandated a Medicare-like system of payment, DHCFP modified the Medicare payment system. This modified system is a bundled payment system that uses MassHealth bundling methods, which combine certain related services and reimburses them at a facility per visit amount. This bundled system allows DHCFP to meet the mandates of Chapter 58 because the new payment system is associated with Medicare-like payment levels and principles and increases the payment system integrity by implementing claims editing and verifying eligibility prior to payment. Regarding CHCs, the HSN pays on a monthly basis based on the CHCs' reporting of their eligible services provided. The HSN regulations require CHCs to document their claims. HSN examines the claims to ensure that there has been no unbundling of services or other billing inconsistencies. The services that are considered CHCs' eligible services are listed at 114.6 CMR 14.07(2).

The HSN currently uses the most recent public use file published by Centers for Medicare & Medicaid Services ("CMS"), the Version 27 Diagnostic Related Group

("DRG"). The HSN is not only using CMS's DRG calculations, but is using its DRG payment weights as well. These figures are also published in the Federal Register. Each case is categorized into a DRG, and each DRG is assigned a weight. Each DRG has a payment weight assigned to it as well, based on a calculation of the average resources used to treat Medicare patients in that DRG.

While each case type helps to determine payment, it is not the sole criterion. The type of provider that serves the patient also determines how much the provider will be reimbursed for services. For providers that serve patients that have less financial resources, their reimbursement is slightly increased to offset the burden of caring for this population. These providers, referred to as Disproportionate Share Hospitals, can only receive this benefit if a minimum of 63% of their gross patient revenue is attributed to Medicare, MassHealth, and HSN payments. DHCFP then ranks the providers that meet this benchmark by highest percentage.

There are other factors that contribute to the calculation of payment for inpatient services, such as whether the acute hospital is also a medical dependant rural hospital, a critical access hospital, a PPS-exempted hospital, a sole community hospital, or a teaching hospital. Furthermore, other add-ons such as standardized amounts for labor and non-labor costs and add-ons such as pass-throughs and large urban add-ons must also be determined. Further adjustments may be made to include patients with full free care, partial free care and retroactive free care, MassHealth Limited, Children's Medical Security Plan, MassHealth Buy-In, Emergency Aid to the Elderly Disabled and Children, Family Assistance/Premium Assistance, Prenatal Buy-In, and Senior Buy-In. Claims are further adjusted to omit non-reimbursable services, duplicate claims, or claims that have significant errors.

DHCFP must monitor other patient services when administering the HSN. DCHFP must be aware of whether the provider is eligible for HSN reimbursement. To do that, DCHFP must maintain a provider participation file ("ppf") to track who, at what provider, is performing the services for the eligible patient. Provider eligibility is an important safeguard on the HSN, since it establishes a baseline test for whether the service

should be reimbursed; an ineligible provider should not be reimbursed regardless of the service provided or the patient involved. While examining who is performing the service, DCHFP must also be aware of how the patient became available to the provider. In cases where a patient needs several services, transferring between hospital departments or even different hospitals may be necessary. DHCFP must exercise strict control over which provider is reimbursed for the services provided. The reimbursement rules regarding transfer patients are designed to prevent against providers billing for services that they may not have provided, but merely ordered.

Finally, DHCFP requires providers to bill separately for certain services provided, specifically, psychiatric and pharmaceutical services. By having a separate carve out for each of these types of treatment in an inpatient setting, DHCFP has the opportunity to scrutinize these areas more closely. Attention to these areas enables DHCFP to allow for greater payment control over areas that may be over-utilized for reimbursement, as this Office identified in previous reports.

The HSN pays for outpatient services on a per visit basis. Payments are calculated by multiplying the hospital's Medicare Payment on Account Factor by the net uncompensated care charges per visit, which is then adjusted by a cost adjustment factor. Disproportionate Share Hospitals (those hospitals identified as serving a major share of the state's low income clients) receive a transitional add-on of 25% of the outpatient per visit rate.

Office of the Inspector General Review

A. Payments and Utilization of HSN

This Office examined both the payments and utilization rates for the HSN. When examining HSN payments and utilization rates, an interesting trend was identified. In HSN09, hospital service volume decreased by 1%, from 715,000 to 706,000. CHC service volume increased by 3%, from 272,000 to 280,000. Payments to acute care hospitals remained largely flat at $372 million, even showing a 0.1% decrease. Payments to CHCs were $42 million, a 13% increase. DHCFP states: "A portion of the 13% increase in payments may be attributable to increases in dental and medical visit rates, as well as increased pharmacy payments resulting from the availability of new HSN pharmacies." Combined, total payments to CHCs increased 1% from $409 million in HSN08 to $414 million in HSN09. The drop in volume at hospitals and increase in volume at CHCs is a positive trend as CHCs tend to provide services at a lower cost. Another positive trend is that the number of users of the HSN declined by 2%.

B. Oversight and Audit Controls

The Office's 2009 report recommended that DHCFP initiate additional safeguards in the HSN to assure the integrity of the system. As part of a plan to strengthen the oversight of the HSN payment system, DHCFP has hired a consultant to perform on-site compliance reviews of a sample of hospitals and CHCs for HSN08 and HSN09. The reviews will concentrate on compliance with HSN regulations and documentation supporting the claims.

Under DHCFP regulations, each provider, surcharge payer, and ambulatory surgical center must maintain records sufficient to demonstrate compliance with DHCFP regulations. The regulations further state that the provider must provide any information that is required to process the claim. The Office's interpretation of these regulations is that DHCFP has the authority to not only request information that supports the payment of the claim, but also to review any medical records that would support the claim. These records should support that the services on the claim were not only performed but also medically necessary. The Office strongly encourages DHCFP to take any

action necessary to protect the Trust from any inaccurate or fraudulent claims that providers may submit. Medical records review is an excellent method of not just detecting but also preventing payment of claims that are not supported by medical records. The reviews are currently underway.

DHCFP has also asked Commonwealth Medicine to perform a post payment review of all claims paid by the HSN. The review will be used to develop a clinical utilization review model for the HSN to use. Additionally, DHCFP has adopted MassHealth's Drug Utilization Review protocols for prescription drugs. Commonwealth Medicine administers this program. According to DHCFP, the program helps to protect against inappropriate drug usage and leverages best practices for prescribing.

C. Claims Adjudication

In this Office's 2009 report, it was recommended that DHCFP incorporate Outpatient Coding Edits ("OCE"), Medically Unlikely Edits ("MUE"), and the Correct Coding Initiative edits. OCE is software designed to comply with the Balanced Budget Amendment of 1997 to ensure that Medicare did not overpay for outpatient treatment. Medically Unlikely Edits is an editing process to catch billing errors caused by coding or coverage errors. CMS designed these edits to do three things: allow for data review and other types of reviews, such as reviews triggered by complaints, to identify errors in billing; take action to both correct and prevent the errors committed; and ascertain which edits are problematic to providers so that CMS may release medical reviews regarding coding and eligibility education. The Correct Coding Initiative is another CMS editing program that assists in identifying issues associated with Medicare Part B edits. It is a manner to prevent payment of improperly paired codes.

DHCFP indicated that it is using MUEs presently and will be using OCE and CCI edits as the outpatient reimbursement systems begin using the Ambulatory Patient Classification Grouper ("APC") in the future. The Office encourages DHCFP to implement as many CMS edits as it can since it is reasonable to use the editing techniques that CMS is perpetually upgrading. Using the edits is also necessary to help

prevent fraud, waste and abuse of the HSN, since the edits are designed to prevent payment of claims that are undeserving of reimbursement.

DHCFP anticipates using the APC, which will facilitate the use of OCE. Additionally, DHCFP has implemented formatting and coding edits on claims that check for eligibility, covered services, billing deadlines, duplicate claims, and unbundling.

MassHealth recently updated to a new Medicaid Management Information System ("MMIS"). Because of this, DHCFP has been able to update all eligibility edits more easily and now receives a daily feed of eligibility data. Previously, such information was only available on a bi-weekly basis. This has lead to more timely data being available for the use of the HSN.

DHCFP's evolution into being a true payer will continue to improve program integrity, and that it pays claims accurately and prevents fraud, waste, and abuse. Claims adjudication is a part of DHCFP's role as a true payer as defined by its enabling legislation. Being a more Medicare-like payer is another part of the defined role that DHCFP must meet. While this Office has focused some of its attention on the development of DHCFP into a true payer, its ability to be a Medicare-like payer in its claim adjudication is another area this Office has reviewed. As part of this Office's ongoing review of the HSN later this year, the Office will report on DHCFP's status as a claims adjudicator and on the editing system DHCFP has used and will be using in the future as it works towards becoming a truer Medicare-like payer.

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Conclusion

The HSN continues to work on its transformation to a Medicare-like reimbursement system. This conversion has led to more timely and accurate data regarding the HSN. In the past year, there has been a slight decrease in utilization and a small increase in payments. However, payments decreased at the hospitals and increased at CHCs, perhaps due to an increase in eligible services being offered at CHCs. This represents the stabilization of the HSN after the transition year. A 1% increase in expenditures from HSN08 to HSN09, coupled with a decrease of 0.1% in utilization demonstrates a stabilization of the HSN, after a drop of 35% in both utilization and expenditures in the transition year from UCP07 to HSN08.

DHCFP has made attempts to improve HSN reimbursement to hospitals and CHCs. By implementing compliance audits and investigating the establishment of a clinical review process, DHCFP continues to increase safeguards in the HSN. Prior to the transition to the Medicare-like payment system, such safeguards were severely lacking. Improvement of the claims editing process will also add to the integrity of the HSN.

Over the past year DHCFP has continued to institute tighter fiscal controls of the HSN in its transformation to a Medicare-like system. This Office and DHCFP recognize the need to continue efforts to properly monitor the use of the HSN to ensure protection of the Commonwealth's interest in free care expenditures. Continued and expanded on-site compliance audits, as well as implementation of a third party medical record review process and medically necessary procedure reviews, are necessary to ensure that the HSN is used properly and cost-effectively.