



Office of the
Inspector General
Commonwealth of Massachusetts

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Ongoing Analysis of the
Health Safety Net Trust
Fund:
Medicare Based Claims
Payment System
Implementation

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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 182 of the Acts of 2008 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 182, 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. This Office’s analysis tracks the interim reimbursement system utilized by the HSN and the implementation of the permanent Medicare-like claims-based payment system that began on April 1, 2008. We have reviewed the changes in the regulations, the new payment formulas, and key issues that will guide the new payment system.

According to DHCFP’s 2008 Health Safety Net Annual Report, a 38% drop occurred in expenditures from Pool Fiscal Year 2007 (“PFY07”) to Health Safety Net Fiscal Year 2008 (“HSN08”), from \$661 million in PFY07 to \$410 million in HSN08. A similar drop of 36% in utilization has also been reported when comparing the first six months of HSN08 to the first six months of PFY07.

This Office examined two types of HSN utilization rates: inpatient and outpatient utilization rates. These rates determine both hospital volume and community health center volume. By studying how utilization rates affect volume, this Office can assess whether and to what extent HSN is meeting its legislative design: to decrease payments as compared to the Uncompensated Care Pool. Having reliable and current utilization rates will help DHCFP analyze and manage costs as opposed to payment through a block grant methodology.

This Office has been tracking the development of the Medicare-like payment system. This system will rely on paying for treatments that are related to an approved procedure. These procedures are also categorized by whether the procedure is performed on an inpatient or outpatient basis.

Since DCHFP did not transition to the present version of its Medicare-like payment system at the beginning of HSN08, the report reviews the transitional period. This period ran from October 1, 2007 through March 31, 2008. These transitional payments were paid on estimated volumes that were reconciled during the second half of HSN08.

Emergency Room Bad Debt ("ERBD") is another focus of this report. This Office is interested in the use of ERBD and in DHCFP's accounting of ERBD costs. ERBD allows a provider to recover certain charges that the provider could not recover from the patient's obligated payer.

Background

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

On April 12, 2006, Chapter 58 of the Acts of 2006 was signed 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.

HSN payments were required 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). 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.

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.

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 Transitional Period

While attempting to balance the demands that Chapter 58 created with the necessity of continuing its mandate to reimburse hospitals and CHCs that treated uninsured patients who qualified for the assistance, the HSN implemented an interim system to assist with the transition from the requirements of the Uncompensated Care Pool to the HSN. This interim system initially paid based upon DHCFP's projected hospital volume levels utilizing Medicare pricing principles so that hospitals continued to receive timely payments. Hospitals provided information to the DHCFP through their claims data and received their monthly reimbursements accordingly. These payments were subject to a final reconciliation to account for the true inpatient and outpatient volume paid at the new Medicare-based rates. This interim period lasted from October 1, 2007 through March 31, 2008.

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 should be edited through the appropriate Medicare claim specifications in order to identify either type of payable units of service (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 single rate. 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 26 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. This weight is assigned to a factor in the amount of provider resources used to treat that specific DRG in that specific hospital. 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.

There are other factors that contribute to the calculation of payment for inpatient services, such as whether the acute hospital is also a disproportionate share hospital, 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.

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 of 6.8%. 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

The Office examined four areas of interest related to HSN: utilization rates of the HSN for HSN07 and HSN08; the installation of the Medicare-like payment system for HSN08; the transitional period in HSN08; and DHCFP's management of ERBD.¹ DHCFP is attempting to work systematically toward fully implementing the payment system described in Chapter 58. DHCFP has been able to implement some changes methodically, while other changes have proven to be more problematic than DHCFP had anticipated.

A. Utilization of HSN

This Office examined two types of HSN utilization rates: inpatient and outpatient usage. For HSN07, inpatient utilization was 36,899 and outpatient utilization was 1,320,633. For the first six months of HSN08, inpatient utilization was 12,595 and outpatient utilization was 356,764.

The 2008 rates were important because they were used for two purposes: reconciliation and prospective payments. The 2008 rates were used to establish actual volumes for the transitional period. As discussed later, the transitional period for the HSN occurred in the first six months of HSN08. During that period, DHCFP used estimated utilization volumes to pay providers. The HSN08 monthly utilization rates were then used to establish actual volumes to reconcile the payments for the first six months.

The actual monthly utilizations were also used as the basis for the progressive payment system used for the last six months of HSN08. Using actual utilization figures as a basis provides a sound beginning to a Medicare-like payment system. While utilization

¹ As reported in 2008, this Office reviewed other aspects of DHCFP's management of the HSN. It previously looked at the funding mechanisms of the HSN, the distinctions between acute care hospital payments and community health center payments, the use of MassHealth's Pharmacy On-line Processing System to account for pharmaceuticals, and DHCFP's ability to prevent fraud and abuse of the HSN system. This office continues to investigate these areas and will provide further information on them in future reports.

rates are only a part of a Medicare-like payment system, the fact that DHCFP was using actual utilization rates and not estimating volumes or merely providing a block grant to the hospitals based on previous years' performance demonstrates significant progress towards a claims-based system.

B. The Medicare-Like Payment System

DHCFP was charged with creating a fee-for-service payment system that incorporated all treatment variables within one payment structure. In order to create a Medicare-like payment system, DHCFP used a methodology similar to Medicare to categorize an illness in association with diagnosis and procedures provided to treat that illness. To express an illness as it relates to diagnosis and procedures, Medicare uses Diagnostic Related Groups to track provided inpatient care and Ambulatory Payment Classification ("APC") to track provided outpatient care. To maintain grouper and price accuracy, Medicare updates the grouper and pricer quarterly, and submits a new version of the groupers yearly.

Due to the difference in timing between the release of the new Medicare grouper and the implementation of Chapter 58, DHCFP used Version 24, an older version of the grouper, during HSN08. DHCFP is currently using the most recent grouper, Version 26, for its editing and payment adjudication.

Whether using past or present versions, the use of Medicare DRG/APC and the corresponding weights increases the transparency of the process, since it is similar to how CMS adjudicates Medicare. Adherence to the Medicare system creates a related problem for DHCFP by necessitating that it use a bundled payment method. DRGs require far more detailed methodology in tracking the severity of an illness and its corresponding treatment than DHCFP had previously employed. To counter this, DHCFP designed the payment system to handle bundled payments, which would be similar to the MassHealth payments methodology. While this served to make the HSN system more Medicaid-like from a certain perspective, the fact that DHCFP would still be using Medicare groupers and edits would also make it a Medicare-like system.

While DHCFP is still examining the efficacy of this bundled system, this Office will also continue to examine its impact on HSN.

In order to receive reimbursement from the HSN, DHCFP requires providers to submit one of three forms electronically: institutional claims under an 837I format, professional claims under an 837P format, and dental claims under an 837D format. Grouping the treatments into codes is only part of the process; DHCFP then has to edit the codes submitted to ensure that only the appropriate claims are paid, which requires the examination of patient and service eligibility and validity, bill deadline eligibility, DRG eligibility, and provider eligibility. Once these claims are examined, the claims must be assigned a proper weight to help calculate the payment. These weights are set by Medicare itself, to help establish the proper payment amount nationwide. When necessary, the weights can be shifted by geographic area to adjust for that region's cost of living. DHCFP has chosen to use both Medicare DRG/APC and weights in order to ensure the most transparency.

The 837 format is a standard Electronic Data Interchange format. It is the only available electronic format for professional, institutional, and dental claims that complies with the Health Insurance Portability and Accountability Act. This format ensures that the eligibility, billing, and diagnosis information will be submitted with every claim.

By using a fee-for-service payment system, DHCFP should be able to verify whether payment is justified on the claims provided. It should also be able to ascertain which procedures the HSN is paying for on a regular basis. By having this information, DHCFP should have the ability to validate services rendered as well as the diagnoses rendered. The transition to an 837 format helps to transform the HSN into a true payer.² This detail claim information will enable DHCFP to transition to payments based on actual service rendered that met health care industry standards. By using the 837 format, DHCFP should be better able to facilitate savings in paying for actual procedures performed instead of initially making a lump sum payment, and

² A "true payer" is defined as a payer that pays for actual services rendered.

subsequently trying to determine whether an overpayment or underpayment has occurred.

If an error is discovered, DHCFP will issue three different types of reports: a field error report; an 835 report (a receipt that may be accessed through billing software); and a denial report. The field error report alerts the provider that an error was discovered in its claim. The subsequent 835 report informs the providers of the adjudications for that period. If an error is identified, the 835 report allows the provider to access the error through its own billing software. The denial report is issued monthly to catalog the number of denied claims per provider. These denial reports are generated after the editing process but before payment.

While moving providers to an electronic claim submission system with mandated fields is a major improvement from the previous system utilized by the UCP, DHCFP is responsible to fulfill its mandate to institute a Medicare-like system. DHCFP needs to apply all the Medicare edits and medical necessity policies. DHCFP is not currently applying edits that could further identify overbillings and unbundling of services, coding errors or other deniable claims nor is it using outpatient coding edits or medically unlikely edits.

Medicare has established Outpatient Coding Edits (“OCE”) to ensure its Ambulatory Payment Classifications are paid appropriately. OCE is software designed to comply with the Balanced Budget Amendment of 1997 to ensure that Medicare did not overpay for outpatient treatment. DHCFP indicated to this Office that as a part of HSN10, it anticipated that OCE will be used in the adjudication process. 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 catching errors associated with Medicare Part B edits. It is a manner to

prevent payment of improperly paired codes. DHCFP is currently not participating in the Correct Coding Initiative.

While these edits are designed for a CMS-specific task, their importance in monitoring claims should not be discarded. Each has a specific goal to prevent claims with coding errors from being paid. These edits would benefit DHCFP, and this Office strongly recommends that DHCFP incorporate these edits into its claim adjudicatory matrix as soon as possible.

C. The Transitional Period

For HSN08, the Legislature and Governor granted DHCFP authority to use a transitional method of providing payments to providers while it worked to implement a Medicare-like payment system. DHCFP informed this Office that this transitional payment system paid providers based on estimated volume from 2007 UCP claims.³ DHCFP reports that these estimated volumes were then reconciled against the actual volumes for the first six months of HSN08, and overpayments and underpayments were then established. According to data provided by DHCFP, it recovered \$22.3 million dollars through this reconciliation. The recoupment of \$22.3 million is a positive reflection on the Legislature's decision to shift from the UCP to the HSN. These savings demonstrate the difference between estimating costs and making payments for actual services.

D. ERBD

DHCFP paid approximately \$49 million dollars in ERBD for HSN08. By comparison DHCFP paid \$78 million in PFY07 and \$75 million in PFY06. In adjudicating ERBD claims, DHCFP reviews whether providers completed the requisite collection activity.

This required collection activity focuses on whether the provider expended the effort to collect from the party responsible for payment. DHCFP regulations require the provider to demonstrate that it made an adequate effort to collect by maintaining a record that

³ As was mentioned in this Office's 2008 Pool Report, DHCFP previously reported that it was using 2006 – not 2007 – claim volumes.

shows the provider properly billed the appropriate party, keeping a record of subsequent contact, sending a final notice by certified mail for balances over \$1,000, and further documenting the continuous collection action the provider performed.⁴

While this collection requirement demonstrates that DHCFP is taking steps to ensure that providers cannot use ERBD without sufficient collection activity, this Office recommends that DHCFP audit ERBD acute care and non-acute care accounts, audit proof of treatment by the provider, and audit to ensure that critical access regulations are followed. These auditing functions should provide DHCFP with more information about how ERBD dollars are spent and should create greater transparency in the use of ERBD by providers. Controls should also be put in place to define and audit emergency, critical access, and non-urgent care. Focus should be placed on ensuring that non-emergency services are not being reimbursed and on monitoring ERBD for over-utilization, unbundling, and medically unnecessary services.

⁴ A 120-day collection period is mandated by DHCFP regulation.

Conclusion

As DHCFP develops and implements a transition from the payment methodology of the loosely regulated Uncompensated Care Pool to that of the more heavily regulated Health Safety Net, the intention is to add great oversight, transparency, and accountability.

The HSN has shown a decrease in utilization since the passage of Chapter 58 and subsequent health care legislation. This is the result hoped for by state leaders at the time health care reform passed. The effort at moving to a Medicare-like payment system based on actual claims subject to a robust claims-editing system is likely to produce real savings for the taxpayers of the Commonwealth. DHCFP needs to continue to improve this payment system further, including incorporating effective claims edits. The transitional period was a necessary step to convert from the payment structure of the UCP to that of the HSN. The recovery of \$22.3 million demonstrates that the new payment system will help to identify free-care savings. Likewise, the reduction in the amount of ERBD paid out also points to the positive effect the new system may have, but greater controls must be incorporated to tighten up the payment of ERBD. Future audits and controls are still recommended to ensure continued savings in state dollars.

DHCFP continues to initiate additional safeguards in the system to protect against inappropriate claims. This Office plans to continue its review of DHCFP's efforts by focusing on the use of groupers, the system in place for paying pharmacy claims, the claim adjudication system, ERBD, and oversight and audit controls.