Massachusetts Health Care Training Forum
January 2014 Questions & Answers

All information within this document is organized in the order the presentations were given. The Questions and Answers are provided within this document.

**** Please Be Advised ****
The answers to these questions speak in general terms and are not intended to be case specific

Click on any link below to access a Question and Answer section.

MTF Questions and Answers
MassHealth Updates
ACA Learning Series
MassHealth Provider Services
Health Safety Net
One Care (Duals Demonstration)

MASSHEALTH UPDATES

Is the news EVS the same as MMIS?
EVS is not new and it is derived from information gathered through the Medicaid Management Information System.

How can I get access to EVS?
Everyone does not get access to EVS. If you are a provider you may call 1-800-841-2900 and speak with the Provider Customer Service Representative to determine if your organization has completed the necessary provider agreements to obtain access.

What is MassHealth policy of retro coverage?
Once a full eligibility determination has been made, if found eligible for MassHealth coverage, coverage will go back 10 days from the date the application was received.

A member is primary Medicare A & B – member is disabled and under 65 years old – also has MassHealth Standard secondary – Does this member need to enroll in a managed care organization plan in order to cover services for the secondary MassHealth to Medicare?
Because the person has other comprehensive insurance, they are not eligible to enroll in managed care coverage. MassHealth will provide coverage as the secondary insurer.

65yrs and over members that only have MassHealth Standard does a 65 year old need to enroll in a managed care plan (MCO)?
If this person has Medicare they would not be eligible to enroll in managed care. MassHealth will provide coverage as the secondary insurer.

Are you still accepting MH reviews for over 65 transitions?
Only if one is sent to the member, we are not encouraging people to send in a review when one hasn't been issued.

Paper application for individual: cover sheet so can fax-is that still the same?
New Cover Sheets are being worked on now and should be available shortly. The paper application has information on the front page where to send or fax information.

Provider contact update: need information packets.
To order MassHealth publications (including the applications) call 1-800-841-2900

What is the difference between MassHealth Basic and Family Assistance? We have a patient through the VNA that skilled nursing is not covered or home health not covered without prior approval. Our managed care department states that MH tells them we do not need prior approval nor can they get an approval online.
MassHealth Basic coverage ended 12-31-13 and all members transitioned into MassHealth coverage under ACA. Some members who transitioned did receive MassHealth Family Assistance coverage which covers home health services. See all provider regulations for a full list of covered services or call MassHealth Customer Service at 1-800-841-2900 with specific requests.

MassHealth seems to have put annual ERF's on hold; when will these be re-started?
Annual Eligibility Reviews are currently on hold during ACA transition period.

Temporary Eligibility – Provider billing questions?
An all provider bulletin 240 issued in December 2013 explains temporary coverage information in detail.

For temporary coverage, does it say standard/temp or just standard?
In EVS, it will appear as 'Standard". The letter will spell out "Temporary" coverage accompanied by the ID number that should be used when accessing medical services.

The COLA was discussed during Mass Health Updates. What is the spend down level?
$522 is the spend down level.

What is the FPL level for seniors for MassHealth eligibility?
The income level for seniors over 65 and not needing long term care coverage is 100% of the (FPL) Federal Poverty Level.

What are the guidelines for CarePlus Premium Assistance?
To get and keep MassHealth, you must: apply for and enroll in any health insurance that is available to you at no cost, including Medicare, enroll in health insurance when MassHealth determines it is cost effective for you to do so, or keep any health insurance that you already have.

You must also give MassHealth information about any health insurance that you or a household member already have or may be able to get. We will use this information to decide: if the services covered under your health insurance meet MassHealth's standards, and what we may pay toward the cost of your health insurance premium.

Under MassHealth, we may pay part of your health insurance premiums if: your employer contributes at least 50% of the cost of the health insurance premiums; and the health insurance plan meets the Minimum Essential Coverage (i.e., if it provides comprehensive medical coverage to its members including MassHealth-required health care benefits).

If a person has a primary insurance and CarePlus as a secondary do they have to also select a MCO?
MassHealth will not enroll CarePlus members who are enrolled in other insurance into a managed care health plan. However, those members will receive CarePlus benefits that are not provided by the member's primary insurance directly from MassHealth on a fee-for-service basis. MassHealth will also wrap the member's primary insurance to ensure that the member pays no more than nominal copayments.

Is there a form to complete to select an MCO for CarePlus or does it have to be done by phone?
Members can enroll by phone, or by mailing in the enrollment form included with CarePlus enrollment materials mailed directly to the member.

What is the definition of medically frail for MassHealth CarePlus?
Individuals found eligible for MassHealth CarePlus, including MassHealth CarePlus Premium Assistance, can self-identify as being "medically frail" if they have special health care needs that may require additional services, such as community based long term services and supports, which are not provided through MassHealth CarePlus.

A medically frail individual is defined as one who:

- *has a medical, mental health, or substance use condition that limits his or her ability to work or go to school;*
- *needs help with daily activities, like bathing or dressing;*
- *regularly gets medical care, personal care, or health services at home or in another community setting, like adult day care;*
- *or is terminally ill.*

Individuals who meet one or more of these criteria and who identify themselves to MassHealth can choose to change their coverage from MassHealth CarePlus to MassHealth Standard in order to obtain access to the additional services. If a MassHealth CarePlus member is medically frail, he or she should call MassHealth at 1-888-665-9993 (TTY: 1-888-665-9997). MassHealth CarePlus members can tell us at any time if they are medically frail, including if their health changes in the

future. A person who self-identifies as medically frail is treated as having a change in eligibility and can be transferred to Standard right away.

Where do you obtain the frail waiver application for clients to be moved from CarePlus to Standard?
There is not a frail waiver application for CarePlus eligibility. Individuals who meet the medically frail criteria need to identify themselves to MassHealth if they wish to change their coverage from MassHealth CarePlus to MassHealth Standard. He or she should call MassHealth at 1-888-665-9993 (TTY: 1-888-665-9997).

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ACA LEARNING SERIES

What is the timeline for posting payment once payment is received for subsidized and unsubsidized coverage?
Payment needs to be in 5 business days before the end of the month to have coverage for the 1st of the following month.

After open enrollment can individuals change their ConnectorCare plan type?
Consumers will be able to shop outside of the open enrollment period for the following reasons:

- *Determination of new eligibility for ConnectorCare,*
- *Change in ConnectorCare Plan Type,*
- *Approval for a hardship waiver; or*
- *End of hardship waiver period.*

Will Navigator organizations receive outreach lists of community members needing to re-apply?
Navigator organizations have gotten some information about members within their community so that they can conduct outreach in a more targeted manner.

How does a new person applying for health insurance (who never has before) get in the system to get temporary coverage?
Please click the link here for information on temporary coverage and continue to watch the MTF website for future updates: http://www.masshealthmtf.org/news/important-updates-health-connector-and-masshealth-commonwealth-care-temporary-coverage

I was under the impression that Commonwealth Care members under <133% FPL were transitioning to Standard or CarePlus, yet the new ConnectorCare Plan includes those income brackets. I'm confused?
You are correct; most Commonwealth Care members under 133% FPL were transitioned to MassHealth's CarePlus program. However, the Health Connector's ConnectorCare plans include members who are, lawfully present, ages 21+ (the AWSS population) with incomes from 0-300% FPL.

Where/How get navigator and CAC in-field assistance to do apps on-site?
For in person assistance please visit: www.mahealthconnector.org/HomePortal/faces/learn

- *click "Help Center" in the left side navigation box.*
- *then click "Find Local Help" in the white box (entitled "Additional Resources") located on the right.*

Where can we get member booklet with complete list of acceptable ID documents?
Please click here for the MassHealth member booklet with information on plans and required documents:
http://www.mass.gov/eohhs/docs/masshealth/membappforms/aca-1-english-mb.pdf

Is it possible for me to be approved/certified to access the Virtual Gateway common intake and my account page?
For information on becoming a Certified Application Counselor please email your request to CACImplementation@massmail.state.ma.us

What do we do with patients when they just have to enroll in a plan? They have already been approved for QHP. Are they going to receive a package to choose the plan?
Clients who have already completed an application and received a plan selection notice from the Health Connector can complete the selection process by calling the Health Connector's Customer Service Center at (877) 623-6765.

How long is it taking to cover people who have completed unsubsidized applications and made payments before Jan 10, 2014?
Our unsubsidized plans always take effect on the 1st of the month. If a consumer applied and made payment in January, they would be enrolled for February 1 coverage. There is no retroactive coverage. Payments for Health Connector QHPS must be received 5 business days in advance of the first day of the month of enrollment.

Can premium tax credits be connected to Employer-Sponsored Insurance?
No, only plans offered through the Health Connector (Marketplace) are eligible for premium tax credits. If you choose to enroll in your employer –sponsored insurance plan as an active employee or retired employee (even if it is considered unaffordable or does not meet minimum coverage) you are not eligible for the credits.

Is ConnectorCare set up for continuous enrollment?
Under our new ConnectorCare regulations, which we spoke about in our presentation, these members will have access to continuous enrollment, similar to Commonwealth Care. MassHealth will continue to have continuous enrollment throughout the year.

Consumers will be able to shop outside of the open enrollment period for the following reasons:

- *Determination of new eligibility for ConnectorCare,*
- *Change in ConnectorCare Plan Type,*
- *Approval for a hardship waiver; or*
- *End of hardship waiver period.*

For detailed information on closed enrollment rules, please see Policy NG-1E and NG-1F on the Policy Center at MAhealthconnector.org website.

If someone was removed from Commonwealth Care for non-payment will they be able to be approved for ConnectorCare?
Yes, because they are different programs, past due payments will not carry over to this new plan, nor will it preclude an individual from enrolling.

What is happening with students who are offered QSHIP? Can they get MassHealth or Premium Tax Credits?
Students can apply for coverage through the Health Connector. They may be found eligible for MassHealth, ConnectorCare or a QHP with Premium Tax Credits, which would allow them to opt out of the SHIP insurance.

MH CarePlus vs. MH Standard – switching plan timeline? By what day if CarePlus?
All members have a right to transfer to another MCO of their choice. Members should call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497- 4648 for people who are deaf, hard of hearing, or speech disabled) CST to select or change to another health plan. For MassHealth Standard the change is effective the next business day. For CarePlus in most cases, the change of health plan will be effective starting on the first day of the next month.

How long does someone have after determination of CarePlus before being auto assigned?
If a member does not choose an MCO within 14 days they will be auto-assigned to a health plan.

An elderly couple, with long term disability, has their daughter work for them as caretaker. How is the daughter's application completed because she claims her elderly parents on her tax return as dependents?
If she claims her parents on her tax return as dependents then she needs to include them on her application. They do not need to be applying for benefits but they do factor into our determination of her eligibility.

Parent files adult children on her taxes, as they are students, but adult children also file their own taxes as they are also working, how should app be done?
If the parent claims the adult children as dependents on her tax return then they need to be included on the application. Again, as in the above situation, they do not need to be applying for benefits but they do factor into our determination of the parent's eligibility. Their income information should be listed and the system will determine if their income meets the income threshold which would require them to file and, therefore, whether or not it should be counted.

Over 400% do they need to do a HIX application or can they browse and shop for a plan thru MAHealthconnector.org?
The fastest way to shop for a QHP without a subsidy is to go online at MAhealthconnector.org. This is the HIX application system.

Paper applications for unsubsidized QHPs can be found at MAhealthconnector.org under Tools & Resources

ConnectorCare letters directing members to enroll. We have seen copies of member letters – how does this process work?
The Health Connector has created an alternative path to process new applications for subsidized coverage and effectuate enrollment in a Qualified Health Plan with premium tax credits to help pay monthly premiums.

Members eligible to enroll in a Health Connector plan with premium tax credits, as determined through this process, will now be sent letters explaining their access to subsidies and health plan choices (members formerly received two separate letters), and are informed to return a plan selection form or call member service to select a plan (similar to the current plan selection process for Commonwealth Care). These individuals will also receive a Frequently Asked Questions document along with this enrollment letter.

A family purchased a supplemental policy thru the connector and paid by check. The check was cashed. When they tried to access services thru this policy they were "not in the insurers" system.

We are aware of this problem and we are working to rectify this issue with each consumer. Please encourage people when they are sending in payment, to include their payment coupon along with their check, and put the name of the person they are paying for on the check along with a member number.

Does the new ACA application have more household members, the old one designed for the size of the family?

See excerpt from the application instruction page:
Filling out the application: Start with yourself, and then add other adults and children. If you have more than four people in your household including yourself, you will need to make copies of the pages for Person 4 before you fill them out, and attach to the application.

Are the Navigators allowed to submit CACs designation form or not?

No, there are specific designation forms for Navigators and CACs with allow you to speak with MassHealth or the Health Connector customer service centers about the status of a person's application, and get benefit information. CACs have the additional benefit of viewing eligibility notices by submitting a signed PSI.

Someone who is undocumented and is pregnant, what coverage will she get if Healthy Start is going away?

Effective January 1, 2014 Healthy Start no longer exists and now all pregnant women (regardless of immigration status) with income at or below200% FPL are eligible for MassHealth Standard (until the end of the pregnancy plus 60 days).

Why can't we have a credit card machine for payment? Also, regarding EFT, will online payment option be fixed? When?

Currently the only way for consumers to make payments through electronic fund transfer (EFT) is if they take that step immediately after selecting a plan. Members can also make a payment and by mail using check/money order, or in-person at the Health Connector's Boston or Worcester walk-in center.

What number do we need to call regarding under (QHP) 65 application or over 65 application?

Regardless of age, if they submitted an unsubsidized application or an application through the HIX online system they should call the Health Connector 1-877-MA-ENROLL. If they submitted a paper subsidized application they should call MassHealth Customer service at 1-800-841-2900 or the MEC 1-888-665-9993.

No indication in MAP that an application is received and has been processed?
My Account Page (MAP) remains available and works the same way for populations you have always used it for. We are working intensively right now to provide the same or similar information in MAP about individuals and families who applied for ACA post-1/1 coverage. Stay tuned - more to come very soon on this!

MassHealth's Eligibility Verification System (EVS) continues to be available to MassHealth providers who already use it and MMIS, and is updated with members' coverage type (including temporary coverage and "mapped" members) and managed care enrollment.

Where should a member call if they have questions about their MassHealth health plan enrollment?
Consumer should contact MassHealth Customer Service at 1-800-841-2900 if they have questions about their MassHealth health plan enrollment.

If a person is legally in the United States, but for only 1-2 years, do the old rules apply to obtain insurance?
See section 10 of the MassHealth Member Booklet for information regarding U.S. citizenship and immigration rules.

If some information on the application is not exact or incorrectly entered, what are the repercussions?
Eligible persons must tell the health care program(s) in which they enroll about any changes in their or their household's income or employment, household size, health insurance coverage, health insurance premiums, and immigration status or about changes in any other information on your application and any supplements to it within 10 calendar days of learning of the change. Eligible persons can make changes by calling 1-888-665-9993 (TTY: 1-888-665-9997 for people who are deaf, hard of hearing, or speech disabled). A change in information could affect eligibility for these persons or for persons in their household. You can also report changes in any of the following ways:

Send the change information to: Health Insurance Processing Center
P.O. Box 4405
Taunton, MA 02780.
• Fax the change information to: 617-887-8770

If a change is reported, it could have tax implications, if you are receiving premium tax credits.

When new SMBRs are available, where do we submit them?
The New Senior Application (SACA-2) is available on the MassHealth Website please click here for a link to the form: MassHealth Member Forms. The application provides instructions on where to submit the application.

Does the SACA-2 replace Review forms?
No.

Can MassHealth CarePlus be the second insurance of the private? Does MassHealth CarePlus cover co-pays or deductibles when used w/private insurance?
If determined cost-effective MassHealth CarePlus may offer premium assistance to those with private insurance. MassHealth will not enroll CarePlus members who are enrolled in other insurance into a health plan. However, those members will receive CarePlus benefits that are not provided by the member's primary insurance directly from MassHealth on a fee-for-service basis. MassHealth will also wrap the member's primary insurance to ensure that the member pays no more than nominal copayments.

If a husband is an American citizen, his wife only has a greencard and is unemployed, and they file taxes together every year, and the husband has insurance through his employer, can he opt out and apply for ACA? Or can he continue with his insurance and his wife applies for ACA herself? (The wife does not want the insurance through his employer).
If the husband's employer sponsored insurance (ESI) meets minimum value and is deemed affordable, then they should both be on the husband's ESI plan. If it doesn't meet these criteria then they could opt out of the ESI and shop at MAhealthconnector.org

The presenters in the ACA section made it sound like under the ConnectorCare regulations (p.47), if your income is under 300% then you can apply for ConnectorCare at any time, that there is a continuous open enrollment. But when you read p. 48 it states that people can apply only due to triggering events.
Under the new ConnectorCare regulations, those that are found eligible for ConnectorCare can enroll throughout the year, similar to how Commonwealth Care worked. As for triggering events, the first sub-bullet which was: Determination of new eligibility for ConnectorCare, is what can happen throughout the year and for these individuals to be enrolled.

Concerning SHIP, if a student is declared a dependent on their parent's taxes do they have to apply together or can the student apply on their own for Connector plans separate from their parents?
A student can apply separately from their parents, but if they are still claimed on their parent's taxes, we will look at the family's MAGI to determine what that student would qualify for.

For dental patients with CarePlus--who is considered the primary insurance for dental if they have a plan like Fallon who does have dental benefits under their plan?
If the member has other comprehensive insurance coverage the Primary insurer would be billed first for dental, MassHealth secondary;

If the member has a dental insurance plan only and is also enrolled in CarePlus, the Dental Plan is billed first, MassHealth secondary;

How many different insurance companies are offering affordable health plans through the exchange (NOT MAHEALTH)? Just the number of companies - not the number of plans as I believe there are numerous (over 100?) plans? Is there someplace I can get a listing of just the companies?
There are ten (10) health insurance providers and five (5) dental insurance providers. Information on the plans can be found at MAhealthconnector.org.

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MASSHEALTH PROVIDER SERVICE

How do I credential a PCP with MassHealth? *You can enroll individuals, groups, other provider types online; however, PCC applications are NOT available/downloadable online. You must call 1-800-841-2900 and request a PCC (Primary Care Clinician) application.*

CO 185 – supposed to be worked on since summer w/HP – informed not completed – unable to fix on my own on MMIS – too many doctors – site freezes w/error codes. Is this an entity issue?
Please submit your list of individual providers who need to be "linked to the group" to MassHealth PEC (Provider Enrollment & Credentialing). You may submit the list to MassHealth PEC, PO Box 9162, Canton MA 02021 or by FAX: 1-617-988-8974.

Will there be training for online provider enrollment application and when?
Using the POSC (Provider Online Service Center) to enroll is very straightforward. Applicants are given prompts and instructions. Also, "job aids" are available. Go to: https://newmmis-portal.ehs.state.ma.us/EHSProviderPortal/appmanager/provider/desktop. Click on "Enroll Now."

What is the timeline for approval of provider enrollment application?
The timeline starts once the application is received at MassHealth PEC, PO Box 9162, Canton MA 02021. PEC credentialers have ten (10) business days to process the application. They must either enroll OR deny. This timeframe includes PEC sending a WFI (waiting for information) letter to the applicant if the application is incomplete, requesting missing documents, correcting mistakes, etc.

The process may take longer, depending on provider type. CORI checks, Clinical applications, letters of intent, site visit requirements, program manager approval, etc., can/will lengthen the process.

Need follow-up for additional information from MassHealth mail, too: have an issue with 10-day notification going to provider at (DBA) location instead of person submitting application on behalf of provider.
This is MassHealth policy. WFI (waiting for information) letters are system-generated and are sent to the DBA name and address on the application. Applicants must return requested information and documents within ten business days of the date of the WFI letter.

Billing info for pharmacy?
Please refer to MassHealth Drug List:
https://masshealthdruglist.ehs.state.ma.us/MHDL/pubdruglist.do

Where is the EOB denial code listed on MassHealth Website?
Please go to these sites:
http://www.mass.gov/eohhs/docs/masshealth/newmmis/eob-codes-descriptions.pdf
http://www.mass.gov/eohhs/docs/masshealth/provlibrary/5010-crosswalk-reason-remark-codes.pdf

Who can we contact to get help when an MMIS number is linked to the wrong person?
Please contact Customer Service at 1-800-841-2900 or email providersupport@mahealth.net.

Re-submittals to MMIS for HSN claims per HSN billing guidelines can submit with "7" but MMIS will only allow using "7" for adjusted claims.
Denied claims should be re-sent as originals. Paid claims should be re-sent as replacement claims.

Has the issue with request for voided claims prior to migration been resolved with MMIS?
Yes; the provider needs to request a void.

Follow-up on speech prior authorization issue.
Please contact the Prior Authorization Unit at 1-800-862-8341.

Many patients still have not received their temporary letters and there is no way to verify eligibility. How can we ensure payment on the facility side?
Please check EVS for eligibility information.

What are MassHealth customer service contact details for provider specific questions?
Providers with specific call issues should please contact CST at 1-800-841-2900 or providersupport@mahealth.net directly for further assistance.

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HEALTH SAFETY NET

Does HSN act as a secondary coverage for children on premium assistance?
Health Safety Net will continue secondary wrap coverage for all HSN eligible services not covered by the MassHealth program for Family Assistance Children, defined in the HSN regulations as "Minors enrolled in Family Assistance/Premium Assistance whose MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(1), is between 150 and 300 percent of the FPL and who reported to MassHealth that they are enrolled in health insurance. " All other children on Premium Assistance are eligible for secondary coverage through MassHealth.

If a patient has a deductible and pays it in full, how does the provider get paid in full?
Once a patient has met their HSN deductible in a given deductible year, the provider may begin billing the Health Safety Net for additional eligible services. For questions related to billing please refer to the Health Safety Net Billing Guides.

When can we start checking on claims status for HSN?
Claim status checks are currently unavailable in the POSC. This functionality is under consideration for the next stage of the HSN migration process.

Deductibles are not always on MMIS. Why is this? When will it change? The phones are overwhelmed as it is.
We are aware that the deductible amount is not always displayed in EVS. Providers should refer to a patient's eligibility determination notice which will list the HSN deductible. If the determination letter is unavailable or if a patient or provider has a question about the amount of an HSN partial patient's deductible they should contact the Help Desk at (800) 609-7232 or hsnhelpdesk@state.ma.us.

What prime non-covered services are covered by HSN secondary? It seemed to be indicated that it was only dental and outlier days?
Health Safety Net provides secondary wrap to several different MassHealth, Connector, and private coverage types. For patients enrolled in MassHealth Limited, EAEDC, Buy-In, Senior Buy-In, and CMSP, and for Family Assistance Children, the HSN will wrap any eligible service not covered by the primary coverage. For patients enrolled in Standard, CommonHealth, CarePlus, and all other Family Assistance, the HSN will only wrap outlier days and Adult Dental. For patients enrolled in ConnectorCare and otherwise HSN eligible, the HSN will pay for dental services not covered by the primary insurance. For patients enrolled in any other Qualified Health Plan and otherwise HSN eligible the HSN will pay for any eligible services not covered by the primary insurance.

6 month retro coverage: are those dates on MMIS as eligible? If not, how do we get the information?
The six months of retroactive eligibility is reflected in EVS. If a patient has for HSN Retroactive eligibility a restrictive message will appear for the date of service indicating HSN Eligibility. Individuals eligible for HSN, MassHealth Limited, EAEDC, Buy-In, Senior Buy-In, and CMSP, and Family Assistance Children are all eligible for six months of retroactive HSN.

Can we collect money due from patients when 1) they had a deductible but are now Standard 2) when Medicaid secondary but is not compliant in providing necessary information re prime insurance that will not pay as a result 3) when Commonwealth Care eligible and opts to a new plan when they have an old debt?

1. *Once a patient is determined eligible for a MassHealth program providers must cease collection activities.*
2. *No, same as above.*
3. *No, the patient may only be billed up to the current deductible amount if they have one, otherwise they may not be billed.*

MMIS remits stating payment and on some accounts still not received payment.
The HSN cannot address this question without reviewing specific claim examples. Please contact the HSN Help Desk at (800) 609-7232 or hsnhelpdesk@state.ma.us.

Outliers still not paid even though we are following the billing guidelines – still being denied?
The HSN cannot address this question without reviewing specific claim examples. Please contact the HSN Help Desk at (800) 609-7232 or hsnhelpdesk@state.ma.us.

When people are getting this insurance is it explained that this does not cover private provider? There are private providers that work in the local ER Dept; they are contracted providers. The providers' bill patients for services rendered; the hospital is paid by HSN. Do you think that you would ever pay private providers?
The Health Safety Net is only authorized by statute to make payments to Massachusetts Acute Hospitals and Community Health Centers. Payments cannot be made on behalf of patients eligible for HSN to physicians who do not bill through an acute hospital or CHC.

When will our 2 visits same day dental claims get paid?
The HSN cannot address this question without reviewing specific claim examples. Please contact the HSN Help Desk at (800) 609-7232 or hsnhelpdesk@state.ma.us.

For "Buy-in" does MH or HSN cover Medicare co-insurance?
Patients eligible for MassHealth Buy-In and MassHealth Senior Buy-In are eligible for reimbursement of their co-insurance by the Health Safety Net.

Having issue with partial HSN payments secondary to Medicare.
The HSN cannot address this question without reviewing specific claim examples. Please contact the HSN Help Desk at (800) 609-7232 or hsnhelpdesk@state.ma.us.

HSN billing for Commonwealth Care unenrolled individuals for the special period of Nov 23-Dec 31, 2013 same way as regular HSN billing?
For the period of Nov 18-Dec 31 2013 HSN eligible services provided to an individual who was CommCare eligible but unenrolled and had passed their customary 100 day gap period of HSN eligibility may be billed to the HSN. The eligibility will not be displayed in EVS but the HSN claims system has been updated to allow these claims to pass. The claims submission process follows all regular billing rules.

If the gap coverage for ConnectorCare and Qualified Health Plans is not showing in EVS, how are we supposed to know when to bill?
Until the systems can be updated to accurately display this message, we encourage providers to make every effort to determine if the patient is enrolled in a plan through the Connector. If this cannot be determined or the patient is unenrolled then the HSN may be billed.

Also, if people under the QHP programs have implied HSN secondary coverage if they're under 400% of the Federal Poverty level, and we are not able to verify what their poverty level is, and are not able to see that they are eligible for HSN secondary on the EVS website, it doesn't give a good sense of security for anyone providing services to dental patients. I say this because HSN currently uses EVS to verify HSN coverage and if they are not able to see it then charges may be denied or rejected. When can we expect EVS to accurately reflect the correct HSN eligibility status?
EVS will not display to a provider whether or not the patient is enrolled in a Connector plan. However a restrictive message will indicate if the patient is not eligible for any kind of HSN wrap, regardless of enrollment, such as if the individual is over 400% or has not met other HSN eligibility requirements. The restrictive message displayed will read "Reimbursement from the Health Safety Net not allowable for this patient. For information call 1-877-910-2100.

HSN partials- it was stated that if a family is eligible for HSN partial with a deductible, that it would be based on the family member with the lowest income. Is this true with families with children who have no income? Would they have a $0.00 deductible, even if they would have been qualified for a deductible based on income alone?
The Medicaid MAGI income rules calculate income on an individual level based on tax household. For the scenario of a family with a child where the parent(s) and child are filing in the same tax household the MAGI income will be the same for the parent(s) and child. If the family is over 200%, there will be a family deductible. The Premium Billing Family Group rules apply in the case where a traditional family unit may file taxes separately. If two children in the same family are claimed on different tax households they may have different MAGI incomes. In this case, the deductible for the entire PBFG would be based on the lowest MAGI income.

Will Health Safety Net be available to those not eligible for MassHealth/ConnectorCare/QHPs without 'Open Enrollment' restrictions after 1/1/14?
Eligibility for the Health Safety Net is not subject to the Open Enrollment period. If an individual is ineligible for any other program and meets the HSN eligibility criteria, the HSN will be available.

Are patients with MassHealth CarePlus eligible for HSN retro?
Health Safety Net retroactive eligibility does not apply to patients eligible for MassHealth CarePlus. These patients are only eligible to have Adult Dental services and Outlier Days paid by the Health Safety Net. MassHealth CarePlus has fee-for-service coverage prior to enrollment.

Claims HSN? How long does it take for HSN claims to be processed?
Typically, claims which are submitted in a given month are processed in the month following submission and paid in the month following processing. However, in some cases there are exceptions to this schedule. For specific claim examples please contact the HSN Help Desk at (800) 609-7232 or hsnhelpdesk@state.ma.us.

Medical Hardship: how long is the process? Can we fill out medical hardship for patients who have no coverage?
Medical Hardship claims are processed in the order in which they are received. Medical Hardship may be approved for an individual with no current coverage. If an individual does not currently have coverage and they are below 400% of the federal poverty level they are required to fill out an Application for Health Care Coverage and Help Paying Costs before they can be approved for Medical Hardship assistance.

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ONE CARE (DUALS DEMONSTRATION)

Will One Care members be required to have prior authorizations to receive certain services?
One Care plans may establish prior authorization requirements for some services. These requirements may vary from one plan to another. Providers and members should contact the One Care plans to find out whether a given service requires prior authorization and how to obtain prior authorization if necessary.

It is important to know that, to ensure continuity of care, One Care plans must allow enrollees to continue receiving their current services from their current providers for the first 90 days of enrollment or until a comprehensive assessment is completed. During that period, One Care plans will reimburse out-of-network providers at the current MassHealth and Medicare fee-for-service (FFS) rates.

Will a member enrolled in One Care receive a new insurance card that will represent both Medicaid and Medicare coverage?
Yes. With One Care, enrollees will have one card for all of their MassHealth and Medicare services, including prescription drugs. When individuals enroll in a One Care plan, they will receive an ID card from their plan. Enrollees should present this card to their providers and pharmacies to receive their health care services.

In regard to One Care, my agency initially contracted with three insurance plans, but now we are outside the service area. Does MassHealth hold us responsible, now, to complete One Care webinars and receive certification? If so, are all staff members responsible or just program directors?

Providers who are contracted with One Care plans should work directly with the plans to understand the training expectations and requirements.

The trainings include information that is broadly applicable to providers who are serving MassHealth members, particularly those with disabilities. MassHealth encourages providers to participate in the trainings that have been made available under One Care, including the webinars. The webinars are available in real time and are also archived and posted on the One Care website (www.mass.gov/masshealth/onecare) so the providers can view them at their convenience. All MassHealth providers can access the trainings, whether or not they are contracted with a One Care plan.

Is it correct to say that One Care patients are not the same as those patients who have CarePlus?

Yes, that is correct.

One Care *is a new integrated care delivery option for people with both MassHealth and Medicare (dual eligibles). MassHealth and CMS have contracted with three health plans to provide all MassHealth and Medicare benefits (as well as additional behavioral health and community support services) to individuals with disabilities ages 21-64. Eligible individuals must have MassHealth Standard or CommonHealth, as well as Medicare Part A and Part B, and be eligible for Medicare Part D.*

CarePlus *is a new MassHealth benefit plan for adults 21 to 64 years old whose income is at or below 133 percent of the federal poverty level, and who do not qualify for MassHealth Standard. CarePlus is available through six Managed Care Organizations (MCOs), and for some individuals, through MassHealth directly.*

Do rest homes not nursing homes contract with One Care?

Rest homes are licensed by the Massachusetts Department of Public Health, provide 24-hour supervision and supportive services for individuals who do not routinely need nursing or medical care. Rest homes provide housing, meals, activities and administration of medications for individuals who need a supportive living arrangement. A person who lives in a rest home may enroll in One Care if he or she meets all One Care eligibility criteria. However, One Care plans do not directly contract with rest homes.