Massachusetts Health Care Training Forum
April 2013 Questions & Answers

This document supplement the presentations made during the Massachusetts Health Care Training Forum (MTF) meetings by offering Questions & Answers, and additional presenter comments if applicable.

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.

MASSHEALTH UPDATES

Questions from the MTF April 2013 Roundtable Forms:

Concerned about member transition

- **What is the outreach plan?**
- **Notices – timing?**

Member transition will be presented at a future MTF forum in the ACA Educational Series Updates.

Is there any reason that recertify or review eligibility cannot be faxed? Often times hearing form was not received or information not received and it was.

The review form can be mailed or faxed. The address is below.
MassHealth Enrollment Center
P.O. Box 1231
Taunton, MA 02780
Fax: 617-887-8777

Do you have a system which verifies an employer offers health insurance?
The Premium Assistance unit does an investigation to see if applicants/members have health insurance or access to health insurance.

For those who are not affected by Medicaid expansion and currently have MassHealth coverage, will they be required to reapply after January 1st? Even though when eligibility anniversary hasn't reach it's term?
Much of what is happening today with MassHealth will remain the same with the ACA. Annual eligibility reviews will still be required and individuals will need to respond with necessary information to complete the review process. MassHealth will be looking to leverage data matching to make the verification process for the annual review less burdensome for the member. As more functionality is rolled out with the new HIX/IES system, including annual eligibility reviews, MTF participants will be updated.

How do you not get a disability review on someone?
If the disability is approved by the MassHealth disability evaluation unit, it is done with a time frame of expected duration. The review of disability will be based on that, however some disability durations are waived due to severity. In the case of a waived disability determination the member would not need to complete another disability supplement but would still need to complete the annual MassHealth eligibility review.

How long does the unemployment to go on client's record to be counted or set up the data match?
The DWD match occurs when a new application is processed, a new unemployment compensation income is reported, or periodically to determine if active member has a DWD claim that has not been reported. The DWD match will automatically end unemployment compensation income when the last "Received Check Date" returned in the data match is more than one month old than the last data match. This is an indication that the member has not filed a claim for unemployment compensation income. MassHealth plans to enhance this data matching capability with DWD in the future. As a general rule of thumb, the individual should report to MassHealth when there unemployment compensation benefits have ended to ensure the most current information is on file.

How should a person on a J visa or F visa be considered residents or non-residents?
Immigration status and residency are two different concepts and eligibility criteria. For immigration status, send in any and all most current immigration documentation for MassHealth to accurately determine a person's immigration status.

I have been receiving notices with patient's names and our address.
This question has come up before and we are researching as to why that might happen.

If a call goes into the MEC, can the representative decide not to look at the file and verifications submitted because they don't want it assigned to them?
No, if a worker is on duty and answers the call the expectation is that they should do as much as possible to resolve an issue.

It appears that the only way to get Premium Assistance is if you know about it and call them directly. Even if I send the insurance information and write on it that they are looking for help paying for it. Why doesn't the information go directly to them?
There are triggers in the system that make some cases go directly to Premium Assistance but if the triggers aren't matched then some cases don't get picked up. One can call the ECOB Unit (Enhanced Coordination of Benefits Unit at 1-800-462-1120 Option 5 if there are questions).

When are the MassHealth letters going to be rewritten in appropriate language? The majority of our patients do not have the ability to understand this.
They will be revised through the new Health Insurance Exchange Integrated Eligibility System.

Is it true when children are put under CMSP, they automatically get HSN as a secondary which will cover emergency services?
CMSP members up to 400% of the FPL automatically get HSN secondary, which covers anything that the HSN normally covers as long as CMSP doesn't cover it (the provider has to try to bill CMSP first, and then they can bill the HSN for anything denied as non-covered). CMSP members from 200-400% PFL get HSN Partial, which means the family is also responsible for an HSN deductible. CMSP members over 400% are not eligible for the HSN.

We understood that the new Job Update Form does not need to be returned if the member agrees with income listed and has no changes however, we have seen numerous members whose coverage ended and the notice says it's because the member did not return the form. Which is accurate? Do they always need to return the form or only if changes need to be made?
If the member finds the information is current and accurate on the job update form then the member **would not** need to send in the signed job update form.

What does Frail Elder Waiver under MassHealth mean or, any other waiver showing under eligibility?
It is the Home- and Community- Based Services waiver. Members who meet certain clinical and financial criteria may be eligible for the waiver. Full details can be found in the MassHealth member eligibility regulations at 130 CMR 519.007 (B).

Why do some new applications remain unprocessed for months and only get attention when we call to have them expedited?
Certain applications are prioritized, for example pregnant women and individuals requiring immediate medical services. Some applications may take up to 90 days if they need a disability evaluation. If there is a concern a call should be made to customer service to inquire about each specific application's circumstances.

Why is information on MMIS not matching with the information on Virtual Gateway? For example: Names and D.O.B
There are a variety of reasons this could happen. A call would need to be made into customer service at 1-800-841-2900 so the case specifics could be looked up and resolved.

Will the data match process speed up the processing of applications or slow it down? Will applicants be put on HSN until match is complete?
As part of the Affordable Care Act, a new eligibility system is being implemented – the Health Insurance Exchange/Integrated Eligibility System (HIX/IES). This system will utilize data matching and make a real time determination. If unable to match all required eligibility criteria, an applicant will be provided with coverage based self-attested information for up to 90 days. The applicant will be required to send in verifications within the 90 day period or may lose coverage.

With the changes to the definition of family group, we (providers) just put everyone in the household on the same application or will we need to understand new definitions and create applications for different group in a household?
Household composition definitions and how they determine eligibility will be presented at a future MTF forum in the ACA Educational Series Updates.

Questions from the MTF April 2013 Evaluation

Is there a specific number to call for eligibility issues regarding newborn patients?
Providers should call the 1-800-841-2900 number and access the provider customer service.

What are the yearly penalties for having no health insurance? Questioning the self-employment penalties on having more than 11-15 employees under them?
This will be part of the mandate and the Department of Revenue controls this so you may want to contact them.

My agency provides AFC and day habilitation services (LTSS). Many of these clients are Duals Eligible; however, they are primarily mentally and physically disabled. When MassHealth sends out the "packets" of information regarding the IOCs, most of our clients will not be the ones making the decision as to whether to opt out or not. Will this be the responsibility of their legal guardian or their health-care proxy, or both? Will providers be made aware of what these information packets will contain?
The ICO's will be well aware of what is being sent and the Care Coordination Team should be of great assistance with any and all processes for this population. There will be more to come as it is finalized.

What is causing delays with getting an application processed? We have an ongoing issue with the fact that MAPS will say that an application is processed but show no outcome. Originally we were told to wait 48 hours after seeing that to see if a data match finalizes the case. However on a large number of cases we are seeing nothing will happen and when we call the MEC we are told that someone didn't finalize the case and then it is processed while on the phone. There are far too many of these cases for us to call on and we sometimes don't get to them until the client calls us which could be several months after the application is submitted.
Reminders have gone out to staff in regard to proper finalization of the application and determination process so the hope is this will resolve itself. The new Health Insurance Exchange (HIX) will be more efficient and timelier with responses.

I would like to have asked questions regarding Senior Member Benefits under the MassHealth programs especially for both members who should qualify under frail elder and spousal waiver eligibility (HCBS and MFP). We are experiencing problems with waivers not being used to evaluate both initial and ongoing eligibility and the resulting delay and difficulties to remedy these situations. We would also like more detailed information on the Dually Eligible Demonstration to begin in July with regard to those eligible for both benefits and living in Group Adult Foster Care and also those 60 to 64 who are eligible under an provider who is an MCO and an ICO or those members eligible under PACE. Also, with regard to the ACA usefulness to seniors and with their Medicare, Medigap, Advantage and Mass Health benefits.
Information regarding the Duals Demonstration may be accessed at www.mass.gov/masshealth/duals or by e-mailing your question to: duals@state.ma.us.

Affordable Care Act

Questions from the MTF April 2013 Roundtable Forms:

As Virtual Gateway users, will this phase out and will we now strictly be using the Navigator?
Navigators are organizations that have been selected through a grant application process. They will be certified to assist consumers with outreach, education, application and enrollment into a health plan. The current Virtual Gateway community, as well as additional organizations, will assist with health application to determine eligibility for coverage – once certified they will be called "Certified Application Counselors".

How about the undocumented individuals? Will they qualify for anything since now its federal mandate?
Individuals who are ineligible for MassHealth or a Qualified Health Plan may be eligible for Health Safety Net and/or MassHealth Limited if they meet the eligibility criteria.

How is MassHealth going to reach out to the Native American community and help get coverage and apply laws specific to them? How can employers of Indian health care gain knowledge specific to them to help our clients and new federal facility?
We continue to provide outreach and awareness throughout the Commonwealth to all communities and have been working with our partners within the Native American community to inform them of the changes. Communications and updates can be found through the MTF website and listserv.

Is there a match in funding from federal level?
The Health Connector will offer subsidized qualified health plans (QHP) to those with incomes between 134% - 400% FPL (including AWSS 0-133% FPL).

- **Federal Subsidies (134% to 400% FPL)**
- Premium Tax Credits up to 400% FPL
- Cost Sharing Reductions up to 250% FPL

- **Additional State Subsidies (134 - 300% FPL)**
  - State Subsidies up to 300% FPL

Scenario: April 2014, person comes to our office for help with Navigator, they are within 200%-250% FPL, they are not offered insurance offer insurance thru POE (and haven't had insurance for 6 months) next open enrollment not until 10/14. Does this mean they will not qualify for insurance until October 2014?
As the law stands now, it would mean that they would not be able to enroll in a health insurance plan until the next open enrollment. The Health Connector is in discussions with CMS to make it similar to how it is today with Commonwealth Care members, however it has not been finalized.

Will the Virtual Gateway be incorporated into the HIX/IES or will they be separate? Will applications for SNAP still be available through VG?
The Virtual Gateway will not completely go away, as the system provides many functions. This includes being able to do SNAP assistance – this functionality on the VG is not going away. The Health Assistance part of the VG's Common Intake Application will merge with the HIX/IES in late December.
The HIX/IES will be the new integrated eligibility system that will allow residents to apply for and enroll in subsidized and non-subsidized coverage through a single, efficient, and easy to navigate system. More detailed information on VG transition through MTF meetings and listserv.

How about applicants who decide to apply via new paper applications; will APTC's and CSR's only be available in online application form?
No – federal and state subsidies can be determined through either the online or paper application process. Note: In order to receive APTC a person must file taxes for the year that APTCs are received.

How about the role of licensed agents and brokers in the HIX? I understand they are not to receive my consideration directly or indirectly when enrolling clients into QHP so, who'll pay their commission? Insurance Companies?
In Massachusetts, the majority of health producers (aka agents or brokers) work as the trusted advisor for their group clients (aka small businesses), though a producer's license allows them to serve individuals as well.

Today, the Health Connector pays broker commissions on groups of 1-50 sold through the Health Connector/HIX. We do not currently pay commissions on individuals.

How about those applicants who file tax return extensions or cannot file their taxes for whatever reason?
For individuals that we cannot obtain a data match because they did not files taxes, or the information that came back from the data match was not reasonably compatible:
MassHealth: No change to verify income. For those people who do not file taxes, who we cannot get a data match for income, or who are not considered Reasonably Compatible, income verification can be submitted as it is done today.

APTC: Paper verifications can be submitted, as is done for MassHealth today. NOTE*: In order to receive APTC a person must file taxes for the year that APTCs are received.*

Will MassHealth/Commonwealth Care be subject to open enrollment in the HIX/IES?
MassHealth is not subject to open enrollment. Individuals can apply and enroll in coverage at any time throughout the year.

Commonwealth Care individuals above 133% FPL will need to reapply during open enrollment for QHP coverage. Certain MassHealth populations that will be transitioning to QHP will also need to reapply during open enrollment for QHP coverage. Eligible individuals and families' can enroll in or switch into a Qualified Health Plan (QHP) during an open enrollment period or special enrollment. Open Enrollment for non-group (individual and families) for year 1 is October 1, 2013 to March 31, 2014.

Stay tuned - More details related to Member Transition including mailings and outreach will be shared through MTF.

Will people who have access to Employer Health Insurance but find it unaffordable be able to purchase insurance on the exchange with subsidies?
If their ESI is more than 9.5% of their household income then they will be able to shop for a QHP with subsidies.

Will each individuals financial situations (income) be considered in regard to (employer-sponsored insurance) ESI?
The 9.5% affordability will be based on a total household income.

Will recent tax returns duly filed be required to get APTC or CSR's?
No, but there will be data matching to verify MAGI in order to receive them for the first year. In subsequent years, individuals and families will need to file taxes in which they received premium tax credits.

Is there a maximum amount/cap for APTC?
The maximum amount of the Premium Tax Credit is determined by:

- Income level (MAGI)
- The Health Connector's 2nd lowest cost Silver Plan

However, the amount of the tax credit may vary by the plan they choose, unless they choose the 2nd lowest cost Silver Plan.

Let's say an individual was eligible for premium tax credits and selected it; what happens if their incomes change? Will they be penalized at tax season?
If you take the tax credit in **advance**, changes to your family size or income — or even a new job that offers health insurance — could mean you're getting the wrong amount of tax credit. Call the Health Connector to recalculate your tax credit so you won't owe money or miss out on tax credits you qualify for.

Will the new HIX system require or have the capability to upload scanned documents/verifications instead of faxing paper documentation?
One functionality of the HIX/IES will be ability to upload scanned documents. More details to come at future MTF sessions about phased roll-out of various functionalities.

How will Premium Assistance be affected?
There should be little or no impact to how premiums or premium assistance is calculated for MassHealth. Today's Family Group for premium billing and premium assistance rules will be mirrored for premium and premium assistance calculations.
**Note: MassHealth is currently in the process of discussing this issue with CMS.*

Will new eligibility system be used to change health plans?
This is a function that will be part of the system. The system's functionality and phased roll-out of certain functionalities will be provided through MTF.

Questions from the MTF April 2013 Evaluation

Will training be provided on HIX/IES when it is released?
Yes. Information on resources and training will be shared through MTF – please stay tuned.

On the premium tax credit program, are you eligible to receive credits if you have VA insurance?
Most VA coverage does meet MCC, which would make them ineligible for a QHP with premium tax credits.

With the Affordable Care Act coming, will that phase out MSP insurance?
Yes. All Commonwealth Care and Medical Security Plan members will shift to either a Qualified Health Plan (QHP) through the Health Connector or to MassHealth.

ICD-10 Overview

Questions from the MTF April 2013 Roundtable Forms:

Does MassHealth recommend any other consulting groups for the ICD-10 transition?
MassHealth cannot recommend a specific consulting firm.

Will the provider manual be updated to accommodate ICD-10 changes or is it mainly through bulletins?
The provider manual will not be updated to include ICD-10 codes. Providers should refer to the Mass health's ICD-10 website www.mass.gov/masshealth/icd-10 for updates.

Duals Demonstration Overview

Questions from the MTF April 2013 Roundtable Forms:

***NOTE:** The Massachusetts Duals Demonstration is now called **One Care**: MassHealth plus Medicare. Integrated Care Organizations (ICOs) are known as One Care plans. Please visit www.mass.gov/masshealth/duals and click on "One Care: MassHealth plus Medicare" for more information.

Are people on ABI waiver or MassHealth waiver for DDS clients excluded from eligibility?
At this time, individuals who are enrolled in a MassHealth Home and Community-based Services (HCBS) Waiver are not eligible to enroll in a One Care plan. This includes those enrolled in the ABI Waiver and the DDS Waivers.

For a dual eligible enrolled in a One Care plan, how do specialty pharmacies bill MassHealth as secondary?
One Care plans are required to cover the enrollee's Medicare Parts A, B, and D, and MassHealth services. This includes pharmacy products covered under Medicare Part B, Part D, and MassHealth. Specialty pharmacies should bill the plan directly, and should not bill MassHealth as secondary.

How do we assist patients in enrolling in a One Care plan?
MassHealth is developing materials that will help providers act as a resource to individuals who may be interested in enrolling in a One Care plan. This will include a sheet of FAQs created specifically to help providers answer questions. This one-pager will list some resources to which providers can direct patients, including an online guide to One Care for consumers, and contact information for MassHealth Customer Service. MassHealth Customer Service will be able to answer questions about which providers are part of One Care plans' networks. You should direct anyone who wants to enroll in One Care to call MassHealth Customer Service at 1-800-841-2900.

How are DDS or DMH vendors (case managers especially) being involved?
The purpose of One Care is to bring together the benefits and services a person receives from Medicare and MassHealth under a single integrated care organization. For some individuals on MassHealth, other state agencies such as DMH and DDS also provide them with important services. Because some of those services are not covered by MassHealth, and to ensure that important, existing relationships members have with state agencies are not disrupted, One Care plans will not take over the provision of state agency services. State agency services that a member is receiving will remain in place if the member enrolls in a One Care plan. Each member in a One Care plan will have a care coordinator and a care team. The care coordinator will be responsible for interfacing with the state agency, including the member's state agency case manager, and ensuring that the member's One Care services are coordinated with those being provided by the state agency. Where appropriate and in line with the member's needs and preferences, a state agency case manager may be part of the member's One Care, care team and/or attend care planning meetings with the care team and the member.

How will providers know if the patient is in a One Care plan? Can we see it in MMIS eligibility?
MassHealth providers will have similar ability to see a patient's affiliation with a One Care plan as they do now for members enrolled in a MassHealth MCO.

Is someone in the Buy-In program eligible for One Care?
No. Individuals in the MassHealth Buy-In program do not meet the eligibility requirement for One Care of being enrolled in MassHealth Standard or CommonHealth.

How is the Individualized Care Plan (ICP) developed?
Each person that enrolls in a One Care plan will be able to participate in a person-centered assessment and care planning process, including the creation of an ICP. One Care plans will be required to complete a comprehensive assessment of the individual's needs, including medical conditions and needs, behavioral health, and functional status. The assessment will also cover topics including an individual's accessibility needs, health-related goals, housing/home environment, and social supports. The plans will be required to ensure that members receive information and any assistance they may need to prepare for and fully participate in the assessment process. The assessment process will lead to the development of an ICP, which must reflect the member's preferences and needs. One Care plans will be required to provide a mechanism for a member to sign or other indicate approval of their ICP. The ICP will be a living document that is updated over time by the member and their care team as the member's goals, preferences, and needs change.

If a client enrolled in DMH Community Based Flexible Supports (CBFS) services chooses a One Care plan, can the client/still receive DMH/CBFS Services?
Yes. In this case, the individual would receive all of his or her Medicare and MassHealth benefits through the One Care plan, and would continue to receive state agency services (such as those provided by the Department of Mental Health, the Department of Development Services, and other state agencies) through that agency. One Care plans and state agencies will work together to ensure coordination across all of the member's services.

If a member is in One Care and also is in a DMH or DDS residential setting, will the One Care plan be taking over the residential contract costs, or will those contract costs remain through the state agency? How does the project envision cooperation between the state agency, the residence providers and the plan?
State agency services that a member is receiving will remain in place through their state agency if the member enrolls in a One Care plan, and the state agency will continue holding those contracts and paying their contracted providers as they do now. Each member in a One Care plan will have a care coordinator and a care team. The care coordinator will be responsible for interfacing with the state agency and ensuring that the member's One Care plan services are coordinated with those being provided by the state agency. Where appropriate and in line with the member's needs and preferences, a state agency case worker and/or a residential provider may be part of the member's One Care plan care team and/or attend care planning meetings with the care team and the member.

Is MassHealth setting the rates that One Care plans need to pay providers?
In One Care, plans and providers will need to negotiate payment rates. The two parties will need to engage in a dialogue that addresses and ensures both the adequacy and appropriateness of the services rendered, and reimbursements received.

One Care plans will be required to show that they have an adequate network of providers for all One Care covered services in each county in their service areas. In order to secure such a network, the plans will have to work with providers to negotiate and establish mutually acceptable rates. Rates that MassHealth and Medicare are paying the One Care plans are built from historical FFS expenditures, so we would expect that providers and One Care plans use current FFS provider rates as the logical starting point for negotiations. We encourage plans and providers to also consider using alternative payment methodologies other than traditional fee-for-service, such as global payments, bundled payments, or shared savings/shared risk arrangements.

What is the difference between One Care and MFP (Money Follows the Person)?
One Care is a new option for individuals who are eligible for both Medicare and MassHealth, and who are between the ages of 21-64, to receive all of their Medicare and MassHealth services from a single health plan. It is a 3-year demonstration being operated by MassHealth in partnership with the Centers for Medicare and Medicaid Services (CMS).

The Money Follows the Person (MFP) Demonstration is a separate initiative, with different eligibility requirements than One Care, and complementary but distinct goals. The primary goal of MFP is to support MassHealth members ages 18 and older who want to transition from long-term care facility-based settings to community living. The MFP demonstration aims to increase the use of home and community based services, eliminate barriers that prevent transitions from facility settings, and ensure quality assurance and improvement.

Eligible individuals may participate in both One Care and MFP if they meet the qualifications for both programs.

Who will be included in the first wave of auto-assignment into One Care?
The timing and process for auto-assigning members remains under development. However, MassHealth expects that individuals with the highest community-based LTSS and Behavioral Health needs will not be targeted for auto-assignment in the first wave. Individuals being included in auto-assignment will be notified of their assignment at least 60 days before it is scheduled to take effect. During those 60 days, they will be able to opt out of One Care if they so choose, or tell MassHealth that they would like to join a different One Care plan than the one to which MassHealth has assigned them. If they do not act, their coverage with the auto-assigned plan will begin after the 60-day period.

Why are some state agencies services excluded from the list of covered services that One Care plans will provide?
The purpose of One Care is to bring together the benefits and services a person receives from Medicare and MassHealth under a single integrated care organization. For some individuals on MassHealth, other state agencies such as DMH also provide them with important services. As many of those services are not covered by MassHealth, and to ensure that important, existing relationships members have with state agencies are not disrupted, One Care plans are not providing state agency services. State agency services that a member is receiving will remain in place if the member enrolls in a One Care plan. Each member in a One Care plan will have a care coordinator and a care team. The care coordinator will be responsible for interfacing with the state agency and ensuring that the member's One Care plan services are coordinated with those being provided by the state agency. Where appropriate and in line with the member's needs and preferences, a state agency case worker may be part of the member's One Care, care team and/or attend care planning meetings with the care team and the member.

What if someone does not have Part B but has Medicare A and D, MassHealth Standard or CommonHealth?
To be eligible for One Care an individual must meet a set of defined eligibility criteria. The criteria include being enrolled in both Medicare Part A and Medicare Part B, and eligible for Medicare Part D.

What happens to a person who enrolls in a One Care plan when they are under age 65 and then turn 65 during life of the project? Are they un-enrolled?
An individual who enrolls before their 65th birthday will have the option of staying in One Care once he or she turns 65 as long as they are re-determined eligible for MassHealth Standard.

What support will be offered for dual eligible individuals who need language translation services during enrollment and beyond?
MassHealth Customer Service is handling enrollments for One Care, and will provide support to individuals who need enrollment assistance in languages other than English. An enrollment guide that will be sent to individuals eligible to enroll will be available in print form in English and Spanish. It will also include a brief statement ("Babel card") in 18 other languages indicating that interpreter or translation services are available by calling MassHealth Customer Service. One Care plans are also required to provide key member materials in English and Spanish, and to make translation and interpretation services available through their member call centers.

What kind of transportation services will be covered?
One Care plans are required to cover all transportation services covered under MassHealth Standard and CommonHealth. This includes emergency medical transportation and non-emergency medical transportation. In addition, One Care plans may cover non-medical transportation, when doing so would provide sufficient value to the member's care, based on the full range of services included in the care plan, and considering how the services contribute to the health and independent living of the member in the least restrictive setting and with reduced reliance on higher-cost, acute services.

Will One Care plans provide transportation (i.e.: PT 1's)?
One Care plans will cover transportation services, including non-emergency medical transportation. They will be required to contract with the EOHHS-contracted transportation broker(s) in the plan's service area to provide non-emergency medical transportation services authorized by EOHHS for enrollees for their first 90 days, or until a care plan addressing their needs and services is in place. This will include both transportation for Day Habilitation and previously authorized transportation provided through the PT-1 process. For non-emergency medical transportation after that continuity of care period, One Care plans are required to have a contracted network of transportation providers that will offer non-emergency medical transportation as covered by MassHealth. For new transportation requests, the One Care plan will work with the enrollee and arrange for transportation through its contracted network.

Will there be a website provided to inform members of their choices? Will there be information to help members choose between different One Care plans that will include geographic areas, case management, and medical and behavioral health providers on panels?
MassHealth is developing a new website that will help inform consumers about One Care and their choices. The website is expected to go live this summer. In addition, MassHealth is developing a variety of materials directed at consumers and providers that will address questions about which One Care plans are available in which counties, the services that One Care plans will provide, and information about what the member will experience in a One Care plan (including care coordination and care teams). For information regarding which providers are included in which plan's network, individuals should call MassHealth Customer Service.

Will those who join a One Care plan lose access to their primary care provider, specialists, or other providers?
One Care plans are required to contract with a broad array of medical, behavioral health and long-term services and supports (LTSS) providers. They must meet MassHealth and Medicare network adequacy requirements in all the counties in which they operate before they will be permitted to accept enrollments. Before enrolling in a One Care plan, an individual will get more information from MassHealth Customer Service and from individual plans to find out whether the providers they are currently seeing are in the network of a plan offered in their county. (Note that enrollees can see providers anywhere in their One Care plan's service area.) If the individual does enroll with a One Care plan, the plan is required to let them keep seeing their current providers for the first 90 days or until a care plan

is in place that addresses their service needs and transitions them to in-network providers if necessary. This is true even if the individual's current providers are not in the plan's network.

Will vision and hearing be covered services?
One Care plans will be required to cover all vision and hearing services to which the member is entitled under Medicare and MassHealth. This includes audiologist services, hearing aids, and vision care services (e.g. eye exams, glasses).

Questions from the MTF April 2013 Meeting Evaluations

I'd like more details on how the ACA differs from what we already have in Mass.
The Health Connector website includes a webpage called "Health Care Reform: Planning for national reform". This webpage includes FAQs and ppt. presentations with lots of details on how things will change under ACA. Web link below:
https://www.mahealthconnector.org/portal/site/connector/template.MAXIMIZE/menuitem.3ef8fb03b7fa1ae4a7ca7738e6468a0c/?javax.portlet.tpst=2fdfb140904d489c8781176033468a0c_ws_MX&javax.portlet.prp_2fdfb140904d489c8781176033468a0c_viewID=content&javax.portlet.prp_2fdfb140904d489c8781176033468a0c_docName=Exchange_Planning_content.htm&javax.portlet.prp_2fdfb140904d489c8781176033468a0c_folderPath=/Health%20Care%20Reform/Exchange%20Planning/&javax.portlet.begCacheTok=com.vignette.cachetoken&javax.portlet.endCacheTok=com.vignette.cachetoken

If a provider currently contracts with MassHealth MCOs that are serving as One Care plans, will the provider be able to bill for services under One Care? Will they bill the negotiated rate with the plan using a MassHealth billing code?
If a provider wishes to provide services to dual eligible individuals enrolled in a One Care plan, the provider will need to become part of the plan's contracted provider network. This will include negotiating a payment rate with the plan. Having a relationship with a health plan through the MCO program does not necessarily mean that a provider will be able to serve the plan's One Care members. Providers should work with the One Care plans to understand the contracting and billing details and options.

When MassHealth sends out information about One Care and the One Care plans, will the information go to guardians or just the member? Will providers be made aware of what these information packets will contain?
In general, mailings about One Care will go to the same individual that currently receives mail from MassHealth now, which may be a guardian. MassHealth appreciates that providers and others may want to assist members with understanding this information, and we will develop a process for posting notices and other mailed materials online.

Will One Care enrollee have to pay a monthly premium?
In One Care, plans are not permitted to charge any premiums. Currently, some dual eligible individuals must pay a premium to MassHealth in order to be eligible for MassHealth. Those individuals will continue to pay that premium to MassHealth, but no premiums will be charged by or paid to One Care plans.

HEALTH SAFETY NET

Questions from the MTF April 2013 Roundtable Forms:

Any chance of a HSN cards in the future?
HSN is not an insurance program and patients will not receive HSN cards.

For claims that need to be appealed for eligibility; is there any deadline to send the appeals?
The HSN HelpDesk reviews eligibility appeals on a first-come, first-served basis and responds as quickly as possible. At this time we cannot provide a specific timeline.

Can a Medicare beneficiary be denied HSN coverage for prescriptions because he/she is enrolled in or eligible to enroll in a Part D plan?
No. If an HSN eligible patient is enrolled in Medicare Part D, the HSN may be billed as a secondary payer for eligible prescriptions.

Commonwealth unenrolled; do we have to bill MassHealth, get denials and then bill HSN?
If a patient is Commonwealth Care eligible and not enrolled and within their HSN gap eligibility period HSN may be billed as the primary payer.

Currently if a patient is in hospital for more than 20 days (says these are currently denying from MMIS), MassHealth wants 112/114 bill and HSN wants 111 bill. Is this ever going to change to be the same?
Providers should continue to submit outlier claims in accordance with HSN requirements. At this time, there are no plans to change the TOB requirements.

How does one get ID # on a self pay bad debt?
Assignment of a referred eligibility record for an individual receiving bad debt services is still available via claim submission as noted in the HSN 837I billing guide. Use of the bad debt application within the special circumstances application provides another mechanism for creating an eligibility record. Providers should refer to the HSN Billing and Special Circumstances User Guides posted on the HSN website at www.mass.gov/healthsafetynet.

I'd like to know what the claim flow is (for HSN claims) from MMIS to INET? How often are claims uploaded from MMIS to INET and when are they uploaded?
Near the middle of each month, the HSN processes and reviews the previous month's claims data that has been received from MMIS and uploaded into the HSN's claims databases. Once the review is complete, remittance advices are posted in INET. This usually occurs near the 20th of the following month for CHCs, and the 10th of the following month for hospitals.

If a patient is admitted to the hospital with no insurance, during the LOS they fill out an MBR and become eligible. The stay is split between Commonwealth Care/MassHealth and HSN. What portion of this is billed as HSN primary? Do we need a discharge date or in-house stay, as the HSN portion may end before their discharge date?
Please refer to the HSN Billing Guides for recent updates on billing of split bills. Providers may also contact the HSN Help Desk at (800) 609-7232 or hsnhelpdesk@state.ma.us for assistance.

I heard that the state might be creating a dental purchase plan for HSN members. Is this correct? If yes, when will it become available to the public?
A number of dental plans will be available on the exchange for public purchase. Someone who is HSN eligible may choose to purchase one of these plans if they are otherwise eligible for purchase on the exchange. The HSN would then become a secondary payer to the private insurance plan. There will not be plans specifically available to HSN eligible patients or additional subsidies provided through the HSN for dental plan purchasing.

Is anticipated coverage availability for QHP plans similar to current Commonwealth Care HSN coverage?
HSN will continue to pay Massachusetts Acute Hospitals and CHCs for services provided to QHP members who are eligible but have not yet enrolled on a time limited basis.

It appears there is a now column on the payment sheets entitled NET HSN change. Is that correct?
The Net HSN charge is a new data element on the HSN remittance. The net charge is calculated via the estimated amount due logic outlined in the HSN Billing Guides. Billing Guides are located on the HSN website at www.mass.gov/healthsafetynet.

Why are we getting full payments on secondary claims?
Please contact the HSN Help Desk at (800) 609-7232 or hsnhelpdesk@state.ma.us**.**

Would the ICD-10 apply to HSN also?
Yes, the HSN will follow MassHealth covered service rules and billing requirements relative to the ICD10 transition.

Patients have HSN on D.O. S. but received denial claim with error code. "The patient does not appear to be HSND eligible.
Please refer to the HSN Claim Update for Claim Denial Reviews that is posted on the HSN website located at www.mass.gov/healthsafetynet.

What is the future of Health Safety Net in ACA?
The HSN will continue to operate and serve low-income patients throughout the implementation of the ACA. As specific policy becomes clear we will continue to bring this information to providers and other stakeholders.

Why is it that when you go online you cannot find much information on HSN?
The HSN website hosts information for patients and providers and is located at the following address: www.mass.gov/healthsafetynet.

Will HSN cover the person for the rest of the year if they miss open enrollment?
HSN will continue to pay Massachusetts Acute Hospitals and CHCs for services provided to QHP members who are eligible but have not yet enrolled on a time limited basis. As specific policy becomes clear, we will continue to bring this information to providers and other stakeholders.

Would we ever be able to check on claims status on the INET like we used to?
Claim status for 837D is currently availability on INET. For 837I & 837P submissions, providers can check the POSC for file status. Claim status checks are currently unavailable in the POSC. This functionality is under consideration for the next stage of the HSN migration process.

When will HSN send a text file and or edit file in which we can import into our health information system to post cash electronically?
At this time, there are no plans for changes to the HSN's payment process.

Why, when running insurance eligibility and client has partial HSN there's no deductible amount?
For Health Safety Net - Partial patients with Family Income between 201% and 400% of the FPL, there is an annual Deductible equal to 40% of the difference between the applicant's Family Income and 201% of the FPL. If the deductible does not show up in EVS, it should be available in the patient's determination letter. 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 call the Help Desk at (800) 609-7232 or hsnhelpdesk@state.ma.us.

MASSHEALTH BILLING AND PROVIDER SERVICE

Questions from the MTF April 2013 Roundtable Forms:

Dual Eligible (Medicare/MassHealth) using specialty pharmacies; how do specialty pharmacies bill MassHealth as secondary?
MassHealth has contracted with ACS State Healthcare (ACS) to receive MassHealth *pharmacy claims* and answer providers' questions about the Pharmacy Online Processing System (POPS). If you have questions about billing and claims, please contact ACS Technical Help Desk at 1-866-246-8503.

Dialysis Claim – UB04; Does value codes need to be placed on UB04 for Dialysis 0721 claims; hospital?
Institutional Providers should refer to the MassHealth UB-04 Billing Guide available on the MassHealth website under the Provider Library.

I am having difficulty getting 90 day waivers paid. I am choosing reason code 8 (other) and including the waiver form and system generated notes electronically. Is there anything else I can do/any additional information I should provide?
Providers need to follow 90 Day Waiver procedures outlined in All Provider Bulletin 220. Please refer to regulations outlined in MassHealth regulations at 130 CMR 450.309 through 450.314. Providers with specific claim suspension/denial issues should contact CST at 1-800-841-2900 directly for assistance.

Do you know when or if MMIS is going to have actual remits and claim status available online?
Providers have the ability to see both Remittance Advices (RA) and claim status via the Provider Online Service Center (POSC) since May 2009.

Are CHC's allowed to provide Family Planning Services? If so, what level of credentials is required by the staff person providing the service? What CPT code should be billed?
Community Health Centers (CHC) need to refer to Subchapter 4 in the Community Health Center Manual regarding Family Planning.

CPT code 99402 in 2011, CHC regulations had a time factor of 30 minutes in the code description. The 30 minutes have been removed from the code description in the 2012 CHC regulations. Can we bill this code for a visit of any length of service?
Community Health Centers (CHC) should bill 99402 for all HIV counseling visits.

Early intervention codes T1015 have been denying for billed over allowed amount. Providers have been notified that these claims will be reprocessed by MassHealth, and to do nothing. To date, my claims are still not paid. Has payment started on these yet?
According to December 11, 2012 message text MassHealth will systematically reprocess previously adjudicated claims for T1015 denied due to edit 5930 on future remittance advices. No action is required on the part of the provider.

I am having difficulties with the MassHealth shoe form and hoping someone can go over this with me?
The Shoe prescription form is on the MassHealth website and includes instructions on the second page. If you have additional questions, please contact MassHealth Customer Service at 800-841-2900.

Prior to MassHealth implemented an actual referral number we were using the PCC legacy number. We have had some claims process through and pay with the PCC#. If appears that the money has been recouped. Is this something we should expect? When will MassHealth stop accepting PCC numbers?
Providers with specific issues/questions should contact CST at 1-800-841-2900 directly for further assistance.

Regarding MassHealth patients using specialty pharmacies for oral and injectable drugs; how does the specialty pharmacy bill?
MassHealth has contracted with ACS State Healthcare (ACS) to receive MassHealth *pharmacy claims* and answer providers' questions about the Pharmacy Online Processing System (POPS). If you have questions about billing and claims, please contact ACS Technical Help Desk at 1-866-246-8503.

When a MassHealth PCC member has exceeded his 20 visits for PT/OT or 35 visits for SLP for the rolling year, would we be able to use the PCC number (legacy number) in conjunction with the PA in lieu of obtaining an additional referral from the Primary Care Clinician (PCC)?
The PCC referral number requirements and the Prior Authorization (PA) requirements are separate requirements. When a member exceeds the established limits for therapy visits, a PA is required. However, a PCC referral is required for all visits if the member is a restricted to managed care.

What qualifies as grounds for a valid 90 day waiver request?
Please refer to regulations outlined in MassHealth regulations at 130 CMR 450.309 through 450.314.

We have claims rejecting when their patients benefit should reset on their anniversary date (for PT/OT/SLP). How should we handle these issues when the anniversary date is not being recognized?
Providers with specific issues/questions should contact CST at 1-800-841-2900 directly for further assistance.

Questions from the MTF April 2013 Evaluation

My question was regarding the use of the PCC legacy number in place of a referral. We have been obtaining a referral for services provided as we have been instructed. We have had a few claims process through the system with the PCC number we had listed (which would be the correct PCC for the patient) but not the current process. Are we at risk for MassHealth taking the money back on those claims? When is MMIS going to stop accepting the legacy number if the new process requires a referral from the PCC entered into MMIS?
Providers should be requesting a Primary Care Clinician (PCC) referral from the member's PCC prior to providing services to the member. The PCC will enter the referral into the Provider Online Service Center (POSC) and the servicing provider should use the PCC referral number issued through the POSC.

POSC issues with patient eligibility. Bob said it was a billing issue-Barbara said it was a gateway issue? Barbara stated there is too much info in system as to how the member is eligible for MassHealth and claim processing stops.
The Provider needs to contact CST to verify the member's coverage.