MLRI MASSACHUSETTS LAW REFORM INSTITUTE

40 COURT STREET
SUITE 800
BOSTON, MA 02108

617-357-0700 PHONE
617-357-0777 FAX
WWW.MLRI.ORG

June 12, 2017

Kaela Konefal
EOHHS Office of Medicaid
One Ashburton Place, 11th Floor
Boston, MA 02108

Comments for Demonstration Amendment submitted by email to kaela.konefal@state.ma.us

Dear Ms. Konefal,

These comments are submitted by the undersigned legal services organizations on behalf of our clients who rely on MassHealth and the Health Safety Net for access to health care. We appreciate the opportunity to make these comments expressing our strong objections to the proposed amendments pertaining to Nonemergency Medical Transportation and Provisional Income Eligibility for Adults. We support the third amendment to continue coverage for former foster care children.

Non-emergency medical transportation for CarePlus members is a low cost high value benefit for a small population for whom transportation is a barrier to care

MassHealth proposes to eliminate non-emergency medical transportation (NEMT) for adults in the CarePlus program except for travel to substance use disorder services.

There is no financial rationale for reducing NEMT benefits
There are over 300,000 adults enrolled in CarePlus, however, MassHealth estimates that only about 13,000 of them now use NEMT for other than SUD services. As this number suggests, access to NEMT is already very limited. The costs of services in CarePlus are reimbursed at an enhanced matching rate (89.6% in 2018). Thus, for every dollar less in CarePlus benefits, the state will save only ten cents. We have not seen any estimate of total cost savings from eliminating NEMT but given the low utilization and high federal matching rate, it cannot be large given the value of the benefit.

Non-emergency medical transportation is a high value benefit
The Medicaid program has required coverage of NEMT for a reason, studies have shown that it improves health outcomes and in some cases reduces costs. In 2006, the National Academy of Sciences released a report called a "Cost-Benefit Analysis of Providing Non-Emergency Medical Transportation."[i] The study looked at 12 specific preventive services and chronic conditions and found the costs of transportation for the target population resulted in reduced health care spending in four conditions, was highly effective in improving morbidity and mortality for six conditions, and moderately effective in the remaining two. We have not been able to obtain more detailed information on the CarePlus members now using NEMT. However, a doctor must request prior authorization for a patient to obtain a NEMT in the form of a ride to obtain a

``

covered service either because no public transportation is available or because the patient cannot use public transportation for medical reasons. The few patients who use NEMT are likely to be just like those in the target population of the study for whom NEMT is most cost effective.

Transportation is a greater access barrier for low-income Medicaid beneficiaries than for the commercially insured

The state's rationale for eliminating NEMT is to better align CarePlus with commercial insurance. However, transportation is a greater access barrier for low income Medicaid beneficiaries than for the commercially insured. Only six-tenths of one percent of those with private insurance reported that transportation was a barrier to accessing timely primary care treatment, while seven percent of Medicaid beneficiaries did so.[ii] Approximately 25 percent of lower-income patients have missed or rescheduled their appointments due to lack of transportation. [iii] Because of statistics like these, a January 2016 report by the United States Government Accountability Office concluded that the NEMT benefit "can be an important safety net for enrollees as research has identified the lack of transportation as affecting Medicaid enrollees' access to services."[iv]It is ironic that just at the time that the Medicaid agency is attempting to address the role of social determinants of health through its delivery system reforms, it is proposing to eliminate NEMT.

There is little doubt that CMS will approve this change if the state moves ahead with its plans to ask for it. The new HHS Secretary and CMS administrator have called the ACA's Medicaid expansion "a clear departure" from the mission of Medicaid, and invited states to dismantle it. We will be deeply disappointed if Massachusetts accepts that invitation.

Eliminating Provisional Income Eligibility for Adults in MassHealth and the Health Safety Net Will Exacerbate Already Unacceptable Delays

MassHealth is also proposing to change the current practice of providing coverage during a temporary period pending receipt of paper documentation of income with respect to adults (with a few exceptions). This change is not limited to the adults in CarePlus but extends to low income parents and adults with disabilities in MassHealth Standard, CommonHealth and Limited and to the Health Safety Net. While we have very limited information about who will be affected by this proposal, we were told that about 140,000 adults were provisionally eligible based on income last year, about 25 percent (35,000) were ultimately not found eligible, and that the state expects to save about $31 million in state dollars based on this change.

While the 75% of income eligible adults will eventually have retroactive coverage, many will have been unable to access any but emergency room care during the retroactive period. The retroactive period will also be fee for service, delaying enrollment into managed care. This shift from managed care in primary care settings to fee for service for the emergency room undermines the whole thrust of delivery system reform.

The great strength of the current system is that eligible applicants can obtain a real time determination for MassHealth and the Health Safety Net and obtain immediate access to care if needed. It aligns with the real time eligibility determination available in the Connector for ConnectorCare and private insurance. If MassHealth operations are experiencing prolonged

``

delays in call wait times or in paper processing, those delays do not result in access to care delays for eligible applicants.[v] Massachusetts was not alone in welcoming real time determinations; it is one of nine state Medicaid programs that do not require pre-eligibility income verification.[vi]

It is understandable that the state seeks to save money by eliminating the payment of benefits to individuals who are not eligible; we share with you an interest in achieving more accurate program determinations. However, ending provisional income eligibility comes at the cost of delaying eligibility determinations and access to care for a far greater number of eligible individuals. Further, the change will increase the volume of calls to MassHealth and the volume of paper submitted to MassHealth for processing which will delay all customer-facing operations.

We are also concerned with the anticipated timing for this change in October 2017. This will be just the time that health care providers, enrollment assisters and Navigators will be preparing for the massive shift of MassHealth members into new types of managed care, and for the Connector's next open enrollment period. Returning to a more labor intensive process for new applicants with more calls to MassHealth needed and more documents to be gathered and submitted at application or soon after could not come at a more challenging time for everyone.

Eliminating Provisional Income Eligibility Exacerbates All the "Pain Points" in the Current Eligibility and Enrollment System

Prior to January 2014, MassHealth required income to be verified prior to determining eligibility for most adults. Returning to this practice presents new challenges because of changes in the law and the limited capacity of the new HIX-hCentive eligibility system compared to MA-21 and to most other states' Medicaid programs. We urge MassHealth to increase staffing and upgrade technology to assure timely determinations and access to care in medically urgent situations before it goes forward with this proposal.

Prior to 2014, Massachusetts required proof of income to be submitted as part of a complete application. Medicaid law is now explicit that proof of income cannot be required until a state has first checked electronic data sources.[vii] Prior to 2014, most paper applications were processed within a few weeks of submission. Currently the state is taking the full 45 day time frame for an eligibility determination. Prior to 2014, applications submitted by Virtual Gateway providers had a 3-day window to fax proof of income and a "wet" signature to the Central Processing Unit for a timely decision without issuance of a request for information. Currently, assisters report that it is taking several months for proofs to be processed. Further, prior to 2014, assisters (Virtual Gateway providers) could use My Account Page to see requests for information, deadlines and the dates that MassHealth received documents and processed documents. We are told the new assister portal and on-line accounts do not include this information. See Table 1 for an example of the timely processing challenges without provisional income eligibility.

``

Long Call Wait Times

Data released by MassHealth for the period from May 2015 to May 2016 show large fluctuations in call wait times and call abandonment rates at the MassHealth Enrollment Centers and the Customer Service Center. While we are told average call wait times are currently 15 minutes, in almost any customer service setting 15 minutes is not an acceptable time to be on hold. Further, we still hear of callers waiting 30 minutes or more on hold. Other limitations of the current telephone system include hours of operation limited to weekday work hours during which MassHealth applicants who are employed may be unable to call, and an automated attendant in English with only a Spanish language option making telephone service difficult to access for individual who speak other languages. Further, because there are only four MassHealth Enrollment Centers with walk-in service, and none located in the population centers of Boston or Worcester, most applicants rely on the telephone system to communicate with MassHealth.

Responding to a request for information often requires one or more calls to MassHealth to understand what proof is required. This is true when notices are not clear, when a person who reads a language other than English or Spanish receives a request for information, or when an applicant is unable to read or has cognitive limitations understanding written material. With provisional eligibility, individuals have coverage while they try to get through to MassHealth. Without provisional eligibility, long call wait times will add delay to eligibility determination and access to care.

Further, eliminating provisional eligibility can be expected to increase call volume. With access to care now tied to document processing, MassHealth can expect more calls about whether proof was received, whether proof has been processed, and requests for expedited processing in urgent care situations. Even after a determination, there are likely to be increased calls relating to retroactive coverage issues: the retroactive date is not correct, providers are billing patients for services provided during the retroactive period, or providers are refusing to reimburse out of pocket costs incurred during the retroactive period.

We strongly urge MassHealth to improve telephone access prior to any change in provisional income eligibility by:

- staffing-up to meet greater volume of calls including expediting medically urgent cases
- improving telephone access when people call to have a notice translated
- providing clearer information about what to submit in notices, member books, and assister training, and
- improving the capacity of HIX-hCentive to display notices, deadline dates and the status of document submissions.

Lengthy Document Processing Times

It is disappointing to see MassHealth proposing to return to a more paper-driven eligibility system instead of focusing on continuing to improve the current HIX system including by extending data matching to more sources, such as unemployment insurance. As we noted above, HIX-hCentive doesn’t have the capacity of the legacy Virtual Gateway My Account Page to

``

display document-related information to on-line users much less to take advantage of newer technologies to submit documents electronically.

MassHealth already handles a massive quantity of paper. Currently, only a delay in processing a paper application or a delay in processing documents needed to reinstate eligibility after a termination will delay an eligibility determination. However, without provisional income eligibility, all applicants whose income is not verified electronically will need to have at least their income documents processed before they can obtain coverage. Paper applicants, of course, must additionally have had their application processed. Again, we do not have current information on MassHealth processing times, but it appears application forms are being processed within 45 days but other documents may take 30-60 days to process. See Table 1 for examples of the problems created by these time frames.

As with call volume, eliminating provisional income eligibility is likely to increase the volume of documents that must be processed. On the one hand, individuals required to submit documents may be more likely to do so if they have immediate care needs. On the other hand, with this change there is likely to be more documentation submitted than is needed. Paper applications continue to make up a significant portion of all applications submitted to MassHealth, and paper applicants have no way to know whether their income will be electronically verified. Many paper applicants who would not otherwise need to submit proof of income may do so to avoid a potential delay in obtaining a determination. If most paper applications are submitted with proof of income it will significantly increase paper volume.

Further, if individuals are not eligible until proof is processed, in addition to added calls checking on the status of proof, there are likely to be multiple submissions of the same proof. This can be expected if applicants cannot easily confirm document receipt and resend documents or if workers enter the self-reported income into the system and trigger an RFI before the accompanying proof of income is entered.

In addition, for individuals needing immediate access to care, MassHealth should expect that hospitals will make greater use of hospital presumptive eligibility and both hospitals and health centers may make greater use of HSN presumptive determinations. This increases the workload for hospitals and health centers and MassHealth workers who must process the presumptive eligibility information in addition to later processing a full application.

Further, the exchange of documents between applicants and MassHealth can be problematic. Currently, homeless individuals can access care right away based on an on-line application or as soon as a paper application is processed. Even if it is difficult for homeless individuals to reliably receive requests for information or gather documents, they have coverage and 90 days to submit required documents. Without provisional income eligibility, they may easily slip through the cracks. For this reason, we are urging MassHealth to add the homeless to those adults who can still obtain provisional income eligibility.

There are still only limited ways of getting documents to MassHealth. MassHealth has only four walk-in centers statewide and none in Boston or Worcester. MassHealth has not upgraded its technology to enable people to upload documents to their on-line accounts like the majority of

``

state Medicaid programs[viii] or to photograph and submit documents via a smartphone application like DTA Connect www.mass.gov/DTAConnect

Federal regulations allow states to accept a reasonable explanation for a discrepancy in addition to other methods of verification such as documentation. Most state Medicaid take advantage of this option which can avoid needless documentation.[ix]

We strongly urge MassHealth to retain provisional income eligibility for homeless adults and to improve the procedure for processing documents before ending provisional income eligibility for other adults. Such improvements include:

- For on-line applicants, setting up a dedicated fax line or other method to expedite processing proof of income like the current ID-proofing fax line or the earlier 3 day period to fax proofs (& wet signatures) to the CPU for Virtual Gateway applications
- Staffing up to allow for a 2-3 week time frame for processing documents
- Coordinating with the Connector to allow MassHealth applicants to submit documents at Connector walk-in sites
- Upgrading HIX to accept uploaded documents or emailed documents as the majority of other state Medicaid programs and DTA do
- Revising the paper application, RFI for income for adults, member books and notices to be clear that no eligibility decision will be made for adults until income is verified and provide clearer information on acceptable documents
- Retaining provisional income eligibility for adults with disabilities until HIX can electronically verify Social Security Disability Income
- Allowing for a reasonable explanation of a discrepancy to be made on-line or by telephone as the majority of other states do
- And, most importantly, monitoring and reporting on timely processing measured from the date of submission of an application on-line or on paper to the date of the eligibility decision.

Provisional Income Eligibility Should be Retained for the Health Safety Net

The proposed 1115 amendment does not address changes to the Health Safety Net (HSN), but it is our understanding that MassHealth also plans to eliminate provisional income eligibility for adults in the HSN. We strongly object to delaying access to care through the Health Safety Net. Whatever cost savings rationale applies to MassHealth does not apply to the HSN. The Health Safety Net is primarily funded by hospitals and surcharge payers not through state appropriations. The state contribution is likely to be no more than $15 million from the Commonwealth Care Trust Fund in 2018 whether or not there are reduced claims for HSN services. When there is a shortfall, it is borne entirely by the hospitals.

Further, HSN claims were significantly reduced just last year when income eligibility levels for full free care were reduced by 50% of the poverty level and for partial free care by 100% of the poverty level and when retroactive eligibility was reduced from 6 months to 10 days. The HSN does not provide insurance coverage but it does provide important access to care to the uninsured and underinsured and financial support for acute hospitals and community health centers. It is most needed to fill gaps in care such as delays in MassHealth eligibility determinations.

``

Further, it will only increase administrative burdens to require hospitals to use Hospital Presumptive Eligibility for patients with immediate care needs and for hospitals and health centers to use HSN Presumptive Determinations. Hospital PE and HSN PD do address urgent care situations but double the administrative burdens on providers and MassHealth. Another concern is individuals with time-limited HSN from the date of application, like ConnectorCare beneficiaries. They may be enrolled in ConnectorCare coverage (which will still use provisional eligibility for income) before they even obtain an HSN eligibility determination for a time-limited period that has now elapsed.

For the reasons set forth above, we urge MassHealth to reconsider its plans to eliminate NEMT for adults in CarePlus and provisional income eligibility. If MassHealth goes forward with the provisional eligibility change, systems should be in place to address the expected increase in call volume and in document processing, and no changes should be made for homeless adults or to the Health Safety Net.

Yours truly,

Victoria Pulos, Health Law Attorney
Massachusetts Law Reform Institute

Nancy Lorenz, Senior Attorney
Greater Boston Legal Services

Susan Fendell, Senior Attorney
Mental Health Legal Advisors Committee

Jay McManus, Executive Director
Children's Law Center of Massachusetts

Linda Landry, Senior Attorney
Disability Law Center

Margaretta Kroeger, Staff Attorney
MetroWest Legal Services

Brian O'Connor, Program Manager
Justice Center of Southeast Massachusetts, LLC

Ethan Horowitz, Managing Director
Northeast Justice Center, LLC

``

Table 1: Comparison of time from application to eligibility determination with and without provisional income eligibility			
	Current (with PE)	**Proposed (without PE)**	**Key Variables**
Feb. 1 Fax paper application; Mar 1 worker enters info into system (assuming 30 day processing time for applications)	**Application pending**	**Application pending**	**How long from receipt of document to data entry?**
OR Feb. 1 On-line or telephone application	**Provisionally eligible On-line applicant can obtain care**	**Application pending**	
Mar 5 (paper) Feb 5 (on-line) Applicant receives notice & RFI (assuming 4 day for mail)	**Provisionally eligible (Paper) applicant can obtain care**	**Application pending**	**How long to receive mail?**
Mar 5-April 5 (paper) Feb 5-Mar 5 (online) Applicant calling with questions about info needed, applicant gathering docs, applicant submits docs by Fax (assuming 30 days to understand request, gather & submit proof)		**Application pending**	**How long to reach MassHealth to understand request, how long to gather & submit info? Need to call for translation if primary language not English or Spanish**
April 5 (online) May 5 (paper) Worker enters info into system and final notice received by applicant (assuming 30 days processing time for proofs)		**Applicant can obtain care April 5 (on-line) or May 5 (paper)**	**How long from time of document submission for MassHealth to enter info in system? Lost documents? 2d RFI if more proof needed?**
Time from application submission to eligibility decision (assuming 30 days processing for all docs)	**Same day (on-line) 32 days (paper)**	**63 days (on-line) 93 days (paper)**	**45 day legal deadline for eligibility determination from date of application submission**
Time from application submission to eligibility decision (assuming 60 days processing time for proofs)	**Same day (on-line) 32 days (paper)**	**93 days (on-line) 123 days (paper)**	

``

[i] P. Hughes-Cromwick and R. Wallace, et al., Cost-Benefit Analysis of Providing Non-Emergency Medical Transportation, Transit Cooperative Research Program (Oct. 2005), Retrieved from http://onlinepubs.trb.org/onlinepubs/tcrp/tcrp_webdoc_29.pdf.

[ii] P. Cheung, J. Wiler, and et. al., National study of barriers to timely primary care and emergency department utilization among Medicaid beneficiaries, Annals of Emergency Medicine (July 2012), Retrieved from http://www.annemergmed.com/article/S0196-0644(12)00125-4/fulltext

[iii] S. Syed, B. Gerber, and L Sharp, Traveling Towards Disease: Transportation Barriers to Health Care Access, Journal of Community Health (Oct. 2013). Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4265215

[iv] U.S. Government Accountability Office, Efforts to Exclude Nonemergency Transportation Not Widespread, but Raise Issues for Expanded Coverage (Jan 2016). Retrieved from http://www.gao.gov/assets/680/674674.pdf

[v] Data released by MassHealth for the period from May 2015 to May 2016 show large fluctuations in call wait times and call abandonment rates at the MassHealth Enrollment Centers and the Customer Service Center. While we have not been able to obtain more recent information, it appears that the system is once more experiencing wait times of 30 minutes or more.

[vi] The other eight states are: CO, CT, DE, HI, MT, NH, OK and WA. Kaiser Commission on Medicaid and the Uninsured, Medicaid and CHIP Eligibility, Enrollment, Renewal and Cost-Sharing Policies in January 2016, Table 10.

[vii] "An individual must not be required to provide additional information or documentation unless information needed by the agency in accordance with § 435.948, § 435.949 or § 435.956 of this subpart cannot be obtained electronically or the information obtained electronically is not reasonably compatible, as provided in the verification plan described in § 435.945(j) with information provided by or on behalf of the individual." 42 CFR §435.952(c).

[viii] Kaiser Commission on Medicaid and the Uninsured, Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in January 2017, Table 9, "Functions of Online Medicaid Applications for Children, Pregnant Women, Parents, and Expansion Adults, January 2017," and Table 10, "Features of Online Medicaid Accounts, January 2017."

[ix] 42 CFR 435.952. 30 of 51 states and DC., Kaiser Commission on Medicaid and the Uninsured, Medicaid and CHIP Eligibility, Enrollment, Renewal and Cost-Sharing Policies in January 2016, Table 10.

.