Office of the Inspector General

Commonwealth of Massachusetts

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

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Executive Summary

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

With the recent conversion of the Uncompensated Care Pool to the Health Safety Net Office, prescribed in Chapter 58, the office has performed a review of the implementation of the Health Safety Net Office's conversion of the payment system for providers seeking reimbursement from the Health Safety Net Trust Fund into the Chapter 58 mandated Medicare claims-based payment system. Our analysis tracks the interim reimbursement system currently being utilized by the Health Safety Net Office within the Division of Health Care Finance and Policy and the design and planned implementation of the permanent Medicare claims-based payment system currently scheduled to start on April 1, 2008. We have reviewed the changes in the regulations, the new payment formulas, and key issues that will guide the new payment system. Payments and utilization of the Uncompensated Care Pool/Health Safety Net over the last three years have been displayed, indicating that hospital visits have decreased over the past three years: with inpatient discharges decreasing 8.7% from FY 2006-FY 2007; and outpatient visits decreasing 12.1% from FY 2006-FY 2007.

Further, according to the Division, a dramatic drop of 36% from pool fiscal year 2007 to 2008, or $223.4 million in payments, is anticipated in 2008, primarily due to decreased use of the Health Safety Net and increased enrollment of former pool users into Commonwealth Care and MassHealth. As of January 1, 2008, the Connector reported that 88,663 individuals formally eligible for the Uncompensated Care Pool/Health Safety Net have enrolled in one of the four Commonwealth Care insurance plans.

Also presented in this report is a breakdown of Uncompensated Care Pool claims submitted from select hospitals in the Commonwealth (representing almost 60% of all pool claims), as well as total emergency bad debt claims from all Massachusetts' hospitals from 2004-2006. We have reviewed the process that has been designed to increase the validity and eligibility of emergency bad debt claims from hospitals, as well as the procedures established by the Health Safety Net Office to make monthly Health Safety Net assessments as well as payments to hospitals and community health centers. A number of enhancements to the Health Safety Net Trust Fund have been made or proposed, as reported in the December 14, 2007 "Health Safety Net Trust Fund Implementation and Improvement Plan" submitted to the Legislature by the Division of Health Care Finance and Policy and others. Much will be learned following the April 1, 2008 Health Safety Net Office implementation of the Medicare claims-based payment system to reimburse providers for services provided to the uninsured through the Health Safety Net Trust Fund. This office will be tracking the implementation of the many new proposed improvements for management, oversight and program integrity of the Health Safety Net Trust Fund, and continue to audit and report to the Legislature on the accuracy and appropriate use of state funds for the care of the uninsured.

Introduction

Chapter 61 of the Acts of 2007 directed the Office of the Inspector General ("OIG") to maintain a pool audit unit for the Uncompensated Care Trust Fund, or any successor fund. This unit was originally created by the Legislature in 2004 and has been reauthorized in the budget every year since. The pool audit unit would oversee and examine the use of the state's funds for the care of the uninsured including, but not limited to, whether the free care and emergency bad debt charges to the pool accurately represent costs incurred by uninsured patients, the utilization of the fund, and whether the fund was recuperating the assessment from the Massachusetts hospitals. This report is in accordance with the requirements of Chapter 61, in concert with the Inspector General's ongoing review and examination of the successor fund to the Uncompensated Care Pool. This ongoing review has thus far resulted in a number of audits, findings, and recommendations that have been reported to the Legislature, including: *A Preliminary Analysis on Employers and the Massachusetts Uncompensated Care Pool, June 2005; Ongoing Review of the Uncompensated Care Pool Pursuant to Chapter 240 of the Acts of 2004: Second Report to the House and Senate Committees on Ways and Means, November 2005; Tennessee's TennCare - Overview and Lessons Learned for Massachusetts, December, 2005; The Virtual Gateway: MassHealth and Uncompensated Care Pool Web-based Data Intake and Eligibility Determination System, March 2006; Review of the State of New Hampshire Health Cost Website, May 2007; Review of Contract Between The Commonwealth Health Connector and Maximus, Inc., Relative to the Issues of Budget and Reports, June 2007; Status Report on Issues Related to Health Care Reform Implementation Raised by the Joint Committee on Health Care Financing, December 2007.*

In part, Chapter 58 of the Acts of 2006 mandated the creation of a new office called the Health Safety Net Office ("HSN"). The Legislature originally established the HSN as a division of MassHealth, but subsequently moved it under the Division of Health Care Finance and Policy ("Division") to comply with federal funding agreements. The HSN, as part of the Division, was tasked with establishing a new reimbursement system for acute hospitals and community health centers ("CHCs") for covered health services provided to uninsured and underinsured patients.

The Office of the Inspector General reviewed the transition from the Uncompensated Care Pool ("UCP") to the HSN. In particular, the office examined the implementation of the new reimbursement system that HSN established on October 1, 2007, the establishment of groupers (or DRGs-diagnostic related groups) that correspond with the new reimbursement system, the utilization and reimbursement of the HSN/UCP, and the shift in enrollment from the HSN to either MassHealth or to Commonwealth Care/Choice since the passage of Chapter 58. Also presented are reviews of claims from the UCP and emergency bad debt from hospitals throughout the Commonwealth over the past four years. HSN has made great progress in meeting its mandate, but more will be learned when HSN shifts out of its interim rules and into its full fledged implementation of new reimbursement and reporting regulations in the upcoming months.

Background

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

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

HSN payments were required to be made on a claims-basis using Medicare pricing principles modified to reflect the level of appropriation and expanded mix of services (beyond those covered by Medicare). These payments were required to be adjudicated on a claims-based and fee-for-service basis, adjustable for individual hospitals. Chapter 58 also required that the Division create a new methodology for equitably allocating free care reimbursement from the trust fund to acute care hospitals and CHCs for the hospital fiscal year 2008. The law proposed a model to achieve the goals outlined in Chapter 58 by incorporating Medicare payment principles, which will help ensure more appropriate payment for services.

In addition, the Division has begun utilizing the MassHealth Pharmacy On-line Processing System (POPS) for prescription drug claims adjudication in Section 340B community health center and hospital outpatient pharmacies. It is expected that this system will enable the HSN to achieve greater efficiencies through use of the pharmacy management tools available under the MassHealth pharmacy program.

Funding for the Health Safety Net Trust Fund ("Trust") will come from several sources. The Trust will assess a surcharge for certain services from all payers, which the HSN will monitor on a monthly basis. Funds from the state general fund will also be used to ensure that the Trust is adequately funded to achieve it goals. According to the Division, in 2008, the combined funding totaled $354 million, not including an additional

$24 million from prior years' residual balance. Over time, funding for the HSN theoretically should reach an inverse relationship with another Chapter 58 creation, the Commonwealth Care Trust Fund, which is established to fund state subsidized health insurance policies for low income individuals and families. Appropriations for the Trust from the general fund would be reduced as appropriations from the general fund increase for Commonwealth Care, as more individuals receive health insurance and no longer need to use the HSN. Further in the report, data from the Division is presented, which indicate that both utilization and claims for the HSN have declined in the past year.

The Interim System

While attempting to balance the demands that Chapter 58 created with the necessity of continuing its mandate to reimburse hospitals and CHCs that treated uninsured patients who qualified for the assistance, the HSN implemented an interim system to assist with the transition from the requirements of the Uncompensated Care Pool to the HSN. This interim system is composed of a "block grant system" to hospitals based on projected volume utilizing Medicare pricing principles so that hospitals will continue to receive timely payments. Hospitals will continue to provide information to the Division through their claims data and receive their monthly reimbursements accordingly. This block grant system will pay for the following services: inpatient medical and surgical care, inpatient psychiatric care, outpatient services, outpatient pharmacy debt and emergency bad debt. These payments will be subject to a final reconciliation to account for the true, inpatient, outpatient and pharmacy volume paid at the new Medicare based rates. This interim period is expected to last from October 1, 2007 through March 31, 2008. HSN officials stated that starting April 1, 2008, the final reconciliation of the block grant system will begin with reimbursement of the October 1, 2007 claims, and HSN will utilize its new standard payment system from this point forward.

The Standard Payment System

The (new) standard payment system is similar to the payment model of the MassHealth Program, but will feature pricing and payment rates similar to Medicare pricing principles, grouping, and claims editing systems. This system will make payments on

per discharge and per visit rates, but the system is based on actual claims submitted by the hospitals and CHCs. These claims will be edited through the appropriate Medicare claim specifications in order to identify either type of payable units of service (allowable inpatient discharges and allowable outpatient services).

Because Medicare recognizes many different payment levels for inpatient and outpatient services provided to individuals, and Chapter 58 mandated a Medicare-like system of payment, the Division had to modify the Medicare payment system. This modified system is a bundled payment system, which uses MassHealth bundling methods (which combine certain related services and reimburses them at a single rate). This bundled system will allow the Division to meet the mandates of Chapter 58 because the new payment system will mirror Medicare payment levels and principles and increase the payment system integrity by implementing claims editing and verifying eligibility prior to payment. This process may provide a smooth internal transition to the new payment system by using existing processes and information technology and allow for an economical transition because of minimal administrative costs for hospitals and the Commonwealth.

Regarding CHCs, the HSN will pay on a monthly basis based on the CHCs' reporting of their eligible services provided. [114.6 CMR 14.07]. The HSN regulations require CHCs to document their claims. HSN will examine the claims to ensure that there has been no upcoding, unbundling of services, or other billing inconsistencies. The services that are considered CHCs' eligible services are listed in the regulations at 114.6 CMR 14.07(2). For purposes of this review, the remainder of this report will focus on the billing and payment methodologies of only acute care hospitals.

The HSN Regulations

As a result of the development of a new HSN payment methodology, the Division had to develop regulations that established and explained the payment methodology, insured payments during transition, and established the future payment transparency components required by Chapter 58. The HSN regulation 114.6 CMR 14.00 governs

how the HSN will pay and receive funds from acute hospitals and CHCs. There are seven areas on which the regulations focus:

- sources and uses of funds;
- total hospital assessment liability;
- surcharge payments;
- payments to hospitals;
- payments to CHCs;
- reporting requirements; and,
- other special provisions.

This set of regulations governs the sources of revenue for the HSN, as well as establishing how and when the HSN will pay the hospitals and the CHCs. These regulations also govern how the hospitals, CHCs and payers will pay the assessments they owe on certain services provided, how the assessments are calculated, how the assessments are billed to the payer, and how the payer forwards payment to the HSN.

According to the HSN regulations, the available revenue to fund provider payments includes: revenue produced by hospital assessments and hospital surcharges; funds from the Commonwealth Care Trust Fund authorized to transfer to the HSN; amounts transferred from the Uncompensated Care Trust Fund; any interest earned in the funds of the HSN, and any additional funding made available to the fund through appropriation by the General Court. [114.6 CMR 14.03(1)]. The HSN Trust Fund may maintain up to 10% of its funds for the following year. [114.6 CMR 14.03(2)(a)].

Regarding hospital assessment liability to the HSN, the assessment is the product of the ratio of the specific hospital's private sector charges to all hospitals' private sector charges, and $160 million. [114.5 CMR 14.04]. The $160 million is the dollar amount of liability to hospitals as allowed in Mass. Gen. Laws c. 118G § 37. Id. The regulations define private sector charges as "the gross patient service revenue subtracted by the gross patient service revenue attributed to Title XVIII, XIX, XXI." [114.6 CMR 1(4).02].

The Division will use data submitted by acute hospitals in their RSC-304 Form to determine private sector charges.

Private Sector Charge Calculation

Gross Patient Service Revenue
– *Gross Patient Service Revenue attributed to Title XVIII, XIX, XXI*
Private Sector Charge

The Division states that there will be a surcharge on certain services that are performed at either acute hospitals or ambulatory surgical centers. [114.6 CMR 14.05]. The payments, according to the regulations, are made by national insurance companies or other payers for charges from 1998 through the present for chargeable services at acute hospitals or Massachusetts ambulatory surgical centers, and are currently capped at $160 million. These payments are billed by the hospitals to the insurance companies. The payments are made to the HSN.

In order to provide services in the Commonwealth, the Division compels the insurance companies, which could be defined as payers under the regulations, to register with the Division by completing a form called the Surcharge Payer Registration Form. After the payors are registered, the Division provides that payors may pay by request on either a bi-annually or monthly basis, and informs the companies of their portion of the surcharge. Examining the regulations, the Division instructs the hospitals and surgical centers to bill for the surcharge after it provides the surcharge percentage for that month to the hospital or surgical center. The Division maintains an accounting of what is owed through its hospital reports and sends accountings to the payers as well. Adjusting out of $160 million, HSN will project annual aggregate payments subject to the surcharge based on historical data, so the calculation will be:

Surcharge Percentage Calculation

Projected Payments ÷ 160,000,000 = ***Surcharge Percentage***

In order to receive payment from the HSN trust, hospitals and CHCs must file a claim to the specifications of the HSN. [114.6 CMR 14.06]. Failure to do so will trigger a denial of payment to the provider for that particular claim. The provider may then re-file, correcting any error that encumbered the original claim. The provider will categorize the claim into one of the following groups for payment: Inpatient/Medical, Inpatient/Psychiatric, inpatient/rehab, outpatient, emergency bad debt/Inpatient medical, emergency bad debt/inpatient psychiatric, and emergency bad debt/outpatient.

According to the regulations, the HSN will pay providers either under the 2007 Section 1115 Demonstration Waiver or by MassHealth supplemental hospital rate payments. These payments, however, must comply with Federal laws regarding pricing, payment methodologies, and rate setting. In order to accomplish this and comply with the requirements in Chapter 58, HSN will follow the Medicare rate and fee schedules created by the federal government.

The HSN will use the most recent public use file published by CMS (Centers for Medicare & Medicaid Services) as of June 30, 2007 for inpatient payments. Thus, the HSN will use the Version 24 Diagnostic Related Group ("DRG"), instead of Version 25, which was released in October, 2007. Due to the regulation's use of June 30, 2007 as the date to be used for the DRGs, Massachusetts is using Version 24, whereas the Federal CMS will be using Version 25, which has retooled its coding significantly. This will impact providers by requiring them to have both Version 24 and 25 DRG payment programs set up in order to be paid by the HSN.

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

There are other factors that contribute to the calculation of payment for inpatient services, such as whether or not the acute hospital is also a *disproportionate share hospital, a medical dependant rural hospital, a critical access hospital, a PPS-exempted hospital, a sole community hospital, or a teaching hospital.* Furthermore, other add-ons such as standardized amounts for labor and non-labor costs and add-ons such as pass-throughs and large urban add-ons must also be determined. Further adjustments may be made to include patients with full free care, partial free care and retroactive free care, MassHealth Limited, CMSP, MassHealth Buy-In, EAEDC, Family Assistance/Premium Assistance, Prenatal, and Senior Buy-In. Claims are further adjusted to omit non-reimbursable services, duplicate claims, or claims that have significant errors.

The HSN will pay for outpatient services on a per visit basis. It is calculated by multiplying the hospital's Medicare Payment on Account Factor by the net uncompensated care charges per visit, which is then adjusted by a cost adjustment factor of 6.8%. Disproportionate Share Hospitals ("DSH") hospitals (those hospitals identified as serving a major share of the state's low income clients) will receive a transitional add-on of 25% of the outpatient per visit rate.

Emergency Bad Debt ("ERBD") services will be calculated using the appropriate methodology for either inpatient or outpatient services. The HSN will increase its monitoring of eligibility, charges and volume of ERBD claims. Depending on volume, the hospital's claims may be denied by the HSN because the HSN may limit the number of discharges and visits recognized as ERBD.

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Office of the Inspector General Review

Once the HSN regulations took effect on October 1, 2007, the Office of the Inspector General began its review of the regulations and how they were different for the Uncompensated Care Pool. An initial presentation from the Division was made to the OIG in October 2007 to review the transitional reimbursement system designed by the Division. Furthermore, the OIG is monitoring the implementation of the plan developed by HSN/MassHealth; [Chapter 118G §35 (c)]:

> [(c) The (HSN) office shall enter into an interdepartmental service agreement with the office of Medicaid to develop and implement a plan to enhance oversight and improve the operations, management, payment processes and data integrity of the Health Safety Net Trust Fund, consistent with clauses (2) to (5), inclusive, of subsection (b).
>
> The plan shall include: (i) an analysis of free care and emergency bad debt claims submitted in the most recent 3-year period to determine patterns most appropriate and promising for targeted audits and reviews; (ii) a cost-effective approach to maximizing the identification of all sources of third-party liability for patients receiving free care or emergency services; (iii) a cost-effective approach to establishing an ongoing claims and utilization review system for uncompensated care claims that effectively identifies and disallows inappropriate claims, but also takes into consideration the practicality of that approach considering the small volume of claims relative to other payers that make routine use of claims and utilization review systems; (iv) an approach that maximizes the use of existing eligibility determination and review systems, coordination of benefits, claims review and provider integrity systems, interdepartmental service agreements and related program and provider integrity contracts available to the office of Medicaid for achieving the management improvements required under this section; and (v) a proposed timeline for implementation.]

More recently, a series of specific questions were developed by the Office of the Inspector General to help evaluate progress on the transition to the new reimbursement system, and some of those questions were posed to the Division, in part, as the basis for this review.

The OIG has learned from the HSN that many of the identified changes in reimbursement will take effect after April 1, 2008, and thus cannot be currently evaluated for effectiveness or compliance. However, this review process is ongoing

and will yield more information about the regulations and payments as the HSN trends away from the October 1, 2007 interim regulations and begins reimbursing hospitals through the planned Medicare based claims system on April 1, 2008. The Division also proposed a number of new oversight, operational and program integrity enhancements to the HSN in its December 14, 2007 report to the Legislature regarding their implementation and improvement plan for the HSN. This office will be tracking the implementation and effectiveness of these proposed oversight and program integrity enhancements, including, but not limited to, stricter eligibility standards, revised claims adjudication efforts, provider billing practices, utilization review services, third party liability efforts, provider audits, and the use and value of outsourced consultant organizations assisting the HSN, and report to the Legislature accordingly.

HSN Payment System

- **What is the status of the new payment models, which reflect Medicare pricing principles, which the Division began phasing in starting 10/1/07?**

  The Division stated that for the months of October 2007 through February 2008, the Division has made payments to hospitals based on the transitional payment method. The transitional payment method applied estimated volume from 2006 Uncompensated Care Pool claims to actual Medicare based, provider specific payment rates. These new Medicare based rates, as required by Chapter 58, went into effect on October 1, 2007 and will be paid for allowable services to eligible individuals during HSN FY 2008.

  According to the Division, beginning in April 2008, hospitals will be paid at the new Medicare based payment rates using an adjudicated, claims-based payment system. The April payment, however, will be based on claims for October 2007 dates of service and will reconcile accounts for the difference between the October transitional payment that had been based on estimated volume and the actual volume of allowable services to eligible individuals based on the new system. These claims will be the first claims to be reviewed for compliance with the new HSN regulations governing eligibility, covered services, and compliance with the Division's

billing deadlines. Claims not meeting these rules will be denied and not paid until corrected.

Hospitals are also moving to a revised claims submission format ("Medicare 837-I"). This new format will substantially improve the quality of the data the Division receives and will allow it to process these claims using the Medicare inpatient and outpatient DRG groupers. Hospitals are currently in the testing phase. The Division expects that most hospitals will be using this format by April 2008.

- **How were the Massachusetts groupers for reimbursement established and how are they working?**

  The Division states that the 2008 HSN inpatient rates were established using the Medicare version 24 DRG. The Division maintains that after the hospitals convert to the revised claims format, the Division will implement the Medicare version 25 inpatient grouper and the Medicare Ambulatory Patient Classification ("APC") grouper and pricer. The Division anticipates that the HSN 2009 rates will incorporate the results of these groupers.

- **How have specific HSN hospital reimbursement rates changed since the transition system began last October?**

  The Division reports that payments made to hospitals in October 2007 were calculated at the new Medicare-based payment rates. Following the public hearing on the rates, the Division revised the rates to incorporate changes based on the consideration of the comments received. These rates were implemented in November and have not changed to date, according to the Division. Beginning with the April 2008 HSN payments, the monthly payment amounts will change to reflect the replacement of estimated volume with actual, adjudicated service volume for October 2007.

  The Division anticipates that the new payment system will reimburse hospitals at a slightly higher rate for inpatient care than the typical cost-to-charge ratio payment rates in the past, particularly for teaching hospitals because Medicare rates include reimbursement for teaching costs. However, the Division stated that the new

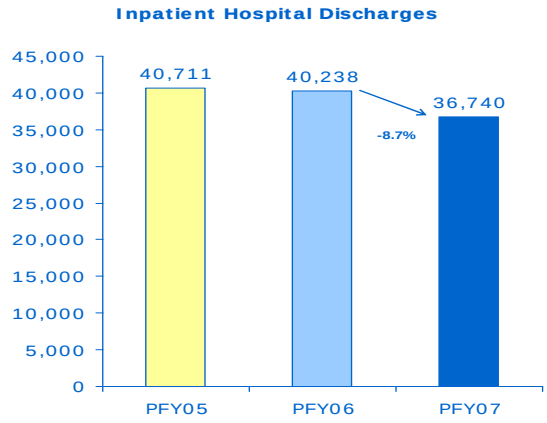
reimbursement will be based on reviewed and approved claims, which will help reduce any mistaken, inappropriate or inflated charges. Outpatient rates using the Medicare based payment system will be slightly reduced from the previous method, and the median CHC reimbursement rates will be higher.

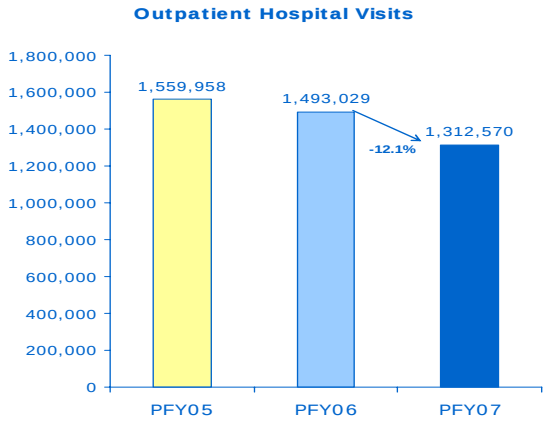
According to the Division, HSN pharmacy claims are now being paid using the Pharmacy On-line Payment System (POPS), incorporating the MassHealth preferred drug list and clinical utilization review program. This system implements the MassHealth ingredient payment level and dispensing fees for pharmacy services paid by the HSN out of the hospital and CHC Section 340B pharmacies. In pilot testing, the Division reported that the POPS system functioned well, paying at MassHealth rates. The previous pharmacy reimbursement system was based on cost-to-charge ratios. With the far better controls of the POPS system, pharmacy charges are anticipated to be much reduced. The availability of the new Medicare Part D pharmacy benefit in 2006 has also resulted in reduced utilization of the HSN for pharmacy needs of elderly low income individuals.

- **What are the HSN total inpatient and outpatient utilization and reimbursement levels for hospitals and CHCs, currently and for the last 3 years?**

  The first chart below from the Division indicates that UCP/HSN inpatient hospital discharges and outpatient hospital visits have decreased over the past three years: with inpatient discharges decreasing 8.7% from FY 2006-FY 2007; and outpatient visits decreasing 12.1% from FY 2006-FY 2007.

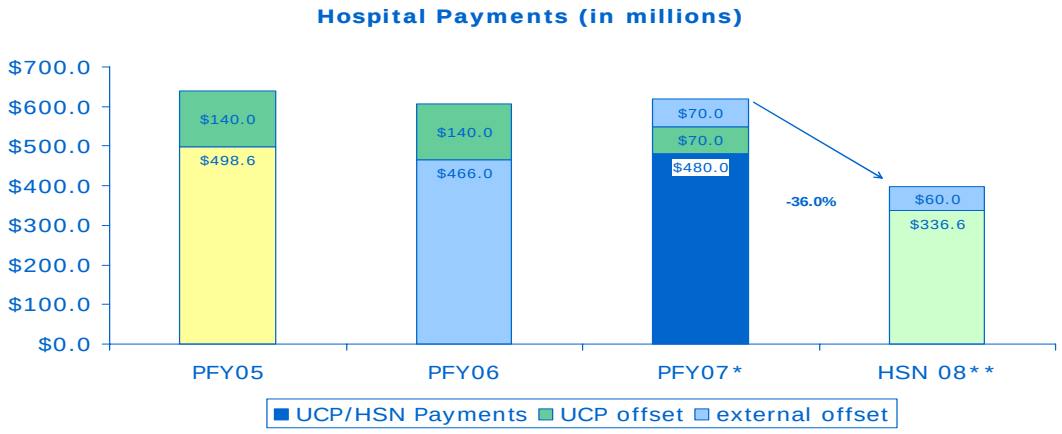
UCP Inpatient and Outpatient Hospital Utilization





Data based on year end filings as of February 5, 2008

UCP / HSN Hospital Payments

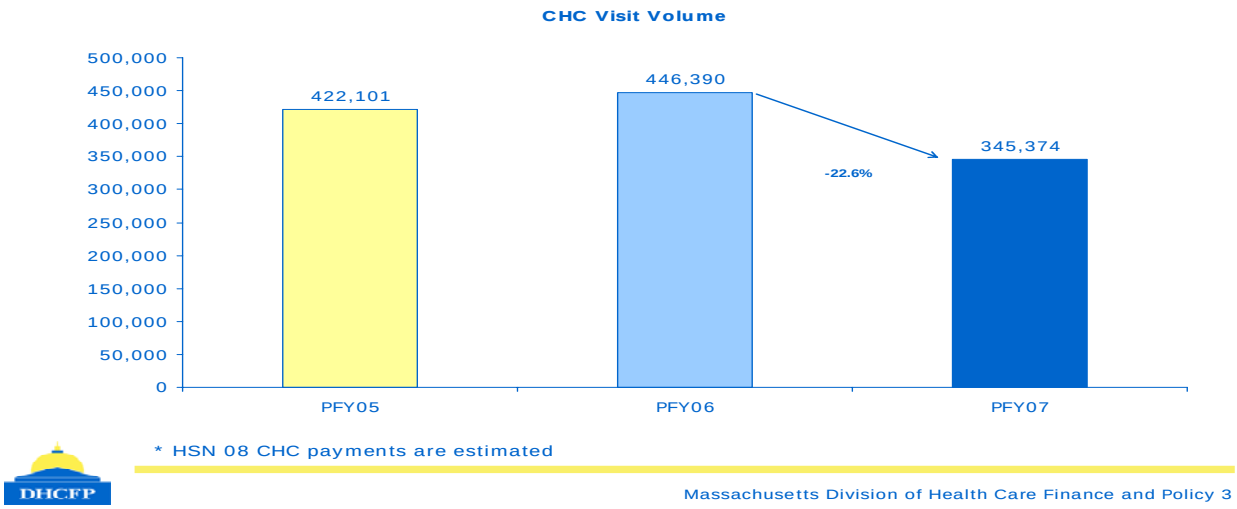


* PFY07 includes $70m in external funding to offset UCP hospital costs.
** HSN08 represents total estimated hospital funding including Medical Assistance Trust Fund offset payments

The second chart (above) displays the level of hospital payments out of the UCP/HSN over the past four years, including estimates from the HSN for 2008. According to the Division a dramatic drop of 36%, or $223.4 million in payments is anticipated in 2008, primarily due to decreased use of the HSN and increased enrollment of former pool users into Commonwealth Care and MassHealth.

Community Health Center volume and payments within the UCP/HSN have also decreased, as reflected in the charts below from the Division. After rising in 2006, CHC visits has decreased about 22% in 2007. CHC claims have decreased by $6 million from 2006-2007, and are anticipated by the Division to decrease further by another $5 million in 2008. Once again, some of this recent decrease in HSN volume and payments can be attributed to increased enrollment of former UCP/HSN users into Commonwealth Care.

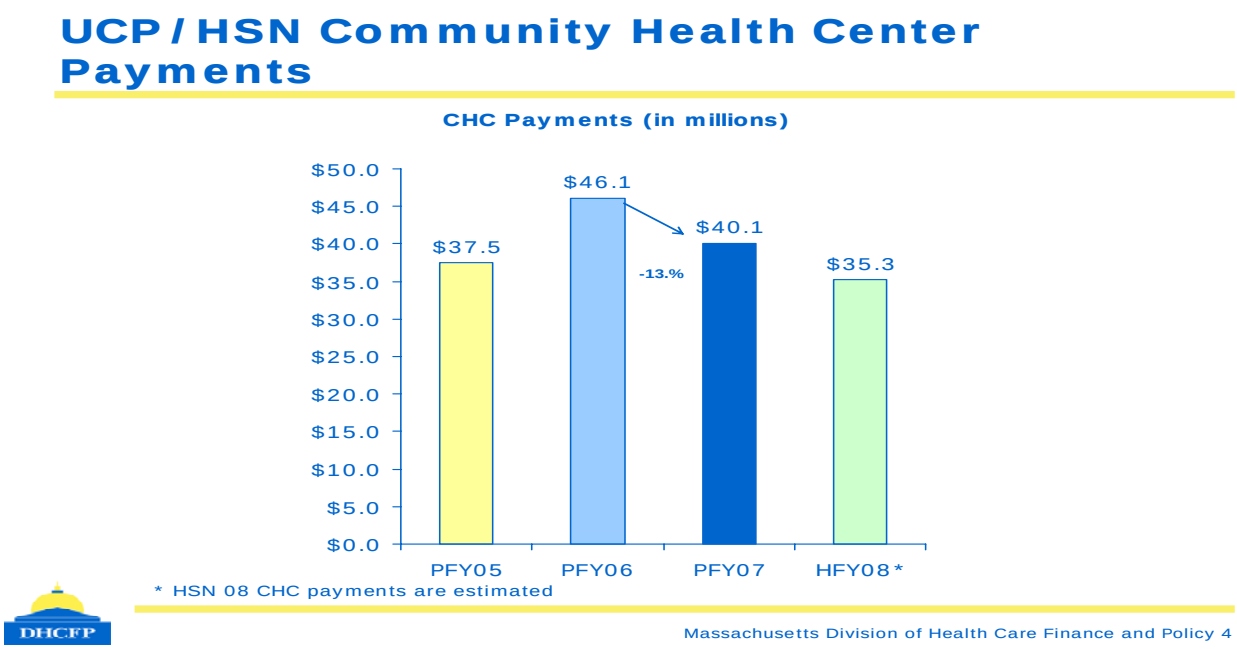
UCP / HSN Community Health Center Utilization



* HSN 08 CHC payments are estimated

DHCFP

Massachusetts Division of Health Care Finance and Policy 3



The three tables below, analyzed from data from the Division, provide: a breakdown of total UCP/HSN charges from 2004-2006; totals from select hospitals (collectively representing approximately 60% of all UCP/HSN claims) including the percentage increase or decrease experienced by each select hospital; and the percent of total UCP/HSN charges each hospital represents. Actual payments to hospitals are a percentage of the charge master rate charges filed, reduced by each hospital's cost to charge ratios.

Table 1. Total Charges: Regular UCP Claims, Pool Fiscal Years 2004 – 2006

10/1/03 – 9/30/04 (PFY04)	10/1/04 – 9/30/05 (PFY05)	10/1/05 – 9/30/06 (PFY06)	**Percent change PFY04 vs. PFY05**	**Percent change PFY05 vs. PFY06**
$1,250,827,965.00	$1,379,386,194.52	$1,480,939,124.82	**10.3%**	**7.4%**

Table 2. Total Charges: Regular UCP Claims, Pool Fiscal Years 2004 – 2006 (Selected Hospitals)

Hospital	PFY 2004	PFY 2005	PFY 2006	Percent change PFY04 vs. PFY05	Percent change PFY05 vs. PFY06
Beth Israel Deaconess Medical Ctr	$ 56,935,247.93	$ 55,012,892.92	$ 71,004,391.31	**-3.4%**	**29.1%**
Boston Medical Center	$233,639,290.74	$249,817,404.77	$239,026,750.37	**6.9%**	**-4.3%**
Brockton Hospital	$ 16,915,933.23	$ 18,614,905.33	$ 21,065,005.82	**10.0%**	**13.2%**
Cambridge Health Alliance	$194,970,960.75	$223,208,585.04	$201,684,515.19	**14.5%**	**-9.6%**
Lawrence General Hospital	$ 9,480,153.21	$ 9,750,344.45	$ 12,944,495.33	**2.9%**	**32.8%**
Massachusetts General Hospital	$153,691,082.11	$184,374,906.99	$190,610,143.05	**20.0%**	**3.4%**
Mercy Medical Center	$ 15,013,071.15	$ 14,245,362.81	$ 14,756,012.31	**-5.1%**	**3.6%**
Southcoast Hospitals Group	$ 33,629,851.46	$ 35,754,046.15	$ 40,652,777.05	**6.3%**	**13.7%**
UMass Memorial Medical Center	$ 55,653,599.09	$ 84,035,744.23	$ 77,136,505.40	**51.0%**	**-8.2%**
Total	**$769,929,189.67**	**$874,814,192.69**	**$868,880,595.83**	**13.6%**	**-0.7%**

Table 3. Percent of All Regular UCP Claims, Pool Fiscal Years 2004 – 2006 (Selected Hospitals)

Hospital	PFY 2004	PFY 2005	PFY 2006
Beth Israel Deaconess Medical Center	4.6%	4.0%	4.8%
Boston Medical Center	18.7%	18.1%	16.1%
Brockton Hospital	1.4%	1.3%	1.4%
Cambridge Health Alliance	15.6%	16.2%	13.6%
Lawrence General Hospital	0.8%	0.7%	0.9%
Massachusetts General Hospital	12.3%	13.4%	12.9%
Mercy Medical Center	1.2%	1.0%	1.0%
Southcoast Hospitals Group	2.7%	2.6%	2.7%
UMass Memorial Medical Center	4.4%	6.1%	5.2%
Total Percent of All UCP Claims	**61.6%**	**63.4%**	**58.7%**

- **How many former UCP users have been enrolled in either a MassHealth program or in Commonwealth Care/Choice since Health Care Reform began in September 2006?**

  According to officials at the Commonwealth Connector, a review of the data base of enrollees indicated that as of January 1, 2008, a total of 89,663 individual Commonwealth Care enrollees were previously UCP-eligible (but not necessarily

users) and identified in the UCP roles within the past 12 months prior to enrollment in Commonwealth Care. The total number of UCP individuals who may have enrolled in one of the Commonwealth Choice programs is unknown because some may have enrolled directly through the private insurance plans. The transition of this population from the UCP/HSN to Commonwealth Care was the primarily reason for the decrease in volume and expenditures in the HSN over the last 18 months.

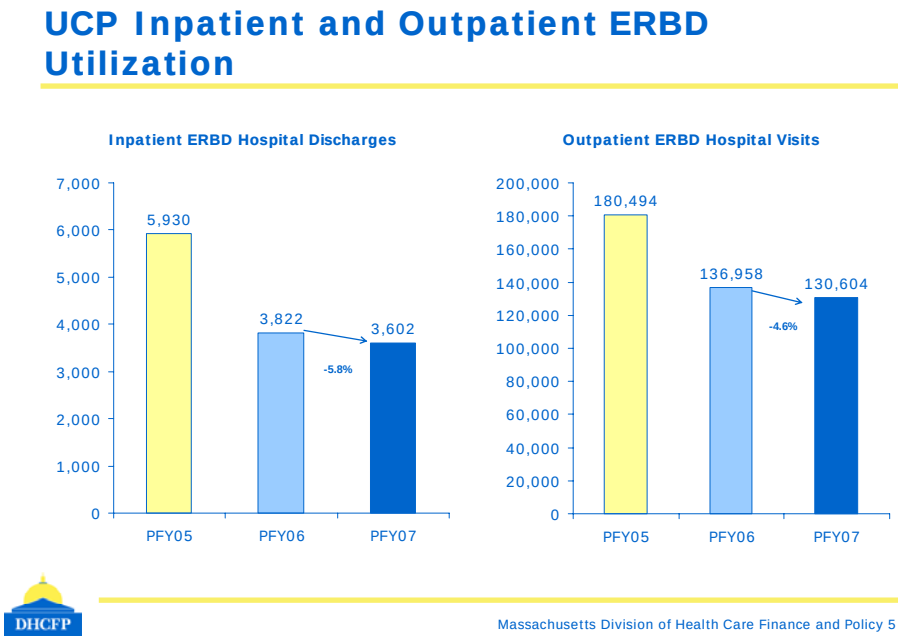
Emergency Bad Debt (ERBD)

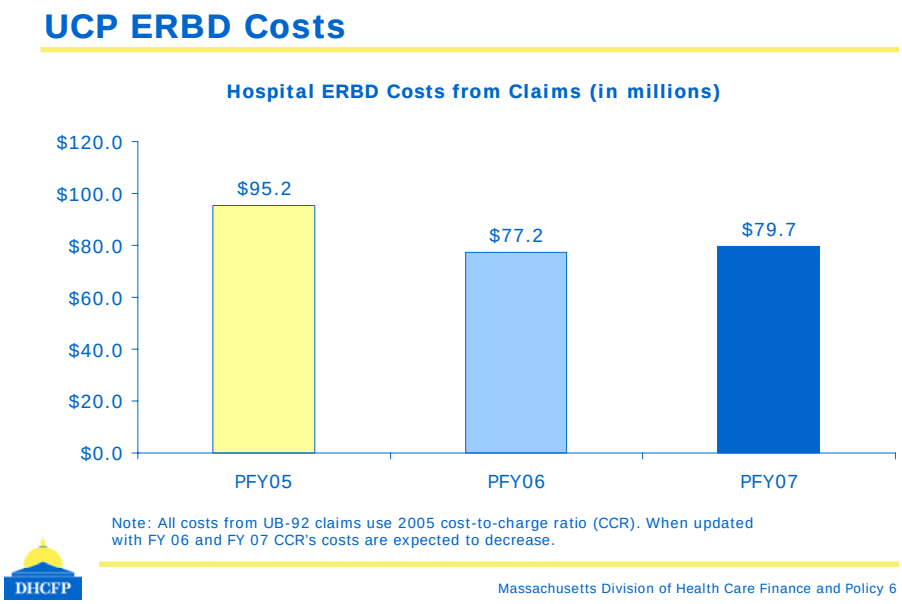
- **What is the total annualized reimbursement for each of the last three years in the ERBD component of the HSNTF?**

Emergency bad debt is one of the categories of services that are reimbursable to hospitals under the HSN. To be eligible to be covered under the ERBD provision, an individual must have received medically necessary emergency care, be uninsured for the services provided, and not be a low income patient (otherwise eligible for MassHealth or Commonwealth Care or other state subsidized care).[114 CMR 12.04]. The provider seeking ERBD reimbursement must obtain personal financial information from the patient and check the state Recipient Eligibility Verification System ("REVS") system to verify the patient's eligibility status, and then comply with all ERBD collection requirements in order to be reimbursed by the ERBD for the services provided (detailed in the following section).

In the November 2005 OIG report on the review of the Uncompensated Care Pool, this office recommended that the eligibility and supervision of the ERBD be improved because audits of this sector indicated a lack of enforcement of medical necessity criteria, patient income eligibility criteria and verification of collection efforts resulting in inappropriate reimbursement for ERBD charges. Subsequently, as the two charts below indicate, ERBD volume decreased significantly from 2005 to 2006, and then decreased at a slower rate in 2007. Expenditures also decreased dramatically by $18 million from 2005 to 2006 ($95.2 million to $77.2 million), and then actually increased by $2.5 million the following year. According to the Division, ERBD rates

are expected to decrease further in 2008 once hospitals are reimbursed through an updated cost-to-charge ratio base rate, and then through a subsequent Medicare-based rate system. Further, the Division has indicated that they have developed a supplemental electronic submission requirement for all inpatient ERBD claims to help verify diligent collection efforts by the provider prior to payment of the ERBD claim. However, this area still needs to be closely monitored for potential inappropriate use resulting from individuals who remain uninsured because of affordability criteria, yet are still not eligible for MassHealth or Commonwealth Care.





The data presented in the charts below were calculated from the Division's UCP data base and represent total ERBD charges and claim counts by facility, from lowest to highest, from October 1, 2004- September 30, 2005, and from October 1, 2006- September 30, 2006. Hospitals are paid an amount less than total charge master rate charges, reduced by their cost-to-charges ratios.

Total Emergency Bad Debt Claims, October 1, 2004 – September 30, 2005

Hospital	Total Charges	Total Count
Boston Community Leadership Academy	$562.00	3
Jeremiah Burke Student Health Center	$1,032.50	6
Tufts-New England Medical Center	$250,072.31	568
Fairview Hospital	$263,680.49	2,246
Beth Israel Deaconess Hospital – Needham	$272,072.41	1,844
Athol Memorial Hospital	$369,382.26	1,837
Emerson Hospital	$440,563.63	3,172
Clinton Hospital	$514,557.30	3,082
North Adams Regional Hospital	$521,974.86	3,175
Wing Memorial Hospital and Medical Centers	$557,168.58	6,857
Nantucket Cottage Hospital	$617,995.90	3,792
Cooley Dickinson Hospital	$648,730.36	5,800
Martha's Vineyard Hospital	$652,967.85	3,620
Baystate Mary Lane Hospital	$682,922.31	3,552
Milton Hospital	$785,336.20	4,320
Nashoba Valley Medical Center	$864,722.67	4,353
Franklin Medical Center	$866,664.36	4,250
Noble Hospital	$885,243.24	7,075
Harrington Memorial Hospital	$904,635.54	6,553
Saints Memorial Medical Center	$1,297,054.27	13,527

Ana Jaques Hospital	$1,314,380.59	9,818
Northeast Health System	$1,426,972.74	11,680
Mount Auburn Hospital	$1,452,072.74	7,364
Holyoke Medical Center	$1,482,262.96	9,602
Merrimack Valley Hospital	$1,582,851.84	9,131
Caritas St. Elizabeth's Medical Center	$1,630,380.14	7,109
Lowell General Hospital	$1,683,727.21	8,796
Hubbard Regional Hospital	$1,697,119.24	11,211
Falmouth Hospital	$1,712,958.47	8,115
Newton-Wellesley Hospital	$1,854,276.89	8,761
Caritas Norwood Hospital	$1,982,255.96	10,867
Winchester Hospital	$1,997,673.50	15,609
Berkshire/Hillcrest	$1,998,670.97	16,814
Mercy Medical Center	$2,071,355.96	16,734
Caritas Carney Hospital	$2,113,546.05	13,797
Sturdy Memorial Hospital	$2,131,412.26	14,695
Children's Hospital	$2,321,030.00	7,463
Massachusetts Eye and Ear Infirmary	$2,336,370.67	6,774
Quincy Medical Center	$2,392,294.71	12,634
Faulkner Hospital	$2,402,006.96	12,175
Caritas Holy Family Hospital and Medical Center	$2,435,650.70	19,049
Milford Regional Medical Center	$2,442,090.52	11,922
Caritas Good Samaritan Medical Center	$2,498,613.04	16,238
Marlborough Hospital	$2,510,139.78	11,836
Saint Anne's Hospital	$2,539,388.77	13,835
Morton Hospital and Medical Center	$2,608,080.17	15,526
Jordan Hospital	$2,917,112.40	9,422
Lahey Clinic	$3,195,770.90	11,299
Hallmark Health System, Inc.	$3,409,901.72	19,755
MetroWest Medical Center	$3,700,273.94	14,630
Health Alliance Hospital, Inc.	$3,817,742.65	17,694
Saint Vincent Hospital	$3,928,565.55	14,508
South Shore Hospital	$3,949,566.76	21,184
Cape Cod Hospital	$4,707,259.39	22,353
Baystate Medical Center	$4,811,731.77	20,925
Lawrence General Hospital	$5,434,920.29	33,463
Heywood Hospital	$5,508,298.98	28,230
Brockton Hospital	$6,359,461.20	51,584
North Shore Medical Center, Inc.	$6,716,334.48	52,944
Brigham and Women's Hospital	$6,936,369.16	14,369
Southcoast Hospitals Group	$6,955,995.27	39,495
Beth Israel Deaconess Medical Center	$8,039,704.44	19,390
UMass Memorial Medical Center	$8,440,250.59	35,792
Massachusetts General Hospital	$11,747,988.08	31,002
Cambridge Health Alliance	$21,038,559.33	124,414
Boston Medical Center (Hospital only)	$21,734,397.87	74,922
Total	**$207,365,126.65**	**1,044,562**

Total Emergency Bad Debt Claims, October 1, 2005 – September 30, 2006

Hospital	Total Charges	Total Count
Jeremiah Burke Student Health Center	$1,218.50	7
Athol Memorial Hospital	$239,607.41	1,163
Fairview Hospital	$260,180.52	2,142
Wing Memorial Hospital and Medical Centers	$375,282.47	4571
Massachusetts Eye and Ear Infirmary	$407,020.82	1,224
Beth Israel Deaconess Hospital – Needham	$411,642.35	2,056
Clinton Hospital	$437,866.41	2,290
Harrington Memorial Hospital	$515,753.25	3,410
Cooley Dickinson Hospital	$526,857.30	4,435
Emerson Hospital	$560,998.95	3,000

Baystate Mary Lane Hospital	$563,201.40	2,921
Nashoba Valley Medical Center	$716,639.41	3,391
North Adams Regional Hospital	$718,894.12	3,996
Martha's Vineyard Hospital	$754,226.92	3,515
Nantucket Cottage Hospital	$757,308.45	4,455
Milton Hospital	$768,308.48	3,340
Tufts-New England Medical Center	$811,897.18	2,428
Franklin Medical Center	$930,800.55	4,153
Heywood Hospital	$989,918.63	5,118
Noble Hospital	$930,800.55	6,815
Holyoke Medical Center	$1,062,385.21	6,865
Quincy Medical Center	$1,206,057.30	6,382
Mount Auburn Hospital	$1,263,803.99	5,915
Saints Memorial Medical Center	$1,326,046.37	14,611
Ana Jaques Hospital	$1,464,886.00	9,583
Falmouth Hospital	$1,561,766.35	7,629
Caritas Carney Hospital	$1,571,917.90	9,317
Winchester Hospital	$1,597,838.86	12,097
Merrimack Valley Hospital	$1,598,288.61	8,187
Caritas St. Elizabeth's Medical Center	$1,619,247.67	7,152
Newton-Wellesley Hospital	$1,670,837.01	9,722
Caritas Norwood Hospital	$1,690,816.66	9,019
Lowell General Hospital	$1,723,367.69	9,132
Marlborough Hospital	$1,775,216.74	7,656
Children's Hospital	$1,781,746.17	5,488
Faulkner Hospital	$1,978,942.96	11,369
Sturdy Memorial Hospital	$2,006,815.53	12,239
Caritas Good Samaritan Medical Center	$2,039,977.02	12,144
Caritas Holy Family Hospital and Medical Center	$2,186,144.69	14,965
Saint Anne's Hospital	$2,300,112.24	13,038
Lahey Clinic	$2,387,173.10	6,921
Milford Regional Medical Center	$2,418,549.43	11,194
Northeast Health System	$2,430,203.18	12,962
Berkshire/Hillcrest	$2,457,774.82	16,989
Morton Hospital and Medical Center	$2,492,623.08	13,485
Health Alliance Hospital, Inc.	$2,569,221.47	11,113
Mercy Medical Center	$2,606,865.33	17,216
South Shore Hospital	$2,689,378.34	14,082
Saint Vincent Hospital	$2,869,540.80	10,727
Hallmark Health System, Inc.	$2,722,816.56	14,890
Jordan Hospital	$3,486,893.40	10,105
Hubbard Regional Hospital	$3,660,795.04	22,411
Cape Cod Hospital	$4,112,767.66	17,756
Lawrence General Hospital	$4,377,269.12	26,446
Brigham and Women's Hospital	$4,421,600.26	8,008
Brockton Hospital	$4,836,556.78	36,607
MetroWest Medical Center	$4,968,077.82	19,567
Baystate Medical Center	$4,974,565.90	19,488
Beth Israel Deaconess Medical Center	$5,719,020.46	14,495
North Shore Medical Center, Inc.	$5,791,552.28	41,495
Massachusetts General Hospital	$6,559,301.14	12,409
Southcoast Hospitals Group	$6,732,030.01	36,686
UMass Memorial Medical Center	$8,251,113.72	27,975
Boston Medical Center (Hospital only)	$11,800,477.84	41,319
Cambridge Health Alliance	$14,223,225.18	72,658
Total	**$164,748,936.24**	**793,944**

As noted above, total charges and claims count had decreased significantly from one year to the next. Since the Connector had not yet been established, the reduction most likely occurred, in part, as a result of stricter enforcement of eligibility

criteria by increased use of the web-based Virtual Gateway automated eligibility verification system.

- **How are ERBD expenses currently being monitored, verified and reimbursed?**
  For FY 2008, the Division allows hospitals to continue to submit claims for ERBD under certain eligibility verification and collection criteria. This is only permitted after providers complete the required collection activity.

  The required collection activity is defined in the Division's regulation [114.6 CMR 13.06 (1)(a)(3)] as:

> Reasonable Collection Efforts.
>
> a. A provider must make the same effort to collect accounts for uninsured patients as it does to collect accounts from any other patient classifications.
>
> b. The minimum requirements before writing off an account to the HSN include:
>
> i. an initial bill to the party responsible for the patient's personal financial obligations
>
> ii. subsequent billings, telephone calls, collection letters, personal contact notices, computer notifications, and any other notification method that constitutes a genuine effort to contact the party responsible for the obligation
>
> iii. documentation of alternative efforts to locate the party responsible for the obligation or the correct address on billings returned by the postal office service as "incorrect address" or "undeliverable"
>
> iv. sending a final notice by certified mail for balances over $1,000 where notices have not been returned as "incorrect address" or "undeliverable"
>
> v. documentation of continuous collection action undertaken on a regular, frequent basis. When evaluating whether a Provider has engaged in continuous collection action, the HSN Office may use a gap in collection action of greater than 120 days as a guideline for noncompliance, but may use its discretion when determining whether a provider has made a reasonable effort to meet the standard.
>
> c. If, after reasonable attempts to collect a bill, the debt for emergency care for an uninsured patient remains

> unpaid for more than 120 days, the bill may be deemed uncollectible and billed to the HSN Office.
>
> d. The patient's file must include all documentation of the provider's collection effort including copies of the bill(s), follow-up letters, reports of telephone and personal contact, and any other effort made.

The Division asserts that hospitals must submit a claim for each inpatient ERBD. For inpatient ERBD, providers are required to submit the following information:

1. Patient Identifiers:
   - Name
   - Address
   - Phone#
   - DOB
   - SSN#
   - TCN
   - Med Record#
   - Mass Health # (RID and/or RHN)
   - DOS
   - Total Charge for Services
   - Net Charge submitted to Health Safety Net
2. Evidence of Reasonable Collection Efforts-
   - Date of Initial Bill
   - Date of Second Bill
   - Date of Third Bill
   - Date of Fourth Bill
   - Date of Returned Mail
   - Date of Certified Letter for accounts over $1,000
   - Date of Initial Phone Contact
   - Date of Follow up Phone Contact
   - Dates of Other Efforts (other phone calls, letters to patient, attorney or referral to collection agency)
   - Date Account was submitted to Health Safety Net Office

The Division explains that this information is required for each hospital inpatient ERBD claim and must be submitted before the claim will be considered for payment by the HSN. The Division asserts that it has developed and deployed an internet based application for providers to document evidence of reasonable collection efforts.

The Division states that it will implement the following processes to monitor and verify ERBD and urgent care claims. Claims will be processed in part as follows:

- matched to MA-21 patient eligibility files to ensure that the patients are not low income patients;
- edited to ensure the presence of emergent procedure codes;
- edited to ensure there were no other payers liable for the service; and,
- edited to ensure Provider has complied with the collection efforts and evidence documentation submission requirements.

For hospital outpatient bad debt, the process is the same with the exception that the evidence requirement need only be submitted upon request of HSN. This process will be administered by exception and random selection.

The HSN will also monitor hospital ERBD claims volume and may limit reimbursement to the average volume of the 12 month period from July 2006 to June 2007 as provided in the regulation. In addition, the HSN will also conduct audits at the providers' sites to review documentation to substantiate the evidence requirement, and to ensure appropriate account collection activity.

ERBD claims that meet the service, collection activity and documentation requirements will be paid at the hospital's established rates for the appropriate service. The Division has calculated Medicare-based payment rates for Inpatient (Medical) ERBD, Inpatient psych ERBD and outpatient ERBD for each hospital. The allowable ERBD payments are included in the gross liability from the HSN and are subject to the shortfall allocation, if any.

HSN Revenue

- **Explain how the Division performs the calculation, billing, reporting and monitoring of what each hospital owes on its HSN provider surcharge (assessment).**

  The Division states that it bases the calculation, billing, reporting and monitoring of the amount each hospital owes on its HSN provider surcharge (assessment). The Division calculates the hospital assessment using the $160 million hospital

assessment revenue requirement in the legislation and allocates portions of that total to each hospital. Each hospital's payment amount is the product of the proportion of each hospital's private sector charges to the statewide total of all hospital private sector charges; multiplied by the total hospital liability of $160 million. The current uniform assessment percentage is 1.0623%, which serves as the base rate from which adjustments are made to each hospital's payment obligation towards the assessment.

The source of private sector charges data is the annual DHCFP 403 Report on Costs, Revenues and Statistics filing. The monthly liability amount that hospitals pay to the HSN is estimated and is derived by assessing each hospital 1/12 of the estimated annual amount using the most current available data.

For the HSN FY 2008, the most current DHCFP- 403 data is from FY 2006. This data represents the best available estimate for billing hospitals on an interim basis. When the Division completes its review of the FY 2007 DHCFP- 403 data, the allocation basis will be updated. This will occur most likely in the last quarter of FY 2008.

The Division reports that it will recalculate the FY 2008 hospital assessments when the hospitals' FY 2008 DHCFP-403s have been reviewed and reconciled to the audited financial statements. This is the last phase and is considered the Final Settlement on the Hospital Assessment. The Division will calculate the difference between what the hospitals paid on an interim basis and the computed final totals, and will then notify hospitals of the differences. Subsequently, hospitals will either be billed or paid the difference.

- **How does the Division reconcile the provider surcharge (assessment) payments due monthly with the monthly claims billing submitted by the hospitals?**

  The Division states that it issues a monthly calculation to each hospital. It contains the calculation of the assessment or the "gross liability to the HSN" and payment

from the HSN or the “gross liability from the HSN” and the allocation of any shortfall. It also contains the net amount each hospital will pay or receive from the HSN.

Conclusion

As the conversion from the Uncompensated Care Pool to the Health Safety Net continues to evolve, the Office of the Inspector General will continue to monitor the practices of the Division of Health Care Finance and Policy in its implementation and oversight of the HSN operations as per the requirements of Chapter 58. The next critical performance point will be the full implementation of the Medicare based claims payment system, scheduled to begin on April 1, 2008. At this time, all claims will be checked for eligibility, proper submission and timeliness, etc. This may be the Commonwealth's first opportunity to assess the true cost of providing healthcare for individuals qualified to participate in the Health Safety Net.

Another area that the OIG will be tracking is the volume of activity in the HSN and the transition of participants into one of the subsidized insurance plans of Commonwealth Care. This office will also be tracking HSN pharmaceutical use and expenses and the appropriate use and oversight of the Emergency Bad Debt fund, as well as the many oversight, program integrity and consulting activities that have been proposed to assist the Division in operation of the HSN. It is expected that another follow-up report will be submitted to update all these areas once enough experience with the new Medicare based claims payment system and other proposed enhancements have occurred.