Office of the Inspector General

Commonwealth of Massachusetts

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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

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INTRODUCTION

Chapter 240 of the Acts of 2004 directed the Office of the Inspector General to examine the practices of the state's Uncompensated Care Pool to determine whether charges made to the pool accurately represent costs incurred by uninsured patients, whether costs are being diverted or shifted to the pool, and whether the pool is foregoing reimbursement from Medicaid-eligible patients. This report is the second in a series of reports that will be presented to the Senate and House in accordance with the requirements of Chapter 240, in concert with the Inspector General's ongoing review.

The pool provides reimbursement to hospitals, hospital-based clinics, and community health centers for providing free or partially-subsidized medical services to uninsured or underinsured patients.

The Office of the Inspector General reviewed the pool's financial and management control systems, conducted financial and clinical audits of pool claims at each of the commonwealth's hospitals, examined the demographic make-up of free care recipients, reviewed prescriptions at five hospital-run outpatient pharmacies, and used claims analysis technology to test more than 100,000 claims for charges that would have been rejected by other health care payers. The Office of the Inspector General obtained and analyzed 4.8 million electronic pool claim records filed with the Division of Health Care Finance and Policy from Oct. 1, 2002 to March 7, 2005.

The Inspector General's review has identified several areas of weakness in the pool's current administrative system as well as outside factors that can and should be remedied in order to better monitor and control costs, ensure appropriate levels of treatment, and safeguard against overpayments.

Before critiquing the pool's problems, however, the Inspector General first recognizes its successes. Over the past two decades, the medical professionals of the commonwealth's private hospitals and health centers have provided billions of dollars worth of charitable care to sick and vulnerable people. While the pool receives partial public reimbursement and serves as an integral part of the commonwealth's health care

system, the pool is first and foremost a public/private partnership that gives daily evidence of the charitable purposes of its member non-profit hospitals and health centers.

The pool has evolved from its origins as a small-scale, hospital-sponsored, charitable-care cost-sharing program into its current status as a large-scale legislatively mandated program that collects $320 million per year from hospitals and insurance providers to pay for medical care. In fiscal year 2004, the pool paid for medical services for more than 450,000 individuals at 67 hospitals and 185 community health center sites at a cost – supplemented with public funds – of more than $720 million.

The pool reimburses most hospitals – particularly those with a relatively large proportion of privately insured patients – far less than their actual costs of providing free care. A major share of pool funding is used to reimburse two large hospital/clinic systems that provide a disproportionately large percentage of care to pool patients. Together with a second tier of 14 hospitals providing above-average levels of free care, these hospitals get paid first from the pool, receiving either 85 percent or 88 percent of their respective allowable uncompensated care costs. The other acute care hospitals then share what is left in proportion to their respective free-care costs. Each hospital is assessed a percentage of its revenue from private payers. Therefore, hospitals that provide less free care pay proportionately more into the pool's trust fund.

Because of the pool's burgeoning scope, its history of evolution from a private to a public/private system, its largely non-transparent cost accounting system, and its arcane, controversial and ever-changing method of assessment and cost redistribution, the pool has become a source of continuing friction among providers, insurers, taxpayers and public officials.

Over the past three years, the Legislature has attempted to address the escalating costs, lack of controls, and questions about the fairness of distribution of the Uncompensated Care Trust Fund, which is administered by the Division of Health Care Finance and Policy. In 2003, the Legislature directed the division to:

- Improve the way medically necessary care is provided and financed through the Uncompensated Care Pool;
- Establish a fair and equitable program to fund uncompensated care;
- Achieve efficiency and accountability in the management and administration of the Uncompensated Care Pool;
- Create a reimbursement system which works efficiently on a statewide basis;
- Develop a system for tracking and analyzing Uncompensated Care Pool utilization;
- Promote the delivery of patient care in the most appropriate, cost-effective manner and location available, while protecting patient access to medically necessary care, and
- Develop effective forms of care management for Uncompensated Care Pool patients.

In the context of the ongoing public policy debate about the future of the state's Uncompensated Care system and the federal Section 1115 waiver, under which the state's Medicaid program operates, the Office of the Inspector General concurs with the conclusion expressed by the Massachusetts Hospital Association and others that substantial residual uncompensated care will likely need to be provided under any of the suggested approaches currently under consideration.

If that is the case, the Inspector General recommends that state leaders take action to make the reimbursement system for uncompensated care more efficient, fair and cost-effective. The Office of the Inspector General offers its findings and recommendations in this context.

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EXECUTIVE SUMMARY

The Uncompensated Care Trust Fund has operated since its inception under Chapter 574 of the Acts of 1985. Initial funding came from surcharges from private payers' hospital bills which were redistributed to designated hospitals to compensate for bad debt and free care to the uninsured population. The trust fund has been modified through the years as it has grown in size and complexity, serving more than 450,000 individuals with a total budget of approximately $800 million in fiscal year 2005.

At the direction of the Legislature, the Office of the Inspector General performed a comprehensive study of the pool to understand its origin and mission; document its operation; identify problems or shortcomings, and recommend solutions to help the state administer the pool with accountability in spending, responsiveness in service, fairness in allocating resources and effective management of medical services.

The Inspector General consulted many stakeholders, including state officials, health care trade association representatives, hospital administrators, insurance executives, health care consultants, reform advocates as well as concerned citizens of the commonwealth. In exchange for the cooperation of the hospitals throughout the state, the Inspector General agreed not to single out any institution in this report.

The review found that there are many factors affecting the performance of the pool. The pool lacks reasonable management systems to control costs, ensure appropriate levels of treatment, and safeguard against improper billing. Among other things, the Inspector General found that low Medicaid reimbursement rates have encouraged hospitals to turn to the pool to offset shortfalls. With the application of controls and protections that are used widely elsewhere in hospitals and large-scale medical claims systems, the pool can be better-insulated from waste and cost shifting overcharges, and more deserving of the confidence of all parties that contribute to financing this critically important program.

The Legislature has provided the Division of Health Care Finance and Policy with broad authority to implement effective controls on pool operations and has expressly directed

the division to do so. However, the division has not yet complied with many of these legislative directives. When the Legislature instituted a prospective payment system in 2003, for example, it did so with the express recognition that the prospective payment system was not intended to be a permanent system, describing its inequities and requiring the administration to submit a plan by October 2003 to reform the underlying pool system.

No such plan was ever forwarded that addressed the legislative mandate of instituting effective utilization controls and claims management within the pool.

Instead, the administration chose to go in a different direction and recently proposed eliminating the pool and replacing it with a subsidized insurance program for the poor. While it is certainly within the administration's prerogatives to make such a proposal, the administration nevertheless has a continuing obligation to fulfill its statutory responsibilities to address the pool's outstanding problems.

In addition, many entities and organizations involved in the ongoing health care debate have acknowledged the likelihood that under any proposal there will be a substantial number of people who will show up at the doorsteps of hospitals and community health centers without the means to pay for their care. Furthermore, the House recently rejected the administration's health care reform plan and passed legislation requiring employers to provide health insurance or pay a health care assessment. The House plan continues the Uncompensated Care Pool under new, tighter management. The Senate has not yet voted on its health care reform plan.

Finally, unless underfunded Medicaid rates are adjusted, hospitals will most likely be forced to back away from providing uncompensated care at current levels because of overwhelming losses.

In any case, the pool is accruing approximately $2 million a day in costs while no real efforts are being made to fulfill the outstanding legislative mandates to reform and better manage the pool's operations.

The prospective payment system, enacted by the Legislature in 2003 for the 2004 budget year, has been counter-productive to controlling pool costs for several reasons. Styled as a kind of “block grant” system to facilitate planning and constrain escalating costs, in practice it has served to undermine the Legislature’s goal of controlling utilization and costs.

Several people who were involved in the negotiations that created the prospective payment system in 2003 have told the Inspector General that it was intended to be a short-term compromise. Prior to the prospective payment system’s first appearance in fiscal year 2004, hospitals were paid on the basis of charges submitted, adjusted by the hospital’s cost-to-charge ratio and payment ratio. Hospitals submit claims based on their internal fee schedule, which is called a chargemaster. Each charge is reduced using cost-to-charge and payment ratios, which vary from hospital to hospital. Throughout this report charges are used to describe the chargemaster rate that hospitals and other providers sent to the Uncompensated Care Pool, not the lower amount the pool paid the hospitals. Allowable uncompensated care costs describe charges that have been multiplied by the hospital's cost to charge ratio.

Since the prospective payment system’s “block grants” are based on old claims, the division’s refusal to scrutinize them undermines the Legislature’s attempts to rein in spending.

When the Inspector General’s office asked division officials this year why they were not examining claims for overcharges, double billing, upcoding, unbundling and other common medical billing issues, they said that the Legislature had laid out an exact payment methodology and the division’s scrutiny of claims was not a part of it – other than for policy analysis purposes.

Division officials also said that because the Legislature has not yet set out the funding formula for future years, there was no point in examining any claims. This ignores the fact that past claims have formed the basis of current payments and that current claims are likely to become the basis for future payments.

In fact, the prospective payment system did not seem to do much for legislative analysts during its first year of operation. When hospital officials argued near the end of the first year of the prospective payment system that costs had ballooned, the Legislature was more frustrated than ever with the lack of real information about what was going on inside the pool.

In 2004, while the administration was long overdue with its legislatively-requested recommendations and the division was late in engaging the auditors that the Legislature had ordered, the Legislature directed the Inspector General's office to conduct its own independent review.

The following findings are from ongoing audits, research, interviews and analyses. These findings point out weaknesses that could be effectively addressed by the application of familiar control systems used by most payers including Medicaid, known in Massachusetts as MassHealth, the Group Insurance Commission, which provides health insurance for state employees, Medicare, and private insurers like Blue Cross/Blue Shield of Massachusetts. The report also advises the Legislature to examine the impact of low Medicaid payment rates to hospitals and community health centers.

FINDINGS

FINDING 1. The Division of Health Care Finance and Policy has failed to follow legislative mandates and take steps to improve the administrative and financial oversight of the Uncompensated Care Pool.

The Division of Health Care Finance and Policy has failed to implement administrative controls that would allow it to properly manage the fund. The division's lack of oversight leaves it vulnerable to overcharging and ill-equipped to detect billing errors.

Over the past three years, the Legislature has attempted to address the escalating costs, lack of controls, and questions about the fairness of distribution of the Uncompensated Care Trust Fund, which is administered by the Division of Health Care Finance and Policy. In 2003, the Legislature directed the division to:

- Improve the way medically necessary care is provided and financed through the Uncompensated Care Pool;
- Establish a fair and equitable program to fund uncompensated care;
- Achieve efficiency and accountability in the management and administration of the Uncompensated Care Pool;
- Create a reimbursement system which works efficiently on a statewide basis;
- Develop a system for tracking and analyzing Uncompensated Care Pool utilization;
- Promote the delivery of patient care in the most appropriate, cost-effective manner and location available, while protecting patient access to medically necessary care, and
- Develop effective forms of care management for Uncompensated Care Pool patients.

The Inspector General's review found that the division has not completed its audit of the viability of the prospective payment system as required by the Acts of 2003. Nor has it followed legislative mandates to review the appropriateness of care, monitor utilization of services, identify duplication of services, control costs or establish reasonable charges. This has led to uncontrolled charges to the pool, lax administration of eligibility of pool users and inappropriate bad debt expenditures paid by the pool.

For example, the division does not ask hospitals to report pharmacy charges in a way that would allow the agency to detect overcharging on individual medications. Rather than reporting each individual drug by quantity, dosage and charge, the division allows hospitals to lump pharmacy claims together as a non-specific “pharmacy charge" entry on each patient’s claim.

The division does not pay for medical care based on a fee schedule with consistent charges and/or negotiated rates for laboratory services, radiology procedures, other clinical services or supplies. While other payers control costs by limiting payments to negotiated rates for specific medical procedures, the pool does not. Often, the amounts paid by the pool to hospitals for specific procedures exceed by substantial amounts limits that other payers have put on the same procedures. The Inspector General’s review has found that cost shifting to the pool is occurring, notwithstanding application of cost-to-charge ratios in determining allowable costs. While this review has also found that cost shifting serves to subsidize Medicaid shortfalls, the Inspector General also concludes that cost shifting makes the funding system less transparent and accountable.

The division’s lack of proper oversight of the Uncompensated Care Pool has allowed the pool to be one of the only health care payers in the state that:

- accepts a percentage of hospital charges for all treatments – instead of establishing a rational relationship between charges and costs for pool-funded procedures;
- permits a patient to repeatedly receive the same lab test, treatment or prescription drug without question of duplication, appropriateness, or charges;
- doesn't systematically check to see if the services they pay for were actually delivered, and
- does not place limits on payments for hospital stays regardless of the patient's diagnosis or treatment plan.

Proper oversight and compliance with the legislative mandates and statutes governing the administration of the Uncompensated Care Pool would have given the commonwealth tighter control of the more than $1.2 billion it spent on the Uncompensated Care Pool over the last two years. The division also would have

detected the waste, errors, and inappropriate uses of the pool uncovered by the Office of the Inspector General.

RECOMMENDATION 1.

The Division of Health Care Finance and Policy should immediately implement the Legislature's 2003 mandates and properly enforce them. Following the other recommendations in the report – including creating utilization controls, enforcing enrollment and eligibility rules, reviewing all charges and creating a transparent payment system – will also help the pool become a more effective health care payer.

FINDING 2. Inadequate Medicaid payments have created "public payer" revenue shortfalls at Massachusetts' acute care hospitals. For hospitals with a relatively small private payer mix, the commonwealth has created a patchwork of direct and indirect supplemental payments to protect access to care for Medicaid and uninsured patients.

For hospitals with a disproportionately high share of public payers, the Uncompensated Care Pool currently serves as part of a multi-faceted supplemental payment system, often paying at rates effectively higher than Medicaid, Medicare and commercial payers.

The Inspector General's analysis has confirmed that Medicaid reimburses hospitals at rates far less than those of other payers. A study commissioned by the commonwealth in Section 63 of Chapter 236 of the Acts of 2000, the Lewin Report of 2001 ("Reimbursement Rates for Acute Hospitals, Non-acute Hospitals and Community Health Centers"), found that in 2000 Medicaid in Massachusetts reimbursed acute care hospitals only 71 percent of their costs. In contrast, a 2001 study by the Medicaid Payment Advisory Commission estimated that nationwide Medicaid reimburses hospitals for 95 percent of their costs. In October, the state increased funding for Medicaid reimbursements. One hospital executive told the Inspector General that hospitals now get 80 cents for every dollar they spend on Medicaid patients.

The commonwealth has established a system of special payments to disproportionate share hospitals, including supplemental hospital rate payments and supplemental Medicaid Managed Care Organization rate payments, with the acknowledged intent of addressing hardships caused by insufficient non-public operating revenue at disproportionate share hospitals.

The pool's system of assessments and reimbursements has created a wide spectrum of economic effects at different types of hospitals. Some hospitals are net payers into the pool and actually pay assessments greater than the reimbursement they receive for providing allowable free care. Other hospitals receive only a modest reimbursement for providing allowable free care. These hospitals are on the paying side of a cost sharing system that was established – originally by the hospitals themselves – in order to equalize the burden that hospitals bear in providing free care in accordance with their charitable purposes. On average, hospitals receive approximately 41 percent reimbursement for free care, net of their assessment to the pool. Most hospitals in effect are paid at rates far less than Medicaid rates for equivalent services. At the other end of the spectrum are the hospitals that serve a disproportionately high share of free-care patients.

The Inspector General's review found that Uncompensated Care Pool payments at these hospitals often serve not only to compensate for free care, but also to supplement Medicaid shortfalls attributable to the high percentage of Medicaid patients these hospitals serve. The Inspector General's anecdotal comparison of net payment rates from the Uncompensated Care Pool to these highly disproportionate share hospitals found that the pool is paying at higher effective rates than Medicaid, Medicare or commercial payers in most cases. A comprehensive side-by-side comparison of all public payers could confirm this anecdotal evidence.

Inadequate Medicaid payments at disproportionate share hospitals create particularly difficult economic challenges since these hospitals have few viable alternatives to recover costs since they serve so many low-income patients. For example, one disproportionate share hospital provides 83 percent of its care to Medicaid, Medicare

and uncompensated care patients, leaving only 17 percent of commercial and self-pay clients to make up for reimbursement shortfalls from the public payers. The hospital does not have an adequate base of private patient volume to leverage any bargaining power with these other payers for higher rates to make up the difference.

The Inspector General has observed adverse side effects to the commonwealth's current system of making relatively inadequate Medicaid payments and then adjusting for them with a patchwork system of direct and indirect supplemental payments to disproportionate share hospitals. One drawback to this system is that it makes it almost impossible to compute the actual amount of compensation that is being paid to the disproportionate share hospitals for any particular transaction, considering that funding comes from such a wide array of direct and indirect funding sources. This limits the commonwealth's ability to have a rational and transparent relationship between charges and costs. Another drawback is that many acute care hospitals are unable to offset inadequate Medicaid payments with higher commercial rates because they lack the leverage to negotiate those higher rates with commercial payers.

RECOMMENDATION 2.
The Medicaid and free-care reimbursement systems should be analyzed and adjusted to adequately and accountably compensate hospitals for efficiently delivering medical services.

FINDING 3. Under any of the healthcare reform plans currently under consideration, some Massachusetts residents will remain uninsured and in need of health care. Hospitals will need funding to cover their care.

An estimated half a million Massachusetts residents don't have health insurance and rely on the Uncompensated Care Pool to pay for their health care. These people are among the most needy in the state and the least capable of affording health care services. Under any of the health care reform plans under consideration by policymakers, there will continue to be people who do not qualify, are not able to comply, or cannot afford or otherwise access healthcare. For those people, there needs

to be a safety net structure. Hospitals and community health centers need to be assured of reasonable reimbursement in order to provide necessary services to this population.

The Uncompensated Care Pool currently reimburses acute care hospitals for only a portion of their allowable hospital uncompensated care costs. According to the Division of Health Care Finance and Policy, the pool paid acute care hospitals $386.7 million from Oct. 1, 2003 to Sept. 30, 2004 – 68 percent of the $565 million in allowable uncompensated care costs the hospitals billed the pool. The pool is financed, in part, by hospital assessments that essentially redistribute money from hospitals that don't provide much free care to hospitals that serve a great deal of uninsured patients. Of the $386.7 million, $157.5 million came from assessments on the hospitals themselves. Those assessments bring the average system-wide reimbursement rate to 41 percent. In other words, most hospitals receive only partial reimbursement for the free care they provide.

As a case in point, Massachusetts General Hospital paid approximately $17 million in assessments to the pool in hospital fiscal year 2004, provided approximately $50.9 million of allowable free care and was reimbursed approximately $26.8 million for those services. Subtracting its assessment from its pool reimbursements, Massachusetts General Hospital received just $9.2 million from the pool but delivered $50.9 million in free care services. Most of the hospital's free care patients were Massachusetts residents who lived outside of Boston.

Another case in point is Milford-Whitinsville Hospital that paid $1.9 million in assessments to the pool in hospital fiscal year 2004, provided $2.4 million of allowable free care, and received $1.5 million in payments for services it provided.

Therefore, for its provision of $2.4 million of allowable free are in hospital fiscal year 2004, Milford-Whitinsville received no reimbursement from the pool, net of its assessment, and instead made a net payment of $365,000 into the pool. This hospital is an example of a "net payer" into the pool.

Under state and federal law, hospitals and community health centers bear the burden of providing emergency medical services to the free care population. Experience with initiatives such as the MassHealth Essentials program has revealed that it is difficult to achieve enrollment targets with this population due to the lack of proper incentives and difficulties in enrolling uninsured individuals into new insurance programs.

Given the predictable enforcement challenges inherent in the implementation of a new safety net system, some reasonable measure of pool funding to reimburse hospitals and community health centers should be maintained to protect the financial stability of those institutions.

RECOMMENDATION 3.

The Inspector General recommends that any change to the current system assure that a reasonable system of reimbursement be maintained to account for residual uncompensated care that will continue to be provided by hospitals and community health centers.

FINDING 4. The Inspector General's audit of Uncompensated Care Pool claims has uncovered problems involving claims review.

The Division of Health Care Finance and Policy has not taken advantage of the electronic clinical claims review process that is used by other health care payers to reject claims that include inappropriate charges, unbundling of laboratory services, excessive charges for evaluation and management, and over-billing.

The lack of such systematic claims "scrubbing" programs could be costing the pool tens of millions annually, according to a claims analysis commissioned by the Inspector General's office. The analysis, conducted by a national claims review company, looked at more than 100,000 pool claims and found that a large proportion of them would have been initially rejected by Medicare. More than 2 million claims from more than 450,000 pool users are submitted annually to the division.

The pool allows millions of dollars of improper “unbundled” charges to slip through when other payers would automatically reject them. Currently, the Division of Health Care Finance and Policy has no policy against this but it should. The auditors found 8,584 cases of unbundled laboratory charges in its claims sample, resulting in more than $2 million in apparently unjustified charges to the pool. Unbundled tests are separate tests that are usually provided (and charged for) in a bundle or group because of clinical relevance.

For instance, on Jan. 5, 2005, one hospital billed the pool $97 for seven separate blood tests to assess liver function. Both Medicare and Blue Cross would have rejected the claims because all seven tests are part of a “bundle” of tests that has a Medicare contracted reimbursement rate of $11.42. Insurers – and even the pool – reimburse much less for bundled tests. In other words, unbundling tests is the equivalent of asking a consumer to pay for an entire loaf of bread slice by slice.

Unlike other payers, the pool commonly pays multiple evaluation and management charges for a single patient’s visit in a hospital-affiliated clinic. For instance, the pool will pay for both hospital overhead and a professional services charge related to the doctor’s services. These fees, which come on top of any procedure or service fee, are either eliminated or discounted by most other payers. The audit found that more than 64,000 claims – and $35.5 million in pool charges – would have been rejected by Medicare because of this type of billing. The Division of Health Care Finance and Policy has no policy against this but it should.

Another area of weakness in the Division of Health Care Finance and Policy’s oversight system is its failure to detect obvious overcharging errors.

The Inspector General reviewed hospital outpatient pharmacy charges made to the Uncompensated Care Pool over a three-year period. The review detected some readily apparent overcharging errors, detailed below, that had been made by one hospital in its submittal of pharmacy charges. In total, the Inspector General identified approximately $5 million in such overcharges, comprised of charges with mark-ups of more than 1,000

percent compared to charges submitted by another outpatient pharmacy. The hospital's allowable uncompensated care costs for theses charges are less than $5 million since charges are always reduced by the hospital's cost-to-charge ratio. The Inspector General brought these issues to the attention of the hospital's administrators and they acknowledged that errors occurred that were attributable to data entry and software errors. The Inspector General recommends that the Division of Health Care Finance and Policy audit pharmacy claims to identify overcharging by this hospital.

The following examples demonstrate that the division's electronic claims review system is not administered in a manner that is capable of detecting even the most egregious over charging errors in the pharmacy area:

- On March 10, 2003, the hospital outpatient pharmacy charged the pool $6,469 for 100 tablets of atorvastatin calcium, commonly known by its brand name Lipitor, for which it should have charged approximately $224. Similar erroneous overcharges for Lipitor during the audit period were more than $1 million.
- On Jan. 18, 2005, the hospital outpatient pharmacy charged the pool $48,517 for 60 syringes of enoxaparin, commonly known by its brand name Lovenox, for which it should have charged approximately $1,800. Similar erroneous overcharges for enoxaparin during the audit period were approximately $540,000.
- On Feb. 5, 2003, the hospital outpatient pharmacy charged the pool $7,826 for 100 tablets of pantoprazole, commonly known by its brand name Protonix, for which it should have charged approximately $398. Similar erroneous overcharges for Protonix during the audit period were approximately $890,000.
- On July 7, 2003, the hospital outpatient pharmacy charged the pool $8,634 for 360 tablets of gabapentin for which it should have charged approximately $468. Similar erroneous overcharges for gabapentin during the audit period were approximately $1.2 million.
- On Feb. 27, 2003, the hospital outpatient pharmacy charged the pool $13,389 for 30 tablets of Triamterene/HCTZ, for which it should have charged approximately $15. Two erroneous overcharges for Triamterene/HCTZ during the audit period totalled approximately $26,748 for this medication.
- On July 23, 2002, the hospital outpatient pharmacy charged the pool $17,612 for 60 tablets of Propranolol HCl, for which it should have charged approximately $28. This represented the sole erroneous overcharge for this medication.

- On Feb. 14, 2003, the hospital outpatient pharmacy charged the pool $2,949 for 6 bottles of latanoprost, for which it should have charged approximately $111. Total overcharges during the audit period for latanoprost were approximately $103,000.

In total, the Inspector General identified more than 5,000 prescription overcharges for approximately 140 medications submitted by this outpatient pharmacy that were allowed by the Division of Health Care Finance and Policy. Each overcharge represented a mark-up of more than 1,000 percent over the charges submitted to the pool by another hospital pharmacy during the same period. In total, this hospital's outpatient pharmacy charged the pool approximately $5.3 million for these prescriptions while the other outpatient pharmacy charges for the same bundle of prescriptions would have totaled approximately $285,000.

RECOMMENDATION 4.

The Division of Health Care Finance and Policy should conduct in-depth electronic claims reviews, which most other payers regularly perform before payment. An effective claims review would allow the division to analyze data and reject inappropriate claims.

FINDING 5. The pool is not operating a transaction-based reimbursement system where charges are clearly related to costs that can be used to assess reasonableness and adequacy of reimbursement.

The Legislature asked the Inspector General's office to investigate whether hospitals are cost-shifting, pushing a disproportionate share of their operating costs into services used frequently by pool patients. The pool doesn't pay for medical care based on a fee schedule with consistent charges and rates for medical procedures, tests, services, prescriptions or equipment. Instead, each hospital sets prices on its individual "chargemaster", a menu listing the prices the hospital would like to be paid for each service.

Cost shifting occurs when a hospital generates extra revenue by setting higher rates for procedures that are used more frequently by pool patients. Since the pool pays for procedures based, in part, on each hospital's underlying costs, when a hospital hikes a procedure's price above its cost, the pool ends up paying more than its fair share of the hospital's total costs.

While the Legislature has directed the Division of Health Care Finance and Policy to implement a fair and cost effective reimbursement system, the agency has failed to do so.

Cost shifting is not only allowed under current pool regulations, but has become standard operating procedure for some hospitals. Hospital executives told the Inspector General that they shift costs to the Uncompensated Care Pool to supplement their revenues and make up for Medicaid shortfalls.

The Inspector General found that one hospital was cost shifting in radiology, a service representing a substantial percentage of pool expenses. Since these radiology tests are often ordered in emergency rooms, they are often billed to the Uncompensated Care Pool as emergency bad debt and as free care.

The Inspector General found that hospitals' allowable uncompensated care costs (after application of the cost-to-charge ratio) for identical CT scans vary widely from hospital to hospital, ranging from a low of $359 to a high of $4,401 for the same procedure, while Medicare's rate for the same CT scan is $344. For another CT scan, one hospital's allowable uncompensated care cost (after adjustment for its cost-to-charge ratio) is approximately $2,677 while Medicare would only pay $272 for the same procedure, an HMO would pay $355 and the Group Insurance Commission's indemnity plan for state employees would pay $436. CT scans are a significant pool expense, generating $64.4 million in charges in hospital fiscal year 2004 alone.

The Inspector General analyzed pharmaceutical prices charged by five hospitals in their outpatient pharmacies. One hospital appears to have significantly marked up its prices, according to electronic records provided by the hospitals.

That hospital charged an average of 300 percent more than other hospitals charged the pool. Translating that markup into allowable uncompensated care costs (the hospital's bill discounted by its cost-to-charge ratio), this hospital over three years charged the pool $30 million more than another major outpatient pharmacy would have charged for the same bundle of medications.

Officials at this hospital told the Inspector General's office that they used these markups to generate needed income to help the hospital pay for funding shortfalls for Medicaid and free-care services.

Cost shifting masks the real problem of these losses hospitals suffer from Medicaid's underfunding and other payer's low reimbursement rates. Once rates are set for the pool, hospitals will lose their ability to make up for their shortfalls through cost shifting. The Inspector General concludes that cost shifting to the pool is problematic in so far as it creates inequities in the broader context of cost sharing among hospitals. It also makes the funding system less accountable and transparent.

RECOMMENDATION 5.

The Division of Health Care Finance and Policy should follow the example of other health care payers and

- set negotiated rates for all medical procedures, tests, services and equipment,
- monitor and control pharmacy rates so it can scrutinize claims to detect and avoid overcharges, and
- provide reimbursement on a straight forward transactional system to provide for consistency, accountability, control and a fair representation of costs of services.

FINDING 6. The pool lacks safeguards to prevent overuse of medical services and fails to enforce medical necessity criteria.

There is no systematic utilization review process in place to examine clinical services provided to pool patients for appropriateness of care, length of stay, quantity of services or whether the tests and procedures billed to the pool were needed.

Currently, the pool lacks effective safeguards against unnecessary utilization of services. Most payers have guidelines that set limits on what care a hospital can provide without seeking additional authorization. The pool doesn't have any guidelines requiring review or pre-authorization.

In interviews, hospital personnel told the Inspector General that the lack of utilization controls leads to overuse of services, including:

- Inappropriate admissions such as allowing surgical day patients to stay overnight when it is not medically warranted;
- Keeping patients in the hospital over the weekend waiting for tests. Other payers would require a patient to go home and get the test as an outpatient; or,
- Delaying a patient's discharge while social workers arrange for other post-hospitalization care.

Additionally, the Uncompensated Care Pool has many variations of the definition of "medically necessary services" and no defined rules for providers to follow, leaving the system extremely vulnerable to abuse.

To test whether the treatments the pool is paying for would be considered medically necessary by other major payers, the auditors hired by the Inspector General analyzed more than 100,000 claims, attempting to match each patient's treatments with the appropriate diagnosis. The auditors, in an experimental electronic claims review, identified more than 18,000 apparently mismatched treatments and diagnoses, totaling $5.9 million in charges to the pool in this sample. This experimental claims review is not definitive, but does identify an area of potential weakness in pool administration.

For example, on Feb. 22, 2005, staff at one hospital ordered two blood tests and a CT scan of the head for a patient, with charges to the pool totaling $982. The blood tests checked for prothrombin time and thromboplastin time, two blood clotting factors that

are affected by the blood thinner warfarin, which is often prescribed to prevent blood clots after surgery. The diagnosis codes for this patient correspond to being acutely drunk and having an unspecified neurotic disorder. Although the treatment may have been appropriate, the information provided to the pool doesn't make that clear. Medicare would have rejected paying for the treatments as suspect. The pool accepted them.

RECOMMENDATION 6.

The Division of Health Care Finance and Policy should establish and enforce guidelines defining clinically appropriate and medically necessary medical care for a full range of treatments, and develop a utilization review system to ensure that hospitals follow those guidelines in order to receive reimbursement.

FINDING 7. Before implementation of the new Virtual Gateway screening system, more than 13 percent of pool users qualified for MassHealth, but never applied.

The Inspector General's review verified that more than 99 percent of pool patients qualify to receive pool services under income eligibility guidelines, but that between 6 and 8 percent of these patients had all their medical claims paid by the pool when they should have been eligible for partial payments.

Based on analysis performed by the Inspector General with the assistance of the Department of Medical Assistance, 13 percent of pool patients who received services between October 1, 2002 and March 7, 2005 were eligible for MassHealth but never applied.

On Oct. 1, 2004, the Executive Office of Health and Human Services started using the Virtual Gateway, an on-line application, to determine free care eligibility. Because hospitals began using the system at different points during the year, it is too soon to tell whether the Virtual Gateway is effectively enforcing the pool's eligibility rules. The Inspector General hopes this system will be able to identify these MassHealth eligible patients and to enroll them in the insurance program, as required by new state rules.

RECOMMENDATION 7.

The Division of Health Care Finance and Policy should conduct an in-depth performance review of the Virtual Gateway system to test its effectiveness in identifying MassHealth-eligible recipients and in addressing ongoing practical problems faced by hospital employees in complying with eligibility documentation requirements.

FINDING 8. Emergency bad debt payments are not properly monitored and are being used to cover hospital losses for non-emergency services.

The pool spent more than $232 million in hospital fiscal year 2004 on emergency bad debt payments, reimbursements to hospitals for emergency medical care bills that patients can't – or won't – pay. Pool regulations allow hospitals to forward emergency – and in some cases urgent care – bills to the pool after they have tried to collect payment for 120 days. The pool pays these bills at the hospital's standard reimbursement rate.
For example, in the audit commissioned by the Inspector General of a small sample of hospital emergency bad debt claims, at least 50 percent of emergency bad debt claims did not have adequate documentation to determine whether the provider should have been reimbursed.

The audit did not examine a second category of bad debt that hospitals do not charge to the Uncompensated Care Pool. The Massachusetts Hospital Association estimates that hospitals will write-off $250 million in bad debt in 2005.

RECOMMENDATION 8.

The Division of Health Care Finance and Policy should more closely review emergency bad debt claims and develop clear policies for hospitals to follow when they submit bad debt claims.

FINDING 9. The pool needs better management of mental health and substance abuse services.

Unlike MassHealth, the Group Insurance Commission, and most other health plans in the state, the pool has no special controls for the management or oversight of mental health and substance abuse services. Together, mental health and substance abuse services make up the pool's largest inpatient diagnostic categories - accounting for 21 percent of all inpatient costs - or nearly $52 million annually. Currently, there is no oversight of appropriateness of admissions, services, or medications, or required clinical outcomes to ensurethat the services being provided are necessary, suitable and effective.

In interviews, hospital officials and health care consultants working with the uninsured population told the Inspector General that many frequent emergency room users have mental health and/or substance abuse problems, which often cause or aggravate other conditions. These patients often have problems complying with enrollment procedures and following aftercare instructions. They tend to seek treatment at acute care hospitals because few other options are available.

The Inspector General plans to continue investigating mental health and substance abuse issues, including inappropriate lengths of inpatient stays and excessive use of medications.

RECOMMENDATION 9.

The Division of Health Care Finance and Policy should adopt specific controls on mental health and substance abuse services to ensure that the appropriate level of treatment and medications are being provided, and that clinical outcomes are being collected and reviewed.

FINDING 10. The vast majority of pool patients are poor and they seek care in Boston.

The Inspector General matched Uncompensated Care Pool application records against Department of Revenue's quarterly wage reports and found that 90 percent of all pool users earn less than $20,000 a year. Less than one percent made more than $40,000.

More than half of the patients receiving care paid through the pool are from Suffolk and Middlesex counties.

However, patients who don't live in these densely populated counties still seek their care in Boston, according to a preliminary review by the Inspector General of where suburban pool patients seek their care.

For example, more than half the pool patients who listed a Norwood address received care at hospitals outside Norwood, which has its own acute care hospital. In fact, the pool paid two Boston hospitals more to treat Norwood residents than it reimbursed Norwood's community hospital for free care.

All hospitals are required by state and federal law to screen emergency room patients; however, hospitals don't have to provide non-emergency care. It appears that suburbanites are migrating to expensive Boston hospitals for follow-up visits and prescriptions because they are unavailable at local hospitals, which don't get paid by the Uncompensated Care Pool for these extra services. These services could be more economically and conveniently provided in suburban hospitals and community health centers around the state.

RECOMMENDATION 10.
Policymakers should explore reimbursement mechanisms to encourage patients to seek care at lower cost suburban hospitals and regional community health centers.

FINDING 11. The prospective payment system needs to be reformed as the Legislature planned.

Attempting to bring predictability to the pool's payment system, the Legislature in 2003 changed the way the Division of Health Care Finance and Policy reimburses hospitals from a claims-based retrospective system to an appropriation-based prospective system.

The prospective payment system was designed to cap spending by designating each hospitals' pool appropriation at the beginning of the year and paying out the money in equal monthly installments. In hospital fiscal year 2004, when prospective payment began, each hospital's claims from prior years formed a basis for its allotment from the pool. On top of these charges, lawmakers added approximately 10 percent to compensate for volume growth and inflation. Since then, the pool budget has been set by taking the 2004 allocation and adding growth and inflation factors.

As documented in this report, thousands of questionable claims from earlier years – inflated drug charges, excessive and overcharged laboratory tests, unreasonably high radiology fees, billing errors and inappropriately long hospital stays – were accepted by the Division of Health Care Finance and Policy. As a result, these inappropriate charges became part of the base amount used to calculate succeeding years' budgets.

In fact, when lawmakers created the prospective payment system, they recognized that they were locking in "any inefficiencies or inequities" in the old, unexamined claims history. Because of that, lawmakers directed the Secretary of Health and Human Services to audit the costs and services billed to the pool and develop a rational "utilization review program to monitor (the) appropriateness of services paid by the pool."

The administration has failed to complete its audit, review the appropriateness of care, monitor utilization of services, identify duplication of services, control costs or establish reasonable charges.

RECOMMENDATION 11.

The Division of Health Care Finance and Policy could go a long way toward remedying some of the reimbursement problems outlined in this report by auditing the effectiveness of and, if appropriate, reforming the prospective payment system, and fully implementing the mandates spelled out by the Legislature in 2003.

HISTORY and BACKGROUND

The Uncompensated Care Trust Fund was established by Chapter 574 of the Acts of 1985 and was originally created by the Legislature as a uniform surcharge placed on all private payers' hospital bills. The state assessed hospitals for the costs of the pool, the hospitals would pass this tax onto private health insurance plans and the plans would recoup their costs through increased premiums.

Hospitals sent the funds to the division, which redistributed the money to hospitals according to how much free health care each provider gave to the uninsured. The pool is governed by M.G.L. c.118G, §18, which charges the division with administering the program.

Since 1988 – just three years after the pool was created – the Legislature has repeatedly attempted to rein in the cost of providing free care.

Chapter 23 of the Acts of 1988, which originally mandated universal health insurance coverage, capped the hospital liability to the pool at $325 million and legislated that it be reduced to $315 million by 1991. The 1988 law acknowledged that the cost of providing health care to the uninsured needed to be controlled. Universal coverage was also expected to gradually reduce the demand for free care. However, because of intense opposition from the business community, universal coverage was never implemented. The mandate was repeatedly postponed and finally repealed in 1996.

By hospital fiscal year 2004, pool funding had increased to over $600 million. The state contributed over $250 million in one-time funds from various sources and pool costs continued to climb and post shortfalls in funding. This prompted the Legislature to enact a series of reforms to the pool designed to rein in rising free care costs and to direct the Executive Office of Health and Human Services to develop a new program to reform the pool.

The reforms included new requirements that pool patients' incomes be matched against Department of Revenue's income data and that hospitals check free care patients'

Medicaid eligibility before approving pool applications. The Legislature also encouraged providers to send patients to community health centers rather than always treating free care patients in extremely expensive hospital settings.

At the same time, lawmakers enacted “prospective payment” – a system setting a fixed annual budget for the pool. The prospective payment system allocates a larger piece of the pool to the hospitals that provide a disproportionate share of care to the poor. The division pays each hospital one-twelfth of its annual fixed payment each month. Although the annual pool payments are supposed to be capped under the prospective payment system, the hospitals have repeatedly asked the Legislature for additional pool payments at the end of their fiscal years for various reasons.

Another legislative effort to shrink pool costs was the Insurance Partnership, created by Chapter 47 of the Acts of 1997. The Insurance Partnership is a program operated by MassHealth with the goal of encouraging small businesses to insure their employees, thereby lowering the number of uninsured Massachusetts residents. MassHealth will pay the employer an incentive of up to $1,000-a-year for each MassHealth eligible insured employee.

To qualify, a business must employ 50 or fewer people and pay at least half of its employees’ health insurance premiums. Only workers who are between the ages of 19 and 64 qualify for the premium subsidies. The employees must also have a gross family income under 200 percent of the federal poverty levels (about $38,000 annually for a family of 4 or $19,000 for an individual). Self-employed persons are eligible if they live in Massachusetts, pay for comprehensive health insurance and are under 200 percent of the federal poverty levels.

The Legislature began funding the Insurance Partnership with a $48 million line-item in fiscal year 2000. However, the program has never spent its full appropriation or met its enrollment targets. In fiscal year 2005 its budget dropped to $37 million and lawmakers were convinced that the eligibility criteria for the program were too restrictive to provide a viable incentive.

Originally envisioned as a way to dramatically reduce the state's uninsured population, the program has not fulfilled its mission. Currently, only about 20,000 people are enrolled in the program. Given the modest incentives offered by the program, the Insurance Partnership, as currently structured, appears unlikely to grow significantly or be a major factor in reducing the state's uninsured population.

Any examination of the pool must be viewed in the context of Medicaid reforms that the federal government has mandated by June 30, 2006. Since 1997, Massachusetts' Medicaid system has operated under a section 1115 waiver from the federal government. The goal of the Medicaid waiver was to allow flexibility in exchange for local innovation that would reduce the number of uninsured and cut the state's health care costs. The pool, originally created in 1985, has evolved around the rules of the Medicaid waiver and will necessarily be transformed by the new waiver rules.

Under the current waiver, the state has been able to trigger hundred of millions of dollars in federal matching funds using intergovernmental transfers, or IGTs, an accounting procedure that credits the state for existing statewide and local health care spending without actually costing state taxpayers any additional money. The federal government has told the state it can no longer use IGTs in the same manner as previously allowed to account for health care spending and trigger federal matching funds. Instead, the federal government will have to approve local health care spending for it to generate matching funds.

The new waiver also capped the federal payments to disproportionate share hospitals – providers that, under federal law are recognized as serving a disproportionately large share of Medicaid and uninsured patients. In Massachusetts, any acute care hospital that generates at least 63 percent of its patient revenue from Medicare, Medicaid, other government payers or the pool, is considered a disproportionate share hospital. Boston Medical Center and the Cambridge Health Alliance are the two leading disproportionate share hospitals in the state.

Since July 1, 2005, disproportionate share hospital payments in Massachusetts were capped at $574.5 million annually. The new waiver combines these payments with the Medicaid Managed Care Organization (MCOs) supplemental payments, which will vary slightly based on enrollment into the MCOs. This combined fund – capped at a maximum of $1.3 billion in federal funds – will be known as the Safety Net Care Pool. That money will be used to support the Medicaid MCOs and cover the health care costs of the state's uninsured and underinsured population through the Safety Net Care Pool.

PRELIMINARY RESULTS OF ANALYSIS AND AUDITS

The Division of Health Care Finance and Policy has been assigned the responsibility and granted the authority to provide overall administration of the state's pool through M.G.L. c.118G, §18.

Included in Chapter 118G are requirements that the division collect data from hospitals in order to manage the costs of the pool, the utilization of medical services within the pool, and examine other comparative data by cost, utilization and outcome.

Specifically, Section 6 of Chapter 118G details the information that hospitals must provide related to reimbursable services including "the uniform reporting of revenues, charges, costs and utilization of health care services delivered by institutional and non-institutional providers." The statute specifies that such information is necessary in order to "enable the division to identify, on a patient-centered and provider-specific basis, statewide and regional trends in the cost, availability and utilization of medical, surgical, diagnostic and ancillary services provided by acute hospitals" and other providers. The statute further requires the division, by regulation, to "designate standard systems for determining, reporting and auditing volume, case-mix, proportion of low income patients. . . and to prepare reports comparing acute and non-acute care hospitals by cost, utilization and outcome."

Section 6 provides the overall authority and control mechanisms for the division to manage the pool and be accountable to the taxpayers for the hundreds of millions of budget dollars appropriated within the program. Without these controls, or without effective enforcement of them, the system is highly susceptible to waste, abuse, mistakes and, even fraud.

Over the past three years, the Legislature has attempted to address the escalating costs, lack of enforcement of controls and accountability standards, and the fairness of how the Uncompensated Care Trust Fund's is distributed among the state's hospitals. Specifically, Section 617 of Chapter 26 of the Acts of 2003 instructed the Secretary of the Executive Office of Health and Human Services to:

- Improve the way medically necessary care is provided and financed through the Uncompensated Care Pool;
- Establish a fair and equitable program to fund uncompensated care;
- Achieve efficiency and accountability in the management and administration of the Uncompensated Care Pool;
- Create a reimbursement system which works efficiently on a statewide basis;
- Develop a system for tracking and analyzing Uncompensated Care Pool utilization;
- Promote the delivery of patient care in the most appropriate, cost-effective manner and location available, while protecting patient access to medically necessary care, and
- Develop effective forms of care management for Uncompensated Care Pool patients.

The Secretary was instructed to file any and all recommendations, including proposed legislation, on or before Oct. 1, 2003. The administration's response was not delivered for another year and a half.

In April 2005, rather than reform the pool, the governor filed legislation introducing Commonwealth Care, a plan to replace the pool with a health insurance program for the uninsured and low income individuals. The governor's plan encourages qualified individuals to enroll in MassHealth, creates the Safety Net Care Pool for the working poor, mandates that individuals secure healthcare insurance coverage, and creates tax incentives for individuals and businesses to participate in the program.

If the Division of Health Care Finance and Policy had followed the existing legislative mandates and properly enforced them, the commonwealth would have had much better use and accounting of the more than $1.2 billion spent on the Uncompensated Care Trust Fund over the last two years, and far less of the waste, errors, and inappropriate uses of pool funds discovered by the Office of the Inspector General.

LACK OF TRANSPARENCY AND COST SHIFTING

One feature of the pool that frustrates efforts to control costs is the convoluted and non-transparent payment system. The current system cedes complete autonomy to

hospitals to set their own fee schedules and – despite legislative mandates to the contrary – never questions hospitals' charges to the pool.

The bills hospitals send to the pool list charges taken from a document called a chargemaster, a menu listing the associated prices the hospitals would like to be paid for each service.

For instance, one hospital's chargemaster lists $2,844 as the hospital's price for a neck CT scan without dye. Every time the hospital bills a patient for a neck CT scan without dye, it bills $2,844, its chargemaster rate. Aside from the pool, almost no other payer would pay the hospital based on the chargemaster rate for the neck CT scan. Most third party payers, including private health insurance companies and the federal Medicaid and Medicare programs, negotiate their own rates with hospitals. The pool is the only major payer that bases its payments solely on a discount off of the hospitals' chargemaster rates formula. As a result, hospital administrators can set their chargemaster rates as high or low as they want, creating the opportunity for hospitals to shift costs.

Cost shifting occurs when a hospital generates extra revenue by setting higher rates for procedures that are used more frequently by pool patients. Since the pool pays for procedures based, in part, on each hospital's underlying costs, when a hospital hikes a procedure's price above its cost, the pool ends up paying more than its fair share of the hospital's total costs.

Such manipulations are not only allowed under current pool regulations, but have become standard operating procedures for hospitals, which take advantage of the fact that the pool bases its payments solely by discounting chargemaster prices.
The first discount applied is a cost-to-charge ratio, which is meant to reduce the inflated prices hospitals use on their chargemasters so that the amount the pool pays is closer to the actual cost of the procedure.

A cost-to-charge ratio is calculated by dividing a hospital's allowable costs by the sum of the full chargemaster rate for every procedure performed in a given year. That sum is called the hospital's gross patient service revenue and does not reflect how much money the hospital actually received.

Although the cost-to-charge ratio was designed as an equalizer, it doesn't work that way because hospitals don't use a uniform markup to build their chargemasters. Instead, they can hike the prices of procedures that pool patients use frequently and lower prices for other procedures.

Hospital executives explained to the Inspector General that they consciously increase rates on procedures where they know they are catering to "charge-based payers" like the Uncompensated Care Pool. This particular hospital hiked its pharmacy charges by $30 million over another area hospital during the 30-month period studied by the Inspector General. The other hospital hiked its radiology prices for similar reasons. In each instance, administrators explained that this kind of cost-shifting helps to offset shortfalls from Medicaid underpayments.

Over the past several years, most health care payers, including private insurers and MassHealth, have identified prescription drugs' costs as a cause of the rapid increase in the cost of health care. Both private health insurers and MassHealth have targeted prescription drugs with greater oversight and management by developing formularies and drug lists to ensure that the most clinically effective and cost effective drug is being dispensed, often guaranteeing that the generic equivalent is dispensed first before its more expensive brand name counterpart.

The Division of Health Care Finance and Policy doesn't even collect the data that would allow it to determine whether the pool is paying a fair price for medications.

The Inspector General analyzed pharmaceutical prices charged by five hospitals in their outpatient pharmacies. While charges from four hospitals reflected the provider's actual acquisition costs, one hospital appears to have significantly marked up its prices, according to electronic records provided by the hospitals.

That hospital charged an average of 300 percent more than the other hospitals charged the pool. Translating that markup into allowable uncompensated care costs (the hospital's bill discounted by its cost-to-charge ratio), this hospital charged the pool $30 million more than another major outpatient pharmacy would have charged for the same bundle of medications.

Officials at this hospital told the Inspector General's office that they used these markups to generate needed income to help the hospital pay for funding shortfalls for Medicaid and free-care services.

Hospitals can manipulate their prices – and ignore economic theory that keeps prices in line with market demand – because the Division of Health Care Finance and Policy doesn't act like a typical consumer.

Unlike an insurance company, the agency that holds the pool's purse strings does not make any effort to get the best price on the services and procedures it purchases. By turning a blind eye to price, the pool ends up subsidizing less-generous payers – like Medicaid. The pool's generosity also allows hospitals to take lower rates from insurance companies and other payers that negotiate rates.

In addition to the cost-to-charge ratio, the hospitals' payments are also reduced by a payment ratio, which is designed to equitably divvy up available pool funding based how much free care each hospital provides. Hospitals that provide a disproportionately high share of care to the state's poorest residents have historically received higher payment ratios.

However, even taking into account the payment ratio, the pool still ends up paying much more for most procedures than any other third party payer. For example, one hospital lists $4,152 on its chargemaster for a certain type of CT scan, Assuming the hospital's cost-to-charge ratio is 64.48 percent and payment ratio is 85 percent, the pool would pay $2,275.45 to the hospital for a certain type of CT scan performed on an uninsured patient. This payment is far in excess of what any other payer pays the hospital.

Medicare, for instance, pays $272 for the same procedure – about one-eighth the amount the taxpayer-funded pool hands out.

CT scans are a significant pool expense, generating $64.4 million in charges in hospital fiscal year 2004 alone. Since CT scans are used frequently in emergency rooms, any costs shifted to these procedures are eligible for reimbursement not only for free care but also for bad debt payments.

Although technically, the division pays a monthly lump sum of a hospital's aggregate bills and not by individual claims, the Inspector General has used actual chargemaster rates and actual reimbursement formulas to illustrate how the pool system works. Throughout this report, the term "payment" means the result of applying the cost-to-charge and payment ratios to the chargemaster rate. Allowable uncompensated care costs describe charges that have been multiplied by the hospital's cost to charge ratio.

EMERGENCY BAD DEBT PAYMENTS

The pool may reimburse providers for bad debt resulting from emergency services provided to uninsured patients. A claim for emergency bad debt is limited to situations where the patient is uninsured and received emergency or urgent care, the provider has documented that it cannot collect payment from the patient, and the patient has not completed a free care application.

During hospital fiscal years 2003 and 2004 the definition of emergency care eligible for bad debt reimbursement through the pool was governed by 114.6 CMR 10.02. Starting in hospital fiscal year 2005, 114.6 CMR 12.00 replaced 114.6 CMR 10.00. The current regulation incorporates a category of urgent care along with a revised definition of emergency services that are eligible for bad debt reimbursement from the pool. In order for a claim to qualify for bad debt reimbursement, the provider must undertake certain required collection actions and the bill must remain unpaid for at least 120 days.

The Inspector General's demographic analysis of the pool for hospital fiscal years 2003 and 2004 found that approximately 18.3 percent or $418 million in charges were related to emergency bad debt claims.

The Inspector General hired outside auditors to analyze a randomly selected sample of 2,400 claims and perform financial and clinical testing on the pool. The sample included more than 250 emergency bad debt claims, which the auditors examined to determine whether these bills met emergency bad debt standards and should have been paid by the pool.

The auditors found that more than 50 percent of the emergency bad debt claims lacked adequate backup documentation by medical staff to show that emergency care was provided or indicated. One example, highlighted by the auditors of an inappropriately billed emergency bad debt, was a routine physical exam performed on a patient visiting from Jamaica.

These inadequately documented claims represented 23 percent of the total emergency bad debt claim dollars in the audit sample covering the period from Oct. 1, 2002 through Sept. 30, 2004.

The auditors also reviewed the collection efforts followed by the hospitals prior to charging these emergency bad debt costs to the pool. They noted that in approximately 10 percent of the cases, collection efforts were not properly documented in the patient files. As a result, there was no proof that the hospitals made reasonable collection efforts prior to requesting reimbursement for these costs through the pool.

INADEQUATE CLAIMS REVIEW

Lack of accountability and presence of waste, abuse and fraud are problems plaguing health care systems across the country. The Congressional Budget Office estimates that fraud, by itself, increases the cost of health care by 10 percent.

State Auditor A. Joseph DeNucci recently issued a report on MassHealth, the state's Medicaid program, citing MassHealth's "lax fraud detection" and estimating that

hundreds of millions of dollars are being wasted on false or questionable claims. The auditor recommended spending $1.5 million more to police Medicaid spending.

The private insurers, Medicare and Medicaid routinely perform a range of tests, some simple and others technically sophisticated, to detect fraud, abuse and errors. The Division of Health Care Finance and Policy, while requiring hospitals to submit much of the data it needs to test for mistakes, abuse, questionable claims and fraud, does not currently conduct even rudimentary tests for detecting any of these problems. Instead, division personnel told the Inspector General that they collect claims data for analysis and budget compliance purposes only – not to decide whether the claims are appropriate and should be paid.

Currently, the division requires providers to submit claims information on a monthly basis in order to qualify for their monthly budget allocation. These claims are submitted electronically in UB-92 format. The division runs these files through an automated edit process to screen out demographic and claim related issues and problems. There are approximately 300 distinct edit checks performed for each claim file submitted; however, the edit process is primarily focused on ensuring the completeness of the data, the formatting of the data and the validity of character types in specific fields rather than detecting fraud, abusive practices or billing mistakes.

The majority of the edits check to ensure that a required data field is populated. Examples include Provider Name, Provider Address, Patient Name (first and last) and Medical Record Number. Certain edits check for format. For instance, the hospital admission date must include a valid, day, month and year. Other edits check for the presence of specific characters. For example, a zip code field must include numbers.

The edit process also incorporates certain basic logic checks. Examples include:

- Edits which ensure that dates fall within a valid timeframe. For instance, the date in the “Processing Date” field, which describes date the hospital submits the claim to the division, can’t be later than the division received the claim.

- Edits which ensure that reported data is consistent with a valid entry for that data type. For instance, an Inpatient Ancillary Revenue Code must be a valid entry as specified in Federal Register Guidelines.
- Edits which ensure that certain fields contain data if appropriate conditions are present. For instance, all inpatient claims should include a Principal Diagnosis Code.
- Basic edits that ensure that clinical utilization is appropriate based on the patient's gender. For example, a patient's gender must be consistent with the Principal Diagnosis Code. In other words, the division should reject a newborn delivery claim for a male patient.

Based on this edit process, a detailed validation report by claim is sent to each of the providers. This report identifies the claims that failed the edit process and provides descriptions for each of the errors. If the value of the failed claims for any particular month is more than 10 percent of the hospital's fixed monthly payment budget, the hospital must make the appropriate corrections and then resubmit the failed claims in order to have them incorporated as part of the claims database. If less than 10 percent of the claims fail, the entire submission is accepted and the division pays the hospital its monthly appropriation without further review.

The division has eight employees in its internal audit division responsible for administering audits for all 68 hospitals and 53 community health care center organizations in the commonwealth. These eight auditors also are responsible for all nursing homes and other long-term care facilities as well. The number of randomly selected providers audited by the division has varied over the course of the last few pool fiscal years. For pool fiscal year 1999, the division completed audits of one hospital and two community health care centers. For the following pool years, completed audit totals by the division are:

Pool Year	Hospitals	Community Health Centers
2000	9	2
2001	8	0
2002	10	0

Currently, the division has 11 audits under way, including the audit of hospital fiscal year 2003. Agency officials told the Inspector General that because some hospitals have not provided completed claim data to the division, some older audits are still incomplete. Division officials state that the objective of their audits is to ensure that the providers are complying with pool regulations 114.6 CMR 10.00 (Criteria for Determining Free Care at Acute Care Hospitals and Free Standing Community Health Care Centers) and 114.6 CMR 11.00 (Administration of the Uncompensated Care Pool). Their auditors review the data on the Uncompensated Care forms.

To demonstrate the value of auditing and screening Uncompensated Care Pool claims, the Inspector General hired a national claims review company to analyze a sample from the 5.6 million pool claims submitted between hospital fiscal years 2003 and 2005.

For comparative purposes, the firm conducted an academic exercise testing more than 107,000 claims – totaling $221 million in pool charges – for substantial errors that would have triggered a payment rejection by the federal Medicare program or Blue Cross/Blue Shield of Massachusetts. The errors the auditing firm looked for included double-billing, treatments that did not match a patient's diagnosis, invalid diagnoses, lack of medical necessity, uncovered treatments and more than 20 other categories. None of these problems would have triggered rejection by the pool because the Division of Health Care Finance and Policy accepts all claims as long as they are submitted in the correct data format.

The claims review company flagged for further review 79 percent of the 107,000 claims they tested. These claims totaled $66 million in charges. Although many of the errors were likely unintentional – and many were easily curable – the fact that the Division of Health Care Finance and Policy does not check any of these categories leaves a huge opportunity for mistakes, waste, abuse, and even fraud.

For instance, on January 5, 2005, a hospital billed the pool $97.00 for seven separate frequently ordered blood tests to assess liver function. Both Medicare and Blue Cross Blue Shield of Massachusetts would have rejected the claims because all seven tests

are so closely related that these two payers – as well as many others – require doctors to order and bill them as a set called a hepatic function panel. Insurers – and even the pool – have a much lower rate of reimbursement for this bundle of tests. Medicare would have reimbursed the hospital just $11.42 for the required hepatic function bundle. In other words, unbundling the package is equivalent to asking the consumer to pay for a loaf of bread by the total of an inflated slice-by-slice amount.

This was not an isolated case. The auditors found 8,583 other cases of unbundled claims, resulting in more than $2 million in charges to the pool.

The auditors also checked whether the tests and procedures billed to the pool were medically necessary by matching a patient's treatments with the diagnoses. In this sample, the auditors turned up more than 18,000 mismatched treatments and diagnoses, totaling nearly $6 million in charges to the pool.

In one instance, auditors found hospital staff had ordered a head CT scan for a patient with a urinary tract infection. Head CT scans are frequently ordered tests that are appropriate for patients reporting headaches, head and neck injuries, certain cancers as well as many other diagnoses. However, the auditors found more than 1,340 instances where hospital staff ordered a head CT scan without an appropriate diagnosis. Hospitals charge the pool an average of $964 for a head CT scan. The total charge for these mismatched CT scans was $1.3 million.

The claims auditors also found 2,700 cases where the pool paid for a glucose test without a matching diagnosis code that Medicare would accept. Glucose tests are used to measure glucose metabolism levels in diabetics, patients with tuberculosis, chronic infections, alcoholism, coronary heart disease or unexplained skin disease. However, the pool paid for glucose tests with the following mismatched diagnosis codes:

300.0	Anxiety unspecified
922.1	Contusion of chest wall
V600	Lack of housing
462	Acute Pharyngitis
611.72	Lump in Breast

The auditors also found that unlike other payers, the pool will pay multiple evaluation and management charges for a single patient's visit in a hospital-affiliated clinic. For instance, the pool will pay for both hospital overhead and a professional services charge related to the doctor's services. These fees come on top of any procedure or service fee and are either eliminated or discounted by most other payers. The audit found more than 64,000 claims – and $35.5 million in pool charges – that would have been rejected by Medicare because of this type of double-billing.

Other examples of errors that could easily be screened by the pool include diagnoses and/or procedures that are inappropriate for the gender or age of the patient. The company flagged 84 instances of apparent gender/age errors, totaling more than $100,000 in charges to the pool. Another 7,400 claims – with charges totaling $614,000 – were flagged for further review under Medicare edits because a separate payment is not allowed when submitted with another reimbursed service, and 14,200 claims – with charges totaling $8.3 million – would have been flagged by Medicare because the standard of care was apparently inappropriate.

Another area of weakness in the Division of Health Care Finance and Policy's oversight system is its failure to detect obvious overcharging errors.

The Inspector General reviewed hospital outpatient pharmacy charges made to the Uncompensated Care Pool over a three-year period. The review detected some readily apparent overcharging errors, detailed below, that had been made by one hospital in its submittal of pharmacy charges. In total, the Inspector General identified approximately $5 million in such overcharges, comprised of charges with mark-ups of more than 1,000 percent compared to charges submitted by another outpatient pharmacy. The hospital's allowable uncompensated care costs for theses charges are less than $5 million since charges are always reduced by the hospital's cost-to-charge ratio. The Inspector General brought these issues to the attention of the hospital's administrators and they acknowledged that errors occurred that were attributable to data entry and software errors. The Inspector General recommends that the Division of Health Care Finance and Policy audit pharmacy claims to identify overcharging by this hospital.

The following examples demonstrate that the division's electronic claims review system is not administered in a manner that is capable of detecting even the most egregious over billing errors.

- On March 10, 2003, the hospital outpatient pharmacy charged the pool $6,469 for 100 tablets of atorvastatin calcium, commonly known by its brand name Lipitor, for which it should have charged approximately $224. Similar erroneous overcharges for Lipitor during the audit period were more than $1 million.
- On Jan. 18, 2005, the hospital outpatient pharmacy charged the pool $48,517 for 60 syringes of enoxaparin, commonly known by its brand name Lovenox, for which it should have charged approximately $1,800. Similar erroneous overcharges for enoxaparin during the audit period were approximately $540,000.
- On Feb. 5, 2003, the hospital outpatient pharmacy charged the pool $7,826 for 100 tablets of pantoprazole, commonly known by its brand name Protonix, for which it should have charged approximately $398. Similar erroneous overcharges for Protonix during the audit period were approximately $890,000.
- On July 7, 2003, the hospital outpatient pharmacy charged the pool $8,634 for 360 tablets of gabapentin for which it should have charged approximately $468. Similar erroneous overcharges for gabapentin during the audit period were approximately $1.2 million.
- On Feb. 27, 2003, the hospital outpatient pharmacy charged the pool $13,389 for 30 tablets of Triamterene/HCTZ, for which it should have charged approximately $15. Two erroneous overcharges for Triamterene/HCTZ during the audit period totalled approximately $26,748 for this medication.
- On July 23, 2002, the hospital outpatient pharmacy charged the pool $17,612 for 60 tablets of Propranolol HCl, for which it should have charged approximately $28. This represented the sole erroneous overcharge for this medication.
- On Feb. 14, 2003, the hospital outpatient pharmacy charged the pool $2,949 for 6 bottles of latanoprost, for which it should have charged approximately $111. Total overcharges during the audit period for latanoprost were approximately $103,000.

In total, the Inspector General identified more than 5,000 prescription overcharges for approximately 140 medications submitted by this outpatient pharmacy that were allowed by the Division of Health Care Finance and Policy. Each overcharge represented a mark-up of more than 1,000 percent higher than the charges submitted to the pool by

another hospital pharmacy during the same period. In total, this hospital's outpatient pharmacy charged the pool approximately $5.3 million for these prescriptions while the other outpatient pharmacy charges for the same bundle of prescriptions would have totaled approximately $285,000.

OVERUTILIZATION OF MEDICAL SERVICES

Most health care payers have developed reimbursement models and/or audit controls that include diagnosis related groups to limit reimbursements, pre-authorization requirements for treatments, and a variety of reviews to limit the amount of time patients remain in the hospital. However, the Division of Health Care Finance and Policy continues to reimburse hospitals for all inpatient days without systematically reviewing the medical necessity of hospitalization.

Under the pool's reimbursement system, there is no program to train physicians to hold down costs and no review of hospitals' utilization patterns.

There are, however, limited guidelines to require that services are reasonable and medically necessary and ensure the protection of the integrity of the pool. Both the Centers for Medicaid and Medicare Services, the federal agency that oversees Medicaid, and MassHealth use MassPRO, a private vendor, to audit their claims and review the appropriateness of services and medical necessity. In August 2005, the division contracted with MassPRO to perform utilization review on claims from the pool. The scope of the project is to review 10,000 claims to identify cases that were inappropriately billed to pool. Data from hospitals was requested in September 2005. This audit, mandated by the Legislature in 2003 is the Division of Health Care Finance and Policy's first clinical audit of pool claims. This audit could be the first step in considering appropriateness of care, medical necessity, correct coding and other compliance issues for pool claims, and may determine if sufficient clinical data is being documented to justify treatment.

The division recently clarified that certain services that are not eligible for reimbursement, including ambulance services, transitional care unit services, skilled

nursing services, home health services, residential treatment programs and certain limitations on family planning or contraceptive services. Despite these limits, there are still many services that the Uncompensated Care Pool covers that other payers – including MassHealth - do not. Often, as opposed to being the payer of last resort, providers see the pool as a payer of all services.

MEDICAL NECESSITY

The definition and enforcement of medical necessity criteria is key to properly managing pool resources. There are several definitions of medical necessity included in the various statutes, regulations and guidelines that govern the Uncompensated Care Pool. The state law that governs medical necessity for the pool is M.G.L. c. 118G. Medical necessity is defined and mentioned in a number of areas of the statute.

In Chapter 118G, Section 1, Definitions:

> *"Medically necessary services", medically necessary inpatient and outpatient services as mandated under Title XIX of the Federal Social Security Act. Medically necessary services shall not include: (1) non-medical services, such as social, educational and vocational services; (2) cosmetic surgery; (3) canceled or missed appointments; (4) telephone conversations and consultations; (5) court testimony; (6) research or the provision of experimental or unproven procedures including, but not limited to, treatment related to sex-reassignment surgery, and pre-surgery hormone therapy; and (7) the provision of whole blood; and provided, however, that administrative and processing costs associated with the provision of blood and its derivatives shall be payable.*
>
> *"Emergency services", medically necessary health care services provided to an individual with an emergency medical condition.*
>
> *"Emergency medical condition", a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the person or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).*
>
> *"Free care", the following medically necessary services provided to individuals determined to be financially unable to pay for their care, in whole or in part, pursuant to applicable regulations of the division: (1) emergency, urgent, and*

critical access services provided by acute hospitals; (2) services provided by community health centers; and (3) patients in situations of medical hardship in which major expenditures for health care have depleted or can reasonably be expected to deplete the financial resources of the individual to the extent that medical services cannot be paid, as determined by regulations of the division.

The state regulation governing the pool which addresses medical necessity is 114.6 CMR 12.02 (2005).

Medically Necessary Service. A service that is reasonably expected to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity. Medically necessary services shall include inpatient and outpatient services as mandated under Title XIX of the Federal Social Security Act…

Urgent Care. Medically necessary services provided in a hospital or community health center after the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person would believe that the absence of medical attention within 24 hours could reasonably expect to result in:

(a) placing a patient's health in jeopardy;

(b) impairment to bodily function, or

(c) dysfunction of any bodily organ or part.

Urgent care services are provided for conditions that are not life-threatening and do not pose a high risk of serious damage to an individual's health.

Title XIX of the Social Security Act, which is referenced in the state law and regulation, allows considerable flexibility within the states' Medicaid plans. A state's Medicaid program **must offer** medical assistance for certain basic services to most categorically needy populations in order to receive federal matching funds. These services include the following:

- Inpatient hospital services;
- Outpatient hospital services;
- Prenatal care;
- Vaccines for children;
- Physician services;
- Nursing facility services for persons aged 21 or older;

- Family planning services and supplies;
- Rural health clinic services;
- Home health care for persons eligible for skilled-nursing services;
- Laboratory and x-ray services;
- Pediatric and family nurse practitioner services;
- Nurse-midwife services;
- Federally qualified health center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings, and
- Early and periodic screening, diagnostic, and treatment services for children under age 21.

If a state chooses to include the medically needy population, the state plan **must provide**, as a minimum, the following services:

- Prenatal care and delivery services for pregnant women;
- Ambulatory services to individuals under age 18 and individuals entitled to institutional services, and
- Home care services to individuals entitled to nursing facility services.

If the state plan includes services either in institutions for mental diseases or in intermediate care facilities for the mentally retarded, federal regulations set out a range of services that must be offered to medically needy groups.

Starting Jan. 1, 2005, the Division of Health Care Finance and Policy put some restriction on where medically necessary or critical access services may be performed. The new regulation, 114.6 CMR 12.03 (2) Permissible Services (2005), attempts to guide patients to lower cost community health centers and local hospitals rather than sending all pool patients to the highest-priced acute care hospitals in Boston:

(a) Providers may submit claims only for services that are Medically Necessary.
(b) Site of Service.

1. *Hospitals. Effective January 1, 2005, a Hospital may submit claims only for Critical Access Services. Critical access services are medically necessary Hospital Services, including inpatient services, certain outpatient services, and services provided in a hospital-licensed facility located off the hospital campus that is a Hospital Licensed Health Center, a school-based health*

center, or other satellite location. Critical access services do not include on-campus outpatient clinic visits for non-emergent or non-urgent Primary Care unless:

a. there is no Community or Hospital Licensed Health Center providing both adult and pediatric Primary Care within five miles driving distance of the hospital campus as determined by the division; or

b. the patient's medical condition is so severe or complex that his/her primary care cannot be adequately provided in a community setting. This determination shall be made by the treating clinician, and must be a reasonable clinical judgment based on prevailing standards of care. The reasons for such a determination must be documented in the patient's record.

The Inspector General's review of the pool's administrative system found that medical necessity criteria should be better defined and standardized.

MENTAL HEALTH AND SUBSTANCE ABUSE

Currently, 21 percent of pool inpatient charges – $55 million a year – are for mental health and substance abuse treatment services.

This percentage could easily be higher when other disorders directly related to mental health and substance abuse issues such as nervous system disorders or trauma caused by drunk driving.

The clinical services provided to mental health and substance abuse pool patients currently do not have any clinical review criteria for admissions, length of stay, level of care or medications. These are critical components included in any appropriate oversight of mental health and substance abuse treatment services, which are used by MassHealth and most other payers, to limit costs.

The Inspector General concludes that the pool should adopt reasonable clinical review criteria.

ELIGIBILITY

In order to be eligible for free care through the Uncompensated Care Pool, a patient must be a resident of Massachusetts, lack health insurance, and fall within certain income guidelines. These requirements are summarized below:

Residency: The patient must be a Massachusetts resident. A resident is defined as someone who lives in Massachusetts and intends to stay in Massachusetts indefinitely. This is not contingent upon citizenship or immigration status. The pool will pay for emergency and urgent care for non-residents.

Income: The patient must fall within the following income guidelines.

- The pool will pay for all medical care (full free care) for people with family income under 200 percent of federal poverty guidelines;
- The pool will pay for medical care for people with family income between 201 percent and 400 percent of federal poverty guidelines but the patient is required to pay a deductible (partial free care);
- The pool, under the medical hardship category, will cover expenses for patients with extraordinarily high medical expenses regardless of their income.

Health Insurance: The pool pays for medical care for low-income patients without health insurance. It also pays for co-pays, deductibles and non-covered services for patients with health insurance who cannot afford these charges.

Residency:

The audit firm contracted by the Inspector General reviewed Uncompensated Care Pool claims, comparing the address on the application with the backup documentation provided to the hospital as required by pool regulations. Documents proving residency include copies of drivers' licenses, utility bills, pay stubs, voter identification cards, and affidavits. One hospital has a special agreement with the division that waives some documentation requirements so this provider's results were excluded from the auditor's analysis. For hospital fiscal years 2003, 2004, and the first five months of 2005, the

auditors found that 12.9 percent, 5.5 percent, and 6.4 percent respectively of the claims tested lacked adequate documentation supporting residency status.

Income:

For patients whose incomes qualify for full free care, hospitals may charge the pool for all eligible services. On the other hand, if a patient is only eligible for partial free care, he must meet an annual deductible before the hospital can charge the pool. A patient's annual deductible amount is equal to 40 percent of the difference between the patient's family income and 200 percent of his federal poverty level within the federal poverty income guidelines. A patient's particular federal poverty level is based on his family size and the rate published every calendar year by the federal Department of Health and Human Services.

A patient may still be eligible for free care if his family income is greater than 400 percent of federal poverty income guidelines if the patient meets the qualifications for medical hardship status. Medical hardship qualifications depend on the patient's allowable medical expenses and all of his available income and assets. Income eligibility standards apply only to people who completed a free care application.

Two important factors in determining a patient's free care eligibility are family income and family size. The definitions for these two terms remain consistent from hospital fiscal year 2003 to 2004, becoming slightly more restrictive in hospital fiscal year 2005. For hospital fiscal years 2003 and 2004, 114.6 CMR 10.00 defines family income as the sum of annual earnings and cash benefits from all sources before taxes, less payments made for alimony and child support. Similarly, the regulation defines a family as the patient, spouse, any minor dependents living in the household, and any unborn children. In hospital fiscal year 2005, 114.6 CMR 12.00 defines family income as the sum of gross earned and unearned income as defined in 130 CMR 506.003. Gross earned income is the total amount of compensation received for work or services performed and gross unearned income is the total amount of income that does not directly result from the individual's own labor. The regulation also defines a family as persons that live

together and consists of (a) a child or children under age 19, any of their children, and their parents; (b) siblings under age 19 and any of their children that live together even if no adult parent or caretaker relative is living in the home; or (c) a child or children under age 19, any of their children, and their caretaker relative when no parent is living in the home. The definition of a family includes a child that is absent from the home to attend school.

Prior to hospital fiscal year 2005, patients applied for free care with the help of hospital personnel, giving hospitals rather than the division the responsibility to make free care eligibility determinations. Hospital personnel also assist low-income patients in applying for other government aid programs, including MassHealth. Free care patients must fill out a free care application and in most instances provide supporting documentation, showing they meet residency and income qualifications.

The financial and clinical audit commissioned by the Inspector General found that a significant percentage of free care applications lacked adequate backup documentation to prove income eligibility. Auditors found that approximately 14 percent of the claims examined from hospital fiscal year 2003, 7.7 percent of claims from hospital fiscal year 2004 and 9 percent of claims from the first five months of hospital fiscal year 2005 lacked sufficient documentation to support income eligibility. These numbers do not include data from the hospital with the special arrangement waiving documentation requirements.

To determine the adequacy the division's pool regulations regarding free care eligibility determinations, the Inspector General decided to independently verify free care eligibility status of pool users. To do this, the Inspector General conducted its own review of patient eligibility by comparing the paperwork submitted to the pool with information filed by employers on the Department of Revenue's Form WR-1, Employer's Quarterly Report of Wages Paid. Massachusetts businesses with at least one employee are required to submit these quarterly reports for each employee who either lives or works in Massachusetts.

Over the period reviewed, the Inspector General's audit of eligibility based on income identified 25,580 ineligible individuals who received free care totaling more than $36 million.

In hospital fiscal year 2003, the pool paid for medical care for 223,887 patients (accounting for 1.38 million claims and $780 million in charges) who applied for free care. Out of these, the Inspector General matched 105,402 patients to the Department of Revenue's wage reporting files. (None of these figures include emergency bad debt claims.)

The Inspector General found that the vast majority of applicants qualified for some form of free care. However, less than 1 percent under-reported their incomes and had annual earned wages greater than 400 percent of their respective federal poverty levels and, therefore, should have been ineligible for free care. However, 584 patients or 92 percent of these patients were approved for full or partial free care. The associated charges to the pool for these people totaled $2.7 million. Another 8,019 patients or 20.8 percent of patients who used the pool and under-reported their family income had annual earned wages between 201 percent and 400 percent of federal poverty income guidelines, making them eligible for only partial free care. However, 6,329 patients of these people were approved for full free care and the associated charges to the pool for these people totaled $7 million.

The combined amount of these improper charges billed to the pool for reimbursement in hospital fiscal year 2003 totaled approximately $9.7 million.

In hospital fiscal year 2004, the pool paid to treat 259,016 patients (accounting for 2.1 million claims and $1.1 billion) who filled out a free care application. Out of these, 146,488 patients were positively matched to Department of Revenue's wage match reporting files.

The Inspector General found that 41 percent of them under-reported their family income on their free care applications, but less than 1 percent of these patients had annual

earned wages greater than 400 percent of their respective federal poverty levels that would have made them ineligible for free care. The associated inappropriate charges to the pool for these patients totaled $5.4 million. Another 13,869 patients who under-reported their family income had annual earned wages between 201 percent and 400 percent of federal poverty levels, making them eligible for partial free care only. The associated inappropriate charges to the pool for these patients totaled approximately $14.5 million.

The combined amount of these improper charges billed to the pool for reimbursement in hospital fiscal year 2004 totaled approximately $19.9 million.

In the first five months of hospital fiscal year 2005, the pool paid to treat 130,764 patients (accounting for 693,145 claims and $310 million in charges) who filled out a free care application. Out of these, 67,383 patients or 80 percent were positively matched to Department of Revenue's wage match reporting files.

The Inspector General found that 40 percent of the 67,383 patients who used the pool under-reported their family income on their free care applications. Of these, 600 patients, or less than 1 percent of the total, had annual earned wages greater than 400 percent of their respective federal poverty levels and, therefore, should have been ineligible for free care. The associated charges to the pool for these people totaled $1.6 million. Five thousand seven hundred twenty-one patients or 82.9 percent of these patients were approved for full free care when they should have been approved for partial free care. The associated charges for these patients totaled $5.6 million.

The combined amount of improper charges billed to the pool for reimbursement in the first five months of hospital fiscal year 2005 totaled approximately $7.2 million.

Overview of Claims Reviewed by the Inspector General

	HFY2003	HFY2004	HFY2005 partial
Total number of users	358,048	403,326	181,271
Total number of reviewed claims	1,600,268	2,378,652	759,756
Total Charges to the pool	$956,635,830	$1,338,218,881	$372,769,198

Patients who used the pool through free care applications	223,887	259,016	130,764
Charges to the pool	$779,789,034	$1,101,387,127	$310,167,638
Patients who used the pool through ERBD	152,899	168,756	53,908
Charges to the pool	$178,767,794	$238,666,707	$63,359,229

Statistics on the Verified Free Care Eligibility Status of Pool Users

	HFY2003	HFY2004	HFY2005 partial
Number of Patients matched with DOR's Income Data	105,402	146,488	67,383
Associated charges	$466,753,986	$712,533,251	$170,391,725
TOTAL IMPROPER CHARGES	$9,669,513	$19,893,471	$7,155,736

The Inspector General identified three patients who, based on Department of Revenue data, each made more than $100,000 in hospital fiscal year 2004 but for whom the pool was charged $33,199. The Inspector General used LexisNexis and other internet sources to find out more about these people.

Patient A: Department of Revenue records indicate this patient had several low-paying jobs, supporting the $13,000 income reported on the free care application. However, in one of the quarters preceding the hospital visit, this patient received a $345,000 payment from a local company. Department of Revenue records list his income as $350,000. The total Uncompensated Care Pool charge for this patient's claim was $2,573.

Patient B: This patient provided identifying information on the free care application that matched records found through Lexis. According to the Department of Revenue records, the patient did not earn any income in the quarter in which free care services were provided; however, his income during the previous four quarters was $198,000. The patient claimed on his free care

application that he had no income. The total Uncompensated Care Pool charge for this patient's claim was $5,329.

Patient C: This patient's identifying information on the free care application matched records found through Lexis. The patient reported having no income and did not list an employer on the application; however, Department of Revenue files show $118,000 in earnings for the year. In 2003, this patient sold a home for $400,000 and had a Porsche 911 registered in his name. Twice in 2003, this person tried to file for Chapter 13 bankruptcy but both cases were dismissed. (Chapter 13 helps individuals or small scale business owners retain non exempt properties and pay back creditors under a repayment plan.) This individual is identified as a principal in three businesses. In a news article he is referred to as an investment banker. The total Uncompensated Care Pool charge for this patient's claim was $25,297.

These examples demonstrate pool applicants that the Virtual Gateway should flag for further income verification.

Other Health Insurance Coverage:

MassHealth

Part of the Inspector General's mandate was to determine whether people who should be insured through Medicaid are instead getting their health care through the pool. In order to determine whether hospitals and the state were directing eligible patients to MassHealth – rather than placing them into the pool – the Inspector General submitted the personal identifying information for 2,400 actual pool claims to MassHealth. MassHealth returned this information to the Inspector General along with a determination of MassHealth eligibility status and the aid category indicating which MassHealth program the person qualified for.

The Inspector General met with staff of the Executive Office of Health and Human Services to discuss the MassHealth eligibility determinations. The Executive Office said some aid categories – specifically MassHealth Limited, Mental Health Services only,

Emergency Aid to Elderly, Disabled, and Children (EAEDC), Pharmacy only, and Detox – do not provide comprehensive benefits. Because of this, claims for patients in these programs are reimbursable by the pool.

On Oct. 1, 2004, the Executive Office of Health and Human Services launched the Virtual Gateway, an automated on-line system to determine eligibility for the pool. While this new system is designed to prevent people eligible for MassHealth from qualifying for free care, the current payment system is based on payments hospitals received in previous fiscal years. These base payments include claims for people who were eligible for MassHealth.

The Inspector General used information derived from its 2,400-claim sample to estimate the financial impact of MassHealth eligible patients on the pool as a whole. The Inspector General found that in hospital fiscal year 2003, 12.3 percent, or approximately 44,000 of all pool users were eligible for a MassHealth program. Overall, the Inspector General found that 8.7 percent, or approximately 31,000, of all pool users were eligible for full benefits under MassHealth, accounting for $58.4 million in free care charges.

In hospital fiscal year 2004, 13.5 percent, or approximately 54,000 pool users were found to be eligible for MassHealth at the time of service. When removing those eligible for MassHealth Limited and other restrictive benefit programs, those eligible for full benefit MassHealth programs accounted for 9.2 percent or approximately 37,000 of all free care users. Hospitals charged the pool $126 million to care for these patients.

The Inspector General found that for claims submitted to the pool during the first five months of hospital fiscal year 2005, 13.4 percent were for patients eligible for a MassHealth program and 10 percent were eligible for a non-restrictive MassHealth program. MassHealth eligible patients for non-restrictive benefit programs accounted for approximately $26.3 million in free care charges.

MassHealth Eligible Statistics

	Combined	HFY2003	HFY2004	HFY2005 partial
Sample Size (Claims)	2,425	813	806	806
Eligible for MassHealth	317	100	109	108
Percent Eligible for MassHealth	13.1%	12.3%	13.5%	13.4%
Eligible for Non-Restrictive MassHealth plan	226	71	74	81
Percent Eligible for non-restrictive MassHealth plan	9.3%	8.7%	9.2%	10.0%

Charges Associated with MassHealth Eligible

	Combined	HFY2003	HFY2004	HFY2005 partial
Charges for those eligible for non-restricted MassHealth plans	$116,508	$32,795	$44,788	$38,926
Charges to the pool for the sample analyzed	$1,460,195	$536,957	$476,201	$447,038
Percent of charges for those eligible for non-restricted MassHealth plans	7.98%	6.1%	9.4%	8.7%

Estimated MassHealth Eligible Claims

	Total Claims	Percent of non-restricted MassHealth eligible claims in sample	Number of non-restricted MassHealth eligible claims in each hospital fiscal year
HFY03	1,360,393	8.7%	118,804
HFY04	2,086,294	9.2%	191,546
HFY05	551,879	10.0%	55,462

Estimated MassHealth Eligible Charges

	Total Charges to the Pool	Percent of non-restricted MassHealth eligible charges in sample	Charges attributable to non-restricted MassHealth eligibles in each hospital fiscal year
HFY03	$956,635,830	6.1%	$58,426,353
HFY04	$1,338,218,882	9.4%	$125,863,547
HFY05	$301,622,295	8.7%	$26,263,602

Student Health Insurance:

State law requires that every full-time and part-time student enrolled in an institution of higher learning in Massachusetts have health insurance, either through their school or in a health benefit plan with comparable coverage. A part-time student is defined as a student participating in at least 75 percent of the full-time curriculum. One of the primary reasons for this mandatory health insurance is to reduce the utilization of the pool by students.

Included as part of the random claim samples selected for testing were claims for treating college students. For these student-related charges to the pool, the Inspector General reviewed hospital records to determine whether the student provided an appropriate insurance policy to the hospital and, if not, whether the hospital clearly documented the reason why an insurance policy was not required.

The Inspector General's review found that the documentation supporting student-related charges to the pool was inadequate. Only 23 percent of the charges for part-time students had reasonable supporting documentation. The majority of the part-time student charges, 77 percent, lacked basic information about the student's school, including the name, location or number of classes the student was taking. For full-time students, the Inspector General also found that 46 percent of the charges lacked adequate supporting documentation. In three of these cases, no insurance was identified for the student. In the other three cases, although an insurance carrier was identified, the pool was charged for the entire service. There was no evidence of billing to the insurance company.

Automobile Insurance Coverage for Accidents:

When applying for free care, patients are required to identify whether they are seeking free care due to a motor vehicle accident. They also are required to identify whether they have a lawsuit or other insurance claim pending for coverage for this illness or injury.

As part of this audit, the Inspector General reviewed supporting documentation for motor vehicle accident-related claims to determine whether the patient, driver and/or owner of the motor vehicle had auto insurance and whether a claim was submitted to the insurer.

The Inspector General found that supporting documentation for insurance reimbursement of motor vehicle accident claims was inadequate. The Inspector General found no documentation supporting follow-up by the hospital to obtain insurance settlement payments – even if the patient reported a pending lawsuit or insurance claim.

DEMOGRAPHICS

Residency

Prior to hospital fiscal year 2005, both Massachusetts residents and out-of-state residents could apply for free care, although non-residents were limited to emergency services and urgent care. Massachusetts residents could draw on the pool for any medically necessary service, including preventive care.

Since October 2004, only Massachusetts residents have been allowed to apply for free care. However, providers are still permitted to charge the pool for treating out-of-state patients who fail to pay their bills as emergency bad debt.

The Inspector General used the zip codes provided by patients to determine where the applicants lived. The vast majority of free care patients – 96 percent in hospital fiscal year 2004 – gave local addresses when they applied for free care. From October 2002 to March 2005, out-of-state patients accounted for more than $65.9 million in charges to the pool.

The following tables show out-of-state usage for hospital fiscal years 2003 and 2004 and part of 2005:

HFY2003 Top 10 States by Self Reported Address

	Pool Charges		Number of Claims		Number of Patients	
MA	$914,436,455	95.59%	1,569,251	98.06%	358,725	94.66%
N/A	$15,737,682	1.65%	15,873	0.99%	9,476	2.50%
NH	$8,290,558	0.87%	4,470	0.28%	3,043	0.80%
RI	$3,486,580	0.36%	2,371	0.15%	1,602	0.42%
CT	$3,406,514	0.36%	1,137	0.07%	830	0.22%
NY	$2,213,990	0.23%	1,609	0.10%	1,248	0.33%
FL	$1,361,826	0.14%	1,044	0.07%	758	0.20%
VT	$1,307,794	0.14%	315	0.02%	211	0.06%
ME	$1,092,112	0.11%	660	0.04%	463	0.12%
CA	$778,385	0.08%	412	0.03%	300	0.08%

HFY2004 Top 10 States by Self Reported Address

	Pool Charges		Number of Claims		Number of Patients	
MA	$1,295,764,222	96.83%	2,355,503	99.03%	415,654	96.30%
NH	$11,616,518	0.87%	5,334	0.22%	3,373	0.78%
N/A	$9,986,823	0.75%	6,055	0.25%	4,230	0.98%
CT	$4,341,761	0.32%	1,128	0.05%	846	0.20%
RI	$4,265,278	0.32%	2,734	0.11%	1,746	0.40%
NY	$2,110,741	0.16%	1,716	0.07%	1,268	0.29%
FL	$1,734,242	0.13%	1,187	0.05%	876	0.20%
ME	$1,322,378	0.10%	758	0.03%	507	0.12%
IL	$790,578	0.06%	136	0.01%	115	0.03%
VT	$783,465	0.06%	369	0.02%	219	0.05%

HFY2005 Top 10 States by Self Reported Address

	Pool Charges		Number of Claims		Number of Patients	
MA	$363,218,532	97.44%	754,110	99.26%	177,248	97.57%
N/A	$2,562,773	0.69%	1,037	0.14%	774	0.43%
NH	$2,285,117	0.61%	1,348	0.18%	1,014	0.56%
RI	$915,465	0.25%	599	0.08%	468	0.26%
CT	$848,706	0.23%	373	0.05%	291	0.16%
NY	$635,730	0.17%	509	0.07%	434	0.24%
FL	$389,464	0.10%	331	0.04%	266	0.15%
VT	$267,757	0.07%	79	0.01%	59	0.03%
NC	$250,385	0.07%	68	0.01%	51	0.03%
ME	$183,838	0.05%	154	0.02%	129	0.07%

Within Massachusetts, more than half of all patients who used the pool are from Suffolk and Middlesex counties. While those two counties account for 33 percent of the state's population, these patients account for more than half of all charges to the pool every year. The following tables show pool usage by county in hospital fiscal years 2003 and 2004 and part of 2005:

HFY2003 MA Counties

COUNTY	Pool Charges	% of Total Charges	Pool Claims	% of Total Claims	Pool Patients	% of Total Pool Patients
SUFFOLK	$320,971,522	33.55%	743,280	46.45%	128,149	33.82%
MIDDLESEX	$215,801,593	22.56%	365,554	22.84%	68,308	18.03%
ESSEX	$77,718,823	8.12%	101,844	6.36%	36,328	9.59%
WORCESTER	$61,402,658	6.42%	63,121	3.94%	26,647	7.03%
NORFOLK	$60,373,703	6.31%	93,940	5.87%	22,555	5.95%
PLYMOUTH	$54,257,012	5.67%	62,154	3.88%	20,638	5.45%
BRISTOL	$42,084,034	4.40%	47,722	2.98%	19,960	5.27%
HAMPDEN	$35,542,347	3.72%	36,747	2.30%	15,064	3.98%
BARNSTABLE	$19,391,879	2.03%	21,155	1.32%	8,730	2.30%
BERKSHIRE	$12,250,493	1.28%	13,887	0.87%	5,715	1.51%
FRANKLIN	$6,290,872	0.66%	7,110	0.44%	2,518	0.66%
HAMPSHIRE	$5,559,987	0.58%	10,120	0.63%	2,918	0.77%
NANTUCKET	$1,658,336	0.17%	2,129	0.13%	1,030	0.27%
DUKES	$1,133,188	0.12%	488	0.03%	165	0.04%

HFY2004 MA Counties

COUNTY	Pool Charges	% of Total Charges	Pool Claims	% of Total Claims	Pool patients	% of Total Pool Patients
SUFFOLK	$448,339,632	33.50%	1226258	51.55%	143592	33.27%
MIDDLESEX	$289,618,140	21.64%	487,490	20.49%	77,954	18.06%
ESSEX	$110,766,338	8.28%	134,469	5.65%	42,373	9.82%
WORCESTER	$96,629,423	7.22%	83,486	3.51%	33,103	7.67%
NORFOLK	$91,463,893	6.83%	147,332	6.19%	25,394	5.88%
PLYMOUTH	$78,244,010	5.85%	91,957	3.87%	24,016	5.56%
BRISTOL	$61,372,533	4.59%	64,170	2.70%	24,094	5.58%
HAMPDEN	$55,304,411	4.13%	53,275	2.24%	19,831	4.59%
BARNSTABLE	$25,194,292	1.88%	25,520	1.07%	10,034	2.32%
BERKSHIRE	$17,069,925	1.28%	18,580	0.78%	7,066	1.64%
HAMPSHIRE	$9,565,332	0.71%	13,001	0.55%	4,322	1.00%

FRANKLIN	$8,736,077	0.65%	7,638	0.32%	2,861	0.66%
DUKES	$2,028,123	0.15%	900	0.04%	337	0.08%
NANTUCKET	$1,432,086	0.11%	1,427	0.06%	677	0.16%

HFY2005 MA Counties

COUNTY	Pool Charges	% of Total Charges	Pool Claims	% of Total Claims	Pool Patients	% of Total Pool Patients
SUFFOLK	$125,657,562	33.71%	423,160	55.70%	68,844	37.90%
MIDDLESEX	$75,941,196	20.37%	135,977	17.90%	34,678	19.09%
WORCESTER	$36,095,073	9.68%	29,169	3.84%	14,088	7.75%
ESSEX	$26,875,813	7.21%	34,267	4.51%	14,377	7.91%
NORFOLK	$24,823,647	6.66%	46,153	6.07%	10,622	5.85%
PLYMOUTH	$24,229,053	6.50%	29,555	3.89%	10,373	5.71%
BRISTOL	$17,458,375	4.68%	18,678	2.46%	9,415	5.18%
HAMPDEN	$12,527,355	3.36%	14,700	1.93%	6,672	3.67%
BARNSTABLE	$8,426,088	2.26%	9,329	1.23%	4,444	2.45%
BERKSHIRE	$6,452,715	1.73%	6,930	0.91%	3,556	1.96%
HAMPSHIRE	$2,224,876	0.60%	3,752	0.49%	1,468	0.81%
FRANKLIN	$1,642,832	0.44%	1,736	0.23%	874	0.48%
NANTUCKET	$504,365	0.14%	528	0.07%	329	0.18%
DUKES	$330,455	0.09%	176	0.02%	65	0.04%

Just as Suffolk County accounts for a disproportionate share of pool charges, Boston residents use the pool more intensively than residents of any other community. While Boston makes up less than 10 percent of the state's population, its residents generate more than 28 percent of the charges billed to the pool. The following tables show the top 10 cities and towns using the pool in hospital fiscal years 2003 and 2004 and part of 2005.

HFY2003 Top 10 Cities/Towns

CITY	Pool Charges	% of Total Charges	Pool Claims	% of Total Claims	Pool Patients	% of Total Pool Patients
BOSTON	$268,439,399	28.06%	633,886	39.61%	109,258	28.83%
SOMERVILLE	$40,052,201	4.19%	87,574	5.47%	12,236	3.23%
CAMBRIDGE	$31,587,802	3.30%	66,064	4.13%	8,873	2.34%
CHELSEA	$26,889,898	2.81%	52,809	3.30%	9,370	2.47%
BROCKTON	$26,659,562	2.79%	34,456	2.15%	10,164	2.68%

WORCESTER	$26,139,743	2.73%	25,375	1.59%	9,791	2.58%
LYNN	$22,654,150	2.37%	35,062	2.19%	10,449	2.76%
EVERETT	$21,706,960	2.27%	41,321	2.58%	7,191	1.90%
REVERE	$21,484,618	2.25%	46,410	2.90%	7,930	2.09%
MALDEN	$19,589,208	2.05%	35,849	2.24%	6,195	1.63%

HFY2004 Top 10 Cities/Towns

CITY	Pool Charges	% of Total Charges	Pool Claims	% of Total Claims	Pool Patients	% of Total Pool Patients
BOSTON	$379,421,449	28.35%	1,079,381	45.38%	123,146	28.53%
SOMERVILLE	$51,701,466	3.86%	111,077	4.67%	12,589	2.92%
WORCESTER	$40,474,369	3.02%	34,201	1.44%	12,403	2.87%
CAMBRIDGE	$39,920,352	2.98%	81,281	3.42%	8,739	2.02%
BROCKTON	$37,711,684	2.82%	53,571	2.25%	12,096	2.80%
LYNN	$32,209,683	2.41%	48,316	2.03%	12,622	2.92%
CHELSEA	$31,264,164	2.34%	65,885	2.77%	9,830	2.28%
REVERE	$30,703,401	2.29%	66,276	2.79%	8,863	2.05%
MALDEN	$28,363,649	2.12%	50,494	2.12%	7,305	1.69%
EVERETT	$28,211,976	2.11%	55,076	2.32%	8,212	1.90%

HFY2005 Top 10 Cities/Towns

CITY	Pool Charges	% of Total Charges	Pool Claims	% of Total Claims	Pool Patients	% of Total Pool Patients
BOSTON	$108,769,004	29.18%	383,467	50.47%	60,480	33.29%
WORCESTER	$17,436,605	4.68%	12,459	1.64%	5,629	3.10%
SOMERVILLE	$13,027,241	3.49%	29,308	3.86%	6,365	3.50%
BROCKTON	$12,391,499	3.32%	17,919	2.36%	5,796	3.19%
CAMBRIDGE	$9,611,014	2.58%	22,533	2.97%	4,353	2.40%
MALDEN	$7,806,987	2.09%	15,216	2.00%	3,494	1.92%
REVERE	$7,756,803	2.08%	18,287	2.41%	4,422	2.43%
CHELSEA	$7,507,263	2.01%	17,549	2.31%	4,718	2.60%
QUINCY	$7,411,995	1.99%	15,135	1.99%	3,324	1.83%
LYNN	$7,352,414	1.97%	12,548	1.65%	4,454	2.45%

The Inspector General compared pool users' home addresses with the location where they received their care. In hospital fiscal year 2004, the Inspector General found that more than half of the free care provided at the 12 Boston hospitals was are to pool

users who live outside the city of Boston. The Inspector General found that nearly half of the pool users who live in Norwood, for example, did not go to the local hospital, Caritas Norwood Hospital. These patients accounted for 69 percent of Norwood pool users' charges. Thirty percent of Norwood pool users went to Boston Medical Center for their care. More than half of these patients' claims were for prescriptions from Boston Medical Center's outpatient pharmacy. Boston Medical Center and Massachusetts General Hospital each account for 20 percent of the total claims charged to the pool for treating Norwood residents.

Suburbanites travel to Boston hospitals in part because local hospitals' reimbursements are lower. All hospitals are required by state and federal law to screen emergency room patients; however, hospitals don't have to provide non-emergency care. It appears that suburbanites are migrating to expensive Boston hospitals for follow-up visits and prescriptions because they are unavailable at local hospitals, which don't get paid by the Uncompensated Care Pool for these extra services.

Free Care Provided at the 12 Boston Area Hospitals

	Charges to the Pool	Number of Claims	Number of Users
Care Provided to Boston Residents	$309,463,770	765,485	93,737
Care Provided to Non-Boston Residents	$335,059,164	516,199	57,921

Free Care Usage by Norwood Residents

	Charges to the Pool	Number of Claims	Number of Users
Norwood Caritas Hospital	$1,549,469	1,202	683
Boston Medical Center	$935,602	2,778	239
Massachusetts General Hospital	$909,734	415	28
All other providers	$1,614,537	2,369	520

Employment status and Income

The Inspector General matched Uncompensated Care Pool application records against Department of Revenue's quarterly wage reports and found that 90 percent of all pool users earn less than $20,000 a year. Less than one percent made more than $40,000.

Annual Income Statistics for Pool Users

	HFY2003		HFY2004		HFY2005 partial	
Users Matched	105,402		146,488		67,383	
Users Analyzed	21,600	100%	133,942	100%	71,569	100%
Zero Income	7,031	32.55%	40,540	30.27%	20,878	29.17%
$0.01 - $9,999	8,454	39.14%	50,993	38.07%	25,300	35.35%
$10,000 -$19,999	4,177	19.34%	27,861	20.80%	16,064	22.45%
$20,000 - $29,999	1,448	6.70%	10,666	7.96%	6,755	9.44%
$30,000 - $39,999	363	1.68%	2,747	2.05%	1,843	2.58%
More than $40,000	127	0.59%	1,135	0.85%	729	1.02%
Mean Income	$10,209		$10,966		$11,934	
Median Income	$3,440		$4,362		$5,305	
Mode	$0.00		$0.00		$0.00	

In hospital fiscal year 2003, the Inspector General found that 67.5 percent of all patients who used the pool by filling out an application were employed. Out of the population of pool patients who were employed, 32.6 percent worked for more than one employer in a given quarter and 67.4 percent worked for only one employer in a given quarter. The Inspector General also found that 41.7 percent worked for more than one employer in a given year and 58.3 percent worked for only one employer in a given year.

The statistics were similar in hospital fiscal year 2004: 67 percent patients who used the pool by filling out an application were employed and 32.9 percent were unemployed.
Out of the population of pool patients who were employed, 40.9 percent worked for more than one employer in a given quarter and 59 percent worked for only one employer in a given quarter. The Inspector General also found that 43.9 percent worked for more than one employer in a given year and 56.1 percent worked for only one employer in a given year.

In the first five months of hospital fiscal year 2005, the Inspector General found that 69.2 percent of all patients who used the pool by filling out an application were employed and 30.7 percent were unemployed.

Out of the population of pool patients who were employed, 37.8 percent worked for more than one employer in a given quarter and 62.2 percent worked for only one employer in a given quarter. The Inspector General also found that 41.9 percent worked for more than one employer in a given year and 58.1 percent worked for only one employer in a given year.

During the period reviewed, the Inspector General found that approximately 97 percent of pool users analyzed made less than $30,000 a year with a third of them earning zero income. The Inspector General also found that 1 percent or less made more than $40,000 a year. The median income for 2003 was $3,440, for 2004 was $4,362, and for 2005 was $5,305.

Visits

The Inspector General found an almost even split between free care patients who use the pool only once in a hospital fiscal year and those who have multiple pool-paid medical visits.

Pool Patients – Visits

Number of Visits	HFY2003	% of Total	HFY2004	% of Total	HFY2005	% of Total
1 visit	178691	49.90%	188027	46.62%	92462	51.00%
2 or more	179357	50.09%	215299	53.38%	88809	48.99%
3 or more	124230	34.70%	153461	38.05%	59175	32.64%
4 or more	94879	26.50%	119857	29.72%	43023	23.73%
5 or more	75614	21.12%	97633	24.21%	32561	17.96%
6 or more	61879	17.28%	81876	20.30%	25120	13.86%
12 or more	23668	6.61%	36751	9.11%	6108	3.37%
24 or more	5696	1.59%	10486	2.60%	592	0.33%

The Inspector General also found that the vast majority of patients – more than 85 percent in each of the years studied – received their medical care from a single hospital or community health center.

CONCLUSION

The Uncompensated Care Pool has been a cornerstone of Massachusetts' health care safety net for 20 years. Its cost effectiveness has been compromised by poor oversight and administration. However, the problems outlined in this report can be easily fixed by introducing controls common to other health care payers.

The Inspector General plans to continue to examine the operations of the pool and report to the House and Senate Ways and Means Committees as required by statute.