RFR FOR COMMODITIES AND SERVICES THAT FALL UNDER C,H,J,N,R OBJECT CODES

Purchasing Department: Office of the Inspector General

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RFR File Name/Title: Audit and Review of the Massachusetts Uncompensated Care Pool

RFR File Number: 2005.15

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Comm-Pass Procurement Category: Professional Services

Response Due: Wednesday January 26, 2005 5:00 p.m. (E.T.)

Purpose of Procurement:

The Office of the Inspector General for the Commonwealth of Massachusetts (hereinafter "the OIG") intends to select a vendor to conduct an audit and review of the Massachusetts Uncompensated Care Pool (hereinafter "the Pool"). The vendor will review and audit free care practices in the emergency rooms of all Massachusetts hospitals (see attached listing). Those practices shall include but not be limited to:

- Enrollment of uninsured patients into MassHealth or other available programs;
- Free care charges hospitals are making to the Pool and whether these charges accurately represent costs incurred by uninsured or underinsured patients and whether these charges comply with applicable regulations;
- Services claimed for payment comply with applicable regulations for allowable free care services including emergency, urgent care and critical access services, and
- Any cost diversion or shifting to the Pool that might be occurring in hospital emergency rooms as the result of inadequate payment from public or private payers.

This request for response requires bidders to submit proposed detailed audit plans including staffing requirements and activity schedules. A detailed audit program along

with proposed sampling techniques needs to be included. Statistically valid samples of records shall be examined so that findings may be relied upon with a reasonable level of confidence. The bidders also need to provide details on how findings will be documented and reported to the OIG. The complete RFR is available on line at www.comm-pass.com

Acquisition Method

The result of this RFR will be a fee for service contract.

Request for a Single Contractor

The OIG plans to award one contract covering all aspects of this procurement.

Single Department Procurement

This procurement is conducted and managed solely by the OIG for the purchase of services to meet the needs of the OIG, which cannot be met by an existing statewide contract.

Expected Duration of Contract

It is expected that the vendor will complete the necessary planning (including staffing and audit program development) by late January 2005 and implement the field audits by February 1st 2005. By late spring 2005 the fieldwork will be completed and preliminary findings and recommendations will be available for review with the Office by July 1st 2005. A final report will be submitted to the Office by August 15, 2005.

Agency Information – Office of the Inspector General

The Massachusetts Office of the Inspector General is a state watchdog agency. The Office was established in 1981 as the first statewide inspector general's office in the country. It was created in the wake of a major construction procurement scandal.
It was created by Chapter 388 of the Acts of 1980; its enabling statute is Chapter 12A of the General Laws. The Governor, State Auditor, and the Attorney General appoint the Inspector General to a five-year term. The Office has a broad mandate to prevent and detect fraud, waste and abuse in government and in the expenditure of public funds. The work of the Office includes conducting operational and management reviews, analyzing legislation and regulations, providing technical assistance and conducting civil and criminal investigations.

Section A: Introduction

This document entitled "Request for Response: Audit and Review: Massachusetts Uncompensated Care Pool:" (RFR) is issued by the OIG, an independent state watchdog agency. The following terms are used interchangeably in this document: "bidder" and "vendor" and "response" and "proposal".

Words used in this RFR shall have the meanings defined in 114.6 CMR §§ 10.02, 11.02, and 12.02. Additional definitions may also be identified in this RFR.

Summary of Requested Services

The OIG has a broad mandate to prevent and detect fraud, waste and abuse in the expenditure of public funds. The legislature recently charged the OIG to hire auditors to oversee and examine the free care practices in the emergency rooms throughout the Commonwealth. Free care services are funded through the Pool. The allowable free care services are to be audited against the definitions and guidance provided pursuant to Chapter 118G of the Massachusetts General Laws and regulations promulgated thereunder. Based upon findings from this audit, the OIG will submit a report to the house and senate committees on ways and means.

The Pool, which is administered by the Division of Health Care Finance and Policy (DHCFP) pays for medically necessary care provided by hospitals and community health centers for uninsured and under-insured individuals who qualify for free care. The Pool also pays for emergency bad debt in accordance with applicable statutes and regulations.

The goal of this RFR is to select a vendor to conduct a comprehensive audit and review of both the financial and clinical aspects of the free care services funded through the Pool. The audit/review will cover hospital fiscal years (October 1st through September 30th) 2003, 2004 and the first six months of 2005.

The primary objectives of the audit/review are to:

- Review the practices followed by emergency rooms when initiating free care charges to the Pool and determine the validity and accuracy of these charges. Specifically:
    - Validate that the costs were incurred in caring for uninsured or underinsured eligible patients.
    - Ensure that the hospitals are not diverting or shifting other costs to the Pool
    - Ensure that bad debt charges into the Pool are in accordance with applicable regulations, including but not limited to ensuring that:
        - the clinical nature of the service billed is Emergency Care,
        - the patient is uninsured, and
        - the provider's collection efforts are reasonable.
- Determine the effectiveness of emergency room practices for enrollment of

uninsured patients into MassHealth or other available programs
- Ensure that provider's claims data comply with allowable services under Pool regulations
    - Compare provider claims data to patient medical records

The vendor will access provider data submitted to DHCFP and will perform field audits at various hospital provider sites. Statistically valid sampling and testing will be performed in order to provide a reasonable level of confidence in determining compliance levels for each provider. Audit and review findings will be reported back to the OIG in a format agreed upon by the OIG and the chosen vendor.

The scope of work for this contract is described in greater detail in Section B.

Overview of the Uncompensated Care Pool:

The Massachusetts legislature established the Pool in 1985 as a financing mechanism to distribute the burden of bad debt and provide free care (together known as "uncompensated care") more equitably among acute care hospitals. The creation of the Pool was intended to help pay for the costs of providing care to the uninsured, and also to eliminate financial disincentives that a hospital might have to providing such care. Since its creation, the Pool has evolved into a key component of the Commonwealth's health care safety net, helping to ensure access to needed health care services for people with no other source of health care coverage.

The enabling legislation for the Pool is M.G.L. c. 118G. DHCFP has implemented several regulations governing the Pool. The most pertinent regulations relative to the audit include: 114.6 CMR 10.00 – Criteria for Determining Eligibility for Free Care at Acute Care Hospitals and Freestanding Community Health Centers; 114.6 CMR 11.00 – Administration of the Uncompensated Care Pool; and 114.6 CMR 12.00 Services Eligible for Payment from the Uncompensated Care Trust Fund.

Note: 114.6 CMR 12.00 became effective October 1st 2004. This new regulation requires patients applying for uncompensated care to be screened for MassHealth eligibility. The Virtual Gateway is now the new application system to be implemented system-wide. Non-residents are no longer to be covered by the Pool. This regulation provides direction as to critical access services, which can be funded through the Pool.

The Pool pays for medically necessary inpatient and outpatient services provided by acute care hospitals and community health centers to low-income uninsured and underinsured individuals who meet the Pool's income and residency criteria when no other source of payment exists. The Pool is not insurance, and it does not pay for the cost of services provided by independent groups such as private physicians and specialty care groups. The individual must apply for free care service at a hospital or community health center where they wish to receive the service. There are 68 acute care hospitals that participate in the Pool. Attached to this RFR is a current list of participating hospitals.

Beginning in October 2003 the method for Pool payment to hospitals changed from a retrospective fee-for-service system to a prospective payment system. Under the new system, acute care hospitals are paid a pre-determined amount from the Pool each month based in part on historical free care costs. Community health centers continue to be paid on a fee-for-service basis up to an annual cap that applies to all community health care expenditures.

The Pool provides payments to participating providers for several types of Free Care. These include the following: Full Free Care, Partial Free Care, Medical Hardship, and Emergency Bad Debt.

Full Free Care is available for people with family incomes at or below 200 percent of the Federal Poverty Guidelines (114.6 CMR 10.03(1)).

Partial Free Care is available for people with family incomes between 201 – 400 percent of the Federal Poverty Guidelines and requires patients to pay an annual deductible based on family income, which must be met before services can be billed to the Pool. At community health centers, recipients of partial free care pay for services according to a sliding fee scale until they reach their deductibles (114.6 CMR 10.3(2)).

Medical Hardship is available for individuals at any income level who need assistance paying extraordinarily high medical expenses. Determinations are made based on both an income and asset test in relation to the medical bills (114.6 CMR 10.03(3)).

Emergency Bad Debt may be reimbursed to providers for bad debt resulting from emergency services provided to uninsured patients. A claim for emergency bad debt is limited to situations when the patient is uninsured, the provider cannot collect payments from a patient, and the patient has not completed a free care application. Emergency bad debt criteria are further defined in 114.6 CMR 10.03(4).

DHCFP has characterized the number of claims billed to the Pool by Free Care Type as follows:

- Full Free Care 80%
- Partial Free Care 1.3%
- Medical Hardship <0.1%
- Emergency Bad Debt 19%

Eligibility Requirements:

In order to be eligible for Free Care through the Pool a patient must meet the following tests:

Residency: Patient must be a Massachusetts resident except for emergency/urgent care. 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. Note as of October 1, 2004, non-residents are no longer eligible for any free care services.

Income:

- Under 200% of Federal Poverty Guidelines – full uncompensated care
- Between 201% and 400% of Federal Poverty Guidelines – partial uncompensated care on a sliding scale
- Medical hardship – any income with extraordinarily high medical expenses

Health Insurance: Individuals must have no health insurance or meet certain income standards and have co-pays, deductibles, or receive non-covered services.

Note: eligibility requirements are described in more detail in 114.6 CMR 10.00.

Pool Utilization – FY2003 Characteristics

According to DHCFP, over 90% of Pool applicants and users are uninsured. The Pool is intended to be the payer of last resort. In FY2003, the Pool paid for an estimated 35,000 inpatient and 1.5 million outpatient visits for 405,561 different individuals. The most common users of the Pool are young adults between the ages of 25-44 with incomes under 200% of the Federal Poverty Guidelines. Almost 90% of inpatient services charged to the Pool are provided on an emergency or urgent basis. Over 22% of outpatient services paid for by the Pool were provided in an emergency department. Discharges for circulatory and digestive system diagnoses represent the greatest share of inpatient charges for free care patients. Mental health and alcohol and drug-related disorders represent a much greater share of the Pool's inpatient free care charges than they do for other payers, including MassHealth.

Hospital outpatient claims represent 85% of the total claims billed to the Pool, hospital inpatient claims account for 2% of the total, and community health care center claims represent the remaining 13%. Although hospital inpatient claims account for only 2% of all claims billed to the Pool, these claims represent 39% of all the charges. The average charge for an inpatient claim was $9,700; the average charge for a hospital outpatient claim was $376.

The Boston Medical Center and the Cambridge Health Alliance are the two providers who receive the majority of the payments from the Pool at 34% and 17% respectively. The remaining Pool payments are distributed 44% to all other hospitals, 4% to community health centers and 1% for demonstration projects.

Section B: Scope of Services

The audit will encompass diverse elements including financial and clinical aspects. Fieldwork will be performed at the various hospital provider sites. Specifically, the vendor will perform the following functions for the OIG.

Financial Aspects

For payment purposes, providers submit monthly charges to the Pool in aggregate format using DHCFP UC Forms for hospitals. Claims and billing data are stored at DHCFP in separate databases. DHCFP monitors compliance with data reporting requirements by comparing charges reported on claims to charges reported on billing forms. The vendor will validate claims charge data submitted to DHCFP by providers against financial records at provider sites. Additionally, charges billed to the Pool must be accurately reflected on provider financial records in accordance with applicable Pool regulations. The vendor will review the accuracy of data reported on the UC forms and ensure there is an auditable trail between the aggregate charge forms and the provider's financial documentation. Any charges or recoveries through the Pool reported on billing forms that are not submitted in claim format must be accurately reflected in the provider's financial documentation.

The vendor will audit hospital claims and monthly billings into the Pool to ensure that charges are:

- Billed in compliance with applicable regulations for allowable charges
- Submitted for allowable services to individuals with a valid free care eligibility determination
- Supported by underlying financial records

The selected vendor will audit providers for compliance with regulations regarding residency requirements of individuals for whom services are claimed for payment by the Pool. The selected vendor will also audit providers to ensure that only services provided to individuals with a valid-eligibility determination are claimed for payment from the Pool.

Clinical Aspects

Allowable free care services in hospitals consist of emergency services, urgent care services, and critical access services. Regulations defining critical access services went into effect in October, 2004. The selected vendor will perform a series of medical record reviews that will determine if hospitals are compliant with allowable free care services, including critical access services criteria.

Through detailed compliance testing, the vendor will determine hospital compliance with applicable regulations concerning allowable services claimed for payment through the Pool. The vendor will conduct audits of provider claims data by reviewing and comparing this claims data against the underlying medical record data.

The vendor's proposal will describe procedures the vendor will use to perform these reviews and present its findings. The OIG expects that statistically valid samples of records will be examined so that findings may be extrapolated for the purpose of developing compliance thresholds and measures and for identifying the services and amounts charged to the Pool that may be determined not allowable.

Compliance Testing - Financial and Clinical Aspects

The selected vendor will perform detailed financial and clinical testing at each provider site on the selected claims test samples. The testing will include but not be limited to the following:

- Presence and availability of supporting documentation
- Eligibility of patient and claim
- Patient meets residency requirement
- Patient is not covered by insurance
- Patient meets financial guidelines
- Charge in agreement to fee schedule
- Claim is submitted only once (no duplicate billings)
- Correct arithmetic calculations
- Time of service to Pool billing

More specifically, at a minimum, the vendor will perform the following tests:

- Review each patient's Application For Free Care for completeness including signatures
- In cases where a Condensed Free Care Application was completed, verify that at least one of the following applies:
    - Patient is eligible for MassHealth and enrollment in process (copy of EAEDC card included as documentation)
    - Patient is ineligible for MassHealth include a copy of the completed Medical Benefit Request which is dated within the past 6 months
    - Patient is a member of CenterCare (copy of membership card needed as documentation)
    - Patient is a member of Children's Medical Security Plan or Healthy Start (copy of membership card needed as documentation)
- Verify that the provider has given (within 30 days) a decision letter to patients submitting applications for free care/partial care/medical hardship. Review the content of the decision letters to ensure compliance with 114.6 CMR 10.08(3).
- Verify data on Application to data on billing submission to hospital
- Verify arithmetic calculations/totals on the Application For Free Care
- Ensure reported Earned Income on the Application For Free Care is within the Federal Poverty Income Guidelines (<=200% Full Free Care/201%-400% for Partial Free Care
- Review for adequacy the documentation used by the provider to verify a patient's residency

    - Confirm assertions for MA residency status (interrogate MA DOR, MA RMV databases)
- Review for adequacy the documentation used by the provider to verify a patient's reported income and assets
    - Independently ascertain income and asset level for the patient (i.e. through review of DOR, RMV, local RE Tax records etc.)
- Review for adequacy the process and documentation used by the provider in determining whether the patient was enrolled in MassHealth (evidence of check through Division of Medical Assistance)
    - Independently verify whether the patient was enrolled in MassHealth at the time of service (interrogate MassHealth database)
- Review provider's screening process for determining whether the patient has any alternative insurance coverage
    - Independently verify through major health insurers whether the patient was in fact covered through them at the time of the service
- Review for adequacy the process and documentation used by the provider to enroll uninsured patients into MassHealth or other available programs
    - Verify that eligible patients have in fact been enrolled in MassHealth or other available programs. Verify that there are no multiple billings for these eligible patients
- Verify that services billed to the Pool are consistent with the patients' clinical records maintained by the hospital
- Verify that the charges for services billed into the Pool agree to the uniform prices typically charged for these services by this provider
- Verify arithmetic calculations/totals on service billings into the Pool
- Contact patients to confirm that services were actually received
- Determine that charges into the Pool for non-Massachusetts residents are related only to Emergency Care or Urgent Care
- Ensure that for all hospital charges into the Pool the supporting free care documentation was prepared within a year from determination of patient financial liability. Exception when the hospital can document continuous collection action or regular patient payments during the intervening time

Emergency Bad Debts

The selected vendor will perform clinical and financial testing of emergency bad debt charges billed to the Pool. The purpose of this testing is to ensure that charges billed to the Pool as emergency bad debt meet established clinical criteria for emergency services or conditions and also meet the criteria contained in the applicable regulations for billing emergency bad debt charges to the Pool. Proposals must describe the criteria the vendor will use for identifying emergency services.

At a minimum perform the following for emergency bad debt charges:

- Review the patients' files maintained by the service provider to ensure that documentation supports that the patient was uninsured for the services provided
- Verify that the patient was not covered under MassHealth at the time of service
- Review patient file and confirm that the service billed is for emergency care as defined in 114.6 CMR 10.02.
- Verify that the service provider's documentation includes a determination by the responsible physician that the patient's condition in fact required emergency care as defined in 114.6 CMR 10.02 and the provider's Credit and Collection Policies.
- Review documentation maintained by the provider showing that appropriate collection action was made pursuant to 114.6 CMR 10.05. *Note the provider must make the same effort to collect accounts for Emergency Care for Uninsured Patients as it does to collect accounts from any other patient classifications.* The patients file must include all documentation of the Provider's collection efforts including copies of the bill(s), follow-up letters, reports of telephone and personal contact and any other effort made. Through review of the patient files ensure that at a minimum the following documentation exists:
    - an initial bill sent to the patient or to the financially responsible party
    - subsequent billings, telephone calls, collection letters, personal contact notices, computer notifications and any other notification method
    - alternative methods used to locate the party responsible for the obligation or the correct address on billings returned by the postal service as "incorrect address" or "undeliverable"
    - sending a final notice by certified mail for balances over $1,000 where notices have not been returned as "incorrect address" or "undeliverable"
- in addition to the reasonable collection efforts, an account must remain unpaid for at least 120 days prior to billing into the Pool
- determine whether the patient was offered a payment plan by the provider. *Note for patient balances of $1000 or less a one year payment plan with a minimum monthly payment of $25 must be offered. Those patients with balances greater than $1000 must be offered at least a two year payment plan*

Special Circumstances

- For Free Care Charges, which are related to covering costs after insurance has paid the portion for which it is responsible – verify that the provider's documentation files include either a copy of the policy's Explanation of Benefits, the bill from the provider, the patient's insurance card or the policy. Ensure appropriate documentation exists for Medicare Bad Debts

- For Partial Free Care Charges ensure that the provider has properly calculated the deductible amount and has excluded this from the billing to the Pool. Also determine that the provider is properly tracking the annual deductible balance

- For Medical Hardship Charges review the process that the provider followed in determining that the patient met the expense and resource qualifications.

- In those cases where the patient was injured in a motor vehicle accident, ensure that the provider documentation includes results of the investigation determining whether the patient, driver and/or owner of the other motor vehicle had a motor vehicle liability policy and where applicable, properly submitted a claim for payment to the motor vehicle liability insurer.
    - Review documentation supporting follow-up by the provider to obtain payment for Free Care from the motor vehicle liability insurer
    - Verify that payments received by the provider from the motor vehicle liability insurers are reported to the Fund for credit, in a timely manner

Audit Selection and Sampling

The vendor may suggest a sampling methodology for each of the audit functions described in this procurement. However, the OIG will review and approve or modify, as needed the final sampling methodology. All of the providers may be audited. The OIG will determine which providers will be audited for each of the audit criteria. Finally, the OIG will review and approve or modify the volume of audits and reviews that will be performed for each audit function.

Audit and Review Findings

The vendor will produce preliminary reports and a final report for the OIG describing audit and review findings. The vendor may suggest in its proposal the format for these reports but the final report format, will be determined by the OIG. The vendor should address in their response a proposed approach and timeframe to be followed in providing the OIG with periodic status updates.

Section C: Pricing Proposal

The vendor must propose a pricing methodology that specifies the volume of reviews that will be performed in each of the identified audit categories described above.

The vendor must indicate the number of claims (visits) to be reviewed and the charge associated with each type of review or audit. The OIG will determine which providers will ultimately be targeted for audit although emphasis may be placed on the highest volume free care providers.

Pricing proposals must be submitted under separate cover.

Section D: Response Evaluation

Responsiveness of Proposal

Vendors must prepare comprehensive and accurate responses. A response, which merely states that the vendor will meet the requirements of the RFR, will be considered non-responsive. The response must contain a comprehensive description of how the vendor plans to meet the requirements of the RFR, including both the technical aspects of the project as well as the pricing requirements.

Any proposal determined to be non-responsive to any specification or requirement of this RFR, including instructions governing submission of responses, may be disqualified without evaluation unless the procurement team determines that the noncompliance is not substantial, in which case it may seek clarification, or apply appropriate penalties in the evaluation, or both. The team will evaluate each response properly submitted and may require oral presentations, follow-up questions and/or on-site visits as circumstances dictate. All inquiries before or during the response evaluation period should be directed in writing to the team leader.

Written inquiries will not be accepted after the deadline specified in this RFR. Vendors are advised that only the team, meeting in its official capacity, can answer questions, clarify issues or render any opinion regarding this RFR.

The team reserves the right to reject in whole or in part any or all responses received if it deems such action to be in the best interest of the Commonwealth. Vendors will be evaluated based on the technical evaluation criteria listed in the RFR, the ability to meet the minimum contractor requirements, and the project requirements specified in this RFR.

Contract Award Process

Award for this procurement will be based on consideration by the procurement management team of all the factors previously mentioned, including cost. The vendor deemed to be the most responsive and responsible, will be selected.

Upon award, a contract will be negotiated in a timely manner. The contract will incorporate the RFR and any or all portions of the selected response. At the time of the award, initial meetings will be scheduled and a project plan will be developed.

No commitment is offered or implied by the Commonwealth prior to the execution of a signed contract. The OIG retains the right not to offer any bidder a contract under this RFR.

Vendor selection will be based upon the contractor who will provide the OIG with the best value. All vendor submissions will be considered in the evaluation of proposals. The OIG reserves the right to request clarification on any material submitted. The OIG may reject any and all proposals that may or may not meet the conditions of this RFR.

The selection process is described below.

The OIG envisions a possible two-phase selection process but reserves the right to select a contractor based solely on the results of Phase One.

Phase One

A procurement management team consisting of selected OIG staff, relevant Commonwealth oversight agencies, and any party the OIG deems appropriate will review each proposal to determine if it demonstrates that the contractor can meet or exceed performance specifications. The OIG reserves the right to reject any and all proposals. The OIG will either; select the best value proposal and begin meetings and negotiations with the vendor, or select the best value proposals to move onto a Phase Two evaluation. The team reserves the right to request clarifications of a vendor's proposal before the proposal advances to Phase Two.

Phase Two

Vendors will be asked to respond to a series of questions the OIG has regarding the bidder's proposal. The OIG will either conduct Phase Two evaluations face to face with the vendors or through written correspondence. If Phase Two meetings are held, they will take place at One Ashburton Place Boston, MA. Any Phase Two evaluations, which take place will be in the same format for all vendors responding to this RFR. Vendor responses will be evaluated and scored.

The OIG will enter into a contract with the overall best value vendor. If chosen by the OIG the contractor must be prepared to negotiate a contract immediately upon notification from the OIG that it wishes to negotiate a contract. The OIG will make every effort to finalize a contract within 30 days. The vendor will be expected to begin service to the OIG immediately following contract execution. In the event that an agreement cannot be reached with the chosen vendor, the next best value vendor will be contacted.

Evaluation Criteria

The procurement management team will use the following criteria to evaluate vendor proposals and select a vendor to negotiate a contract with the OIG.

- Experience and planned approach to performing provider clinical and financial audits using medical records, claims data and financial data
- Experience and knowledge related to auditing in a medical claims and payment environment
- Experience in managing a large medical audit engagement
- Experienced audit staff with both clinical and financial strengths
- Experience in developing audit review criteria, selecting test samples, performing detail audit tests and reporting findings

- Demonstrated understanding of the Uncompensated Care Pool including applicable laws and regulations
- Experience in healthcare (clinical and claims payments)
- Sufficient information explaining how the vendor developed its pricing and compensation proposal

The OIG will give preference to responses, which meet all of the criteria for performing both clinical and financial audits described in this RFR.

Performance Criteria

In order to ensure contract compliance with the RFR the contractor's performance will be measured in the following areas:

- Timely project delivery
- Responsiveness to OIG inquiries
- Quality of deliverables
- Performance against targets/benchmarks

Section E. Vendor's Requirements

Record Retention

The vendor must maintain records of activities it undertakes as part of the contract. Such records shall be maintained in the principal office of the vendor or another location specified by the OIG.

The vendor must maintain data, records of audits and reviews, and any other reports required by the contract. The vendor must maintain a log and filing system which will ensure the retrieval of information for six (6) years for electronic data and three (3) years for manually held paper data after the last payment made to the vendor pursuant to the contract that results from this RFR.

The vendor must keep these materials in a separate secured area to which unauthorized access is prohibited. OIG documents and records must be physically protected from being commingled with other vendor client records.

Upon completion or termination of this contract the vendor shall transfer to the OIG all paper, files, electronic records, electronic forms, and any systems developed and maintained as required by this contract.

Ownership of Data

The contractor shall become a holder of personal data pursuant the M.G.L. c.66A. All data acquired by the contractor from third party payers, hospitals, the Division of Health

Care Finance and Policy, and the OIG in the performance of this contract, whether or not it is personal data shall remain the property of the OIG.

The OIG shall retain unrestricted ownership rights to all property prepared, acquired, designed, developed or improved by the contractor for delivery to the OIG under this contract.

The contractor shall deliver all OIG-owned property to the OIG promptly upon request or upon contract termination, in whatever form maintained by the contractor. The contractor shall destroy all copies and reproductions of all OIG owned property remaining in its possession including all machine-readable copies.

Disaster Recovery

The vendor must provide, as part of their response, evidence that they have a disaster recovery plan. The disaster recovery plan must demonstrate that in the event of a catastrophe at the vendor site, data and reports held by the vendor will be protected and that audit activities will continue with minimal disruption. The vendor's disaster recovery plan should delineate in detail the steps that the vendor would take to minimize the disruption of audits and reviews in the event of a disaster.

Health Insurance Portability and Accountability Act

The administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) have established standards and restrictions on the handling of confidential patient level information. This project entails working with confidential patient level data and having access to databases and organizations that are HIPAA covered entities. The vendor must be knowledgeable of and comply with any HIPAA requirements that pertain to this project.

Designated Contract Manager

The designation and resume of the contract manager who will be responsible for the day-to-day operation of the contract shall be included in the response. It is expected that the contract manager shall be available in the event of any and all problems, concerns and issues with the contract.

Relevant Experience of Vendor

The vendor must describe the experience it has in performing services similar in size and scope to what is required in this RFR. The vendor must describe in detail any relevant operations where it has performed services similar to those required under the RFR The vendor should choose to describe past experience in which the project

deliverables mirror the deliverables of this RFR as closely as possible. When explaining the related experience, the vendor should clearly state the function or requirement by name or number.

The vendor must provide at least three references for services similar in size and scope to what is required under the RFR. Each reference's name, address and telephone number along with the contact person should be clearly identified. The vendor must also provide a description of the type of work performed for each reference, including approximate volume, processing requirements and other factors the vendor feels will help the procurement team understand the work the vendor performed for the reference. The OIG reserves the right to contact other entities not reported by the vendor for which the vendor performed similar services. The vendor should only list references which are accessible and willing to answer questions the OIG has regarding the reference's experience with the vendor. References for subcontractors must be provided separately. The vendor may not list the Office of the Inspector General as a reference.

Conflict of Interest Disclosures

Vendors must disclose any and all contracts whether pending or executed with any agency of the Commonwealth regarding the Uncompensated Care Pool (Chapter 118G).

Vendors must also disclose any previous or current services provided to any of the participating hospitals to be reviewed under this audit.

Accessibility

The vendor must provide evidence that it either possesses or plans to acquire a data warehousing site within the Commonwealth of Massachusetts. The vendor may also meet this requirement by providing evidence that the OIG will at least have ready access to data collected under a vendor contract within the Commonwealth. The vendor's Massachusetts operation must be sufficient enough so that the OIG may conduct a complete audit of the vendor's operation in the Commonwealth.

Licenses, Registrations and Corporate Good Standing

The vendor will provide a statement that it meets all applicable state and federal requirements, and has all the licenses and registrations necessary to perform the contract. If incorporated, the vendor will provide identification of the state of incorporation and a statement that the vendor is in good standing in that state. If the state of incorporation is not Massachusetts, the vendor will also provide a statement that the company is in compliance with all filing requirements of the Massachusetts Secretary of State.

Certification of Tax Compliance

The bidder must provide certification on its letterhead that it meets the tax requirements of the Commonwealth. A bidder must certify that it has made all required filings and has no outstanding tax obligations.

A bidder, which is not currently subject to Massachusetts tax laws, may so state in response to this requirement. A bidder, which is currently subject to Massachusetts tax laws, but has not fully complied with all its obligations, should indicate in the certification what the state tax issues are. An indication by a bidder that it has not fully complied with its state obligations will not disqualify the bidder or affect the scoring of the bidder's response, but the OIG may not award a contract to such a bidder until all state tax issues have been resolved. The successful bidder may be required to re-certify as to its tax status periodically during the contract term.

Cancellation Agreement

The vendor understands, that the OIG reserves the right to cancel a contract with or without cause upon a 30 day written notice delivered to the contract manager by certified mail, return receipt requested. The contractor may cancel a contract with or without cause upon a 180 day written notice delivered to the procurement manager by certified mail, return receipt requested.

Evidence of Financial Condition and Reputation

The vendor must submit audited financial statements for the last three years, including balance sheets and profit and loss statements and any related notes and the auditor's report. In addition the vendor must include with its response, certification that the vendor has not been in bankruptcy and/or receivership within the last three calendar years.

The vendor must provide details of any pertinent judgment, criminal conviction, investigation, or litigation pending against the vendor or any of its officers, directors, employees, agents or subcontractors of which the vendor has knowledge, or a statement that there is none. The OIG reserves the right to reject a response based on this information.

Subcontracting

The vendor shall be allowed to subcontract some of the responsibilities under the contract to any other organization, association, individual, corporation, partnership, group of individuals, or other such entity if it chooses to enter into such an arrangement. Subcontractors are bound by all terms and conditions of the vendor's contract.

The vendor is fully responsible for all subcontractor performance. The identity of any subcontractor must be made known at the time the bid is made. If a vendor intends to subcontract any of its responsibilities under this contract, it shall state explicitly in its

proposal which responsibilities are being subcontracted. Proposals must include an itemized list of subcontracted duties and a detailed description of how the subcontractor will perform those duties. Bidder responses must indicate which protocols, procedures, or other information in the response apply to the vendor's operation and which apply to the subcontractor's operation. Vendors must also identify in their cost proposal all itemized costs for subcontracting. Vendors must illustrate within the proposal how information will flow between the subcontracting vendor and the primary vendor who is contracting with the OIG and how payment to the subcontracting vendor will be made. Vendors will also include in their proposals how they will meet all contract requirements if a subcontractor fails to perform its duties.

All subcontracts or other agreements or arrangements must be in writing and are subject to prior approval from the OIG. The OIG will only enter into one contract with a vendor and any subcontracted vendors are bound to the terms of that contract. It will be the responsibility of the contracted vendor to meet all contract requirements. References made to contractor employees and personnel in this RFR refer to subcontractors as well.

Quality Control

The vendor must provide documentation of its internal quality control processes and contract monitoring procedures.

Resumes

All vendors must submit, as part of their responses, the resumes of all key personnel expected to manage aspects of the contract resulting from this RFR. At a minimum, this includes the responsible senior management staff.

Vendor Staffing

The OIG requires that the selected vendor discuss all suggested changes to personnel with specific OIG staff before any changes are initiated. In addition, the vendor may not change the contract manager without prior written notice to the OIG. The vendor is prohibited from interviewing and offering employment to any employee of the OIG for the purpose of meeting the requirements of this contract.

The OIG reserves the right to investigate and review the backgrounds of any and all vendor personnel assigned to work under this contract, and to reject the assignment of any persons upon a finding that such assignment would not be in the best interests of the OIG and/or the Commonwealth.

The contracted vendor will have adequate and capable staff assigned to the contract sufficient to meet or exceed all performance standards and requirements provided in the contract. As staff is identified and assigned to the project, the vendor will provide the OIG with current resumes for each staff member assigned.

The contracted vendor will provide a projected staffing plan as part of its response. In developing the projected staffing plan, the vendor should consider; adequate segregation of duties, normal versus peak processing periods, turnaround timeframes, use of full-time, part-time and temporary staffing and additional work shifts.

Contract Performance Monitoring

The OIG will measure contractor performance to ensure that all contractor responsibilities are met prior to making payment to the contractor. The OIG will review all contractor reports for completeness and consistency with the OIG and contractor agreed upon reporting requirements. Deficiencies will be noted by the OIG and must be corrected by the contractor prior to payment.

Submission of Responses

Vendors shall be responsible for any liability or cost incurred in connection with their responses to this RFR. Responses should provide a straightforward, concise description of the vendor's ability to satisfy the requirements of this RFR.

Responses must be delivered no later than the date and hour specified in this RFR and only to the procurement team located at the OIG.

Each vendor must submit seven (7) sealed sets of its response, which include both the technical and compensation proposals. The bidder must submit one (1) original response on 81/2" x 11" white paper in a three (3) ring binder. Both the original and copies must be submitted on recycled paper. All RFR responses should be printed double-sided. The bidder must submit one (1) electronic copy of its response on a, 3.5 floppy diskette, or compact disk. The bidder must use Microsoft Word for Windows, (Version 6.0 or higher) and Microsoft Excel for Windows, Version 4.0 or higher. Attachments to the bidder's response are not required to be submitted on diskette.

In the event of a discrepancy between a paper submission and an electronic submission, the paper submission will prevail. The bidder is requested to label the disk with the following information: Bidder's company name, mailing address, contact name, telephone number, and the RFR#. The bidder must guarantee that the electronic submissions are virus-free.

Clarification of Responses

The procurement management team may require any vendor to discuss or clarify its response. Further, the procurement management team retains the right to visit any and all locations of the vendor in order to evaluate the vendor's response.

Response Acceptance Period

The vendor's response must remain in effect for a period of forty-five (45) days after the deadline for the submission of responses and thereafter until the vendor withdraws it, or a contract is made and approved, or the procurement is terminated, whichever first occurs.

Rejection of Responses

The OIG reserves the right to cancel this procurement at any time before a contract has been executed and approved. Non-acceptance of any response means only that another response was deemed more advantageous to the Commonwealth or that none were acceptable.

Addenda to RFR

If it becomes necessary to revise any part of the RFR, or if additional data are necessary to clarify any of its provisions, a supplement will be issued. The supplement will be distributed via Comm-PASS. The OIG reserves the right to amend, alter, or change the RFR at any time prior to the deadline for submission of responses. It is the bidder's responsibility to ensure that it has the latest version of the RFR.

Restrictions on Contact with State Personnel

All contacts with personnel employed by the OIG, former employees employed with the OIG during the RFR preparation period, or members of the procurement team concerning this procurement are prohibited, except for contacts specifically described herein or in accordance with contracts or work established prior to the release of this RFR. This prohibition shall apply to all prospective vendors from the date of release of this RFR until a vendor is selected. It shall further apply to the selected vendor until such time as the contract has been signed. Violation of this condition may be considered sufficient cause by the Commonwealth to reject the response and/or selection of a vendor.

Procurement Calendar

Release of RFR	Friday December 10, 2004

A Bidders Conference will be offered. The date, time and location are reflected below.

Bidders Conference	Wednesday December 22, 2004 10:00 a.m. (E.T.) Office of the Inspector General One Ashburton Place Boston, Massachusetts 02116
Deadline for Submission of written inquiries	Monday December 27, 2004 5:00 p.m. (E.T.)

The Office's response to written inquiries posted:	Wednesday December 29, 2004 5:00 p.m. (E.T.)
Responses Due	Wednesday January 26, 2005 5:00 p.m. (E.T.)

Bidder Conference

Prospective vendors are invited to attend a bidder conference at the location, date and time specified in the RFR. Attendance at the vendors' conference is not mandatory. At this conference, representatives of the procurement management team will accept questions regarding the RFR. The procurement management team will prepare and make available written answers to questions of general interest raised at the conference. Only written answers will bind the OIG.

If possible, vendors are asked to provide the OIG with hard copies of questions that the vendor plans to ask at the vendor conference. Questions may be provided at or anytime before the conference.

Inquiries

Prospective vendors may submit written technical and contractual questions raised by this RFR to the procurement management team leader no later than the date and time specified in the RFR. The procurement management team will review and consolidate inquiries received before the deadline and prepare written answers to questions of general interest. Only written answers will bind the OIG.

Required Forms

The following forms, which can be found at **http://www.comm-pass.com/comm-pass/forms.asp** must be completed and submitted with the proposal. Failure to return these forms with the response may disqualify the response.

- Contractor Authorized Signature Verification Form
- Affirmative Action Plan Form
- Northern Ireland Notice & Certification
- Affirmative Market Program (AMP) Form
- Authorization for Electronic Payments Form
- HIPAA – Business Associate Agreement

The following forms will be required at contract award.

- Commonwealth Terms and Condition Form
- Standard Contract Form
- Consultant Contractor Mandatory Submission Form
- Business Reference Form
- Verification of Taxation Reporting Information (MA Substitute W-9 Format)

REQUEST FOR RESPONSE

GENERAL INFORMATION

The terms of 801 CMR 21.00: Procurement of Commodities and Services (and 808 CMR 1.00: Compliance, Reporting and Auditing for Human and Social Services, if applicable) are incorporated by reference into this RFR. Words used in this RFR shall have the meanings defined in 801 CMR 21.00 (and 808 CMR 1.00, if applicable). Additional definitions may also be identified in this RFR. Unless otherwise specified in this RFR, all communications, responses, and documentation must be in English, all measurements must be provided in feet, inches, and pounds and all cost proposals or figures in U.S. currency. All responses must be submitted in accordance with the specific terms of this RFR. No electronic responses may be submitted in response to this RFR.

Affirmative Market Program AMP. Massachusetts Executive Order 390 established a policy to promote the award of state contracts in a manner that develops and strengthens Minority and Women Business Enterprises (M/WBEs) and resulted in the Affirmative Market Program in Public Contracting. As a result, M/WBEs are strongly encouraged to submit responses to this RFR, either as prime vendors, subcontractors, joint venture partners or other type of business partnerships.

Non-certified bidders are strongly encouraged to develop creative initiatives to help foster new business relationships with M/WBEs within the primary industries affected by this RFR. In order to satisfy the compliance of this section and encourage bidder's participation of AMP objectives, the Affirmative Market Program Plan for large procurements greater than $50,000 must be evaluated at 10% or more of the total evaluation. Once an AMP Plan is submitted, negotiated and approved, the agency will then monitor the contractor's performance, and use actual expenditures with SOMWBA certified contractors to fulfill their own AMP expenditure benchmarks. M/WBE participation must be incorporated into and monitored for all types of procurements regardless of size, however, submission of an AMP Plan is mandated only for large procurements over $50,000.

Agencies may require some or all of the following components as part of the Affirmative Market Program Plan submitted by bidders: Sub-contracting with certified M/WBE firms, Growth and Development activities to increase M/WBE capacity, Ancillary use of

certified M/WBE firms, Past Performance or information of past expenditures with certified M/WBEs. Agencies are encouraged to include additional incentives for bidders to commit to at least one certified MBE and WBE in the submission of AMP plans.

A Minority Business Enterprise (MBE), Woman Business Enterprise (WBE), M/Non-Profit, or W/Non-Profit, is defined as such by SOMWBA. All certified businesses are required to submit an up to date copy of their State Office of Minority and Women Business Assistance (SOMWBA) certification letter. The purpose for this certification is to participate in the Commonwealth's Affirmative Market Program for public contracting. Minority- and Women-Owned firms that are not currently certified but would like to be considered as an M/WBE for the purpose of this RFR should submit their application at least two weeks prior to the RFR closing date. For further information on SOMWBA certification, contact their office at 1-617-727-8692 or via the Internet at mass.gov/somwba.

Affirmative Market Program Subcontracting Policies. Prior approval of the agency is required for any subcontracted service of the contract. Agencies may define required deliverables including, but not limited to, documentation necessary to verify subcontractor commitments and expenditures with Minority- or Women-Owned Business Enterprises (M/WBEs) for the purpose of monitoring and enforcing compliance of subcontracting commitments made in a bidder's Affirmative Market Program (AMP) Plan. Contractors are responsible for the satisfactory performance and adequate oversight of its subcontractors. Subcontractors are required to meet the same state and federal financial and program reporting requirements and are held to the same reimbursable cost standards as contractors.

Best Value Selection and Negotiation. The PMT may select the response(s) which demonstrates the best value overall, including proposed alternatives, that will achieve the procurement goals of the department. The PMT and a selected bidder, or a contractor, may negotiate a change in any element of contract performance or cost identified in the original RFR or the selected bidder's or contractor's response which results in lower costs or a more cost effective or better value than was presented in the selected bidder's or contractor's original response.

Bidder Communication. Bidders are prohibited from communicating directly with any employee of the procuring department except as specified in this RFR, and no other individual Commonwealth employee or representative is authorized to provide any information or respond to any question or inquiry concerning this RFR. Bidders may contact the contact person for this RFR in the event this RFR is incomplete or the bidder is having trouble obtaining any required attachments electronically through Comm-PASS.

Comm-PASS. If this RFR has been distributed electronically using the Comm-PASS system, RFR attachments that are referenced are available either as separate pdf files with this RFR or on the OSD forms page (mass.gov/osd). Bidders are solely responsible for obtaining and completing the required attachments that are identified in this RFR and for checking Comm-PASS for any addenda or modifications that are subsequently made to this RFR or attachments. The Commonwealth and its subdivisions accept no liability and will provide no accommodation to bidders who fail to check for amended RFRs and submit inadequate or incorrect responses. Bidders are advised to check the "last change" field on the summary page of RFRs for which they intend to submit a response to ensure that they have the most recent RFR files. Bidders may not alter (manually or electronically) the RFR language or any RFR component files. Modifications to the body of the RFR, specifications, terms and conditions, or which change the intent of this RFR are prohibited and may disqualify a response.

Contract Expansion. If additional funds become available during the contract duration period, the department reserves the right to increase the maximum obligation to some or all contracts executed as a result of this RFR or to execute contracts with contractors not funded in the initial selection process, subject to available funding, satisfactory contract performance and service or commodity need.

Costs. Costs which are not specifically identified in the bidder's response, and accepted by a department as part of a contract, will not be compensated under any contract awarded pursuant to this RFR. The Commonwealth will not be responsible for any costs or expenses incurred by bidders responding to this RFR.

Electronic Funds Transfer (EFT). All bidders responding to this RFR must agree to participate in the Commonwealth Electronic Funds Transfer (EFT) program for receiving payments, unless the bidder can provide compelling proof that it would be unduly burdensome. EFT is a benefit to both contractors and the Commonwealth because it ensures fast, safe and reliable payment directly to contractors and saves both parties the cost of processing checks. Contractors are able to track and verify payments made electronically through the Comptroller's Vendor Web system. EFT applications can be found on OSD forms page (mass.gov/osd). Additional information about EFT is available on the VendorWeb site (mass.gov/osc: click on MASSfinance).

Successful bidders, upon notification of contract award, will be required to enroll in EFT as a contract requirement by completing and submitting the *Authorization for Electronics Funds Payment Form* to this department for review, approval and forwarding to the Office of the Comptroller. If the bidder is already enrolled in the program, it may so indicate in its response. Because the *Authorization for Electronic Funds Payment Form* contains banking information, this form, and any information contained on this form, shall not be considered a public record and shall not be subject to public disclosure through a public records request.

The requirement to use EFT may be waived by the PMT on a case-by-case basis if participation in the program would be unduly burdensome on the bidder. If a bidder is claiming that this requirement is a hardship or unduly burdensome, the specific reason must be documented in its response. The PMT will consider such requests on a case-by-case basis and communicate the findings with the bidder.

Identifiable Health Information: HIPAA and Protected Health Information: The administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) have established standards and restrictions on t he handling of confidential patient level information. This project entails working with confidential patient level data and having access to databases and organizations that are HIPAA covered entities. The vendor must be knowledgeable of and comply with any HIPAA requirements that pertain to this project. Business associate obligations of the vendor include but are not limited to, the vendor's obligation to adequately safeguard the information (in whatever form it is maintained or used, including verbal communications) from inappropriate or unauthorized use or disclosure: provide individuals access to their records; and strictly limit use and disclosure of the information for only those purposes approved by this Office and DHCFP.

Northern Ireland Notice and Certification. All bidders must complete the Northern Ireland Notice and Certification form to satisfy M.G.L. c.7 section 22C, which states that no state agency may procure commodities or services from any bidder employing ten (10) or more employees in an office or other facility located in Northern Ireland unless the bidder certifies through the notice and certification form that if it employs ten or more employees in Northern Ireland, a) the bidder does not discriminate in employment, compensation or the terms, conditions and privileges of employment on account of religious or political belief, b) the bidder promotes religious tolerance within the workplace and the eradication of any manifestations of religious and other illegal discrimination and, c) the bidder is not engaged in the manufacture, distribution or sale of firearms, munitions, including rubber or plastic bullets, tear gas, armored vehicles or military aircraft for use or deployment in any activity in Northern Ireland.

Pricing: Federal Government Services Administration (GSA) or Veteran's Administration Supply. The Commonwealth reserves the right to request from the successful bidder(s) initial pricing schedules and periodic updates available under their GSA or other federal pricing contracts. In the absence of proprietary information being part of such contracts, compliance for submission of requested pricing information is expected within 30 days of any request. If the contractor receives a GSA or Veteran's Administration Supply contract at any time during this contract period, it must notify the Commonwealth contract manager.

Pricing: Price Limitation. The bidder must agree that no other customer of similar size and

similar terms and conditions shall receive a lower price for the same commodity and service during the contract period, unless this same lower price is immediately effective for the Commonwealth. The bidder must also agree to provide current or historical pricing offered or negotiated with other governmental or private entities at any time during the contract period upon the request of the contract manager.

Public Records. All responses and information submitted in response to this RFR are subject to the Massachusetts Public Records Law, M.G.L., Chapter 66, Section 10, and to Chapter 4, Section 7, Subsection 26. Any statements in submitted responses that are inconsistent with these statutes shall be disregarded.

Reasonable Accommodation. Bidders with disabilities or hardships that seek reasonable accommodation, which may include the receipt of RFR information in an alternative format, must communicate such requests in writing to the contact person. Requests for accommodation will be addressed on a case-by-case basis. A bidder requesting accommodation must submit a written statement which describes the bidder's disability and the requested accommodation to the contact person for the RFR. The PMT reserves the right to reject unreasonable requests.

Subcontracting Policies. Prior approval of the department is required for any subcontracted service of the contract. Contractors are responsible for the satisfactory performance and adequate oversight of its subcontractors. Subcontractors are required to meet the same state and federal financial and program reporting requirements and are held to the same state and federal financial and program reporting requirements and held to the same reimbursable cost standards as contractors.

Free Care Application (Eligibility) Data Available
Applicant and family member demographic information

First Name: Address:
Last Name: Gender:
Date of Birth: SSN or DOR issued Tax ID#:
Family member relationship to applicant:
Telephone number (home and work):
Pregnancy indicator (Y/N): Homeless indicator (Y/N):
Race (optional):

Income Information

Earned Income Information
Name of working family member:
Name and address of employer:
Amount earned annually (from each employer):
Employer size:

Unearned income
Name of family member receiving income:
Type of unearned income:
Amount received annually:

Alimony, child support, or personal needs allowance
Type of payment made:
Name of family member making payment:
Amount of payments (annually):

Insurance information (all are Y/N indicators)

Any insurance coverage — College Student
- If yes … name of insurer — if yes … full or part-time
- Policy number
- Name of policyholder

FC because of work related accident
FC because of motor vehicle accident
Lawsuit or insurance claim pending for coverage of this illness or injury

Pending application for:

CMSP	Health Start
MassHealth	Transitional Assistance
Boston Health Net	Cambridge Hetwork Health
CenterCare	EAEDC

Approved for FC at another CHC or hospital … if yes, name of hospital or CHC

Hospital or CHC provided information

Patient record information
Medical record number:
Patient billing number:

Documentation
Type of income documentation collected:
Type of residency documentation collected:
Asset documentation collected:
Indicator if documentation was not collected because charges are <$500

Alternative program screening
Reason why patient was not enrolled in MassHealth
- Income ineligible
- Characteristically ineligible
- Applied but denied
- Declined to apply
- Asset ineligible
- Patient already enrolled in MassHealth

Free Care approval
Type of free care awarded
- Full free care
- Partial free care
- Medical hardship
- Free care denied

Amount of patient contribution or deductibles before awarding full free care

Date of Application:
Eligibility begin date:
Eligibility end date

Indicator if patient signature is on file (Y/N):
Name of provider employee making determination:
Name of provider employee reviewing and approving determination:

For Medical Hardship applications only

Type of medical expenses	**Assets**
Health insurance premium:	Name (type of asset):
Allowable medical bills:	Owner of asset:
Medicare part A premium:	Bank or other loan holder name:
Medicare part B premium:	Account number:
Annual cost of medical expenses:	Cash Value:

LISTING OF PARTICIPATING HOSPITALS:

Hospital Name	Free Care % of Total Volume	Approximate FY03 Free Care Costs
Anna Jaques Hospital	1.6%	$1,240,475
Athol Memorial Hospital	2.5%	$325,097
Baystate Medical Center	2.3%	$9,075,810
Berkshire/Hillcrest	2.6%	$3,972,522
Beth Israel Deaconess Medical Center	2.6%	$13,970,039
Boston Medical Center	23.4%	$152,200,000
Brigham & Women's Hospital	2.3%	$15,678,319
Brockton Hospital	5.4%	$6,230,831
Cambridge/Somerville Hospital	29.5%	$85,800,000
Cape Cod Hospital	2.2%	$4,015,662
Caritas Norwood	1.5%	$1,696,187
Carney Hospital	3.7%	$3,154,817
Children's Hospital	0.9%	$3,975,386
Clinton Hospital	3.9%	$520,869
Cooley Dickinson Hospital	2.2%	$1,344,415
Dana-Farber Cancer Institute	0.9%	$1,141,964
Deaconess Glover Hospital	0.9%	$204,884
Deaconess Nashoba	2.0%	$594,547
Deaconess Waltham	2.2%	$1,429,217
Emerson Hospital	0.9%	$776,896
Essent Health/Merrimack Valley	2.1%	$830,526
Fairview Hospital	2.9%	$571,454
Falmouth Hospital	1.6%	$1,273,126
Faulkner Hospital	2.4%	$2,105,744
Franklin Medical Center	3.7%	$2,105,244
Good Samaritan Medical Center	3.2%	$3,247,559
Hallmark Health	1.8%	$3,985,699
Harrington Memorial Hospital	2.3%	$990,860
HealthAlliance	1.8%	$1,527,527
Henry Heywood Memorial Hospital	1.9%	$1,051,648
Holy Family Hospital	2.6%	$2,548,951
Holyoke Hospital	2.6%	$1,628,503
Hubbard Regional Hospital	3.0%	$640,420
Jordan Hospital	1.5%	$1,348,717
Lahey Clinic Hospital	0.8%	$2,589,949
Lawrence General Hospital	4.0%	$4,136,287
Lowell General Hospital	1.5%	$1,529,590
Marlborough Hospital	3.5%	$1,168,577
Martha's Vineyard Hospital	N/A	N/A
Mary Lane Hospital	2.4%	$450,732
Mass. Eye and Ear Infirmary	1.2%	$994,270
Mass. General Hospital	2.6%	$20,623,735
Mercy Hospital	2.3%	$3,009,965
Metrowest Medical Center	2.2%	$3,836,638

Milford-Whitinsville Hospital	1.8%	$1,376,572
Milton Hospital	1.2%	$490,162
Morton Hospital	2.1%	$1,541,734
Mount Auburn Hospital	1.5%	$2,166,526
Nantucket Cottage Hospital	4.7%	$698,074
New England Baptist Hospital	0.1%	$102,953
New England Medical Center	2.1%	$6,031,933
Newton-Wellesley Hospital	0.9%	$1,288,302
Noble Hospital	1.9%	$667,990
North Adams Regional Hospital	1.4%	$452,520
Northeast Hospital Corporation	2.8%	$4,004,401
North Shore Medical	2.6%	$4,148,631
Quincy Hospital	2.3%	$2,153,319
Saints Memorial	2.3%	$1,964,512
South Shore Hospital, Inc.	1.4%	$2,740,869
Southcoast Hospital	2.2%	$8,170,807
St. Anne's Hospital	2.2%	$1,683,207
St. Elizabeth's Hospital	1.1%	$2,026,594
St. Vincent Hospital	2.7%	$4,762,143
Sturdy Memorial Hospital	2.2%	$1,601,754
UMass Memorial	2.2%	$11,613,681
Union Hospital	2.9%	$2,263,523
Winchester Hospital	0.6%	$750,441
Wing Memorial Hospital	3.5%	$1,204,861

$433,449,167