Office of the Inspector General

Commonwealth of Massachusetts

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Ongoing Analysis of the Health Safety Net Trust Fund And Other Health Care Issues

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Massachusetts Office of the Inspector General

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Introduction

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

Section 152 of Chapter 131 of the Acts of 2010 directed the OIG to maintain a pool audit unit to oversee and examine the practices in all Massachusetts hospitals, including the care of the uninsured and the resulting free care charges. This report is in accordance with the requirements of Chapter 131, in concert with the OIG's ongoing review and examination of health care in Massachusetts.

As the cost of providing health care has grown, the OIG has explored cost containment and reimbursement issues related to the HSN, MassHealth, and the private insurance market. In addition, during 2010 the OIG reviewed the method by which CHCs were reimbursed by the HSN and by MassHealth and examined whether these two programs have effective eligibility review procedures.

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HEALTH SAFETY NET

A) Claims and Eligibility Editing

Chapter 58 of the Acts of 2006, which created the Health Safety Net, required that reimbursement for services be structured in a manner similar to Medicare's methodology. The Division of Health Care Finance and Policy's ("DHCFP") regulations regarding reimbursement, 114.4 CMR 14.00, reference various Medicare formulae and indices, which guide DHCFP when reimbursing acute care hospitals and community health centers for HSN services.

In order to minimize erroneous reimbursement, the HSN, like Medicare, was supposed to install Medicare-like claim edits. Claims editing is a process in which a third party examines codes, such as the Healthcare Common Procedure Coding System ("HCPCS") codes and diagnosis codes, associated with health care services provided to a patient. These codes form the basis of Medicare reimbursement and are used to determine HSN reimbursements. To date, many of these Medicare-like claim edits have not been implemented effectively. For example, Correct Coding Initiative Edits are one set of edits used by CMS to secure the accurate reimbursement of outpatient claims. DHCFP is not using these edits on its outpatient claims, and the HSN is therefore paying larger claim amounts than should be paid by a Medicare-like system.

If implemented properly, appropriate edits would minimize, if not eliminate, the following:

1. *Payments for Non-Massachusetts Residents*

   By statute, M.G.L. c.118G, §39, only Massachusetts residents qualify for HSN services. The OIG has found HSN primary reimbursements for patients with out-of-state addresses and with foreign addresses. In addition, there were HSN primary reimbursements for patients who reside outside of Massachusetts but who list Massachusetts Post Office Boxes as their addresses.

2. *Payments for Medically Unnecessary Services*

Medicare claims editing can determine common tests associated with a diagnosis. Thus, if a claim is submitted for a test or service not associated with the diagnosis, the claims edit process allows Medicare to deny the claim and, if appropriate, reimburse after an investigation. The OIG observed that DHCFP is not using this claims editing process. Without this particular claims editing, DHCFP has less control over reimbursing hospitals and CHCs than Medicare does. The OIG will further review how this weaker control environment impacts the HSN.

3. *Duplicate Payments for the Same Services for the Same Patient*

Some providers may erroneously bill more than once for the same procedure to a patient. The OIG has observed several instances where a service has been billed more than once for the same patient, at the same time, and on the same date.

4. *Payments for Medical Unlikely Events*

On rare occasions, claims associated with one gender-specific procedure are erroneously submitted on behalf of a patient of the other gender. The OIG observed DHCFP reimbursing some of these claims.

B) Other Reimbursement Issues

1. *Excessive Payments for Primary Care at Hospital Settings*

Prior to 2010, acute care hospitals were not reimbursed by the HSN for primary care services if a CHC was located in the same geographic location. This prohibition no longer applies, and all acute care hospitals may now be reimbursed for primary care services. Historically, CHC payments have represented less than 12% of HSN claim payments. Allowing more primary care reimbursements for acute care hospitals should have the undesirable effect of reducing that 12% figure. The OIG questions the logic of allowing a

patient to obtain similar services at a more expensive setting. The system now has added an irrational and inflationary defect: The Health Safety Net will reimburse for primary care received at the most expensive setting – acute care hospitals – but not for primary care received at lower-priced and geographically convenient physician practices and mini-clinics.

2. *Reimbursements at Rates Above Hospital Charges*

The HSN reimburses for a very large number of claims at rates higher than hospital charges. For many outpatient claims, this might not be an unusual result; but for inpatient claims, there appears to be no valid reason for HSN reimbursements to exceed hospital charges. There are tens of millions of dollars of claims paid by the HSN in which the payments exceed hospital charges, and at least some of those payments appear to be for inpatient claims. Further investigation of this issue is recommended, but pending such an investigation, the OIG suggests that consideration be given to amending HSN rules to state that reimbursements for inpatient claims cannot exceed hospital charges.

3. *Reimbursements for Third Party Liability*

The OIG has observed several instances in which the HSN has become the primary payer for claims that appear to be related to either an automobile accident or a workers' compensation case. In both cases, the HSN should not be utilized to cover costs. While the HSN has contracted with the Accident Trauma Recovery Unit of the Commonwealth Medicine Division of the University of Massachusetts Medical School to provide third party liability recoupment, it appears that eligible recoupment amounts greatly exceed amounts actually recouped. Moreover, it appears that there has been no attempt yet to recoup HSN payments from other third party liability sources such as commercial health insurers. DHCFP has stated that it is in the process of negotiating a contract with an entity that would seek such recoupment. Also, there appear to be a large number of HSN primary

reimbursements for seniors, many of whom are likely to be covered by Medicare. And there appear to be many HSN primary reimbursements for college students, who are generally covered by health insurance policies as required under the Qualified Student Health Insurance Program. Third Party Liability recoveries should be pursued in all of these cases.

C) Primary Care Delivery

One of the goals of the HSN is to pay for primary care services in the most cost-effective manner. Since non-hospital licensed CHCs generally deliver primary care at a lower cost than hospital outpatient departments, DHCFP regulations encourage HSN patients to receive primary care at these centers.

DHCFP considers CHCs to be a cheaper setting because reimbursement by the HSN to the community health center is usually based upon the Medicare Federally Qualified Health Center ("FQHC") patient visit rates, currently set at $125.72. While ancillary services would add to that rate, the same services delivered in a hospital setting, under the Medicare methodology, would cost considerably more.

A related reimbursement issue affecting all Commonwealth programs is the apparent distinction that is made between hospital-licensed CHCs and other CHCs that are independently owned and licensed and referred to as "free standing" clinics. This latter group is reimbursed for all public programs at rates ranging from $128 to $135 for basic medical visits (see 114.3 CMR 4.00). The hospital-licensed centers are paid as if they are outpatient departments of the hospital. These rates are considerably more than the $128 to $135 range. Inasmuch as the hospital-licensed centers are delivering the same services as the free-standing centers, the discrepancy in reimbursement should be questioned.

D) Eligibility Issues

In order for the HSN to reimburse acute care hospitals and CHCs for services rendered to uninsured or underinsured patients, the patients must be eligible for HSN assistance. Under M.G.L. c.118G, §35(b), the HSN is required to ensure that payments from the

fund are made for health services for which there is no other public or private third party payer, and is directed to disallow payments to acute hospitals and community health centers for health services provided to individuals if reimbursement is available from other public or private source. Unfortunately, under the current eligibility review procedures, the HSN often is not the payer of last resort.

The Commonwealth determines HSN eligibility by reviewing the Medical Benefits Request ("MBR") form that all individuals applying for medical assistance must complete. Examination of MBR data and the MBR form suggests that there are several potential eligibility concerns.

Of particular concern is a loophole that makes it practically impossible for reviewers to verify the income levels of HSN applicants. Specifically, the MBR form is flawed in two respects: (1) The form allows applicants – and not the Commonwealth – to make the determination that they are applying for the HSN; and (2) Once applicants make this determination, the form also allows them not to provide a Social Security Number ("SSN"), even if they have one. Without an SSN, reviewers have very little ability to verify an applicant's income, making it possible for any higher income applicant potentially to receive health care services that are reimbursed by the HSN.

It should also be noted that even when an applicant does provide an SSN, reviewers verify only wage income, not total income. There does not appear to be any good reason to exclude non-wage income from verification.

Another concern, mentioned in the discussion of third party liability above, was the issue of college students who were determined to be eligible for HSN primary reimbursement. On numerous applications, college students even listed an institutional address (i.e., a college address) as their home address. The OIG believes that the practice of listing a college address as a home address should raise an alarm for MassHealth reviewers. The HSN is the payer of last resort and should not be billed for services that a college health plan is responsible for providing.

Also, the OIG believes that the HSN has reimbursed for children who should have been eligible for MassHealth. Because the OIG's investigation is based on claims submitted, further time and information is needed to review this issue. Anecdotally, date of birth does not seem to trigger any system alert since the OIG found that the HSN reimbursed providers for claims with patient birthdays in the 1880s.

Finally, the OIG has learned that MassHealth performs redeterminations on a yearly basis. In this current economic climate, the Commonwealth should take steps to ensure that it is providing assistance to those who truly need it. More frequent redeterminations would provide early identification of recipients who have significant increases in their income. Increasing the frequency of redeterminations to a quarterly basis, while time consuming, could save millions of dollars. This conclusion is consistent with findings by Pennsylvania Auditor General Jack Wagner, who found that quarterly redetermination would produce substantial savings for Pennsylvania's Medicaid program.

MASSHEALTH

A) Reimbursement Practices

The Office of the Inspector General is reviewing MassHealth's reimbursement practices with respect to three specific areas:

1. Reimbursements for similar services are higher at teaching hospitals than at non-teaching and community hospitals.

2. Some providers have negotiated higher reimbursement rates from MassHealth because they have a larger volume of the MassHealth market. The OIG questions why MassHealth is reimbursing certain providers at a higher rate for the same service.

3. The OIG understands that hospitals and clinics located outside of Boston but operating as a component of a Boston-based health network charge MassHealth an additional fee, referred to as an "institutional fee." While the services provided at facilities within a health network located outside of Boston should be less expensive than those provided at facilities within the same network located in Boston, the imposition of an "institutional" fee results in the same charge from both facilities. This eliminates any savings from providing the services outside of Boston. Do MassHealth payment guidelines allow for this additional charge? If not, has MassHealth challenged the imposition of the institutional fee?

B) Approaches to Contain MassHealth Costs

Currently, MassHealth Managed Care Organizations ("MCO") do not compete for business on the basis of price. While MCOs do make price bids, there is little incentive to bid low because low bids do not lead to an increased MassHealth market share for the MCOs. In fact, if an MCO were to attempt to produce a low bid by significantly limiting its network of providers available to MassHealth members, the MCO would actually lose market share. This is because MassHealth members are allowed to

choose any MassHealth MCO, and the MCOs with the broadest provider networks are more attractive to members.

Since the capitated payment MassHealth pays to the MCO is irrelevant to MassHealth members, the best strategy for an MCO is to use the broadest provider network at the highest price acceptable to MassHealth. Essentially, instead of competing on the basis of the lowest price, the MCOs are competing on the basis of the broadest provider network. A truly limited network, which is the best available tool to contain MassHealth costs, would place the MCO at a competitive disadvantage in the MassHealth marketplace.

The most recent round of MassHealth bids illustrate the anti-competitive nature of the bidding process. For contracts effective July 1, 2010, all five MCO bidders proposed broad provider networks at prices deemed too high by MassHealth. MassHealth then negotiated separately with each MCO to lower those bids somewhat. However, the provider networks were not modified as part of these negotiations and remained broad, indicating that the significant savings associated with adopting truly limited networks were not realized. MassHealth members still had access to many of the highest-priced providers in Massachusetts, thereby inflating the MassHealth capitated rates of the MCOs.

The Patrick Administration has announced that it intends to rebid the MCO MassHealth contracts for FY 2012. The OIG strongly supports this process as a way to control MassHealth costs.

In the rebidding process, the OIG recommends using at least one – and possibly both – of the following approaches to containing MassHealth costs:

1. MCOs should be informed that significant reductions in capitated MCO payments will be required and that the MCOs should restrict their provider networks accordingly in order to achieve these reductions.

2. The bid process should be revised to select only the two lowest bidders in each region and to allow MassHealth members to have their choice of the two lowest bidders in their region.

The OIG strongly recommends that any bid process involve two steps. First, there should be a pre-qualification of all bidders based only on the quality of the MCOs and the health care services they provide. The quality standards should be rigorous and should require that MassHealth members receive high quality health care services. The MCOs that meet the quality standards should then advance to a second round of bidding, which should be based only on price. In its oversight of procurement by the Commonwealth, the OIG has determined that this kind of two-step process yields high quality services, as well as the best value for the public.

C) Asset Testing

Participation in many MassHealth programs, particularly long term care services, requires virtually a complete depletion of liquid assets. The HSN has no such requirement. An applicant with an unlimited net worth could therefore qualify for participation in the program. While the OIG recognizes that the HSN does not cover the depth of services that are covered by long term care, the fact remains that one program requires that need not only be demonstrated but verified, while the other does not.

Furthermore, DHCFP stated in its 2010 report that 45% of the HSN applicants reported no income at all on the MBR. This number is troubling to the OIG because any form of public assistance must be reported as income on the MBR, so either applicants are not on public assistance or they are failing to report. This issue coupled with the OIG's review of 2009 claims raise a red flag that applicants may be deceiving MassHealth to gain access to the HSN. Even the threat of an asset test could be sufficient to curb this reporting trend.

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PRIVATE HEALTH INSURANCE

A) Premium Regulation

The OIG approached the Patrick Administration in December of 2008 and proposed that the Division of Insurance ("Division") use existing premium regulation authority to examine the cost containment activities of the insurers and to reduce premiums. The Supreme Judicial Court has stated on several occasions that premium regulation should provide cost control as well as cost observation.

While the Division of Insurance did regulate premiums for small businesses to some extent in 2010, the Division has generally reduced double-digit increases for these businesses to an average annual increase slightly below 10%. Average increases not exceeding 9.9% are typically permitted for the small employer market, and for the large employer market, premium increases are generally unregulated and can be even higher than 10%.

Most significant, the Division's review of health insurance premiums did not appropriately examine the cost containment efforts of the insurers and did not hold insurers accountable for premium increases that were the result of the failure by insurers to exercise reasonable efforts to control health care costs. The OIG recommends that premium regulation should include a comprehensive examination of efforts by insurers to contain costs and should exclude from premiums all costs resulting from inadequate and unreasonable cost containment by insurers.

B) Global Payments

In the effort to contain health care costs, much discourse has centered on moving from a predominantly fee-for-service system to one based mainly on global payments to providers organized as Accountable Care Organizations ("ACO"). There is little doubt that fee-for-service reimbursements create incentives for providers to increase utilization of health care services, with obvious inflationary consequences. But moving to an ACO global payment system, if not done properly, also has the potential to inflate health care costs dramatically.

There is nothing inherent in the current marketplace that would cause an ACO-based global payment system to contain health care costs. The evidence, in fact, suggests the opposite conclusion. For the past two years, the primary experiment with global payments in the private insurance market in Massachusetts has been the Alternative Quality Contract ("AQC") popularized by Blue Cross Blue Shield of Massachusetts ("Blue Cross"). The payments to providers under this contract are made on a global capitated basis. The capitated amounts are determined by starting with the previous year's experience of the population of lives covered by the specific AQC. That entire amount becomes the base year from which all future payments are derived. Therefore, the AQC embraces and adopts any excessive or wasteful payments in that base year, including all overutilization resulting from over a decade's worth of fee-for-service provider contracts. Implicitly, the premium increases of that decade, which overall were well in excess of 100%, are made a permanent part of our health care system's cost structure.

Once the base year is determined, any excessive provider costs from that year are trended into the future. And the rate of the trend is alarmingly high. While specific details of individual AQCs are kept confidential by Blue Cross and the contracting providers, the OIG estimates that increases in reimbursements to providers over the five-year term of an AQC could be in the 50% range.

CONCLUSION

The OIG is engaged in several areas of the health care field in order to assist the Commonwealth in meeting its mandate to provide affordable, high quality health care. In doing so, the taxpayers' interest must also be protected. While the challenge of this task is significant, it also presents the opportunity to make the current system more responsive, equitable, and affordable for the citizens of the Commonwealth. The OIG will continue to work with any entity to take full advantage of this opportunity.