Report of the Special Commission on

Uncompensated CARE

December 27, 2002

UNCOMPENSATED CARE POOL
SPECIAL COMMISSION

December 16, 2002

Her Excellency the Governor
The Honorable Mark Montigny, Chair, Senate Ways and Means Committee
The Honorable John H. Rogers, Chair, House Ways and Means Committee
Patrick F. Scanlan, Clerk of the Senate
Steven T. James, Clerk of the House
The State House
Boston, MA 02133

Dear Governor Swift, Senator Montigny, Representative Rogers, Mr. Scanlan and Mr. James:

The Special Commission on Uncompensated Care hereby submits its final report. The Commission was established by Section 74 of Chapter 177 of the Acts of 2001, as amended by Sections 171 and 173 of Chapter 184 of the Acts of 2002. The Commission first met on September 9, 2002. Pursuant to Section 26 of Chapter 300 of the Acts of 2002, the Commission is required to submit its final report by December 16, 2002.

This Special Commission met while the environment for providing and funding health care for the uninsured and low income population was stressed and in flux. The Commonwealth is experiencing a fiscal crisis. One response to that crisis is to plan to limit eligibility for the MassHealth Basic program effective April 1, 2003. Another is to eliminate some benefits in the MassHealth program. Unemployment is also increasing, and many who rely on employer health insurance may be forced to utilize the Pool for health care in the upcoming months. These factors are expected to increase demand on the Uncompensated Care Pool. The Division of Health Care Finance and Policy and the providers were just completing implementation of a new electronic data submission, analysis, and reconciliation system that is producing new information on Pool usage. It should result in not only more timely and useful data for policymakers, but also more effective administration of the Pool, as the prior Commission had recommended. But, it also meant that trending of consistently defined data was not always possible and the data and analysis were not always available during the time the Commission met. Finally, changes in both the executive and legislative branches of government will occur in January 2003.

Because of these many changes that are currently in process, and in light of the time available to the Commission, it is not surprising that the Special Commission is not able to submit agreed to recommendations on which the full Commission took individual votes. However, the attached report provides detailed information about the various issues that we have explored, and transmits the reports and options proposed by the Division of Health Care Finance and Policy,

members of the commission and sub-committees established by the Commission. The information and analysis submitted by members of the commission and by the Division of Health Care Finance and Policy, as contained in the report, do not necessarily represent the views of the entire commission.

At the final meeting of the full commission, the options that the sub-committees developed, two by votes, and one by consensus, were received. There was a unanimous vote by Commission members that the sub-committees' work and additional options submitted by individual and groups of commission members should be identified as such and included in the Commission's final report. The Commission further agreed that a seven-day period would be allowed for interested parties to submit additional materials for inclusion as part of the record.

The report presents information and analysis submitted to the Commission, including background information on Pool history, current structure, management and relationship to other programs, as well as data demonstrating cost trends, services paid for by the Pool, and demographics of patients who incurred these services.

In addition, the report transmits options for future study by the Administration and Legislature submitted to the Commission regarding the future of the Uncompensated Care Pool. Several of these were presented to the Commission during its meetings. The first of these was submitted by five Commission members: Associated Industries of Massachusetts; Blue Cross Blue Shield of Massachusetts; Massachusetts Association of Health Plans; Massachusetts Business Roundtable; and Massachusetts Taxpayers Foundation. Other recommendations were submitted separately by the Massachusetts Council of Community Hospitals, the Massachusetts League of Community Health Centers, staff of the Division of Health Care Finance and Policy, and the Massachusetts Hospital Association. Subsequent submissions included a joint letter from the Massachusetts Hospital Association, the Massachusetts League of Community Health Centers, Health Care for All, the Massachusetts Nurses Association, and the Massachusetts Council of Community Hospitals, as well as additional separate recommendations from Children's Hospital, Health Care for All, and the Massachusetts Nurses Association.

The members of this Special Commission believe that resolving the issues facing the Uncompensated Care Pool requires the urgent attention of the Legislature and the new Administration. The detailed information and the broad range of options included in this report will enable you to make informed decisions regarding the Uncompensated Care Pool.

Senator Richard T. Moore
Co-Chair

Representative Daniel Keenan
Co-Chair

Secretary Robert Gittens
Co-Chair, Designee for the Secretary of Administration and Finance
Sec. 173 of Ch. 184 of the Acts of 2002

Bruce Bullen

Bruce Bullen

Ronald M. Hollander

James W. Hunt, Jr.

Richard C. Lord

Peter Meade

Robert Restuccia

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STATUTORY MANDATE

This Special Commission was established by Chapter 177, section 74 of the Acts of 2001, as amended by Chapters 184, sections 171 and 173 and by Chapter 300, section 26 of the Acts of 2002. The amended language is as follows.

"There shall be a special commission for the purpose of devising a fair and equitable allocation of the burden of uncompensated care and free care among affected participants in the health care delivery system, so that no single participant or group of participants bears a disproportionate burden for the cost of providing such care.

"The commission shall consist of 9 voting members as follows:

1 member of the house of representatives,
1 member of the senate,
the secretary of administration and finance or his designee,
and 6 persons to be appointed by the governor,

1 of whom shall be a representative of the Massachusetts Hospital Association,
1 representative of Blue Cross and Blue Shield of Massachusetts,
1 of whom shall be a representative of the Massachusetts Association of Health Maintenance Organizations,
1 of whom shall be a representative of Associated Industries of Massachusetts,
1 of whom shall be a representative of the Massachusetts League of Community Health Centers,
and 1 of whom shall be a representative of Health Care for All.

"The commission shall also consist of 5 nonvoting members to be appointed by the governor,

1 of whom shall be from the Massachusetts Council of Community Hospitals
1 of whom shall be a representative of the Massachusetts Nurses Association,
1 of whom shall be a representative of Children's Hospital,
1 of whom shall be a representative of the Massachusetts Business Roundtable, and
1 of whom shall be a representative of the Massachusetts Taxpayers Foundation.

"The commission shall be jointly chaired by the members from the senate and house of representatives and the secretary of administration and finance or his designee and shall adopt such rules and establish such procedures as it considers necessary for the conduct of its business. No action of the commission shall be considered official unless approved by a majority of the voting members of the commission.

The commission shall have the following duties and responsibilities:

(a) to develop a suitable plan to establish a fair and equitable assessment to pay for the uncompensated care and equitable distribution of any such assessment, including maximizing the amount of federal financial participation to which the commonwealth may be entitled;

(b) to develop a plan that includes incentives for the utilization of insurance programs, including programs operated by the division of medical assistance, wherever possible, such as payment methodologies that are not more favorable than those used by such insurance programs, as well as recommendations for more efficient and effective administration of the uncompensated care pool; and

(c) to prepare any legislation necessary to effectuate the recommendations of the commission.

"In pursuing its responsibilities and duties, the commission shall consult with parties affected by the commission's study, and shall, prior to voting on any final recommendations, consult with the parties affected by the recommendations, including, but not limited to,

the executive office of health and human services,
the division of health care finance and policy,
the division of insurance,
the division of medical assistance,
the Massachusetts Health Care Purchasers group,
the small business advisory board, established pursuant to section 22 of chapter 188G of the General Laws,
the Massachusetts Law Reform Institute,
the Massachusetts Council of Community Hospitals,
the Life Insurance Association of Massachusetts,
the AFL-CIO and
organizations representing chambers of commerce.

"The commission shall use as the basis for the development of its plan quantifiable data as it relates to the projected impact of any assessments, provider taxes and federal financial participation; provided, however, that the data shall be included in the commission's final report.

"The commission shall file its final report, including any proposed legislation necessary to effectuate the recommendations of the commission, with the clerks of the senate and house of representatives, with the house and senate committees on ways and means and with the governor on or before December 16, 2002."

MEMBERSHIP

Co-Chairs:	Senator Richard T. Moore, Senate Chair Joint Committee on Health Care
	Representative Daniel Keenan, House Chair Joint Committee on Insurance
	Secretary Robert Gittens, Administration Chair Executive Office of Health and Human Services
Voting Members:	Bruce Bullen, Chief Operating Officer Harvard Pilgrim Health Care representing the Massachusetts Association of Health Plans
	Ronald M. Hollander, President Massachusetts Hospital Association
	James W. Hunt Jr., President and CEO Massachusetts League of Community Health Centers
	Richard C. Lord, President Associated Industries of Massachusetts
	Peter Meade, Executive Vice President Blue Cross and Blue Shield of Massachusetts, Inc.
	Robert Restuccia, Executive Director Health Care For All
Non-Voting Members:	Dale Lodge, President Winchester Hospital representing the Massachusetts Council of Community Hospitals
	Alan Macdonald, Executive Director Massachusetts Business Roundtable
	James Mandell, CEO Children's Hospital
	Julie Pinkham, Executive Director Massachusetts Nurses Association
	Michael J. Widmer, President Massachusetts Taxpayers Foundation

SPECIAL COMMISSION PROCESS

The Special Commission held public meetings on the following dates:

September 9, 2002
September 30, 2002
October 21, 2002
November 12, 2002
December 2, 2002
December 16, 2002

In addition, the Chairs established three sub-committees, focusing on Funding, Management, and Scope of Services. The membership of these sub-committees, and the dates of their public meetings are as follows.

Funding

Secretary Gittens (Chair)	October 21, 2002
Bruce Bullen	November 5, 2002
Ronald Hollander	November 12, 2002
Michael Widmer*	December 2, 2002
	December 16, 2002

Management

Senator Moore (Chair)	October 21, 2002
Peter Meade	November 7, 2002
James Hunt	November 12, 2002
Alan Macdonald*	December 2, 2002
Dale Lodge*	December 16, 2002

Scope

Representative Keenan (Chair)	October 21, 2002
Richard Lord	October 29, 2002
Robert Restuccia	November 12, 2002
Julie Pinkham*	November 19, 2002
James Mandell*	December 2, 2002
	December 16, 2002

* Non-Voting Member

Finally, the Commission held an open forum for the parties named in statute as affected by the Commission's study to present their views on November 25, 2002.

BACKGROUND INFORMATION

Legislative History of the Uncompensated Care Pool

Ch. 574 of the Acts of 1985	Establishment of Uncompensated Care Pool • Hospital assets the only source of funding • Included all allowable costs for uncompensated care (free care & bad debt) • Pool costs = Maximum Allowable Costs ≠ actual costs • No aggregate cap: Pool funding = Pool costs • Allowable UC costs subject to cap (114% private sector patient care costs) • Administered by Rate Setting Commission
Ch. 23 of the Acts of 1988	Universal Health Care statute • Set limits on the size of the Pool ($325M in 1988, declining to $312 in 1991) • Established Department of Medical Security to set rules for the Pool and administer it • Established the Uncompensated Care Trust Fund to hold payments to and from the hospitals
Ch. 495 of the Acts of 1991	Deregulation of Hospitals • Changed reimbursement, restricted payments • Continued $315M cap indefinitely • Expanded definition of free care to include emergency bad debt, provided that the Pool would only pay for free care, not bad debt • Instituted greater proportional requirement provision for distributing the shortfall • Deleted the 114% cap on UC payments • Made freestanding community health centers eligible for payments from the Pool
Ch. 151 of the Acts of 1995	• Moved administration of the Pool from DMS to DHCFP
Ch. 47 of the Acts of 1997	Reform of the Uncompensated Care Pool • Hospital assessment reduced by $100M • $100M surcharge established • Commonwealth's contribution increased • Authorized transfer of funds to DMA • Instituted screening requirement • Restricted non-residents eligibility for free care • Authorized standard eligibility and other rules to be established by DHCFP • Required patient-level data collection • Authorized the Pool to participate in DOR wage reporting and income tax refund programs

Recent History of the Uncompensated Care Pool (1997-present)

Regulations
Following the last Special Commission on Uncompensated Care in 1997, the Division developed a new set of regulations governing free care eligibility and administration of the Uncompensated Care Pool.

114.6 CMR 10.00
114.6 CMR 10.00 establishes both the eligibility criteria for free care at acute hospitals and community health centers and the free care application process.

Development
114.6 CMR 10.00 was developed through a collaborative workgroup process. The workgroup included representatives from the Massachusetts Hospital Association, individual hospitals, the Massachusetts League of Community Health Centers, Health Care for All, Health Law Advocates, and other interested parties. This included development of a single free care application form to be used by all hospitals and community health centers. The application forms implemented the Division's new screening requirements by asking applicants a set of questions that indicate possible eligibility for other assistance programs, such as MassHealth. The regulation became effective October 1, 1998.

Implementation
- **Training** The Division conducted several training sessions for providers prior to the regulation's effective date in order to teach providers how to use the new application forms and conduct free care eligibility determinations. The Division has continued to conduct large annual training sessions for providers, in addition to many smaller training sessions throughout the year at the Division, on-site at provider locations, and at regional public health offices.
- **Credit and Collection Policy Review** The Division conducted a review of all providers' credit and collection policies to ensure compliance with the Division's requirements.
- **Publications** The Division wrote *The Free Care Application: A Guide for Acute Hospitals and Community Health Centers*, which is a handbook that walks providers through the free care eligibility process. The Division also created *Free Care Notes*, a quarterly newsletter for providers.
- **Grievance Process** The new regulation established a grievance process whereby applicants can appeal free care eligibility decisions directly to the Division if they choose. Approximately 80 to 90 patients per year exercise this option; approximately half are resolved in favor of the applicant and half in favor of the provider.
- **Other Support Services** The Division created the free care help line, which is a staffed phone line for answering questions about free care eligibility. This phone line receives approximately 80-90 calls per week from both applicants and providers. The Division translated the free care application into several languages: Spanish, Portuguese, Chinese, Vietnamese, Khmer, and Haitian Creole.

The Division continues to work closely with providers and patient advocates on issues surrounding free care eligibility to ensure that free care eligibility determinations are being made correctly.

114.6 CMR 11.00
114.6 CMR 11.00 governs the procedures for administering the Uncompensated Care Pool, including payments to and from hospitals, payments to community health centers, collection of payments from surcharge payers, and the Division's data collection requirements.

Development
114.6 CMR 11.00 was developed through an internal process, except for the sections regarding the surcharge (discussed below) and data collection requirements (see below). The regulation went into effect October 1, 1998.

Surcharge
The total amount to be collected via the surcharge, which was a new component of Pool funding in 1997, was established by the legislature. The Division sets the surcharge percentage annually at a level to produce $100 million. In order to develop an effective and equitable surcharge collection system, the Division established a surcharge workgroup to solicit input and advice from interested parties. This group—comprised of HMOs, commercial insurers, the Massachusetts Hospital Association, small businesses, labor representatives, and providers—met regularly over the course of several months as it developed the new system. This group continues to offer its assistance as the Division looks to make process improvements to the surcharge payment system.

The first year of the surcharge implementation was the most challenging, as the Division had to estimate the surcharge percentage needed to generate $100 million. In fact, the Division overestimated the surcharge in the first year, so the Division worked with the surcharge workgroup to determine the most appropriate way of distributing the excess. The Division decided to use a multi-year approach, which would make the surcharge percentage as predictable and constant as possible. Therefore, the Division has adjusted the amount collected each year so that the surcharge payers would not overpay the surcharge and so that the Division would collect enough to meet the $100 million requirement.

Currently, the Division is developing more automated ways for providers and payers to comply with surcharge reporting requirements, which will also assist the Division in its analysis and monitoring responsibilities. The cooperation of payers and providers has contributed to the Division's successful ongoing administration of the surcharge.

Settlements
The Pool makes monthly payments to hospitals and hospitals make monthly payments to the Pool on an estimated basis. The Division calculates the payment amounts based on a rolling average of each hospital's most recently reported 12 months of free care and private sector charges, adjusted for industry trends.

As required by M.G.L. c.118G, §18(h), the Division calculates the final payment amounts to and from the Pool after all hospitals' final audited Pool year data is available. The final payments made based on this final calculation are referred to as the final settlement of the Pool year. At final settlement, a hospital pays the Pool or the Pool pays the hospital the difference between amounts that were paid previously and the actual amount that should have been paid based on final data. Factors that would cause the final payment to differ from the initial estimated payment include a change in the amount of free care provided by the particular hospital or by all hospitals statewide, a change in the hospital's mark-up of charges over costs, a change in the hospital's overall payer mix, audit adjustments, and a change in the total funding available for uncompensated care statewide.

Final settlements cannot be completed until final audited free care charges, private sector charges, total charges, and total patient care costs are available for all hospitals. It often takes several years to resolve all outstanding audit issues for all hospitals, and as a result final settlements are often delayed.

In order to ensure that as little money as possible is held up until final settlement, the Division also conducts preliminary settlements. The Division conducts an preliminary settlement as soon as 12 full months of free care charges and private sector charges are available for the Pool year, as well as an updated cost to charge ratio. Conducting preliminary settlements helps prevent the need to transfer large unexpected dollar amounts upon final settlement.

At the time that the administration of the Pool was transferred to the Division, final settlements with hospitals for payments to and from the Pool were behind schedule. The Division has since succeeded in settling Pool years 1990 through 1998. Preliminary settlements with hospitals are up to date. The Division interacts with hospitals and community health centers on a regular basis throughout the year to monitor free care charges and costs, which makes the settlement process more efficient. Final settlements with CHCs are not required.

Data Collection

Chapter 47 of the Acts of 1997 instituted a requirement for hospitals and community health centers to submit data to the Pool. A detailed description of the data collection project is included in the section on Pool administration. The Division worked with hospitals, CHCs, vendors, and other interested parties to develop data collection systems that are reasonable for providers to comply with and that provide the Division with information necessary to administer the Pool.

Prior to drafting free care application and claims data submission standards, the Division held numerous meetings and workshops with hospitals, MHA, CHCs, the Massachusetts League of Community Health Centers, and other interested parties to agree on the best formats for submitting data. Hospitals and CHCs viewed application software prototypes during development and the Division incorporated additional features and functionality based on feedback received.

Free care application data collection started in 1999. Since the claim data specifications were issued in August 2000, the Division has provided ongoing technical assistance to hospitals and billing vendors working to implement the submission requirements. Most hospitals and CHCs are submitting some or all of their free care claims data to the Division.

Demonstration Projects

Chapter 47 of the Acts of 1997 created a number of demonstration projects, all of which are designed to potentially save money to the Pool. Three of these – EcuHealth Care in North Adams, Hampshire Health Access in Northampton, and the Fishing Partnership Health Plan (FPHP) – are designated in statute, with specific dollar award amounts. The Division is also authorized to expend up to $10 million of Pool funds on demonstration projects. The goal of these projects was to explore ways of improving care for the uninsured while reducing costs to the Pool. These projects were chosen through a competitive bidding process.

Uncompensated Care Pool Projections

Uncompensated Care: Sources and Uses of Funds (in millions)

Sources of Funds	**PFY03***	**PFY04***	**PFY05***
Uncompensated Care Pool			
Hospital Assessment	170	215	215
Surcharge on Payments to Hospitals	100	100	100
State Appropriation	45	30	30
Total Uncompensated Care Pool	315	345	345
Other Funds			
Intergovernmental Transfer (IGT)	70	70	70
c.495 §56 Compliance Liability Funds	0	0	0
Prior Fiscal Year Surplus Transfer	0	0	0
Transfer from Medical Security Trust Fund	0	0	0
Tobacco Settlement Fund	30	0	0
Total Uncompensated Care Funds Available	**415**	**415**	**415**
Uses of Funds			
Payments			
Hospital Free Care Costs***	466	494	524
CHC Free Care Costs***	24	25	27
Demonstration Projects	3	3	3
Impact of MassHealth Basic****	76	160	170
Transfer to Children's & Seniors' Health Care Assistance Fund*****	0	0	0
Audit Adjustments	(5)	(5)	(6)
Reserves			
Doubtful Accounts - Hospitals	1	1	1
Doubtful Accounts - Surcharge Payers	0.3	0.3	0.3
Data Collection	2	2	2
Surcharge Expenses	0	0	0
Other Reserves	0	0	0
Total Uses of Funds	**567**	**680**	**721**
(Shortfall) / Surplus	**(152)**	**(265)**	**(306)**

* This is a projection. The final shortfall/surplus estimate may be higher or lower by up to 5%, depending upon the
** Assumes hospital assessment restored to $215 million in PFY 2004.
*** As of May 2002 hospital UC form and CHC PV data (due to DHCFP by July 15). Assumes 6% annual growth in hospital & CHC costs.

**** These cuts are effective 4/1/03. The PFY 2003 estimate is for six months (April - September 2003). The PFY 2004 - 2007 estimates are for twelve months (October - September). Cost to Pool is based upon FY02 MassHealth Basic spending adjusted to reflect Pool benefits, utilization, and payment levels. The estimate is 100% of the Basic spending for inpatient and CHC services, 50% of Basic spending for pharmacy services, and 25% of Basic spending for all other services. Additionally, outpatient spending is adjusted by 40% to reflect higher payment levels from the Pool. Includes assumption of 6% inflation from PFY02 through PFY 07.
***** Assumes that transfer to C&S discontinued after PFY2002.

Hospital Environment

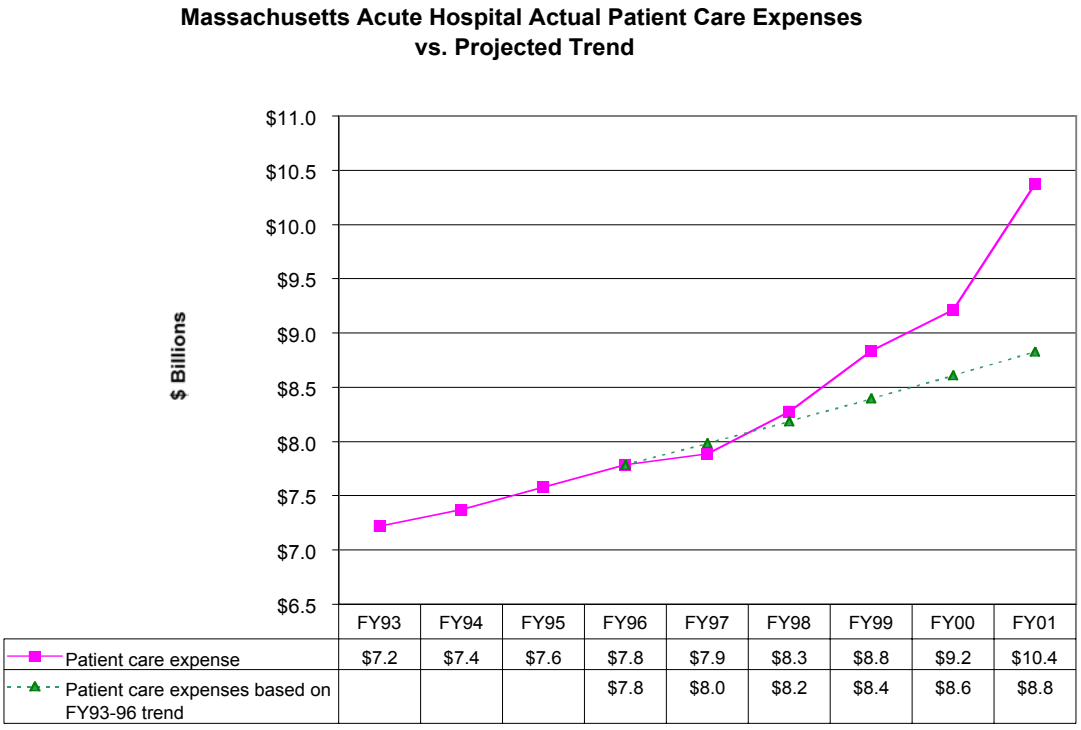
This section investigates how current uncompensated care costs compare to those projected by the 1997 Special Commission, and the differences between them. In particular, it looks at whether the MassHealth expansion had the intended effect on the Pool.

Because Pool pays primarily for hospital services, allowable free care costs are most directly influenced by hospital trends. Therefore, the first set of charts in this section present trends in hospital costs and utilization. The FY 97 Special Commission's projections were based on data through FY95; significant changes in trends after FY95 were not included in their projections.

The second set of charts in this section looks at Medicaid and Self-Pay volume.[1] After the MassHealth expansion that took effect July 1, 1997, Medicaid volume was expected to increase and self-pay volume to decrease.

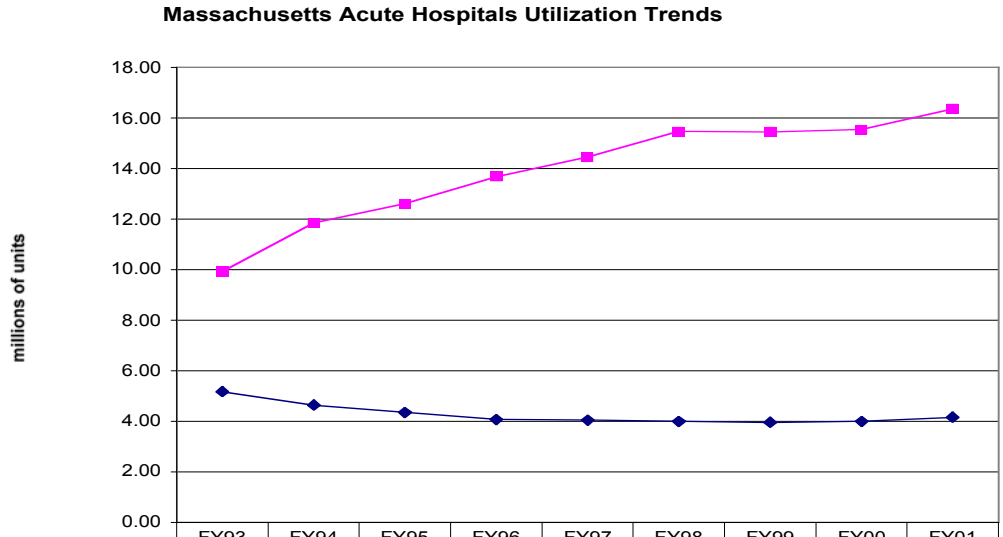
The data source for this series of charts is the DHCFP-403 cost report.

[1] Self-pay trends are largely indicative of free care trends. Self-pay and free care are not exactly the same, but they are largely overlapping categories. Self-pay includes patients who pay their own bills, and patients whose bills result in bad debt that is not billable to the Pool. Free care includes balances after insurance, which would not included under self-pay.



	FY93	FY94	FY95	FY96	FY97	FY98	FY99	FY00	FY01
Patient care expense	$7.2	$7.4	$7.6	$7.8	$7.9	$8.3	$8.8	$9.2	$10.4
Patient care expenses based on FY93-96 trend				$7.8	$8.0	$8.2	$8.4	$8.6	$8.8

Figure 1: Total acute hospital patient care expenses increased much faster in recent years than they did in the early nineties. Changes in total expenses include both changes in price and in utilization.



	FY93	FY94	FY95	FY96	FY97	FY98	FY99	FY00	FY01
Patient Days	5.17	4.64	4.34	4.07	4.03	3.99	3.95	3.99	4.16
Total Outpatient Visits	9.92	11.84	12.60	13.69	14.45	15.46	15.45	15.55	16.37

Figure 2: Total outpatient visits increased rapidly from FY93 through FY98, and more slowly through FY01. Inpatient days decreased from FY93 through FY99 and then increased slightly through FY01.

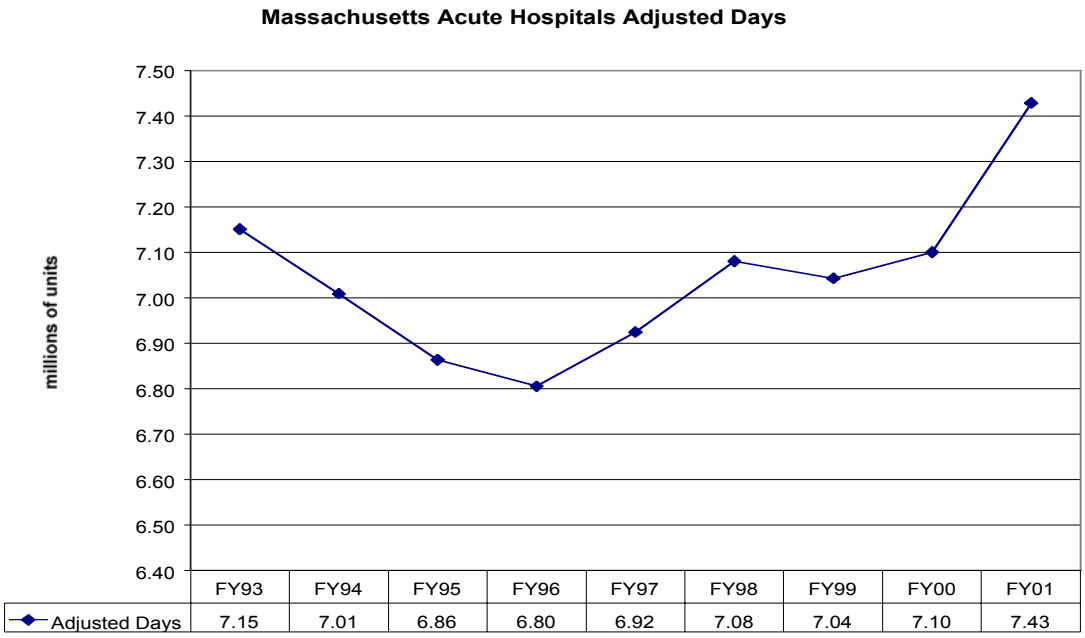


Figure 3: Total hospital volume declined from FY93 through FY96, and then increased through FY01 to a level above the FY 93 level.
NOTE: Hospital adjusted days is a single measure of total hospital volume. An inpatient hospital day costs approximately five times the cost of a single outpatient visit.
Adjusted days = (outpatient visits/5) + inpatient days.

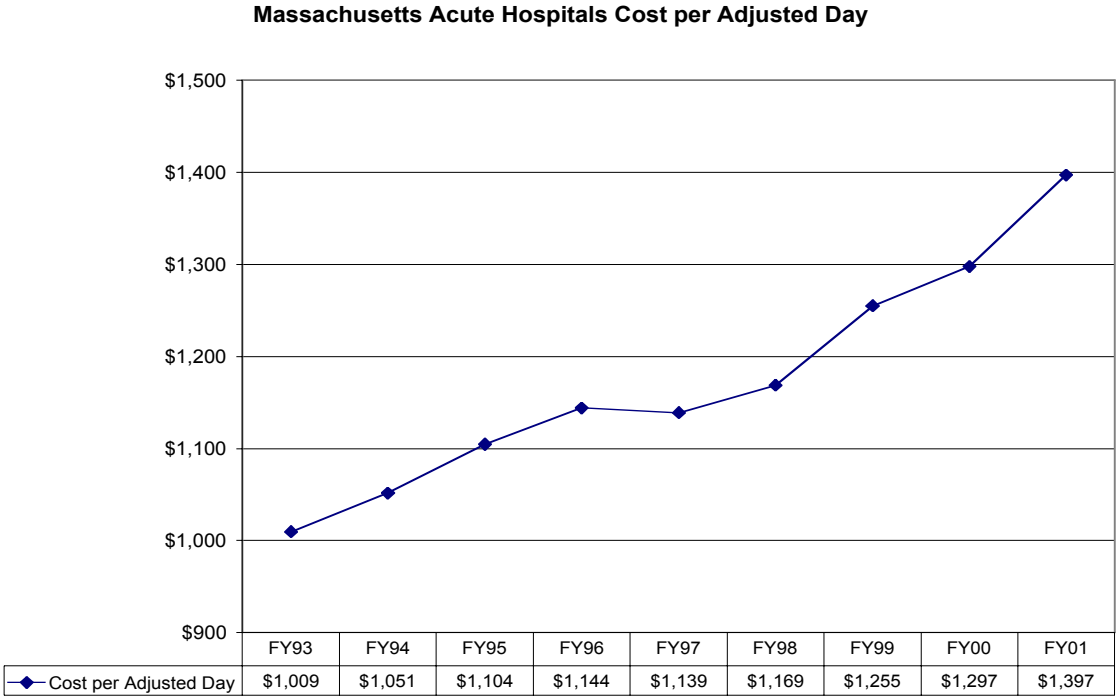
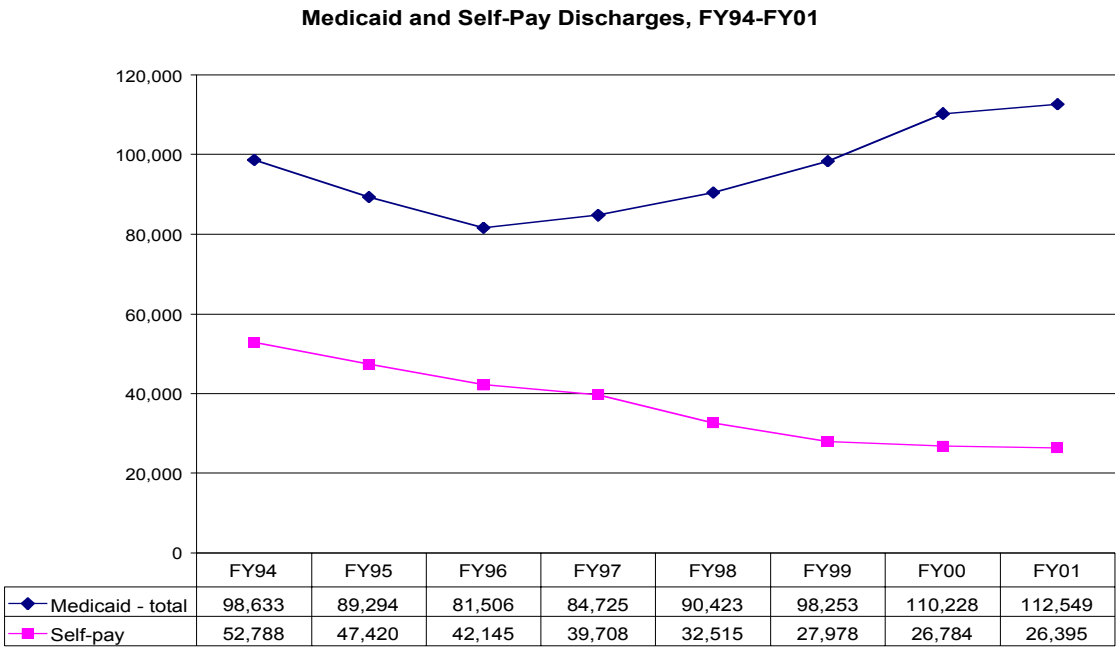
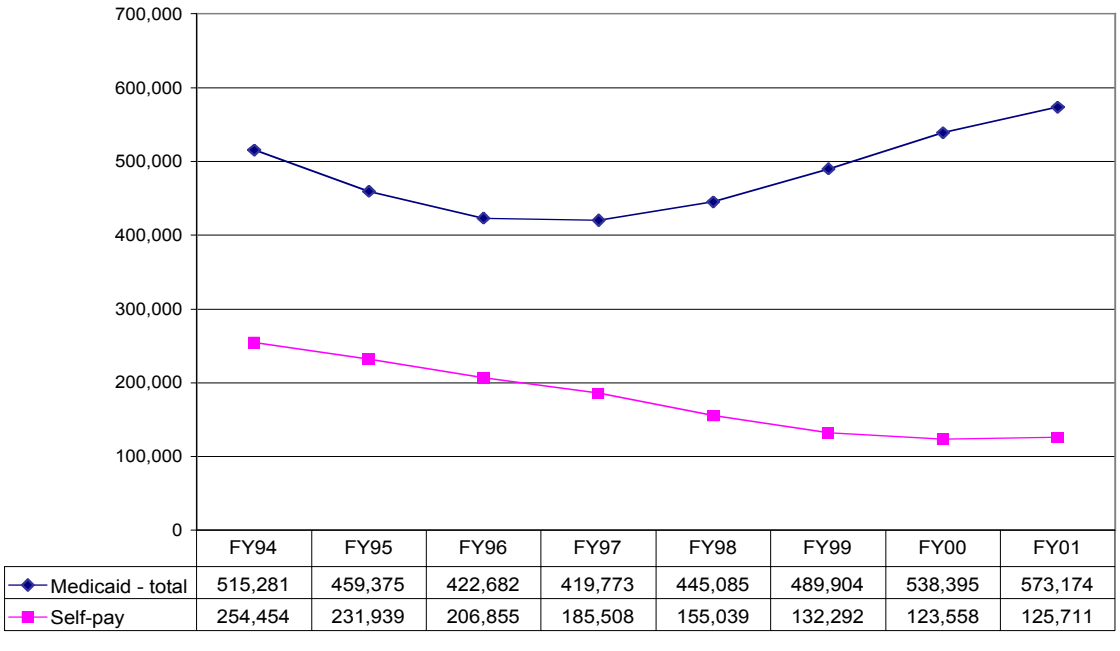


Figure 4: Total hospital cost per adjusted day (that is, cost per unit volume, or price) increased from FY93 through FY01, except for a dip in FY97. The average annual increase from FY93 to FY01 was 4.8%.



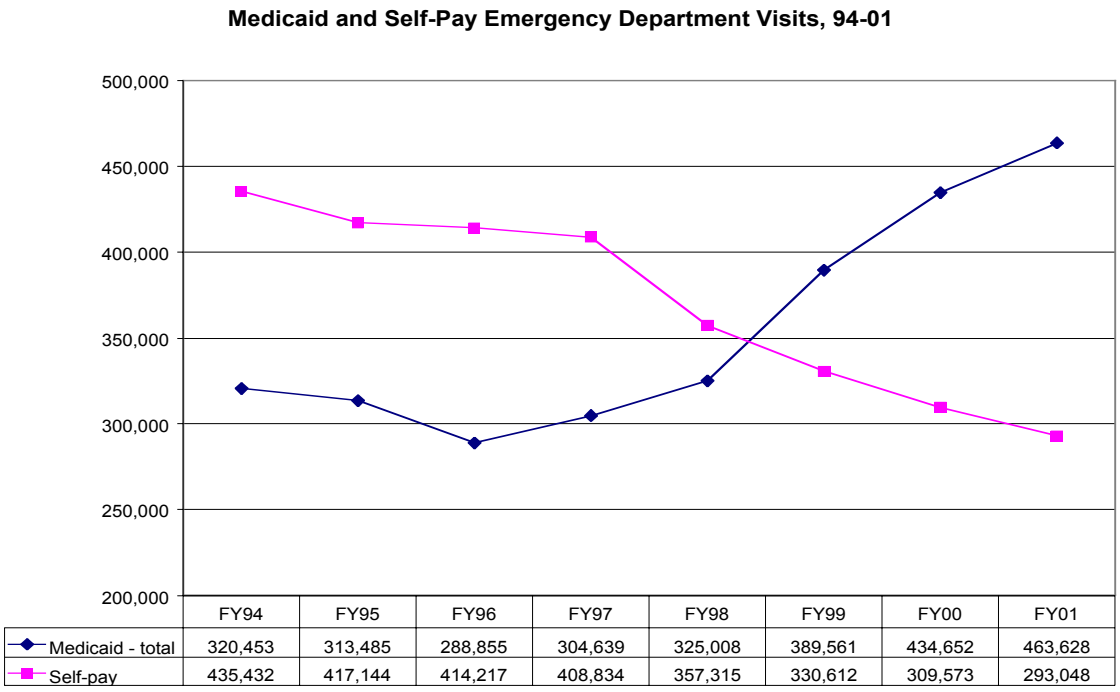
	FY94	FY95	FY96	FY97	FY98	FY99	FY00	FY01
Medicaid - total	98,633	89,294	81,506	84,725	90,423	98,253	110,228	112,549
Self-pay	52,788	47,420	42,145	39,708	32,515	27,978	26,784	26,395

Figure 5: The MassHealth expansion began July 1, 1997, which is the first day of the 4th quarter of hospital's FY97. Both Medicaid and Self-pay discharges deceased from FY94 to FY96. Medicaid discharges increased from FY96 through FY01. During this period, self-pay discharges continued to decrease, but self-pay did not decrease as much as medicaid increased.



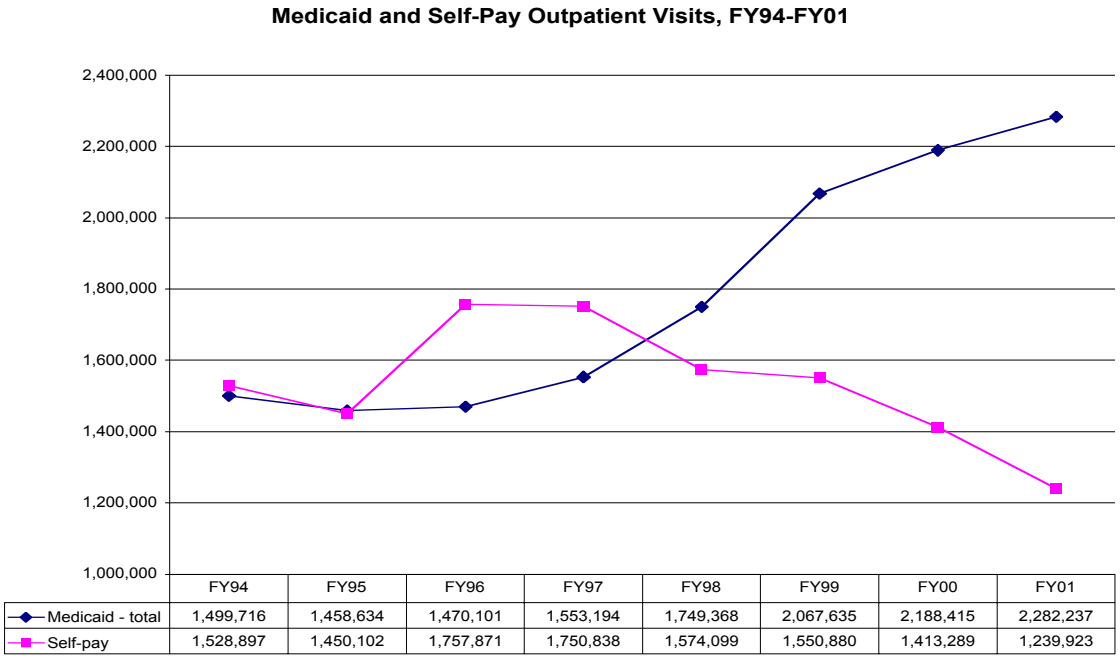
	FY94	FY95	FY96	FY97	FY98	FY99	FY00	FY01
Medicaid - total	515,281	459,375	422,682	419,773	445,085	489,904	538,395	573,174
Self-pay	254,454	231,939	206,855	185,508	155,039	132,292	123,558	125,711

Figure 6: The decrease in self-pay days from FY96 through FY01 was about 50% of the increase in Medicaid days.



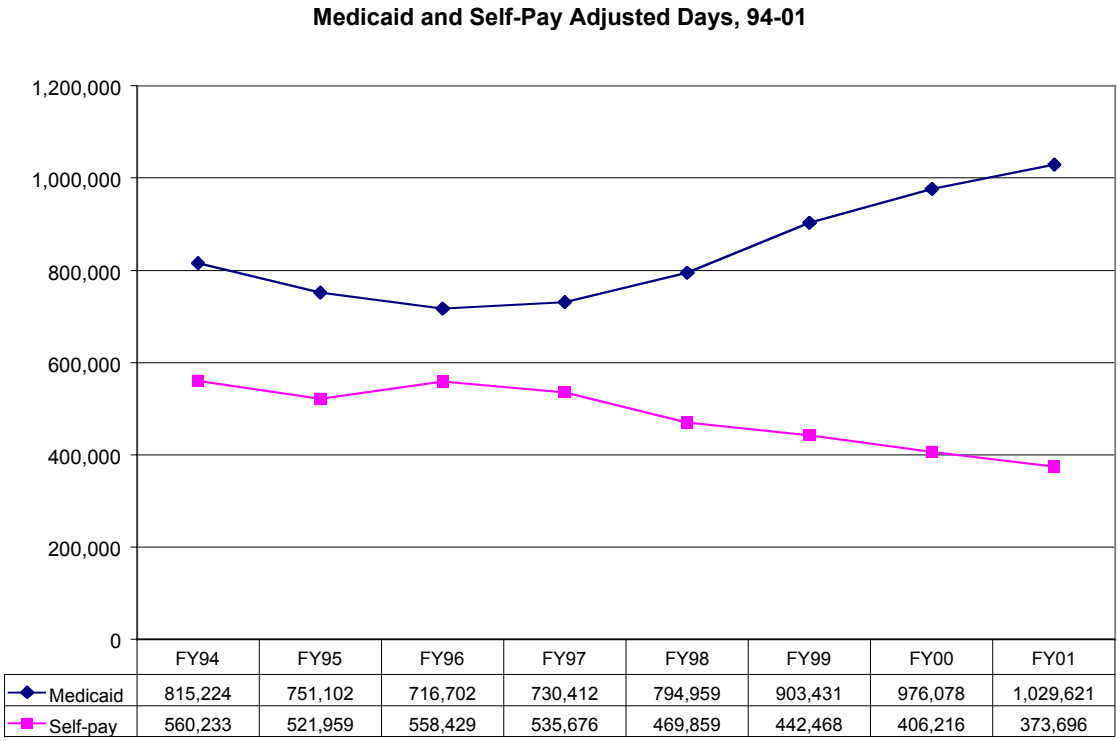
	FY94	FY95	FY96	FY97	FY98	FY99	FY00	FY01
Medicaid - total	320,453	313,485	288,855	304,639	325,008	389,561	434,652	463,628
Self-pay	435,432	417,144	414,217	408,834	357,315	330,612	309,573	293,048

Figure 7: Medicaid emergency visits exceeded self-pay emergency visits for the first time in FY99. Medicaid emergency visits have continued to increase, while self-pay emergency visits have continued to decline.



	FY94	FY95	FY96	FY97	FY98	FY99	FY00	FY01
Medicaid - total	1,499,716	1,458,634	1,470,101	1,553,194	1,749,368	2,067,635	2,188,415	2,282,237
Self-pay	1,528,897	1,450,102	1,757,871	1,750,838	1,574,099	1,550,880	1,413,289	1,239,923

Figure 8: Total Medicaid outpatient visits (including emergency visits) have also increase dramatically. Self-pay outpatient visits declined from FY97 through FY01.



	FY94	FY95	FY96	FY97	FY98	FY99	FY00	FY01
Medicaid	815,224	751,102	716,702	730,412	794,959	903,431	976,078	1,029,621
Self-pay	560,233	521,959	558,429	535,676	469,859	442,468	406,216	373,696

Figure 9: Overall, the decrease in self-pay volume from FY96 through FY01 was about 60% of the increase in Medicaid volume.
Adjusted days = days + (outpatient visits/5)

Analysis of Variance

This analysis attempts to quantify factors that caused actual hospital allowable free care costs to vary from those projected by the 1997 Special Commission on Uncompensated Care. The analysis is quantified on the following page.

The three factors examined are hospital costs increases (including both price and utilization), change in demand for Pool funds due to the MassHealth expansion, and changes in the mix of providers that draw on Pool funds. The analysis attempts to identify the effects of each of these factors separately, if all else were held constant.

It would be desirable to separate the effects of price increases and utilization and to examine the many other factors that could affect Pool demand. However, as each new factor is added, it is necessary to eliminate the overlapping effects of each of the other factors. As a result, each additional factor increases the complexity of the analysis geometrically, to the point that it was beyond the scope of this project.

The Projected values examined in this analysis are from the Report of the Special Commission on Uncompensated Care, February 3, 1997, Appendix N: Sources and Uses of Funds.

Cost increases. The first section of the analysis compares the projected increase in overall costs to actual increases in total hospital costs. The 1997 projections included a 4% annual increase in overall costs. If uncompensated care costs had represented a constant percentage of overall hospital cost increases, then uncompensated care costs would have increased at the same rate as total hospital cost increases. This section indicates that actual hospital cost increases were lower than 4% in FY00, but exceeded 4% in every other year from FY97 through FY02. The cumulative result of these under-projections is that the projections under-estimated expected free care costs by $116m in FY02.

MassHealth expansion. The section examines the impact of the MassHealth expansion. The projections include the share of MassHealth expansion programs' hospital spending that were expected to reduce Pool demand. The projections assumed that Pool demand would decrease by 60% of MassHealth expansion programs' hospital spending. In the 1997 report, the Insurance Reimbursement Program (now the Insurance Partnership and Family Assistance Programs) was broken out separately.

The actual MassHealth spending on hospital care comes from DMA's records, and are listed according to DMA's categories: families, disabled, and long-term unemployed. The actual MassHealth expenditures were also reduced by 60%. The 60% figure is validated by the volume analysis presented above: the reduction in self-pay adjusted days was approximately 60% of the increase in medicaid adjusted days.

This analysis indicates that the actual reduction in Pool demand due to the MassHealth expansion was roughly similar to the projections.

Change in provider mix. The 1997 projections did not assume any change in provider mix. However, the share of hospital allowable uncompensated care costs provided by the two large disproportionate share hospitals, Boston Medical Center and the Cambridge Health Alliance, has increased over time relative to other hospitals. This analysis indicates that this shift increased demand on the Pool by $17 million in FY02.

Analysis of Variance between Expected Savings to the Pool due to MassHealth Expansion vs. Actual Experience

			FY 97	FY98	FY99	FY00	FY01	FY02	
Total Allowable Hospital Free Care Costs									
	Projected			$373	$308	$287	$298	$310	
	Actual			$386	$374	$384	$393	$435	
	Variance			*$13*	*$66*	*$97*	*$95*	*$125*	higher than expected
Hospital Cost Increases (including both price and utilization)									
	Projected			4%	4%	4%	4%	4%	
			$427	$444	$462	$480	$499	$519	
				$17	$35	$53	$72	$92	= expected increase over FY 96 due to inflation
	Actual		4.9%	5.9%	8.7%	1.7%	12.4%	7.7%	= actual increase in MA hospital costs
			$448	$474	$516	$525	$589	$635	
			$21	$47	$89	$98	$162	$208	= actual increase over FY 96 due to inflation
	Variance		*4.9%*	*1.9%*	*4.6%*	*-2.2%*	*8.4%*	*3.7%*	
			$21	$30	$54	$45	$90	$116	higher than expected
Reduction in Demand for Pool Funds due to MassHealth Expansion									
	Projected	MA Exp		($71)	($122)	($127)	($132)	($138)	
		IRP		$0	($32)	($66)	($69)	($71)	
		Total		($71)	($154)	($193)	($201)	($209)	
	MassHealth	Families		($85)	($153)	($167)	($164)	($213)	Total MassHealth Spending on Hospital & CHC care for new members since expansion
		Disabled		($8)	($23)	($32)	($46)	($62)	
		LT Unemployed		($44)	($53)	($52)	($75)	($81)	
		Total		($137)	($229)	($251)	($285)	($355)	
				60%	60%	60%	60%	60%	% share self-pay volume declined relative to increase in MassHealth volume[1]
	Actual			($82)	($137)	($150)	($171)	($213)	
				($11)	*$17*	*$43*	*$30*	*($4)*	negative number = more savings than expected
									positive number = less savings than expected
Change in Provider Mix									
	Projected			$0	$0	$0	$0	$0	
	Actual	DSH hospitals		$23	$36	$17	$41	$28	
		Teaching hospitals		$4	($3)	$0	($19)	($8)	
		Non-Teaching hosps		($12)	($7)	($5)	($4)	($3)	
		Total		$15	$26	$12	$18	$17	higher than expected
Summary of Variances									
	Total Variance			$13	$66	$97	$95	$125	
	Components:								
	Hospital Cost Increases			$30	$54	$45	$90	$116	
	MassHealth Expansion			($11)	$17	$43	$30	($4)	
	Provider Mix			$15	$26	$12	$18	$17	
	Other Factors[2]			($21)	($30)	($3)	($43)	($4)	variance not explained by hospital cost increase or MassHealth expansion

[1]This ratio was used to appropriately adjust MassHealth spending for the proportion of new MassHealth members who, prior to the MassHealth expansion, accessed care through the Pool.

[2]Other factors include, but are not limited to, the effects of (1) Pool management, (2) any increase in awareness of the availability of free care, (3) changes in the economy that affect the rate of insurance, and (4) changes in the level of benefits offered by insurers.

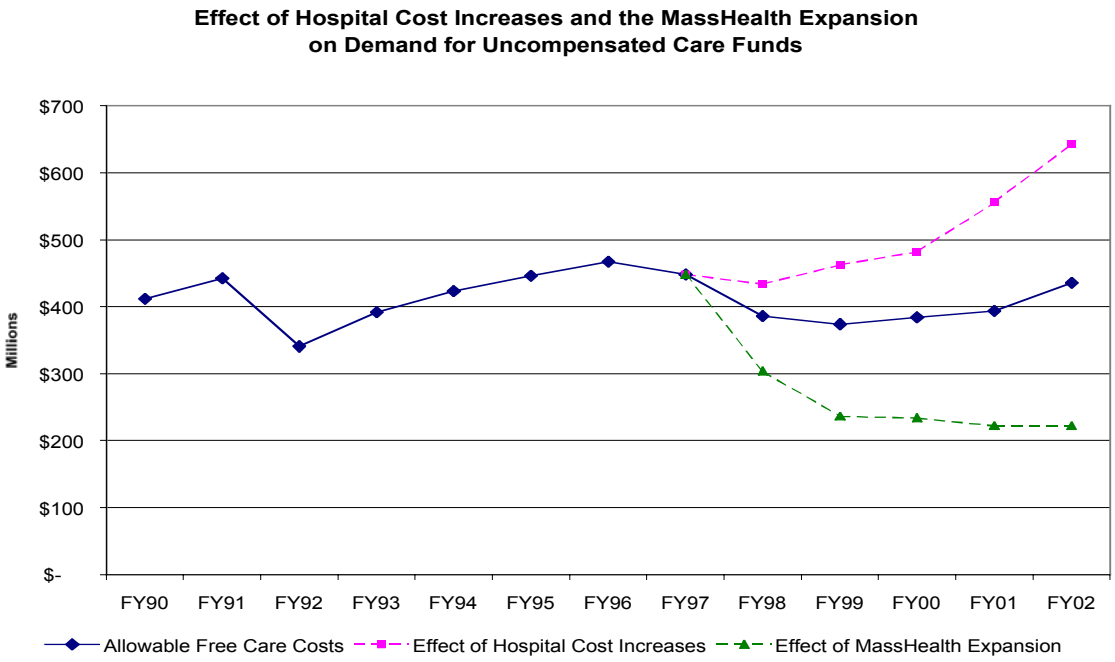
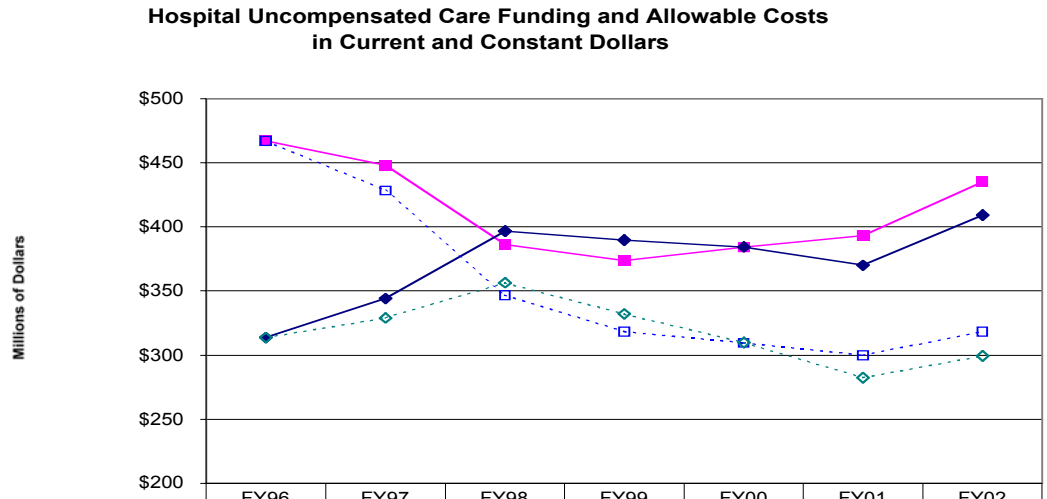


Figure 10: Actual free care costs declined from FY96 through FY99 and then increased slightly from FY99 through FY02. Higher than expected hospital cost increases exerted upward pressure on free care costs, while the MassHealth expansion exerted downward pressure.



	FY96	FY97	FY98	FY99	FY00	FY01	FY02
Cost - Current	$467	$448	$386	$374	$384	$393	$435
Funding - current	$314	$344	$397	$390	$384	$370	$409
Cost - Constant	$467	$428	$347	$318	$310	$300	$318
Funding - Constant	$314	$329	$356	$332	$310	$282	$299

Figure 11: Hospital allowable free care costs decreased in real terms from FY96 through FY01, and increased in FY02. Funding for hospital uncompensated care decreased in real terms from FY98 through FY01.
Note: Figures in constant dollars were calculated using the Medical Care Consumer Price Index (CPI) for the Boston-Brockton-Nashua, MA-NH-ME-CT region.

Eligibility for the Uncompensated Care Pool

Eligibility Criteria
In order to qualify for free care, a person must meet certain income and residency criteria that are established in the Division's statute and regulations.

Income
Applicants must provide documentation of family income when applying for free care. Gross income from all sources is used. A family is defined as the applicant, spouse, any minor dependents living in the household, and unborn children.

Full free care	0-200% FPL
Partial free care	201-400% FPL
Medical hardship	Any income level with very high medical expenses relative to the person's income and assets

Residency
Applicants must provide documentation of residency when applying for free care. A resident is defined as a person living in Massachusetts with the intention of remaining in the state indefinitely. A person who is a resident of Massachusetts is eligible for free care for medically necessary services provided by a hospital or community health center. A person who is not a resident of Massachusetts is eligible for free care only for urgent or emergency care provided by hospitals and community health centers. Residency is not dependent upon U.S. citizenship or immigration status.

Application Process
People must apply for free care at the provider where they are receiving or have received services. All providers use the same application form, which is designed by the Division. The form is available in English, Spanish, Portuguese, Chinese, Khmer, Vietnamese, and Haitian Creole. Free care is not transferable between providers; a person seeking free care at another provider must reapply for free care. It is not necessary to apply for free care in advance of receiving services; many people apply for free care after receiving services and receiving a bill (or many bills). A person's free care eligibility lasts for one year, unless the person's income, insurance status, or residency status changes to such an extent that the person no longer meets the eligibility criteria.

Providers are required to screen patients for potential eligibility for other programs before applying for free care. The electronic free care application is designed to assist with this screening process. Providers assist applicants with the free care application form and collect documentation. Providers are required to complete a free care determination within 30 days of receipt of a completed free care application with documentation. Providers are also required to enter all free care application information into the Division's free care application database. The Division conducts regular audits of providers to ensure that they are using the correct free care eligibility criteria and procedures.

Emergency Bad Debt
Bad debt resulting from emergency services provided to uninsured patients is also allowed to be written off to the Uncompensated Care Pool if the hospital meets the Division's requirements regarding collection activity and can document its collection attempts. Prior to billing the Pool the hospital must have completed and documented all collection activities conducted in compliance

with the requirements of 114.6 CMR 10.00, which includes attempts to obtain financial information and/or a completed Free Care application from the patient.

Uncompensated Care Pool Demographics and Utilization

Data used in this analysis was drawn from the following sources:

1. UCP Claims database: Hospitals and CHCs began electronic submission of data elements from UB-92 claims forms to DHCFP in March, 2001. As with applications, most providers are complying with this requirement, however most have not submitted 100% of the required claims data electronically. The database contains data from 1.7 million claims forms, documenting $1 billion in net uncompensated care charges, as of September, 2002. Claims data written off to free care ("billed" to the Uncompensated Care Pool") in FY01 (October, 2001 through September, 2002) were used for this analysis.

2. UCP Applications database: Hospitals and CHCs began submitting electronic free care applications forms to the Division of Health Care Finance and Policy (DHCFP) in October, 2000. Most providers are complying with this requirement, however most have not submitted 100% of their free care applications electronically. The database contains data from 340,000 application forms, as of September, 2002. Note that this data is as reported by the applicant, with documentation for income and residency.

3. Merged UCP Applications and Claims database: To the extent possible, DHCFP has matched claims data to applications data. Matching was based on social security number or tax identification number where available. Additional matches were based on other available data such as phonetic last name, phonetic first name, date of birth, provider, etc. There is no application associated with Emergency Bad Debt (ERBD), so ERBD claims data is excluded from the match. Approximately 40% of claims data has been matched to applications. Claims data written off to free care ("billed" to the Uncompensated Care Pool") in FY01 (October, 2001 through September, 2002) were used for this analysis.

4. Hospital Discharge Dataset (HDD). This is the inpatient discharge information submitted by hospitals to DHCFP, also known as Hospital Merged Casemix and Charge Data. This dataset includes information on all inpatient discharges from Massachusetts acute care hospitals from FY1985 through FY2001. FY95 and FY01 data are used in this analysis.

5. Report of the Special Commission on Uncompensated Care, February 3, 1997. This report contained a number of analyses of inpatient free care discharges. These analyses have all been replicated using the more recent data described above for purposes of comparison. The 1997 Special Commission analysis was based on the "John Hancock" Dataset. From 1993 through 1995 the Department of Medical Security, then administrator of the Uncompensated Care Pool, contracted with John Hancock Financial Services for utilization review of free care services. As part of this utilization review program, John Hancock created a database containing 11 data elements from UB-92 claims forms for approximately 60% of inpatient discharges written off to the Pool between October 1, 1993 and December 31, 1995. This data was then combined with DHCFP Hospital Discharge Data to create a comprehensive database. This data is referred to as "FY95" data in comparison charts for simplicity.

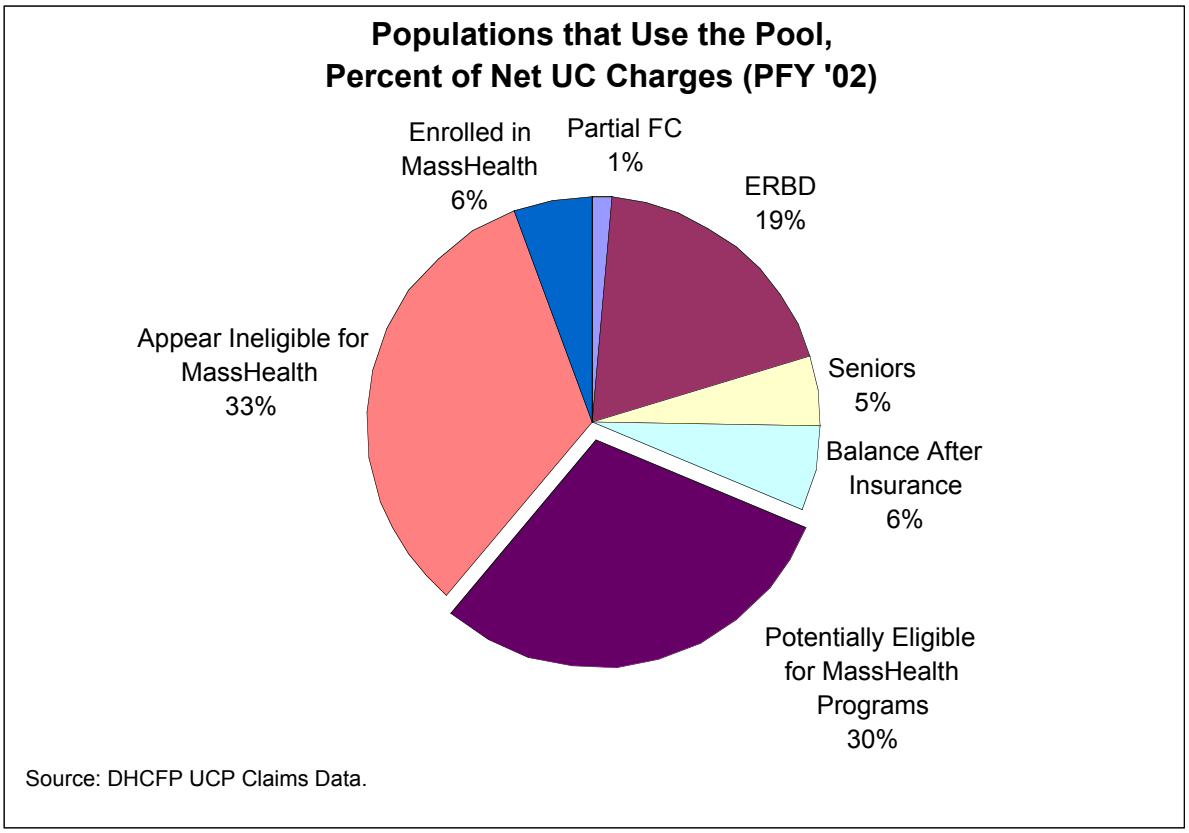


Figure 12: The Pool pays for patient care under many different circumstances. Providers are required to screen all free care applicants for eligibility for other programs. The largest group of Pool users are low-income, uninsured individuals who are ineligible for MassHealth or CMSP; however, this group represents only 33% of charges to the Uncompensated Care Pool. The Pool also pays for low-income individuals for:

- services not covered by other programs (e.g. MassHealth Limited and CMSP);
- services provided prior to MassHealth eligibility dates;
- services provided to patients who apply too late for MassHealth to cover this account;
- patients who decline to apply for MassHealth or other programs;
- balances after insurance for private patients;
- balances after insurance for Medicare patients,
- seniors ineligible for Medicare;
- bad debt resulting from emergency services provided to uninsured patients (patients who do not complete an application form); and
- partial free care for individuals with incomes 200-400% FPL.

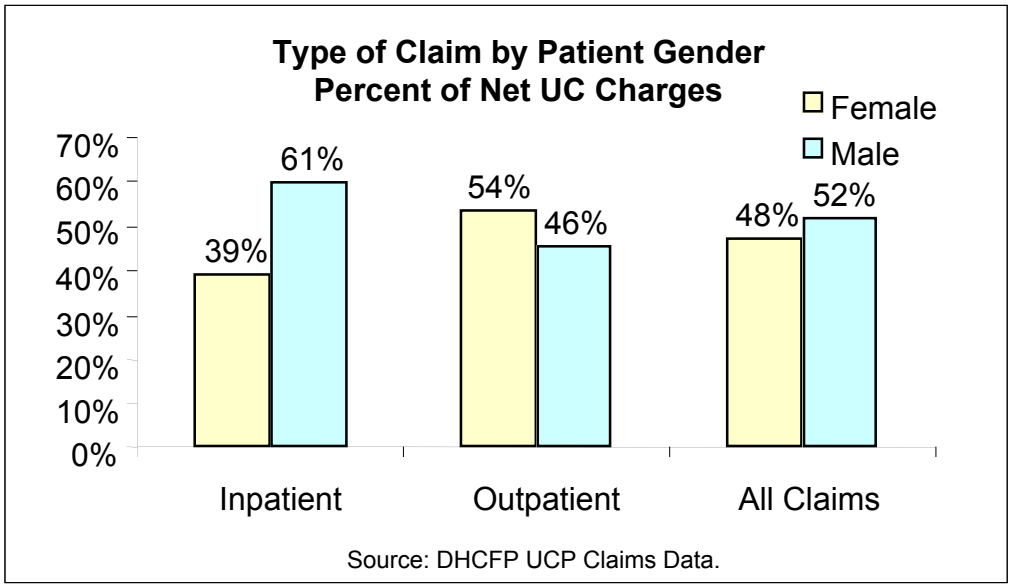


Figure 13: Males comprise a significantly larger proportion of inpatient claims, while females represent slightly more of the outpatient claims.

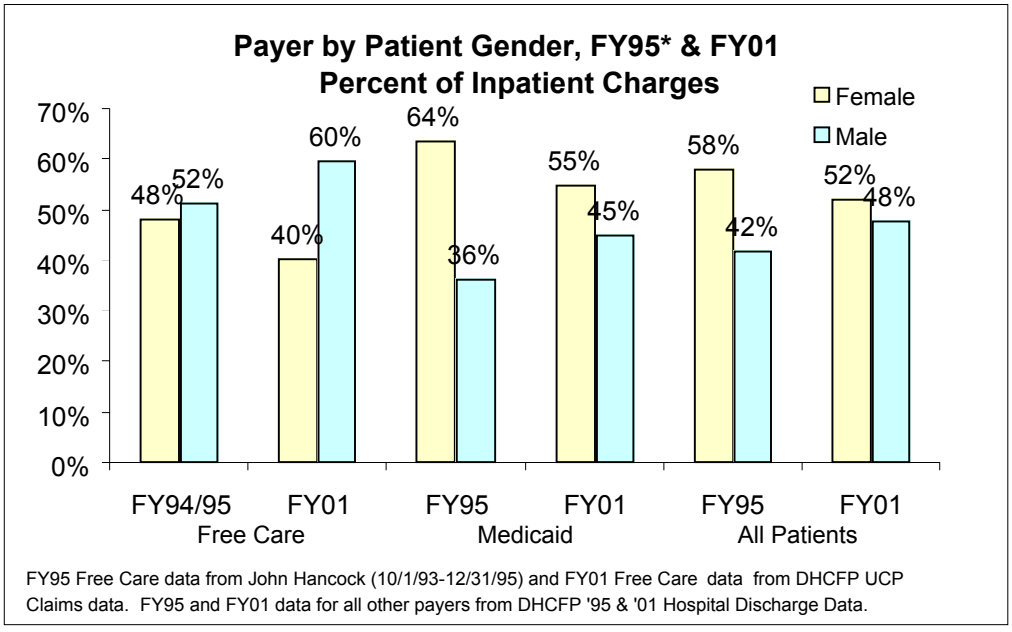


Figure 14: Male individuals represent the majority of total inpatient uncompensated care charges,[2] and the proportion of inpatient charges represented by males increased from FY95 to FY01. In contrast, females represent the majority of inpatient charges for both the total patient population and the Medicaid population.

[2] Uncompensated care charges refer to net uncompensated care charges written off to free care or emergency bad debt.

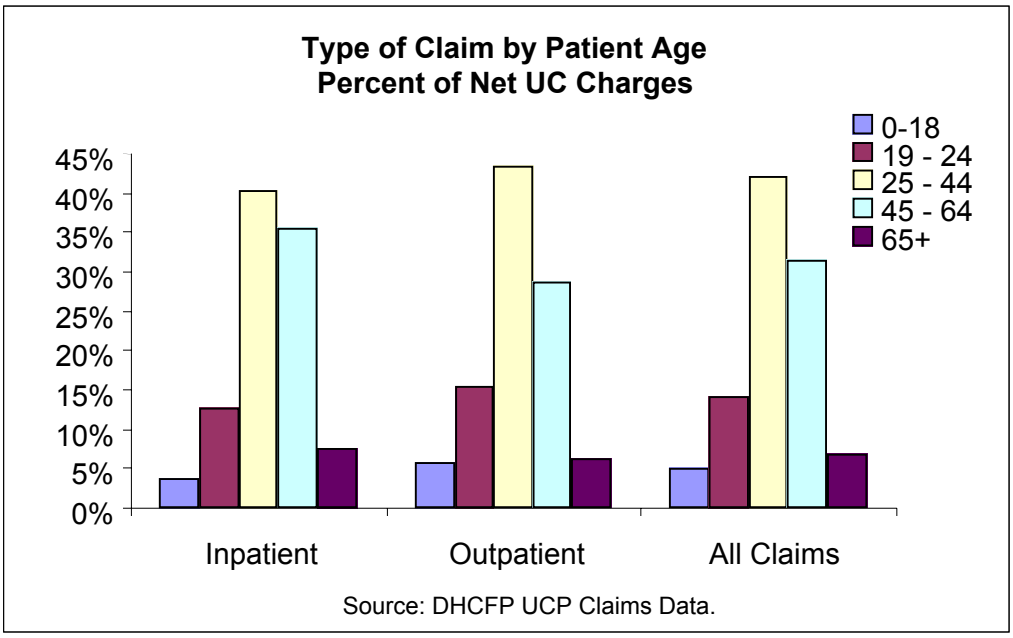


Figure 15: Pool users, age 25 to 64, represent the majority of both inpatient and outpatient uncompensated care charges.

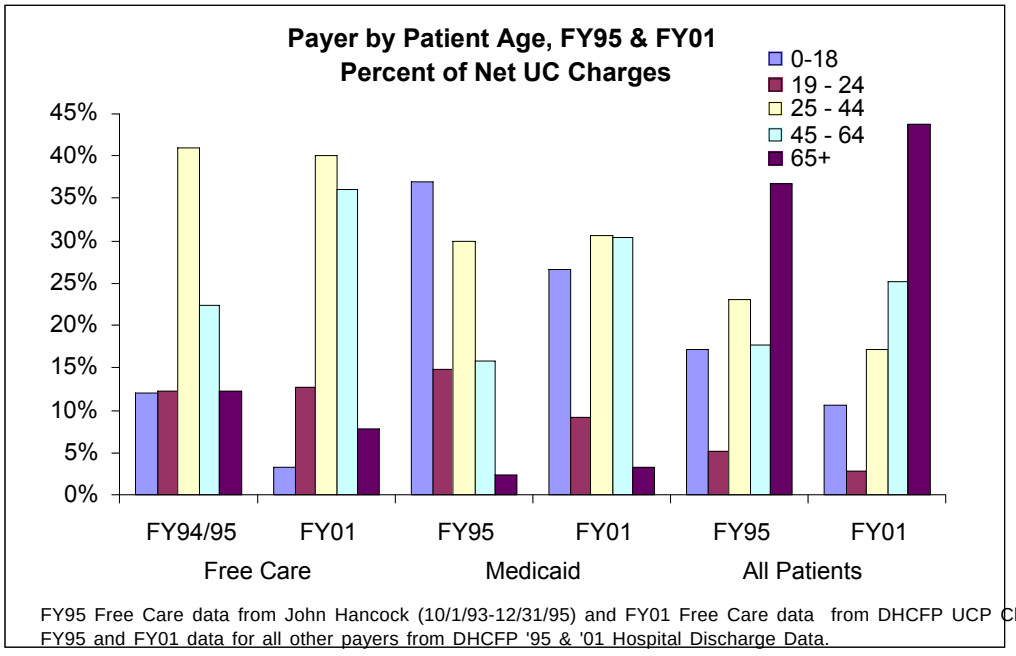


Figure 16: The greatest share of uncompensated care dollars are spent on young adults, age 25 to 44. From FY95 to FY01, patients 45-64 increased as a share of inpatient charges for all payers, and even more so for free care and Medicaid. There was a corresponding decrease in the share of inpatient charges generated by children 0-18. In FY95, children represented the greatest share of Medicaid inpatient charges, but in FY01 charges for adults 25-44 and for adults 45-64 exceeded those for children.

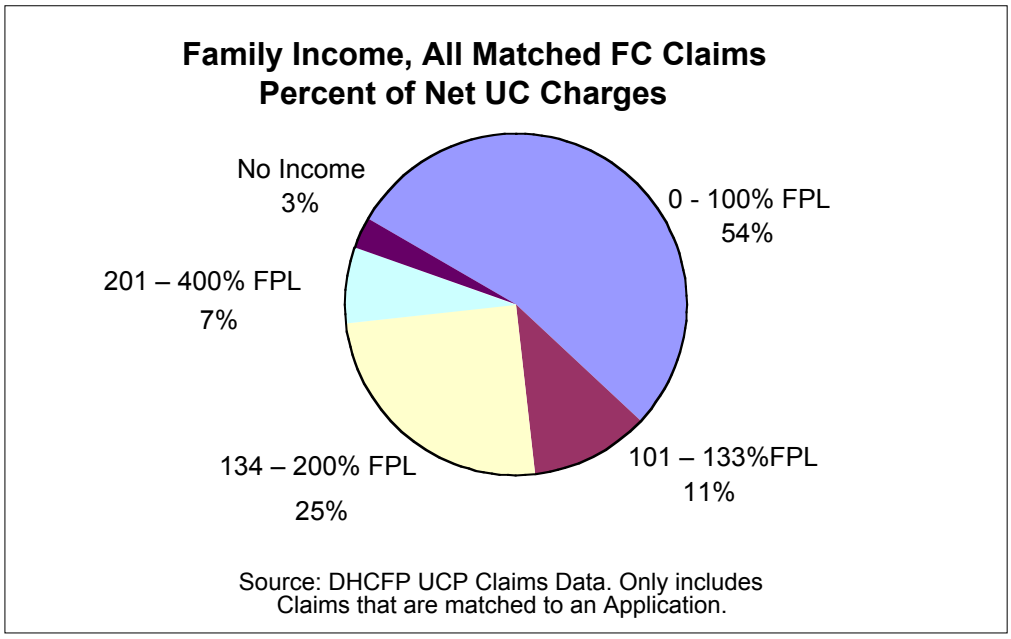


Figure 17: The majority of uncompensated care dollars are spent on individuals with family income at or below 100% of the federal poverty level (FPL).
NOTE: Individuals with family incomes 201-400% FPL are disproportionately represented in the matched claims database; partial free care provided to individuals with family income 201-400% FPL is only 1.5% of free charges written off to the Pool.

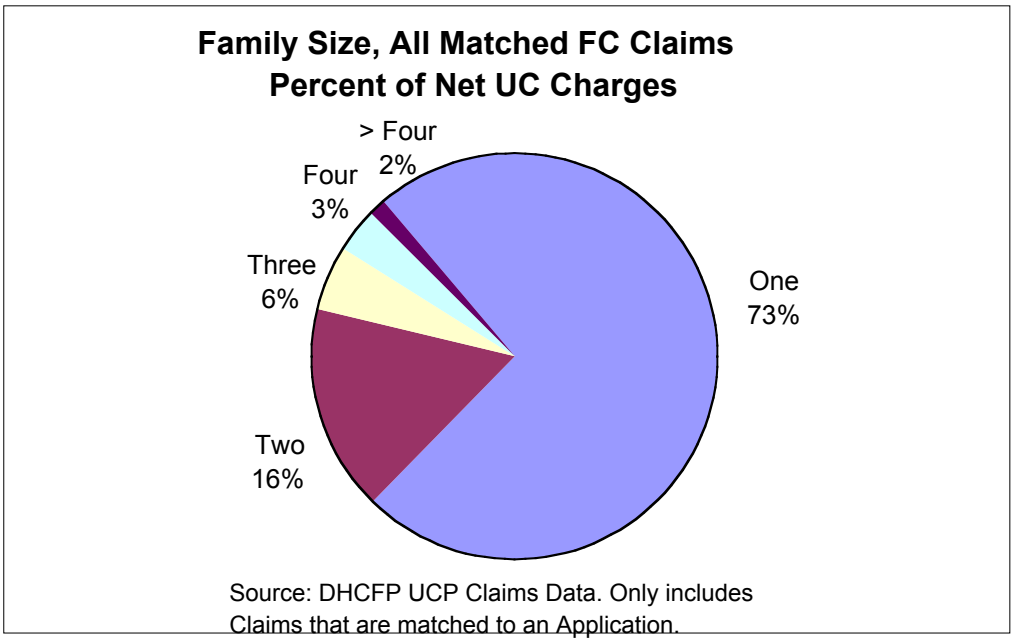


Figure 18: 73% of net uncompensated care charges are generated by individuals without families; 89% are generated by individuals and 2-person families.

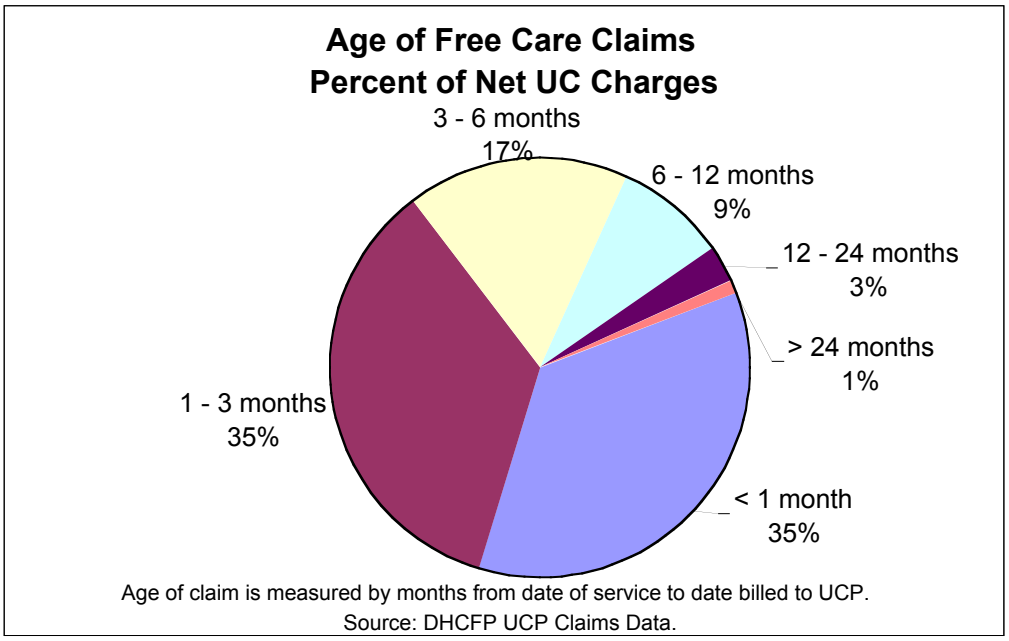


Figure 19: Age of claim is the amount of time between the date of service and the date the account was written off (billed) to the Pool. Because most hospitals write off an account within 1-2 weeks of assigning the liability to the Pool, Age of Claim can be used as a rough approximation of the amount of time between the service date and the free care determination. Patients who applied for free care prior to this date of service would be included in "<1 month."

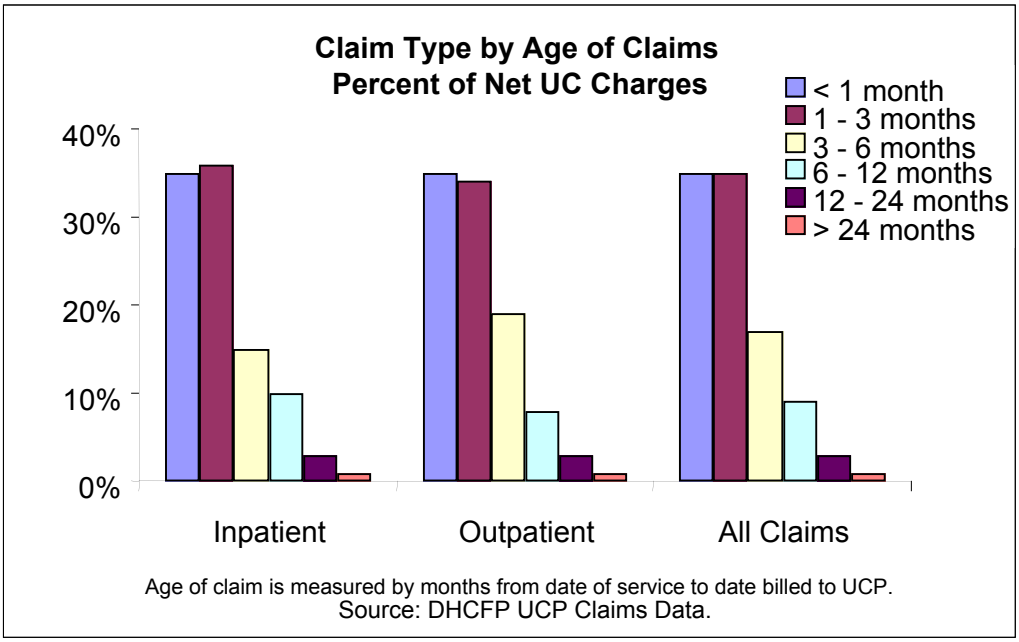


Figure 20: The majority of both inpatient and outpatient claims are submitted within 3 months of the date of service.

Inpatient Major Diagnostic Category[3] by Payer, FY95 & FY01 *Percent of Total Charges*							
		Free Care		Medicaid		All Patient	
UCP Rank	MDC	FY94/95	FY01	FY95	FY01	FY95	FY01
1	Circulatory System	15.7%	18.8%	10.3%	10.8%	24.1%	24.0%
2	Mental Diseases & Disorders	11.7%	11.0%	8.9%	10.7%	4.4%	4.3%
3	Digestive System	9.1%	10.9%	6.6%	6.3%	9.3%	9.0%
4	Musculoskeletal System & Conn Tissue	8.4%	8.1%	5.6%	6.4%	10.4%	10.5%
5	Respiratory System	9.5%	7.0%	9.7%	9.3%	10.6%	10.1%
6	Nervous System	6.1%	6.8%	6.2%	6.1%	6.7%	7.0%
7	Hepatobiliary System & Pancreas	5.3%	5.6%	4.2%	4.3%	3.9%	3.5%
8	Alcohol/Drug Use Related Mental Disorders	3.9%	5.4%	1.7%	3.2%	0.9%	1.0%
9	Injuries, Poisonings & Toxic Effects of Drugs	-	3.1%	-	1.7%	-	1.1%
10	Pregnancy, Childbirth & the Puerperium	4.6%	2.7%	11.2%	11.1%	4.8%	5.3%
	Total	**77.4%**	**79.3%**	**66.2%**	**69.9%**	**77.3%**	**75.8%**

Source: FY95 Free Care data from John Hancock (10/1/93-12/31/95) and FY01 Free Care data from DHCFP UCP Claims data. FY95 and FY01 data for all other payers from DHCFP '95 & '01 Hospital Discharge Data.

Figure 21: Circulatory System diagnoses represent the largest share of inpatient charges for all payers and for free care. Mental Health and Alcohol/Drug Use Related Disorders represent a much greater share of inpatient free care charges than they do of all payers, and a slightly greater share than of Medicaid. Pregnancy, Childbirth & the Puerperium represent a much higher share of Medicaid charges; Pregnancy decreased as a share of free care charges from FY95 to FY01.

[3] Inpatient diagnoses are classified into one of twenty-five major diagnostic categories (MDC), version 12. Inpatient Medicaid and All Patient data comes from the DHCFP 2001 Hospital Discharge Database (HDD).

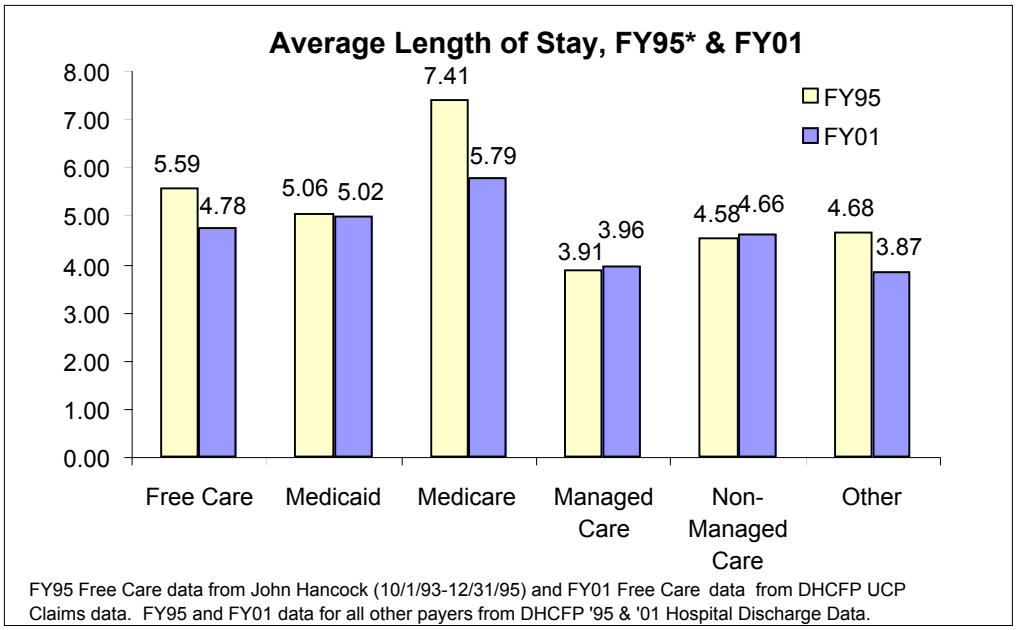


Figure 22: The average length of stay for free care patients decreased from FY95 to FY01, from higher than the Medicaid average to lower. Medicare length of stay decreased even more dramatically, while length of stay for private patients (both managed care and non-managed care) increased slightly.

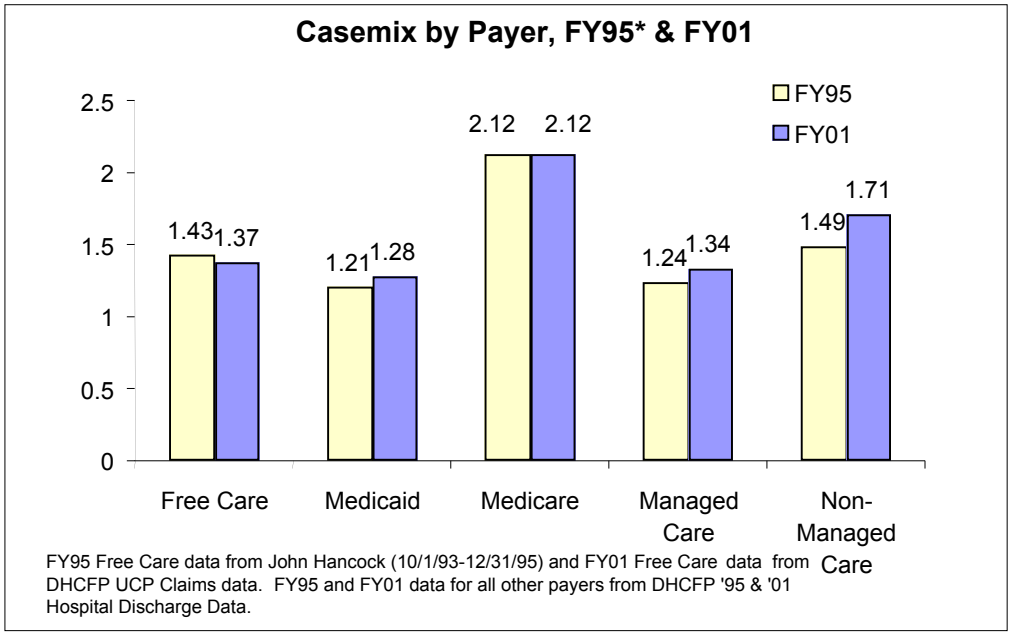


Figure 23: Free care patients use slightly more resources than Medicaid and Managed Care patients, but fewer than non-Managed Care and Medicare patients. From FY95 to FY01, free care case mix declined, while casemix for all other payers increased or remained steady.

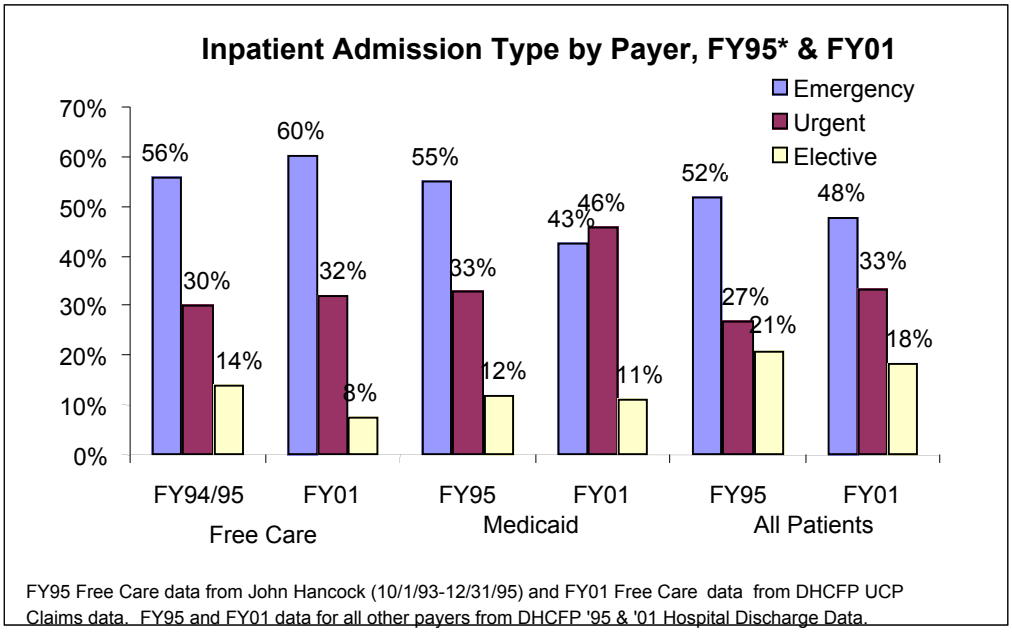


Figure 24: Relative to other payers, a greater (and growing) share of free care inpatients are admitted as emergencies, while a smaller (and declining) share are admitted for elective procedures. Medicaid urgent admissions surpassed emergency admissions in FY01.

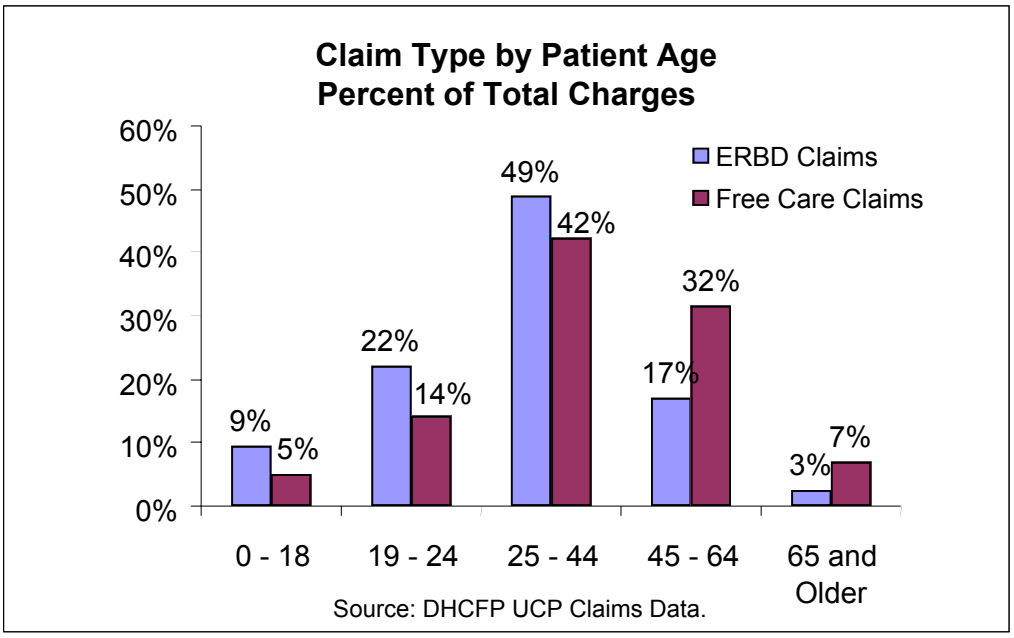


Figure 25: A greater share of Emergency Bad Debt (ERBD) claims, relative to free care, are for children and young adults age 19-44; a greater share of free care claims are for adults over 45.

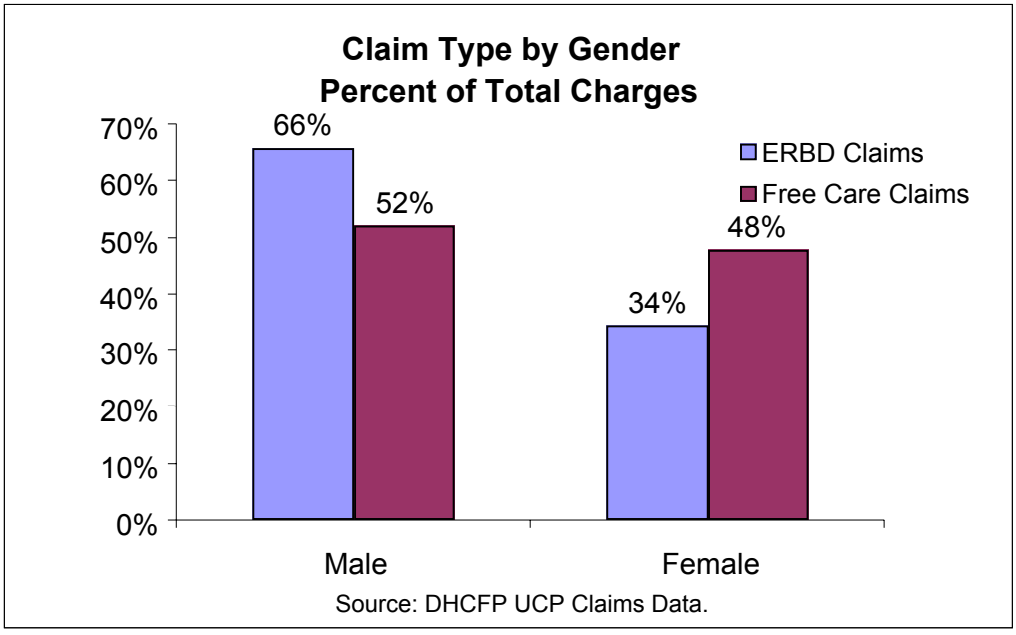


Figure 26: Male individuals account for a larger percentage of Emergency Bad Debt (ERBD) claims.

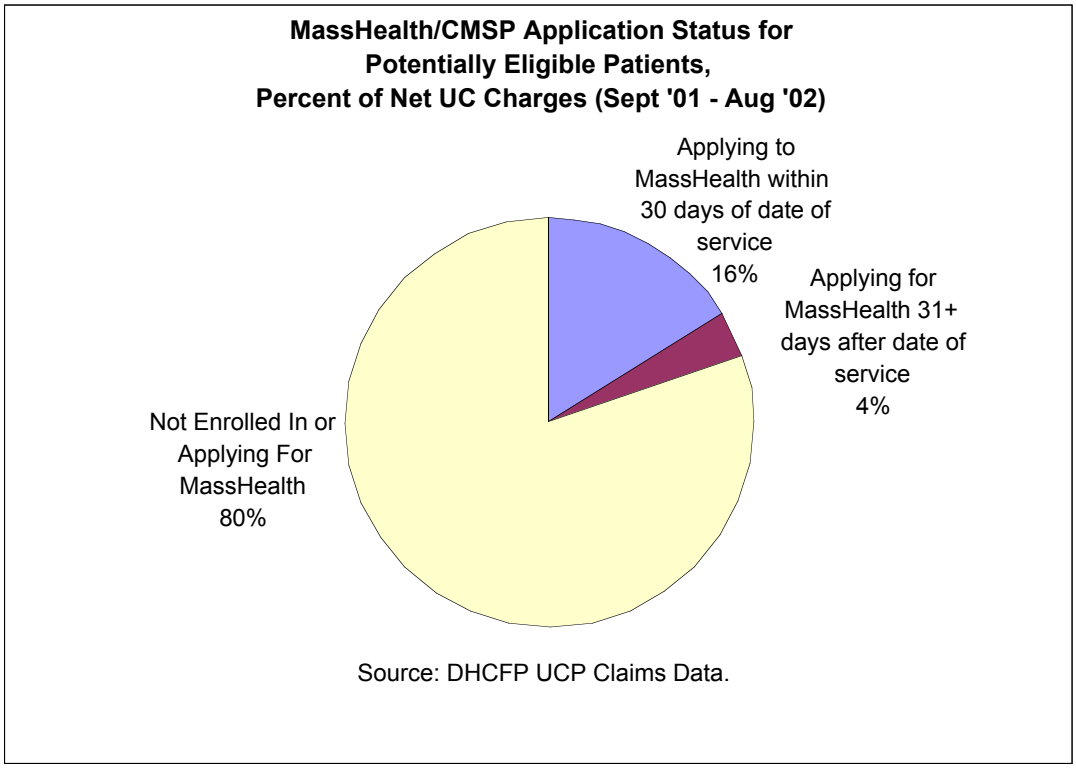


Figure 27: Of those free care applicants who, upon screening, appear potentially eligible for other programs, 20% report a pending application for the other program at the time of the free care application. Providers are required to assist potentially eligible patients with the application process; therefore, many may subsequently submit their applications to those other programs.

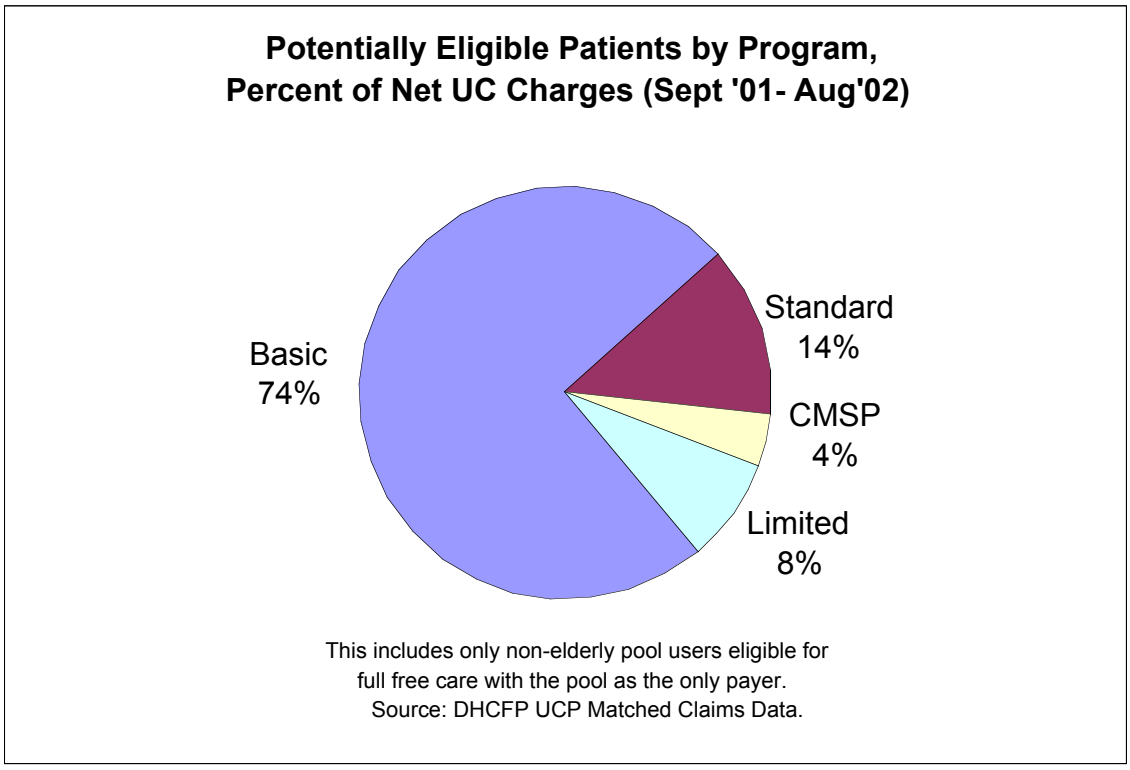


Figure 28: The free care application includes questions that are designed to determine whether an applicant could potentially be eligible for MassHealth or other programs. Providers are required to assist those patients who are potentially eligible to apply for the relevant program. Note that the Uncompensated Care Pool database does not include sufficient information to determine MassHealth eligibility, but it is possible to separate those who are ineligible for MassHealth and other programs from those who could potentially be eligible based on screening requirements.

Of Pool users who could potentially be eligible for one of the MassHealth benefit plans or the Children's Medical Security Plan (CMSP), over 70% are potentially eligible for MassHealth Basic. Another 13% are potentially eligible for MassHealth Standard.

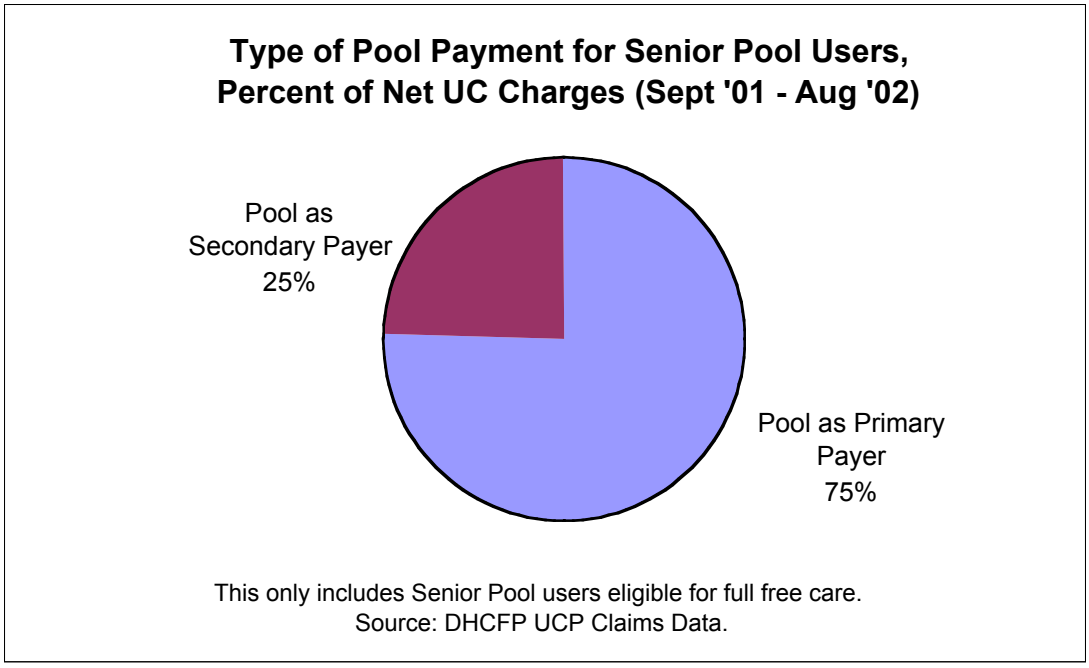


Figure 29: Most seniors qualify for Medicare; however, for the few who do not qualify for Medicare, the Pool is generally their only option. The majority of Seniors who use the Pool have the Pool as their primary payer.

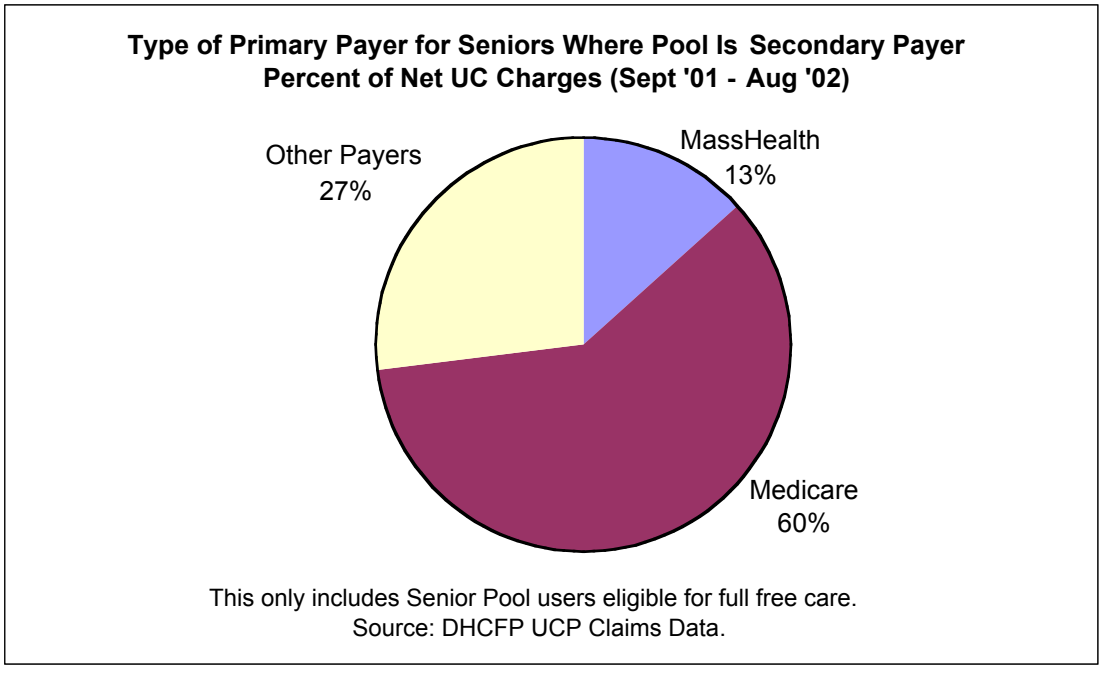


Figure 30: Medicare is the primary payer source for the majority of Seniors who use the Pool as a secondary payer.

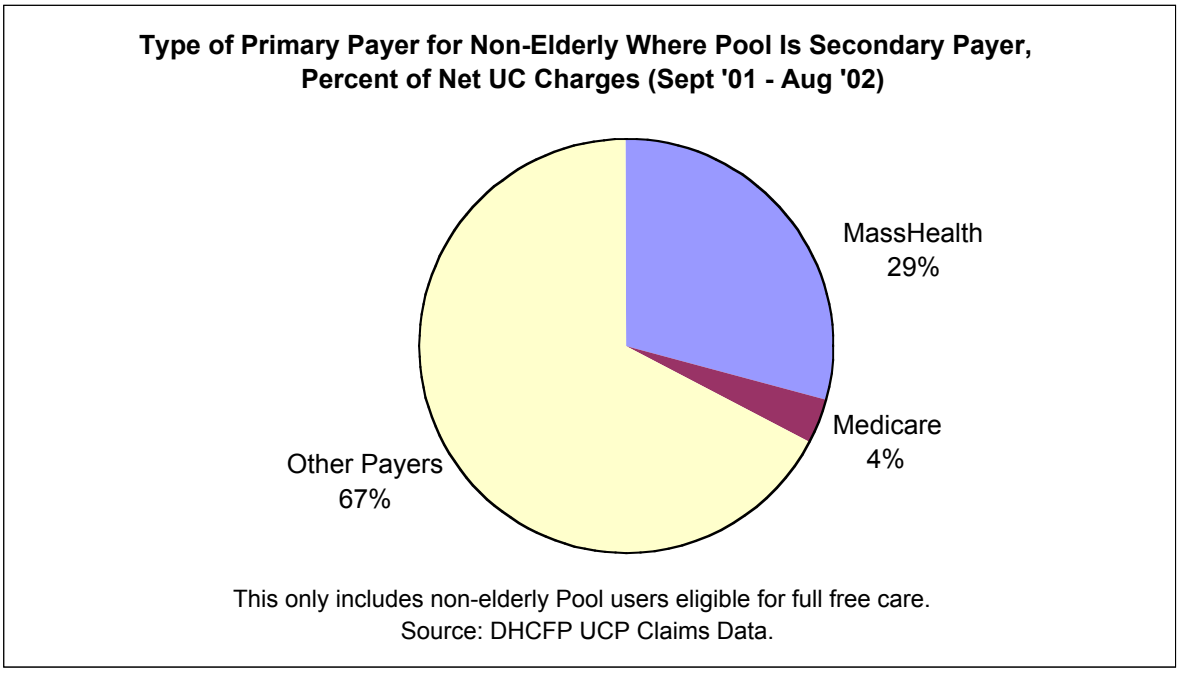


Figure 31: Only a minority of non-elderly patients who use the Pool as a secondary payer have either Medicaid or Medicare.

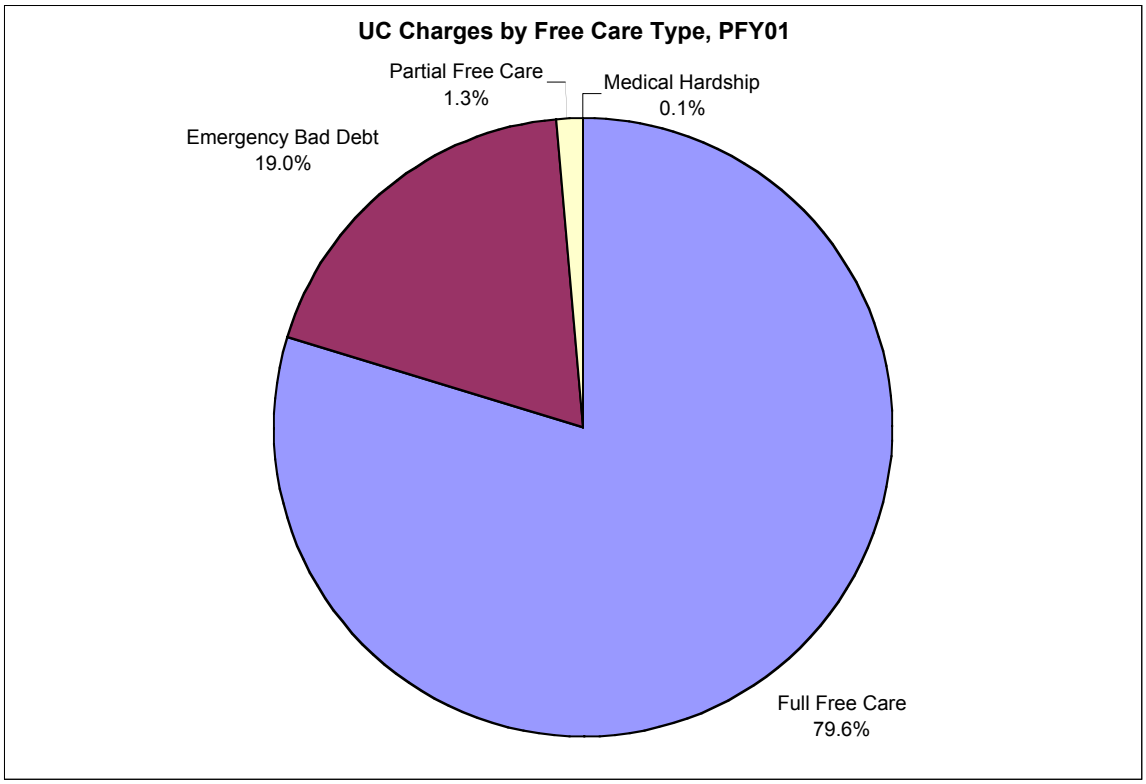


Figure 32: Nearly 80% of Uncompensated Care Pool payments are for people who qualify for full free care (income <200% FPL). Source: DHCFP

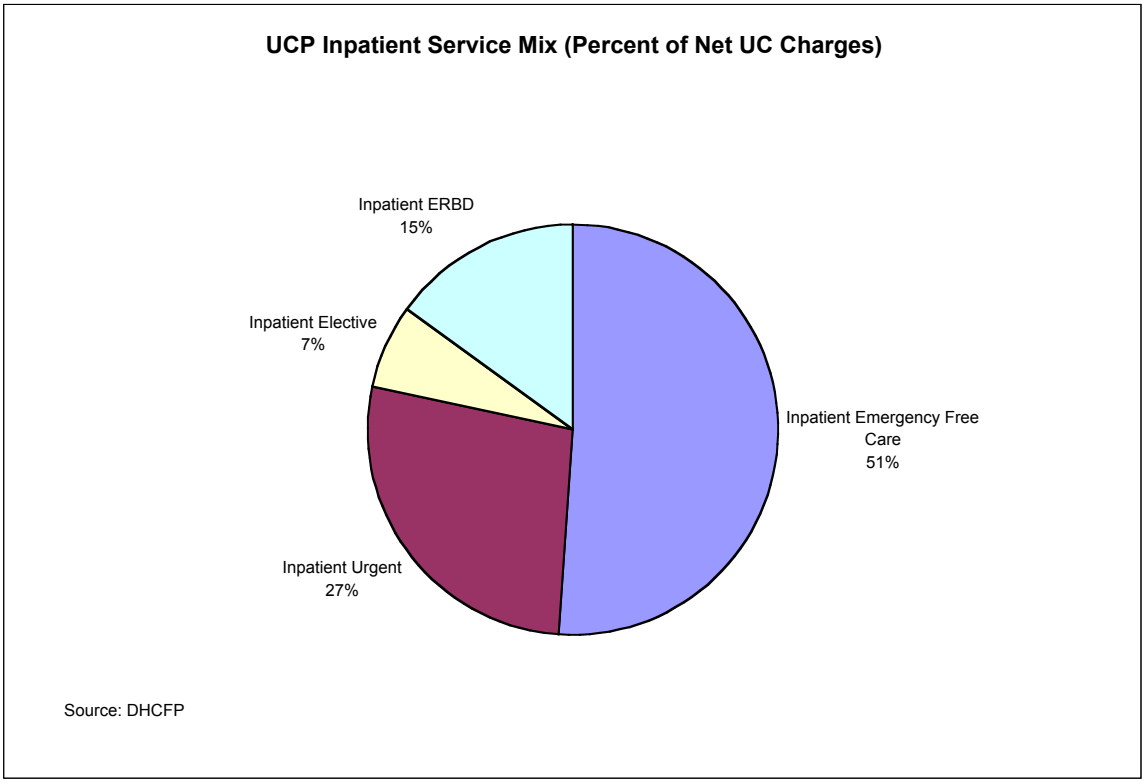


Figure 33: Ninety-three percent of Pool charges for inpatient services are for urgent or emergency care.

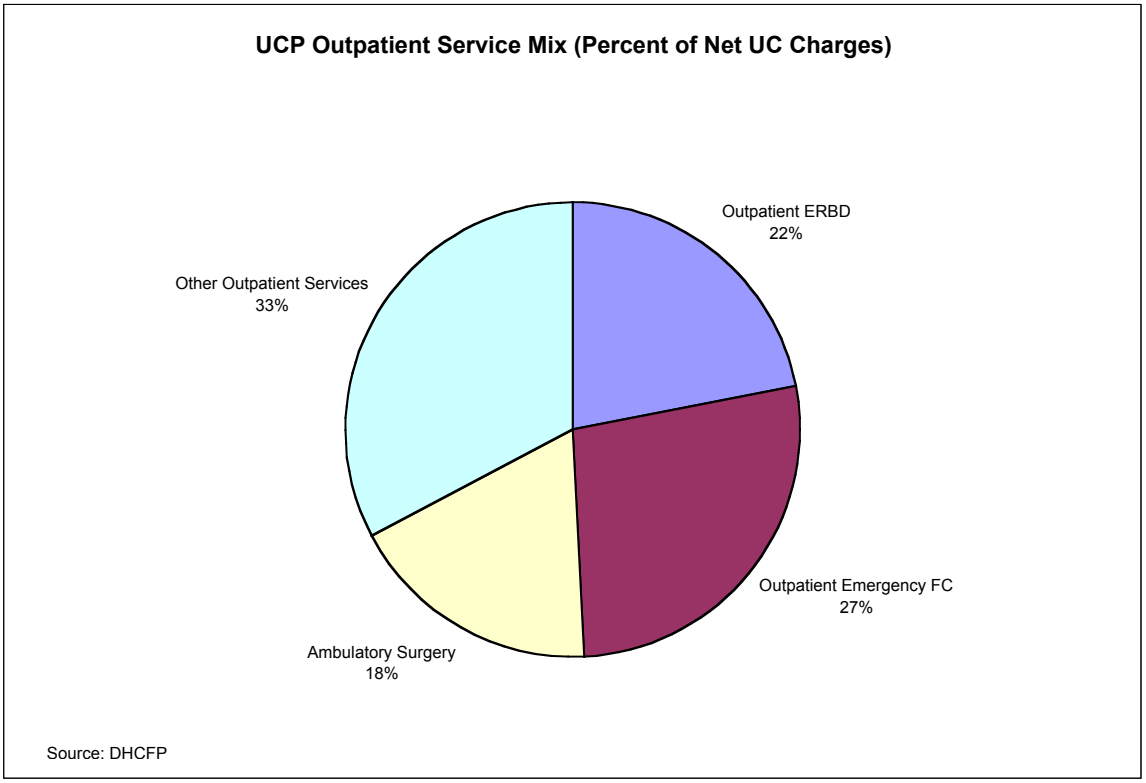


Figure 34: Nearly 50% of Pool charges for outpatient services are for emergency services. Other Outpatient Services includes clinic visits as well as claims for ancillary services only. These ancillary services may be associated with an emergency or ambulatory surgery visit.

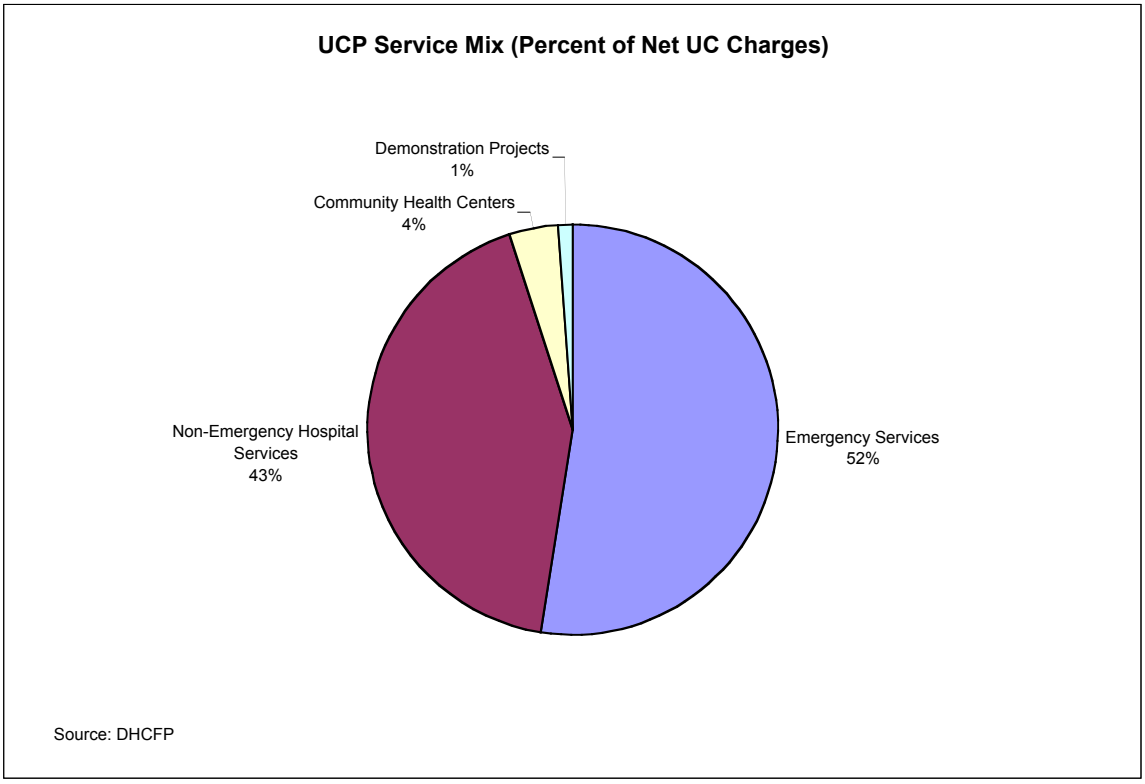


Figure 35: Over 50% of all Pool charges are for emergency services.

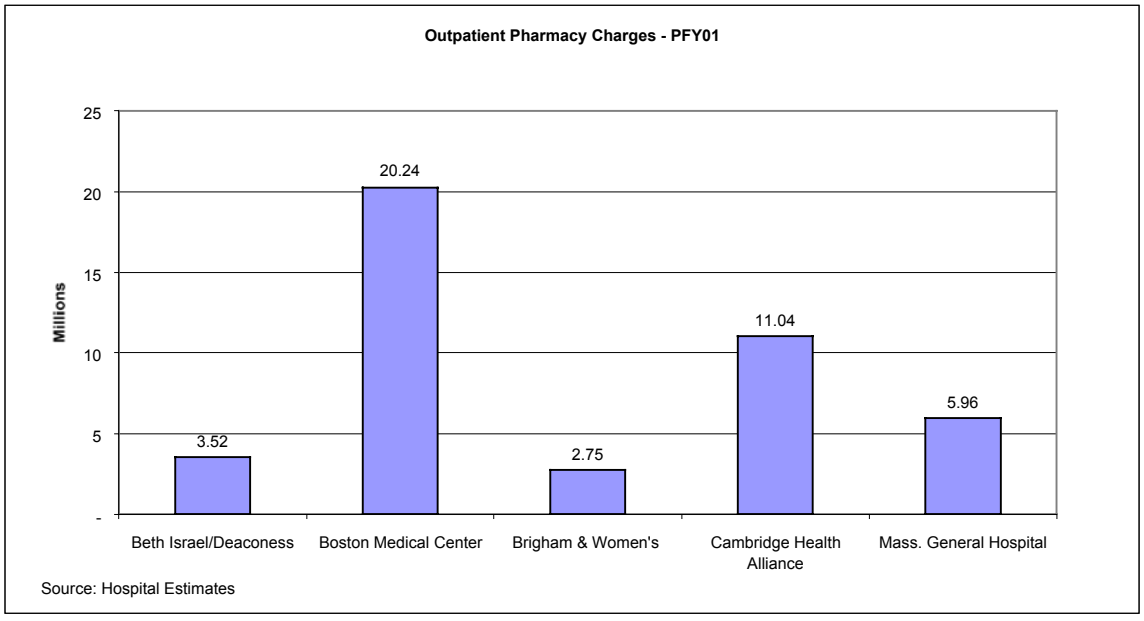


Figure 36: Nearly $45 million in Pool charges in PFY01 were for pharmacy services.

Current MassHealth Eligibility

Children (age 0-18)

Income Level

- Eligible up to 200% of FPL
- Disabled Children at any income level

Coverage Type

- Standard
  - Incomes up to 150% FPL
  - Infants with incomes up to 200% FPL
- CommonHealth: Incomes above 150% FPL and disabled
- Family Assistance: Incomes above 150% FPL, but not more than 200% FPL
- Limited: Undocumented aliens who would have been eligible for Standard

Adults (19-64)

Income Level

- Eligible up to 133% of FPL
  - Parents
  - Long term unemployed
- Eligible up to 200% of FPL
  - Employed by IP participating employer
  - HIV+
  - Pregnant women
- Eligible at any income level
  - Disabled

Coverage Type

- Standard
  - Parents or disabled with incomes up to 133% FPL
  - Pregnant women with incomes up to 200% FPL
- CommonHealth: Incomes above 133% FPL
- Family Assistance:
  - HIV+ with incomes up to 200% FPL
  - Employed by IP participating employer (premium assistance only)
- Basic/Buy-in: Long-term unemployed with incomes up to 133% FPL
- Limited: Undocumented aliens who would have been eligible for Standard

Description of MassHealth Coverage Types

Standard:

Benefits: Full Medicaid package; comprehensive coverage
Delivery Systems: Must enroll in managed care unless have third-party insurance
Cost Sharing: Nominal co-pays for pharmacy and non-emergency use of the ER

CommonHealth:

Benefits: Full Medicaid package; comprehensive coverage
Delivery Systems: Fee-for-service unless voluntary enroll in managed care
Cost-sharing: Nominal co-pays; premiums beginning at approximately 175% of FPL

Family Assistance:

Benefits: Comprehensive coverage; no Transportation or Long Term Care services;
Delivery Systems:
- premium assistance towards employer sponsored health insurance;
- must enroll in managed care

Cost-sharing:: Nominal co-pays; premiums of $10 per child per month; family max of $30

Basic/Buy-in:

Benefits: Comprehensive coverage; no Transportation of Long Term Care services
Delivery Systems:
- premium assistance towards private health insurance; or
- must enroll in managed care (note: not eligible for services until enroll)

Cost-sharing: Nominal co-pays

Limited:

Benefits: Emergency services only

Comparison of MassHealth and Uncompensated Care Pool Services

Within covered provider types there are services that are covered by MassHealth that may not be paid for by the Pool, and vice versa.

Services paid for by MassHealth but not by the Uncompensated Care Pool	**Services excluded by MassHealth that <u>may</u> be paid for by the Uncompensated Care Pool***
<u>At CHCs:</u> Home Health services Glasses & Contact Lenses Hearing Aids Ancillary services - Pool pays only 25% of charges, MassHealth pays full rate. Laboratory Radiology Audiology Occupational Therapy Physical Therapy Speech & Language Therapy Vision Care EKG services 766 core evaluations <u>At Hospitals</u>: Adult Day Health Early Intervention Home Health Private Duty Nursing	<u>At CHCs:</u> CHCs may bill MassHealth for only one visit, treatment or procedure per member per day. CHCs may bill the Pool for multiple visits in the same day to different providers, e.g. to a physician and a dentist. Adult dental services such as cleanings, crowns, and root canals. <u>At hospitals and CHCs:</u> Mental Health: Treatments provided above MassHealth limitations: a) individual therapy: 1 hour per day b) family: 1-1/2 hours per day c) group – 1-1/2 hour minimum-2 hour maximum Pharmacy: 1) brand name drugs for which there is a generic equivalent 2) drugs that treat obesity 3) drugs for smoking cessation 4) topical acne drugs for ages 25 and older Vision Care: Eye exams beyond one every 24 month for adults, one every 12 months under age 21.

* Some providers that offer these services on their hospital or CHC license <u>may</u> bill the Pool for them.

Comparison of Uncompensated Care Pool and MassHealth Benefits

	Uncompensated Care Pool	MassHealth Standard	MassHealth Basic	MassHealth Limited
Abortion	*	x	x	
Acute inpatient hospital	x	x	x	emergency only
Adult day health		x		
Adult foster care		x		
Ambulance	*	x	emergency only	emergency only
Ambulatory surgery	*	x	x	
Audiologist	*	x	exams only	
Chapter 766		x	x	
Chiropractor		x	x	
Chronic disease and rehab inpatient hospital		x		
CHC	x	x	x	emergency only
Day habilitation		x		
Dental	*	x	x	emergency only
Durable medical equipment and supplies		x	x	
[*]Early intervention		x		
Family planning		x	x	
Hearing aid		x	x	
Home health		x	limited	
Hospice		x		
Lab	*	x	x	
Mental health/substance abuse	*	x	x	psychiatric inpatient only
Nurse midwife	*	x	x	emergency only
Nurse practitioner	*	x	x	
Nursing facility		x		
Orthotic		x	x	
Outpatient hospital	x	x	x	emergency only
Oxygen and respiratory therapy	*	x	x	
Personal care		x		
Pharmacy	*	x	x	emergency only
Physician	*	x	x	emergency only
Podiatrist	*	x	x	
Private duty nursing		x		
Prosthetic		x	x	
Rehabilitation		x	x	
Renal dialysis		x	x	
Speech and hearing		x	x	
Therapy--physical, occupational, speech/language	*	x	x	
Transportation		x		
Vision care	*	x	exams only	
X-ray/radiology	*	x	x	

[*] Only if provided under a hospital or CHC license, and provided on-site at the facility.

Hospital Incentives for Assisting Patients to Apply for MassHealth vs. Free Care

Financial Incentives
In aggregate, hospitals' allowable free care costs are higher than their MassHealth payments (for the same set of services), however: (1) The Pool does not pay for 100% of allowable free care costs, depending on the size of the shortfall. As a result, Pool payments may be lower than MassHealth payments overall, and (2) MassHealth may pay more for some services and the Pool may pay more for others.

On the inpatient side, aggregate payments from MassHealth are similar to aggregate free care allowable costs (for the same set of services). However, MassHealth pays using a single flat amount per discharge, regardless of the level of service, and free care allowable costs are a percent of charges. As a result, MassHealth payments exceed allowable free care costs for individual low-charge discharges, while allowable free care costs exceed MassHealth payments for individual high-charge discharges.

On the outpatient side, allowable free care costs are higher than MassHealth payments overall (for the same set of services). But again, MassHealth payments may be higher than free care allowable costs for an individual service.

Regulatory Requirements
The Pool statute require providers to bill any other payer before the Pool. In addition, providers are required to screen patients for potential eligibility for MassHealth and other programs, and to help them to apply for those programs.

Operational Considerations
Providers cannot choose to bill MassHealth for some services and the Pool for other services for the same individual. The discretion that hospitals have is more in terms of how aggressively to pursue enrolling patients in MassHealth. Hospitals can, for example, devote more resources to assisting women in the prenatal clinic with their MassHealth applications than to assisting men in the cardiology clinic. But it would be extremely difficult for hospitals to single out individuals for differential treatment based on the difference in payment level between MassHealth and the Pool.

Comparison of Payment Levels between MassHealth and UCP

CHCs	
Medical Visit:	Same
Other Services:	Varies
Hospitals	
Inpatient	Roughly equivalent
Outpatient	MassHealth payments are 30-40% lower

Insurance Partnership

Through its Insurance Partnership and premium assistance programs, the Division of Medical Assistance ("Division") has supported employer purchase of health insurance. This innovative design is one of the few successful programs of its kind in the nation. The Insurance Partnership was designed to remedy the problem of uninsured workers employed by small businesses by making health insurance affordable for employers and lower income employees. The program appropriately targets small businesses – those with 50 or fewer full time employees – as 76% of the working uninsured work for a small business.[4]

Under the Insurance Partnership, the Division provides premium assistance for individuals and/or families with incomes at or below 200% FPL towards qualifying employer-sponsored health insurance offered by a participating employer. The health insurance must meet a basic benefit level and the employer must contribute at least 50% of the cost. In addition to providing benefits to those who are eligible for MassHealth, the programs, at no extra cost to the Division, make employer-sponsored health insurance available to all family members, even if they are not eligible for MassHealth.

Employers must elect to participate in the program. Participation not only allows for the company's lower income employees to receive premium assistance, but it also provides the employer with a monthly incentive payment towards eligible employees' coverage. Employers' annual savings equals $400, $800, or $1000 for individual, couple or family health insurance coverage respectively.

Over 12,000 people currently benefit from this premium assistance program. As of October 2002, there are over 4000- plus qualified small employers participating in the Insurance Partnership. Two-thirds of the participating employers began offering insurance to their employees when they enrolled in the Insurance Partnership. Likewise, two thirds of the persons receiving premium assistance benefits from the Division began purchasing insurance through their employers upon enrollment in MassHealth.

In addition to providing an important benefit to small employers and their employees, the Insurance Partnership program is a cost-effective way for the Commonwealth to reduce uninsurance rates without crowding out the employer market and while keeping the employer contribution as part of the funding.

[4] Health Insurance Status of Massachusetts Residents, Division of Health Care Finance and Policy, December 2000.

Summary of Uncompensated Care Pool Management Initiatives

C. 47 <u>required</u> the following:	**Status**
1. <u>Surcharge</u>. Implement a surcharge on payments to acute care hospitals and ambulatory surgical centers; collect $100m annually.	Completed
2. <u>Eligibility</u>. Define free care, including qualifications of eligible persons and scope of eligible services. Set standards for notifying patients about the availability of assistance, collecting the costs of emergency care, and determining medical hardship. Develop and implement methods and procedures to verify the eligibility of individuals for free care and to ensure that other coverage options are utilized fully before free care is granted.	Completed
3. <u>Screening</u>. Require acute care hospitals and community health centers (CHCs) to screen each free care applicant for other sources of coverage and for potential eligibility for government programs. Require acute hospitals and CHCs and to assist potentially eligible applicants in applying for these programs.	Completed
4. <u>Residency</u>. Prohibit payments from the Pool for non-urgent and non-emergency health care services provided to residents of other states and foreign countries.	Completed
5. <u>Data collection</u>. Require acute hospitals and community health centers to submit data that the division determines necessary to efficiently and effectively administer the uncompensated care pool, including data that would enable the division to conduct analyses, verify eligibility, and calculate settlements on a case-by-case basis.	DHCFP electronic databases currently contain patient-level data from 340,000 application forms and 1.9 million claims forms documenting $1 billion in free care charges.
6. <u>Enforcement of collection</u>. Establish mechanisms to enforce hospitals' and surcharge payers' obligations to the Pool.	Completed No hospital or surcharge payer is currently out of compliance.
7. <u>Catalog</u>. Compile and maintain a catalog of program information for all programs of health care coverage for low income persons.	Completed
8. <u>Payment limit for underinsured.</u> If free care is granted to cover a patient balance after insurance, no payments shall be made from the Pool that would cause the total payment to the provider to exceed the applicable rates for free care services.	Not implemented. Payment amounts from the primary payer are proprietary and unavailable to DHCFP.

C. 47 authorized but did not require the following:

1. Wage verification. May use DOR's wage reporting system to verify income data for recipients of free care.	In operation (for those for whom such data exists, approx 34% of Pool users)
2. Utilization review. May require utilization review.	Not implemented
3. Third party liabilities. May investigate and recover third party liabilities (TPL).	In process with DMA
4. Penalties. May implement penalties for non-compliance with DHCFP methods and procedures for determining eligibility and for ensuring that other coverage options are utilized fully.	Completed
5. Claims adjudication. If the division finds that hospitals are not complying with the data submission requirements or if the data submitted are not sufficient to enable the division to verify eligibility and calculate settlements on a case-by-case basis, the division may adopt regulations providing for a claims adjudication process for payments from the uncompensated care pool.	Evaluation ongoing
6. Demonstration projects. The division may expend up to $5 million annually for demonstration projects where the division finds such projects are cost neutral or produce savings to the Pool. The division may expend up to $5m annually for contracts with health care or managed care providers to deliver services to individuals eligible for free care, where the cost of such contract does not exceed the amounts that would otherwise have been expended on free care for these individuals.	Funded 13 projects, plus 3 required by statute.

Uncompensated Care Pool Audits

Authorization
Section 18 of chapter 118G, as amended by chapter 47 of the acts of 1997, directs the Division of Health Care Finance and Policy (DHCFP) to "manage…[the] pool in order to encourage maximum efficiency and appropriateness in the utilization of services."

Implementation
DHCFP regularly audits hospitals and community health centers. The Division generally selects providers for audit based upon providers' historical billings to the Pool, free care application submissions, and other reporting requirements. Field audit teams visit hospitals and collect samples of free care applications and patient records to ensure that they comply with the laws and regulations governing free care. The Division's audit activities thus far have had an educational focus, emphasizing a collaborative effort between the agency and providers to learn and implement the regulations adopted by the Division in 1998. The primary goal of the audits has been to identify issues and correct them system-wide through training sessions and newsletters. The Division has also used audits to inform Pool policy development. In prior rounds of audits, the Division did not implement penalties against providers, although it did make adjustments to providers' payments from the Pool.

Initially, the Division primarily audited community health centers because they are an important access point to the health care system. Because of this unique role, enrollment practices at community health centers have an impact on the rest of the system.

Findings
Examples of some of the issues that have been addressed through the Division's audits have included the following:

- Insufficient screening of patients for potential eligibility for other programs;
- Inappropriate use of affidavits as income and/or residency documentation;
- Incorrect use of free care application forms;
- Inappropriate billing of the Pool under the category of Emergency Bad Debt;
- Incorrect billing of dental services.

During the current round of audits, which is focusing primarily on hospitals and hospital-based community health centers, the Division is adjusting free care payments of providers found to be out of compliance with the laws and regulations governing free care eligibility and payment. Adjustments resulting from these audits will be levied during final settlement of the fiscal year being audited.

DHCFP Uncompensated Care Pool Audits

Audits Completed as of 11/08/02:

1	Harvard Street Neighborhood Health	CHC	1998
2	Greater New Bedford Community Health Center	CHC	1999
3	Neponset Health Center -Geiger Gibson	CHC	1999
4	South End Community Health Center	CHC	1999
5	Columbia MetroWest Medical Center	Hosp	1999
6	Lahey Clinic	Hosp	1999
7	Northeast Hospital	Hosp	1999
8	Union Hospital	Hosp	1999
9	Great Brook Valley Health Center	CHC	2000
10	Brockton Neighborhood Health Center	CHC	2000
11	Caritas Norwood Hospital	Hosp	2000
12	Dana-Farber Cancer Institute	Hosp	2000
13	Southcoast	Hosp	2000
14	Children's Hospital	Hosp	2001
15	Lawrence General Hospital	Hosp	2001
16	Saints Memorial Hospital	Hosp	2001
17	Southcoast	Hosp	2001
18	St. Vincent Hospital	Hosp	2001

Audits in Process as of 11/8/02:

1	Beth Israel Deaconess Medical Center	Hosp	2000
2	Brigham & Women's Hospital	Hosp	2000
3	Brockton Hospital	Hosp	2000
4	Marlborough Hospital	Hosp	2000
5	New England Medical Center	Hosp	2000
6	Harvard Street Community Health Center	CHC	2001
7	Baystate Medical Center	Hosp	2001
8	Boston Medical Center (including health centers)	Hosp	2001
9	Cambridge Health Alliance	Hosp	2001
10	Emerson Hospital	Hosp	2001
11	St. Elizabeth's Hospital	Hosp	2001
12	UMass Memorial Medical Center	Hosp	2001

DHCFP Uncompensated Care Pool Audits

Total Audits		
	Number of Providers Audited	Total Charges Represented
CHC	7	$ 7,455,835
Hospitals	23	600,746,923
Total	30	$608,202,758
Completed Audits	18	
In Process	12	
Amount Audited	$106,680,976	
Adjustments	7,322,488	
% Disallowed	6.86%	
Savings to the UCP	**$ 3,927,317**	

2001 Audits			
	Number of Providers Audited	Total Charges Represented	Charges Audited as % of Total UCP Dollars
CHC	1	$ 2,174,064	**72.34%**
Hospitals	15	431,855,067	
Total	16	$434,029,131	
Completed Audits	5		
In Process	7		
Amount Audited	$ 45,270,561		
Adjustments	4,968,030		
% Disallowed	10.97%		
Savings to the UCP	**$ 2,656,722**		

SUBMISSIONS FROM COMMISSION MEMBERS

Senator Richard T. Moore

SPECIAL COMMISSION ON THE UNCOMPENSATED CARE POOL

Goals for the Commission:

- Preserve the Health Safety Net for low income uninsured and underinsured who are ineligible for Medicaid by planning for the future stability of the pool.

Questions for the Commission to Examine:

- Is the Uncompensated Care Pool the most effective method of providing access to health care for the working poor? Is it the best means of assisting hospitals with managing the burden of free care as mandated by federal law?
- Who is using the pool and for what kinds of health conditions?
- What portion of the pool is people who were once served by Medicaid – ie. dental patients?
- What is the expected impact on the pool from the termination of Mass Health Basic April 1? Of the possible termination or reduction of Medicaid prescription drug access on October 2? What was the impact, if any on the pool of the termination of adult dental coverage for Medicaid? Will the cut-backs in private sector insurance coverage for Medicare plus choice have any impact on the pool?
- What are the results of the pool's pilot projects? Have any shown value in expanding statewide?
- What are the results of the insurance reimbursement program? Should it be expanded by raising the size of company eligible to participate? Is it adequately promoted?
- Are providers accountable under the pool? What is the best way to insure accountability?
- What services does the pool cover and which hospitals offer those services? How uneven are the services offered depending on where a patient goes? Should the pool only cover the same programs that all providers can provide? Are there some services that should be limited or require prior authorization?
- What disparities exist in health services provided by the pool between hospitals receiving funds? Is there geographic inequality for patients?
- How is DHCFP accountable - to the state and to the payers? Is DHCFP the most appropriate administrative agency for the pool or should it be placed in a third party?

Data Needed by the Commission:

- Information to help answer the questions above.
- How much of the growth in the pool since 1997 is attributed to health cost increases and how much to increases in the numbers served?

Topics for Commission Meetings:

Mass Health Eligibility

- Demographics of Pool users
- External considerations such as HIPAA, ERISA, FFP, etc.
- Review of Other States Pools such as Maryland and New York.
- Hospital Payment Methodology, Scope of Services, Sources of funding the pool
- Accountability of the pool and of providers to the pool
- Cost containment measures that can be employed
- What has happened with regard to each of the last Commission's recommendations and why did this occur?

TO: Katharine London, Division of Health Care Finance and Policy
FROM: Ronald M. Hollander, President & CEO, Massachusetts Hospital Association
RE: Response to September 10th Memorandum
DATE: September 13, 2002

MHA Perspective on Pool Commission

We are all here because we are committed to ensuring that every citizen of the Commonwealth has reliable and timely access to quality, appropriate care. We are also here because the Commonwealth is facing an immediate challenge. The challenge is more than just fixing the Uncompensated Care Pool. The challenge is the looming crisis of the health care "safety net" which encompasses the pool, Medicaid, and growing levels of unreimbursed care beyond both programs. A second, more profound challenge before us is finding a way to protect and extend healthcare coverage to *all* those who need it in our commonwealth.

Both are daunting challenges, especially in difficult financial times, but I am convinced we can succeed. We can succeed because we can build on the proud tradition in Massachusetts of providing quality care, turning no one away from hospital care, and striving to extend coverage. And, we can build on the work of the last Pool Commission in '97. Several of us served on that Commission which helped us achieve much in stabilizing pool financing and expanding coverage for several years.

However, the current reality threatens our progress:

- ⇒ The growing numbers of uninsured or underinsured has now been documented, a trend most expect to continue;
- ⇒ Structural funding deficits in the Pool projected by Division of Health Care Finance & Policy, for the coming year now exceed $50-70M;
- ⇒ 50,000 people are scheduled to lose MassHealth Basic coverage on April 1, which will throw pool financing into chaos and increase the pool deficit to an unsustainable $140M in FY '03 and over $200M in FY '04.

This isn't the state's problem, it isn't the hospitals' problem, it isn't the private sectors' problem – it's ***our*** collective problem. There will be many uninsured people, they're going to get sick and injured, and we expect that they are all going to be treated. We need a reliable mechanism to finance that care.

We each sit at the Commission table because we are all stakeholders in this issue. While we may each come to this table with different perspectives, I believe that we share common values and I hope we can work collaboratively to create a shared vision of a commonwealth where ***all*** our residents receive the benefit of health care coverage. Until that vision is fully realized, I believe we have an urgent societal responsibility to ensure that there is a stable safety net that works… works reliably for those who receive care, for those who provide care and for those who help pay for the care. Given the current dynamics, the pool will not be able to meet that test. We need to reform and save the safety net.

There are some tough issues that we will have to struggle with in the weeks ahead. I suggest that we must start by articulating **principles** that reflect Commission members' shared values and which can form the basis for our reform efforts.

- First, ***all*** residents should have access to the care they need, ideally through coverage. We need to do everything we can to protect and extend coverage, both public and private.

- Second, since there will continue to be significant (and in the short term, increasing) numbers of uninsured, we need a reliable safety net funding mechanism to fill the coverage gap.

- Third, financing that safety net mechanism is a societal responsibility that must be broadly financed, shared fairly by all stakeholders.

- Fourth, all parties should be accountable; accountable for appropriate care; for effective and efficient administration; for doing everything they can to maintain coverage; and for adequate funding of the restructured pool for those who remain or become uninsured.

- Fifth, while we expect every hospital to keep its doors open to all, those who provide a disproportionate share of services to the medically indigent need a reliable source of funding to meet that special mission.

As an immediate objective, I'd strongly urge that we discuss and agree on guiding principles at our next meeting as the foundation for our work. Once we've agreed on this framework, I would focus the Commission's discussion on lessons from the '97 Commission: what worked, what didn't and why (informed by the work groups outlined below).

Ultimately, we believe the goal of the Commission must be to make recommendations and propose legislation in a report that lays out our plan and the steps to achieve it. I look forward to working with all of you with an eye to completing our work on time so that the next legislature and governor can act upon our recommendations in the early days of the next session.

I'd suggest much of our work be done through workgroups with the following analytical focus:

1. Understanding the nature/size of the uninsured problem:
    - Who are they, how and why are the numbers rising?
    - What are the dynamics of the new high deductible/coinsurance and other private insurance offerings and what will be their impact on the safety net?
        - What will they do to unreimbursed care and who should be responsible for it?
2. The interrelationship with MassHealth:
    - What are the dynamics of decisions to expand or contract coverage? (e.g., the impact of MassHeath Basic cuts)
        - On whom will/should this burden fall?
    - What are the opportunities to make both Medicaid and the pool work better and in a complementary fashion?
3. Maximizing Federal Funding:
    - What are the opportunities to ensure that we take full advantage of federal matching IGT and to devote such funds to financing the safety net?

- **Questions for UCP Commission**

  - What problem are we trying to solve?
  - Why is pool demand higher now than in 1997? (Data: A before and after analysis of the levels of pool demand and costs associated with the population groups covered and not covered by MassHealth)
  - How can a relatively small group of employed individuals not covered by MassHealth be generating pool demand that is greater than the total demand that existed prior to the implementation of MassHealth? (Data: Identification of this group – its size and cost in 1997 and currently)
  - Do we know enough about current pool payments – income eligibility, services, actual rates of payment, third-party coverage – to be confident that the pool is functioning as a last-resort payer? (Data: review of existing HCFP data, verification of its accuracy through audits, if necessary, matching of the data against other relevant data to verify that last-resort payments were made, etc.)
  - Is the pool paying for what was intended in 1997? For instance, the pool reimburses for more outpatient than inpatient services. Are these emergency/urgent services? Should they be provided by hospitals or at freestanding facilities, like CHC' s ? (Data: Collection of service data. Audits to determine site of service and whether services were emergent/urgent in nature.)
  - What is the pool's mission? To reimburse hospitals for otherwise uncompensated emergency/urgent care or to provide comprehensive access to health coverage for the uninsured? What should the relationship between the pool and MassHealth be?

- **Work Groups and Topics**

  - Three work groups should be established: one on the relationship between MassHealth and the pool; one on administrative and management reforms; and a third on mission of the pool.

- **Goals for Commission**

  - Don't jump to conclusions. Base future decisions on data and clear definitions
  - Explore alternative systems of UCP administration (e.g. having claims processed first by DMA or a private TPA) that may be more accountable
  - Define the practical meaning of the pool's statutory mission, which is to "provide access to health care for low-income uninsured and underinsured residents of the commonwealth"
  - Eliminate pool distortions that may make it a preferred (rather than last resort) payer
  - Do not make additional financing recommendations until a consensus has been reached that current and future pool payments can be made accountably and for the purposes intended. In particular, the pool should pay only with prior assurance that all other sources of potential funding have been exhausted (or that payments are not duplicating the payments of other sources), that pool rates of payment are no higher than other sources of payment, that payments are being made for eligible people receiving eligible services, and that the most efficient service delivery systems are being employed. A pilot-test of a new system of administration to identify baseline volume going forward for purposes of addressing questions of appropriate levels of financing should be conducted.

UNCOMPENSATED CARE POOL
September 17, 2002

GOALS

- Determine whether the current mechanism for paying hospitals and community health centers for uncompensated care is equitable and cost efficient.

- Evaluate whether the 1997 reforms of the uncompensated care pool have been fully implemented and whether they have achieved the intended results.

QUESTIONS

- Given the successful enrollment of over 300,000 individuals in the Mass Health program since 1996, including approximately 50,000 chronically unemployed in the Mass Health Basic program who supposedly are heavy pool users, why was there not a corresponding decrease in pool usage?

- Why has the insurance partnership program failed to attract as many small businesses as was anticipated in 1997? Would an increase in the amount of the subsidy or the income eligibility of employers result in greater participation?

- Is there appropriate accountability by hospitals for UCP charges which are submitted for reimbursement? Are billing procedures uniform?

- Is the pool subsidizing underpayments by the Medicaid program?

- Why is pool demand now increasing? How much is due to medical inflation, and how much is due to greater usage?

DATA

- Examine carefully the pool usage data to determine why pool demand did not change following Mass Health expansion.

- Review results of DHCFP audits to determine appropriateness of charges to the pool.

- Enrollment data for insurance partnership program.

WORKING GROUPS

- Data collection and billing

- Insurance Partnership Program

Statement of Peter Meade, Executive Vice President
Blue Cross and Blue Shield of Massachusetts
UNCOMPENSATED CARE POOL SPECIAL COMMISSION
September 9, 2002

I am pleased to have participated in the first meeting of the Uncompensated Care Pool Special Commission. The discussion was informative, providing all of us with an indication of the initial disposition of each of the Commission members.

While I look forward to contributing to the goal of accomplishing the legislative intent for the Commission, I would be remiss if I did not emphasize, now, the need for our work and recommendations to be soundly grounded in reality.

We all share the goal of achieving access to world class health care for all. However, the fiscal crisis we face in the Commonwealth, the increasing cost of health insurance for consumers, the financial dilemmas challenging providers, and the economic downturn affecting working people are all factors that point us to the reality that additional funding to the Uncompensated Care Pool does not appear to be likely at this time.

The Commission should, however, pursue alternate funding sources for the Pool. For example, there may be a segment of the population that benefits either directly or indirectly from the Pool, but do not contribute towards the Pool's funding.

In an effort to address potential increases in demand, the commission should also pursue opportunities to maximize efficiency in how the Pool is administered. I am very interested in learning more about the sources and uses of Pool funds as well as the management tools that are used to ensure the Pool is being operated in the most productive and appropriate manner possible. A few examples of issues that I am specifically interested in are:

- The process for determining eligibility and data submitted to verify eligibility
- The use of audits and other validation mechanisms
- How claims are processed and the appropriateness of claims adjudication processes
- The potential use of fee schedules
- Trends in utilization and where care is delivered
- Potential for redirecting care to more appropriate settings (e.g., community health centers)
- What we have learned from demonstration projects
- The appropriateness of case management and utilization review
- Income matching with the Department of Revenue

Thank you for the opportunity to submit this summary of my initial comments. I look forward to working with the members of the Special Commission.

TO: Katharine London, Division of Health Care Finance and Policy
FR: James W. Hunt, Jr., President and CEO
RE: Response to September 10th Memorandum
DT: 12 September 2002

Our goals for the Special Commission are to:

- identify the financial, legislative, and regulatory requirements necessary for maintaining the Uncompensated Care Pool as a major component of the safety net and a major determinant of access to hospital and community health center care for low income uninsured and underinsured Massachusetts residents;
- foster continued evaluation and referral of pool users to the most appropriate sources of care;
- support the development of systems of care management for especially complex high pool users;
- develop a plan for maintaining the Pool for the next three years while the Massachusetts economy rebounds; and.
- take all reasonable steps to stress the importance of rapid action by all in positions to approve and further such plan.

We think the Special Commission should investigate:

- whether well-designed demonstration projects based on comprehensive care management for Pool patients could in some cases promote Pool savings;
- the recommendations of the Advisory Committee on Consolidated Health Care Financing and Delivery; and
- mechanisms to generate additional pool revenues.

In addition, we recommend that the Division take into consideration a number of studies which demonstrate that careful patient care management can provide savings as well as improved care. Community health centers are interested in assisting the Commonwealth in achieving savings while managing appropriately needed care for Pool users.

We believe that the "smaller working group" would best be comprised of the actual Pool Commission Members, with the Advisory Committee Members serving as a sounding board for their recommendations.

If the decision is made to have working groups, we would request that the following issues be fully explored as part of their activity:

- systems improvement for compliance and reporting;
- opportunities for supplemental pool funding;
- opportunities for supplemental pool coverage;
- building a reliable community-based health care workforce that creates jobs and culturally competent and productive workers and improves recruitment and retention opportunities for physicians, nurses, and dentists;
- improving community health center capacity to provide urgent care, geriatric care and pharmacy services;
- enhancing communication between state health policy makers; and
- developing the state's capabilities to provide consistent and reliable policy and adequate payments for the costs of services.

TO: Katharine London, Division of Health Care Finance and Policy
FROM: Robert Restuccia, Health Care For All
RE: Response to September 10th Memorandum
DATE: September 16, 2002

1. Your Goals for the Special Commission:

- *Overall goal- Improve health care access for the uninsured and underinsured in the state.*
- Develop a plan to address the crisis in the Pool that will be precipitated by the elimination the Mass Health Basic program.
- Expand financial responsibility for uncompensated care to employers who are not providing health coverage to their workers.
- Build upon the positive experiences of the demonstration projects by implementing proven strategies in new areas or statewide.
- Make available a more equitable range of services in all parts of the state.
- Ensure that safety net institutions are not overburdened by providing a disportionate share of free care and that other institutions are encouraged and have incentives to provide free care.
- Ensure that pool money is spent effectively and efficiently.
- Maximize federal contributions.

2. The questions you think the Commission should investigate:

- What will the impact of the elimination of Mass Health Basic be on recipients/patients? on individual hospitals? Health centers? Insurers? Is there a disparate impact on racial minorities?
- What has been the impact of Boston Health Net and Network Health on access?
- What has been the impact of the pool on improving access to care in the state?
- How could the state expand responsibility for uncompensated care to employers that are not providing health coverage to their employers?
- What is the burden on the pool from these employers?
- What is the impact of underinsurance of workers and seniors on the Pool?
- What are the range of services that are funded by the pool in what areas and at what institutions?
- How aware are Massachusetts' residents of the free care pool?
- Has utilization of the pool increased as a result of enrollment activities for Medicaid and other access programs?
- What have we learn from the demonstration projects? and what could be replicated?
- What is the impact of stuck patients on the pool?

3. The data you think the Commission needs in order to answer those questions:

- Develop a model of the impact of the elimination of MassHealth Basic on patient utilization e.g. analyzing impact of the elimination of pharmacy, primary and specialty physician benefits and mental health benefits on patient care and hospital utilization. This should include differences by area of state.
- Survey all hospitals concerning services provided by the pool.
- Data on the impact of Boston Health Net and Network Health on access
- Data on the impact of the pool on reducing unmet health need in the state.
- Data on the impact of stuck patients on the pool.
- Estimates of the burden on the pool from workers who are not receiving health insurance. coverage from their employers or are underinsured. Data on these employers and employee.
- Trends in underinsurance among workers and among seniors who cannot afford supplementary insurance. Trends in high deductible insurance products.
- Polling data on awareness of pool.
- Tracking of free care applications in relationship to outreach and enrollment activities.
- Data on the outcomes of the demonstration products.

4. The topics you think should be investigated by a smaller working group

There should be an access and a finance workgroup and topics divide between the two.

Position Paper concerning the Uncompensated Care Pool from the Massachusetts Council of Community Hospitals

The Massachusetts Council of Community Hospitals (MCCH) represents 23 hospitals in Massachusetts. The pool has affected each of these hospitals in different ways. Some are net receivers and some are net payers, but none are satisfied with the pool as currently constructed. Most importantly we want to emphasize the urgency of identifying and implementing solutions.

OUR GOALS

1. Maintain the safety net.
2. Allow for a mechanism that allows for the UCP "tax" to be passed through to payers and broader constituents in the Commonwealth and not absorbed by the community hospitals.
3. Eliminate the shortfall.
4. Ensure the equality of payments for similar services.
5. Insure that the overall management of the pool expenditures gives great weight to encouraging care in the most cost effective protocol and site.

ISSUES TO EXPLORE

1. The unexpected growth of the UCP must be understood. Data that reveals whether there was a change in the "mix" of services provided, and how those costs were affected by the site of care or medical model adopted by the provider, needs to be understood. How the provider rate structures may have affected the recovery of UCP "costs" versus actual cost, if at all, needs to be examined.
2. The population composition of the pool recipients needs to be better understood and contrasted with the population in MassHealth Basic, as well as the implications on the pool regarding the needs of the population expected to be disenrolled in April. We would like to know the scale of the emerging problem, how it will affect individual providers, and by understanding the needs of these various population(s) craft a way to serve them more cost effectively.
3. We would like to know what other states are doing to maximize FFP or have they otherwise created a more equitable distribution of the free care and bad debt burden on hospitals and physicians. We are told that this is the only claims based mechanism in use in the nation to address this problem. What are the advantages to other models?
4. We would be interested in examining how funds are used by the pool within various regions of the state as a way to find alternatives to cooperatively work together within regions.
5. Explore incentive systems to encourage the use of cost competitive care sites.

Statement of James Mandell, M.D., President and CEO, Children's Hospital Boston
to the Special Commission on the Uncompensated Care Pool
September 9, 2002

As members of this Commission charged with the responsibility of strengthening the current system for providing medical care to the uninsured in Massachusetts, it is incumbent on us to face head-on the problems facing the Uncompensated Care Pool. With an estimated 397,000 uninsured in the Commonwealth, the need for a free care pool to help cover the costs of their medical care is greater than ever. However, the pool is not serving the needs of the uninsured in Massachusetts nor the hospitals that care for them. In fact, as it is currently constituted, the Pool not only falls well short of its original mission; it has instead become a burden on hospitals.

Massachusetts created the Uncompensated Care Pool in 1985 to strengthen the health care safety net for the uninsured by reimbursing hospitals for the free care they provided – a time when the health care environment was radically different. The pool was premised on a simple model, reflecting the then relatively uncomplicated regulated healthcare environment. The state would assess 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. Today, the free care pool tax can no longer be passed on and thus falls directly to the bottom line of the majority of hospitals that are net payers into the system. Hospitals now bare the burden of funding up to $170 million, or over 50%, of the $315 million fixed allotment from the pool to reimburse hospitals. In essence, the Uncompensated Care Pool has become a system where hospitals are, by and large, redistributing their own money.

We are not disputing that hospitals must play a role in caring for the uninsured. However, the system must be reformed to reflect the fact that the private-public payer distinction has become essentially meaningless. The formula for assessing hospital payments – which is based on each hospital's *private sector charges* – reflects a long bygone era. At Children's Hospital, we are penalized by this formula because almost 70% of our revenues come from non-governmental health insurers. As the only hospital in Massachusetts dedicated solely to the care of children, by definition we receive little in Medicare subsidies – resulting in a higher proportion of our payer mix attributable to private sector charges. Despite the fact that we care for more low-income children than any provider in the Commonwealth, we are the single largest hospital net payor into the pool, making $8.9 million *net* payment in FY01.

The criterion for distributing pool funds further distorts the original intent of the free care pool. Monies from the pool are allotted to hospitals and health care centers on the basis of the amount of "allowable free care" that they provide. This standard only captures a portion of the total unreimbursed costs that hospitals incur in treating the uninsured and underinsured. When you consider that the Pool pays only about 42% of the total cost of caring for the poor and uninsured (in 2000, hospitals provided over $400 million in unreimbursed care *over and above* what the pool covered), net pool payers feel particularly disadvantaged by the current system.

There are some who mistakenly argue that the pool is an insurance program and the Massachusetts free care system is too generous. They argue that the key to solving the free care pool crisis is tightening up on eligibility requirements and services. This was never the intent of the state legislature and the governor and overlooks the larger issues that are at the heart of the growing discontent over the pool. Rather than helping to equalize the costs of paying for the uninsured, the pool is creating its own inequities and placing an additional burden on hospitals. Implementing a few insurance-type fixes will not restore fairness and soundness to the system.

Unfortunately, the state already has taken steps in the direction of treating the pool as an insurance product in its lengthy and cumbersome claims and audit process – the most burdensome in the nation. This process imposes an undue burden on hospitals, especially when you consider that the pool is largely funded by hospitals, most of which receive little if any in pool subsidies. We must return to the original intent of the pool and simplify these administrative requirements.

With many Massachusetts hospitals experiencing fiscal crises, they cannot afford to provide the highest level of care to their own patients – both insured and uninsured –while continuing to subsidize the costs of other health care providers. Reform of the Uncompensated Care Pool is necessary both for shoring up this critical safety net and for enhancing the long-term stability of Massachusetts hospitals.'

Massachusetts Business Roundtable

SPECIAL COMMISSION ON UNCOMPENSATED CARE

Goals and Objectives

Through varying levels of contributions for the past 17 years, the business community has been a sponsor, or a co-sponsor, of the Uncompensated Care Pool in Massachusetts to pay for patients receiving necessary medical care not covered by other private or public health care programs.

Throughout this period, the business community has understood that the Uncompensated Care Pool would be a temporary safety net solution for uninsured and underinsured patients in Massachusetts. Of course, this "temporary solution" is still with us, even though the funding of the Pool and the distribution of the Pool's resources has had several revisions during the 17-year period.

From the outset of the Pool's formation, the Massachusetts Business Roundtable has commented that there must be a broader funding formula for the Pool, if the Pool is to be the state's long term solution to pay for the desired safety net. Obtaining payments for free care and bad debt from only those who pay their own way in the health care system – whether those payers are businesses, hospitals or insurers – is not an equitable public solution that should survive as a permanent program for uninsured or underinsured patients.

As Massachusetts has done for the past few years by expanding the state's Medicaid coverage, it will be necessary in the longer term to include the uninsured and underinsured in existing state health care programs. That is a much preferred solution to continuing the uneven funding and distribution of funds through the current make-up of the Uncompensated Care Pool.

In brief, the Massachusetts Business Roundtable believes there are at least three main goals for the future of the Free Care/Bad Debt program in Massachusetts: 1) broader funding of the safety net as a true state program for health care coverage; 2) greater shifting of patients from the Pool to existing state programs, even if legislative or administrative changes are needed to redefine those programs; and 3) more use of appropriate outpatient sites for Free Care medical treatment, particularly in community health centers that are more available now than when the Pool was formed in 1985.

Thank you for the chance to comment on the Special Commission's work on this issue. The members of the Roundtable's Health Care Task Force sincerely desire that all residents of Massachusetts have access to necessary health care. We look forward to working with the Special Commission to find the most equitable ways to achieve that purpose.

Uncompensated Care Pool – Goal of MNA's Participation
September 2002

"The Massachusetts legislature established the Uncompensated Care 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 network of health care initiatives for low-income uninsured and underinsured individuals."
(Uncompensated Care Pool PFYO1 annual report August 2002 Mass. Division of Health Care finance and policy)

"There shall be a special commission for the purpose of devising a fair and equitable allocation of the burden of uncompensated care and free care among affected participants in the health care delivery system, so that no single participant or group of participants bears a disproportionate burden for the cost of providing such care"
(Chapter 177 of the Acts of 2001 Section 74)

With the purpose of the Uncompensated Care Pool (UCP) stated and the purpose of the Uncompensated Care Pool commission stated, the Massachusetts Nurses Association would like to succinctly state how it sees its unique role in the work of the commission.

First, the overarching goal should reflect the UCP purpose, which was and is to assure those unable to afford care are not denied necessary health care. Any decision made by the UCP Commission must be considered with this overall objective in mind, particularly in light of the increasing numbers of individuals expected to be faced with this problem in the current fiscal crisis.

Second, the statement "…that no single participant or group of participants bears a disproportionate burden for the cost of providing such care," should be considered not only in terms of any specific formula allocation between parties but also must take into account the effect on parties as a result of the formula allocation. More specifically, insufficient funding for the cost of health care that is rightfully required to be delivered has had a dramatic impact on nurses over the last decade, which has translated into deterioration in the quality of care for patients. While an overarching goal may be to limit the budget of the state or the insurers or employers with regard to these costs, past history has shown us that hospital administrators often make up for their own budget shortfalls by reducing, sometimes dramatically, nursing care and other direct care services. In the name of reducing budgets and "efficiency" we have seen workforce redesign initiatives in which nurses were purposefully laid off and replaced with unlicensed personnel in a misguided attempt to cut cost while alleging no effect on the quality of patient care. While the nurses raised concerns about the adverse results that would no doubt ensue from these decisions, their voices were drowned out by the shrill cry of cost containment. The result for patents was significant erosion in the quality and safety of their care. Numerous studies validate nurses concerns that went unheeded. The results include a rise in preventable med errors, nosocomial infections, and increases in preventable sentinel events. Ironically while these changes were made in the name of cost savings, the reality is nosocmial infections alone cost the hospital industry more than $4 billion annually.

And while the patients care eroded so too did he nurses' desire to work in settings where they were expected to take care of more and more acutely ill patients whose stay in the hospitals were markedly reduced. Because nurses began leaving for less stressful jobs, hospitals began forcing remaining nurses to stay through mandatory overtime as a means of staffing the hospital. During these years wages remained relatively flat and conditions continued to deteriorate – ultimately leading to two strikes involving Tenet St. Vincent's and Brockton Hospital. It had been fourteen years since a nurses strike had occurred within the state. Not surprisingly, today we find we are a state with the highest per cap of registered nurses per citizen in the country, yet nurses are unwilling to fill the vacancies hospitals have now reopened as a result of these failed strategies. New nurses are leaving within two years and older nurses site their intent to leave within five years if conditions do not improve.

In the view of the MNA, the combined effect of past decisions regarding the CHP, the legislatively sanctioned deregulation of the health care industry and the subsequent free-market competition that ensued have quite literally resulted in a system that is in violation of the intent of the legislation that called for the CHP's creation. Specifically, we have indeed achieved a system that has placed a "disproportioned burden for the cost of providing such care." Those bearing the disproportionate burden have been the nurses and the patients they have cared for.

In the final analysis the net effect of this line of decision making and all-out focus on cost cutting will result in higher costs as we attempt to now retain and recruit sufficient numbers of nurses willing to work in the current system.

In light of these conditions, the MNA's goal in participating in this process is to review carefully those strategies that were successful and to be candid in the review of those strategies that were unsuccessful in order that we can assure patients receive the care they need and that we, front-line nurses, will be there to provide it. We are here to ensure that whatever "equitable allocation of resources" reached by this body does not in reality result in further destructive costs to nurses and patients.

Recommendations Submitted to the Special Commission on Uncompensated Care

This section includes recommendations received by the Commission from various organizations and agencies, including Commission members.

Associated Industries of Massachusetts, Blue Cross Blue Shield of Massachusetts, Massachusetts Association of Health Plans, Massachusetts Business Roundtable, Massachusetts Taxpayers Foundation

December 2, 2002

The Honorable Richard T. Moore
Massachusetts State Senate
State House, Room 312-D
Boston, MA 02133

Dear Senator Moore, Representative Keenan and Secretary Gittens:

As appointees to the Special Commission on the Uncompensated Care Pool (the "Pool"), we are writing to thank you for your leadership as the Commission considers how the Pool should be administered and funded. While we believe that our common goal should be to ensure access to care for all of the Commonwealth's residents, we are also cognizant of the reality of the Commonwealth's current fiscal situation and the limits it places on state funding for health care. We appreciate the opportunity to express our views on how the Pool should be restructured and the potential impact of those reforms.

Over the course of the Commission's deliberations, it has become abundantly clear to us that the Pool's mission must be more clearly defined and that better accountability and management of Pool resources must be implemented. While the Division of Health Care Finance and Policy (DHCFP) has worked diligently to implement Chapter 47 of the Acts of 1997 and improve Pool administration, the fact remains that basic controls used by other payers are not in place for the Pool and we still lack confidence that all Pool payments are appropriate. We owe it to both employers and taxpayers to ensure that dollars flowing into the Pool are used most effectively and that the Pool serves solely as the payer of last resort. We also owe it to those low-income, uninsured individuals who rely upon the Pool. Each dollar inappropriately spent is a dollar taken away from necessary care.

We recognize that if the recommendations included in this letter are adopted there may still be a funding shortfall. In the present environment, it is not fair to ask hospitals, health plans or employers to increase their level of support for the Pool. We recommend that additional state funds be used to cover any deficits, including fiscal 2003, once the reforms outlined in this letter are implemented.

Recommendations

1. **The Pool's mission should be clearly defined as the provision of "safety-net" funding for hospitals and community health centers that provide more than their fair share of**

otherwise unreimbursed urgent/emergent care for the low-income uninsured/underinsured.

Originally, the Pool was designed to compensate those hospitals that provided a disproportionate share of unreimbursed care, primarily emergency and acute inpatient care, to low-income, uninsured individuals. Over time, it has also become a financing mechanism for primary and routine care for the uninsured and is viewed by many as a comprehensive health care program for the uninsured. The Pool, however, was never designed to support a comprehensive program and is a very inefficient means of providing coverage. The Pool pays only for care delivered in a limited number of settings, regardless of whether they are the most appropriate, and the Pool lacks any mechanism to ensure that an individual's care is coordinated among providers.

The Commonwealth already has a comprehensive health care program for low-income individuals – MassHealth. As compared to the Pool, MassHealth covers a broader array of services in more settings and is designed to maximize federal matching funds. The Pool cannot and should not serve as an additional program to provide comprehensive coverage to those ineligible for MassHealth. Instead, we believe that it must function as a more limited safety net for those individuals and the providers who care for them.

Specifically, we recommend that "free care" be redefined so as to include only the following services:

- Emergency and urgent care services provided by acute care hospitals to low-income, uninsured individuals;
- Medically necessary services provided by community health centers to low-income, uninsured individuals; and
- Bad debt associated with emergency services provided by acute care hospitals to uninsured individuals (other than low-income individuals).

This definition recognizes that hospitals are required to treat all individuals who present for emergency services regardless of their insurance status. It also recognizes that community health centers are generally a more appropriate setting than hospital outpatient departments for other non-emergent services.

2. Eligibility for free care should be determined by DMA.

If the Pool is to operate as the payer of last resort, it is critical that we ensure that the Pool does not pay for care provided to individuals who have other sources of coverage, including coverage through MassHealth. While significant work has been done to standardize the eligibility determination process and to assist low-income individuals applying for MassHealth, we believe that more can be done. Today, hospitals and community health centers are responsible for determining free care eligibility in accordance with DHCFP regulations. Unfortunately, hospitals and CHCs have limited information regarding potential third party liability. The Division of Medical Assistance (DMA) is in a much better position to determine whether an individual has other sources of coverage. As such, we believe that free care applications should be processed though the DMA eligibility system and that no payments from the Pool should be authorized until DMA has determined that there is no other source of coverage.

3. Claims against the Pool should be adjudicated by DMA and paid using a fee schedule, such as the one used by MassHealth.

Currently, hospitals are reimbursed for free care based on self-reported, aggregate free care charges. While DHCFP conducts some retrospective audits, the Pool essentially works on an honor system. No other public program or third party payer in the Commonwealth operates in this manner. To ensure that Pool payments are for eligible individuals receiving eligible services, we recommend that all Pool claims be submitted to DMA on MassHealth claim forms for initial processing through MMIS. Pool payment should not be authorized until claims have cleared MMIS edits. Among other things, these edits review claims submissions for service eligibility, appropriate coding, timely filing, duplicate claims, MassHealth eligibility and third party liability.

The Pool's charge-based system, and the complex "cost-to-charge ratio" associated with it, result in variations in Pool payments to different hospitals for the same services. This system, in some instances, also results in the Pool paying more than would be paid by MassHealth for the same services, creating an incentive to steer individuals to the Pool in lieu of MassHealth coverage. To improve payment equity, we recommend that the pool pay claims using a fee schedule, such as the one used by MassHealth.

4. A utilization management system should be established for the Pool.

Little data exists on whether services paid for by the Pool were medically necessary and provided in the most appropriate setting. While the Pool's enabling statute authorizes DHCFP to conduct utilization review, no system for doing so has been implemented. In order to ensure that limited public dollars are being used most effectively, we recommend that DHCFP be required to implement a utilization review system. One area for focus should be the explosive growth in hospital outpatient services paid for by the Pool.

5. Conduct an in-depth analysis of the adequacy of current Pool funding levels with particular attention to the question: "Why isn't there a significant Pool surplus if Pool funding is higher than at any time in its history and MassHealth enrollment has increased by 300,000 since 1997?"

There has been considerable discussion at Commission meetings about this question. We have heard that the MassHealth expansion has had a downward impact on Pool demand. We have also heard that medical inflation and increased outreach have had an upward impact on Pool demand. Still, we do not have a complete answer to this question. Until a complete analysis has been completed and until the management reforms recommended above have been implemented, we will not be able to accurately assess whether the Pool's current level of funding is adequate.

Implementation

We believe that the changes that we have recommended can be implemented prior to the end of Pool Year 2003. Hospitals and community health centers are already familiar with eligibility verification and claims submission procedures for MassHealth. As such, using MassHealth's systems to administer the Pool should be a relatively simple change for the hospitals and community health centers to implement.

Impact

We believe that our proposal has the potential to eliminate the Pool's deficit. While the exact financial impact is difficult to quantify, we note that recent audits by DHCFP found that 10% of audited Pool payments were inappropriate. Extrapolating these results to all Pool payments, we estimate that over $40 million per year is paid out inappropriately from the Pool. The eligibility and

claim audits conducted by DHCFP were fairly rudimentary. Using MassHealth's more sophisticated systems to determine eligibility and adjudicate claims will likely yield even greater savings for the Pool.

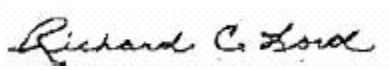
Eliminating the Pool's deficit is in the best interest of both net payers and net receivers from the Pool. The Pool's deficit effectively decreases total reimbursement for net receivers and increases the assessment on net payers. Elimination of the deficit will result in more predictable Pool payments and improved cash flow for hospitals and community health centers. It also may provide additional revenue that could be redirected to the MassHealth program.

Our proposed changes to the definition of free care may result in hospitals directing more uninsured patients to community health centers for non-emergent and non-urgent care, resulting in lower costs to the Pool for the same services. It also may also result in greater equity in the services that uninsured individuals living in different parts of the state receive.

Under our proposal, employers and taxpayers would gain confidence that their contributions to the Pool are used most effectively and that the Pool serves solely as the payer of last resort. Our proposal is preferable to increasing the surcharge, which would result in higher health insurance premiums, and, in turn, more uninsured individuals and greater demand on the Pool.

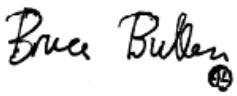
Again, we thank you for your leadership on this issue and we look forward to working with you to strengthen the health care safety net by adopting these important proposals.

Sincerely,



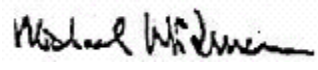
Richard C. Lord
President and CEO
Associated Industries of Massachusetts

Peter G. Meade
Executive Vice President
Blue Cross Blue Shield of Massachusetts



Bruce M. Bullen
Chief Operating Officer
Harvard Pilgrim Health Care
Representing
Massachusetts Association of Health Plans

Alan G. Macdonald
Executive Director
Massachusetts Business Roundtable



Michael J. Widmer
President
Massachusetts Taxpayers Foundation

MHA Response

December 13, 2002

Robert P. Gittens
Secretary
Commonwealth of MA – Executive Office
1 Ashburton Place, 11th Floor
Boston, MA 02108-1518

Dear Senator Moore, Representative Keenan, and Secretary Gittens:

I'd like to respond to the December 2 letter to the Chairmen of the Special Commission on Uncompensated Care from several of the commission members. That letter had five recommendations that focused on redefining and limiting the mission of the pool, restructuring pool administration, and further analyzing pool financing and expense trends. The recommendations were focused on management and scope issues, but not funding issues – certainly not the issue of how the funding of uncompensated care should be allocated. While some of the recommendations merit careful study, they raise as many questions as they seek to answer. Included among the important questions that arise are: Who will the pool **not** serve in the future? What happens to the health care needs of those people? And are so-called "savings" to the pool merely a means of cost shifting to providers?

Clearly, the recommendations in the December 2 letter would not, if implemented, adequately address the funding crisis we are now facing. As some of the members that signed the letter would admit, the recommendations certainly do not address the FY03 shortfall. Unless and until this commission faces the funding crisis, our work will remain unfinished.

The following paragraphs state our understanding of the letter's specific recommendations and our response:

1. **Redefine the Pool's Mission** to include only the following services:
    - **a.** Emergency and urgent care services provided by acute hospitals to low-income, uninsured individuals;
    - **b.** Medically necessary services provided by community health centers to low-income, uninsured individuals; and
    - **c.** Bad debt associated with emergency services provided by acute hospitals to uninsured individuals (other than low-income individuals).

Response: While clarification and refinement of what services the pool should cover and what it should not cover is appropriate, the redefinition spelled out in the proposal would leave many seriously ill patients at risk if the current statutory definition for emergency and urgent care were used. Under that that definition no hospital care would be covered unless the patient was being treated for "the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms" that required treatment within 24 hours. This definition would eliminate, for example, most continuing cancer and heart treatments, diabetes follow-up and the like which are not generally available outside our hospitals for most uninsured patients. If this is what is intended by the proposal, many who currently need and receive care would lose access to treatment, but it is not clear how many or what types of patients would be affected. The impact on patients may literally be "life and death" so any clarifications must be very deliberately thought through before adoption and implementation.

Some questions that this approach raises include:

- What happens in communities that lack a community health center (CHC)? Is no uncompensated care covered unless it follows the sudden onset of serious illness?
- Even in communities that have a CHC, what about medically necessary services that are available in a hospital but not in a CHC? (Examples include specialist services such as oncology, cardiology, etc.)
- Do CHCs have the capacity to absorb the resultant demands on their services?
- If hospitals are no longer reimbursed for non-urgent uncompensated care, will they still be expected and/or required to provide the services?
- What is the rationale for denying care which, while not technically urgent, could prevent serious degradation of health over time, and prevent the need for costly care later in the disease process?
- What system would be used to enable clinicians to make timely determinations of allowable care? How will this affect the broader process of care at hospital-based service sites?
- What is the financial impact on hospitals that have a very high volume of uncompensated care relative to other payers?

Until these and other questions are answered satisfactorily we should not take such a precipitous step. Work on clarifying and limiting what the pool does and does not cover will require careful development to assure that critically needed care is not interrupted and remains accessible to those in need**.** Clarification has to be made *before* the shift in policy – not afterwards.

2. **Eligibility for free care should be determined by DMA.** Free care applications should be processed through the DMA eligibility system and no payments from the Pool should be authorized until DMA has determined that there is no other source of coverage.

Response:
While we agree that better use can be made of DMA's third party insurance data files, we disagree that DMA's currently overburdened eligibility process is the proper place to determine pool eligibility. There are significant worker shortages and system problems at DMA that cause serious delays in eligibility determinations. These problems can and must be fixed, but it won't happen overnight – particularly given the state's current fiscal condition.

We strongly encourage timely file matches of DHCFP's free care application files with DMA's eligibility file and third party liability files. We encourage DMA to facilitate hospital and health center access to those files as well, so that they can make "real-time" inquiries to identify other third party resources before going to the pool. DMA's current authority to collect directly from any other third party insurer for covered services paid by Medicaid should be extended to DHCFP and the pool.

3. **Claims against the Pool should be adjudicated by DMA and paid using a fee schedule, such as the one used by MassHealth.**

Response:
It is instructive that the group making the recommendation to shift administration of the pool to DMA/MassHealth includes representatives of insurance companies that withdrew from participation in the MassHealth program because of issues with program administration and inadequate payment levels.

While it makes some sense to enhance DHCFP's edits and reporting capability for pool claim data by drawing from DMA's experience and systems, the application of such edits should be carefully implemented so as not to create the kinds of claims backlogs and unreasonable denials that hospitals and health centers routinely experience participating in MassHealth.

4. **A utilization management system should be established for the pool.** To ensure that limited public dollars are being used most effectively, DHCFP [should] be required to implement a utilization review system.

Response:
It does make sense that DHCFP implement some form of utilization oversight. However, it does not make sense to institute punitive retroactive approaches. The effort should be collaborative with hospitals and health centers and as prospective as possible in terms of management. For example, medical management, including targeted disease management, would be proactive rather than reactive and, in the long run, much more effective in reducing utilization.

5. **Conduct an in-depth analysis of the adequacy of current pool funding levels with particular attention to the question: "Why isn't there a significant pool surplus if pool funding is higher than at any time in its history and MassHealth enrollment has increased by 300,000 since 1997?"**

Response
This question may have been analyzed and discussed more than any question at the Commission. It should not be used to divert attention from the real funding issues. Current funding of the pool is actually at the lowest point since Chapter 47 was implemented. Over the last several months, DHCFP staff presented careful analysis of trends in uncompensated care pool funding and expenses and variation from projections made by the 1997 commission.

Contrary to the impression left by the December 2 letter, uncompensated care costs at hospitals have dropped since enactment of Chapter 47 and implementation of the MassHealth waiver expansions. In pool year 1996, the year before enactment, allowable uncompensated care costs at hospitals were $467.3 million; six years later, in pool year 2002, DHCFP estimates those costs to be only $427.4 million after six years of cost inflation. The issue brief by Robert W. Seifert, published by the Health Care Policy Forum at Brandeis University, found that "Adjusting for inflation, allowable uncompensated care costs in FY2002 were actually 28 percent below the 1996 level." (See attachment.)

There is no question that the MassHealth expansions, with the extensive outreach by DMA, community groups, community health centers, and hospitals throughout the state, had a dramatic effect -- diminishing the numbers of Massachusetts residents without health coverage, and diminishing the amount of uncompensated care given by hospitals. *But, it is important to note that there was not a one-for-one reduction in the number of pool users for each new MassHealth enrollee*:

- The extensive outreach into low income communities that resulted in increased MassHealth enrollment among the uninsured (who may have been pool users), also resulted in enrollment of many who had been insured by employer groups or individual coverage (and were <u>not</u> pool users). Indeed, for many new enrollees with no private coverage (notably MassHealth Basic enrollees) episodes of care occurring at the time of application continue to be written-off to the pool since under state rules there is no coverage before actual enrollment.
- Further, outreach activities (required by Chapter 47 regulations) also result in increased awareness among low income groups of the availability of hospital "free care." DHCFP has documented a significant increase (around 50 percent) in the percentage of Massachusetts' low-income population aware of that free care as an option for accessing health care services. Not all who apply are found eligible for MassHealth. For example, non-disabled employed adults are not eligible, and other applicants may lack required documentation. Applicants who are not approved for MassHealth most often are approved for hospital free care.

So, MassHealth outreach efforts have had two opposite affects on hospital uncompensated care costs:

1. Shifting many patients from pool-user status to MassHealth coverage; and
2. Increasing awareness of pool availability and, consequently, increasing pool use by low income patients who are:
    a. not eligible or enrolled in MassHealth;
    b. awaiting MassHealth eligibility processing; or
    c. insured through an employer plan but unable to pay deductibles or co-payments.

Discussions at the special commission and in its working groups tend to focus on the first effect while ignoring the second.

The February 3, 1997, Report of the Special Commission on Uncompensated Care included Appendix N that projected expected sources and uses for funding under the MassHealth waiver and projected impact on "pool demand" for hospitals. The projections assumed 4 percent inflation. There is a significant discrepancy between the projections and actual pool costs. Appendix N projected pool costs to be reduced to $310 million by 2002, when actual pool costs reached $435 million. This $125 million variance from the projection can be explained by a combination of factors:

- inflation in hospital costs grew faster than projected, especially in recent years;
- the '97 projections did not account for the "woodwork effect" of outreach efforts among low income patients not eligible for MassHealth;
- the projections anticipated nearly 100,000 low income employees of small businesses enrolling in the Insurance Reimbursement Program; actual enrollment only reached 13,000;

DHCFP has noted that the Appendix N projections significantly under-predicted inflation in hospital costs. We believe that DHCFP's analysis of hospital cost increases is flawed because it reflects growth in total patient care costs, including new volume in all payer categories, as well as unit-cost growth. Actually hospital uncompensated care costs dropped as a share of total hospital business (NPSR), from 5.8 percent in 1996 to 3.8 percent in 2002 – a drop of more than 30 percent. So it is incorrect to ascribe the entire variance to growth in total hospital costs, including volume to hospital uncompensated care costs.

We hope this letter is helpful and we look forward to further consultation with you.

Sincerely yours;

Timothy F. Gens, Esq.
Senior Vice President, Legal Affairs and Counsel

Presentation to the UCP Commission

Massachusetts Council of Community Hospitals

November 25, 2002

MCCH views the current situation as follows:

- The unconstrained growth in the UCP and the resulting current and expected shortfall has created a unsustainable burden for community hospitals
- The inability of many independent community hospitals to pass such increases in cost through to the private sector violates the intent of the original legislation
- The current rates of reimbursement from public payers eliminate the ability to cross subsidize
- The failure of the original UCP legislation to create adequate oversight for the management of the pool expenditures has led to inappropriate charges to the pool, and disincentives to find alternative payments
- The original legislation's ambiguities in defining service levels have created great disparities in service levels across patients and communities
- The absence of clinical information on this population eliminates the possibility to analyze the population for opportunities to reduce the cost of care by more appropriate clinical case management and site of care

Our proposal must recognize the fragile condition of community hospitals and resultant urgency

- Absent a significant change in Medicaid coverage and anticipating further reductions in coverage
- Absent an improvement in Medicaid rates
- Absent a willingness of the Commonwealth to raise taxes in further support of the Pool
- Absent the willingness of the Commonwealth to redirect existing FFP reimbursement to the support of the Pool

MCCH proposes the following:

- In FY2003 raise the payer surcharge to account for the projected shortfall
- In FY2003 eliminate the hospital requirement to support the pool shortfall
- In FY2003 institute a standardized fee schedule using the Medicare Inpatient schedule and APG's for ambulatory reimbursement using Medicare payment levels
- In FY2003 establish a Center for the development and Implementation of UCP Cost Saving opportunities
- In FY2003 eliminate the UCP as a Payer of first choice by requiring hospital pool reimbursement to be priced at the lowest price established by the hospital through its charges or non-public funded contracts.

The expected implications of this proposal are;

- The safety net can be held together in the short run

  Community Hospitals will be stabilized in the short run with about 50% of the hospitals having a loss from operations

  Insurer's will be forced to renegotiate contracts at a higher premium

  Employers will absorb a higher cost for health care and continue to restructure plans to increase employee share of health costs

  Insurer's and employers will have greater incentives to participate in tiered insurance products that reward more appropriate site of care services at a lower cost.

  Hospital direct operating costs will increase in reaction to higher insurance premiums
- The shortfall should decline due to better management caused by restricted fee schedule and pool eligibility enforcement

  Insurer profitability should decline in the short run

  State administrative costs should increase to manage the claims process

  Hospitals will be able to employ current billing systems to support a standardized fee schedule

  A higher quality of patient data will result from the claims process facilitating the ability to identify cost saving opportunity

  The reimbursement for the cost of care will be more equitably distributed resulting in more consistent levels of care

The effects of this proposal can be mitigated by;

- Seeking further FFP enhancements
- Redirecting Tobacco settlement funding to support of the Pool
- Redirecting current FFP from the general funds to support of the UCP

Massachusetts League of Community Health Centers

Statement to the Uncompensated Care Commission, November 25, 2002
Patricia Edraos, Health Resources/Policy Director

Although all residents of the Commonwealth deserve something better than the Pool for their coverage, this is obviously not the year that that will happen. For now, the Pool is the best and only safety net for hundreds of thousands of low income people in need of health care. We believe that maintaining this safety net while improving MassHealth and making a number of other changes listed below is essential until a better system can be devised.

If this is not done we predict the following:

Emergency room usage, already excessive, will increase. According to an Oregon study, people who lost coverage were four times as likely to use emergency rooms for their care than people with coverage. The will not only result in poorer care, but significantly increase costs to the Pool. We estimate that the community health centers currently provide over 200,000 visits per year to approximately 65,000 people. One analyst has noted that if only 50% of these visits were to be diverted to emergency rooms, the added cost to the system would be over $12 million. In addition, preventable hospitalizations, already disproportionately higher among the uninsured than among insured populations, will increase, again adding costs to the system. In short, reducing community health center capacity will exacerbate current staffing and occupancy, and expense, problems throughout the hospital system.

The capacity of community health centers to serve not only the uninsured, but also Medicaid recipients will be severely impaired, as will their capacity to participate as emergency and bio-terrorism responders. Questions have been raised here as to what other states do to care for their uninsured. In a number of other states, the answer is government run tax supported public clinics which lack the capacity to provide the types of care management and cost management that community health centers provide to the Commonwealth.

Our recommendations are as follow:

First and foremost, that the Commission should collectively get itself out of the "what can we cut" box and move into the "how can we finance" mode.

Accept the recommendations regarding MassHealth cuts as set out in the November 13th Health Care For All issue brief entitled *The MassHealth Cuts: What They Are. Why The Don't Work. What We Can Do*. At the least, delay MassHealth Basic elimination for six months while long term plans for appropriate care for people in this category of coverage are considered.

Provide a "lock-in" for MassHealth patients for up to two years to reduce constant churn and to promote case management, or at the very least, restore the capacity of the Division and its vendors to expedite enrollment. One of the major determinants of whether a person is "on" free care or not is how well the MassHealth intake system is working. For the past year, it has not been working very well. Outstationed

eligibility workers were eliminated a year ago, the mini-grants which supported community health center eligibility and outreach were eliminated this year, and some centers are reporting three to six weeks delays in getting MassHealth determinations.

Provide a mechanism, preferably HMO/MCO enrollment, that would allow people who lose MassHealth but remain eligible for Pool coverage to continue to have their care tracked and case-managed. An essential component would be that members could continue to receive the pharmacy and specialty services that they may have been receiving through MassHealth but are not currently likely to receive through the Pool.

Increase participation in the Insurance Partnership through program re-design, and investigate the impact of the methods used by employers, faced by premium increases, to minimize their impact. For many people in our neighborhoods, the Pool serves as "point of service" coverage, coverage that a provider can obtain for someone if and when they have been dropped from MassHealth or are waiting to get onto MassHealth or waiting for employer-based insurance. Our centers report that waiting periods are typically three to six months for employer-based insurance and growing, while coverage is becoming sparser.

Work with the Massachusetts Congressional Delegation to seek an increase in the Federal medical Assistance Percentage (FMAP). We are working with our national association to explore increasing FFP for community health center services and will welcome your support in this.

Take advantage of the health center capacity to access pharmaceuticals at significantly lower costs under the Section 340B program. Evidence from national studies as well as at two of the health centers points to significant savings, particularly among behavioral health patients, from using pharmaceutical case management instead of episodic emergency room services.

Establish longer-term initiatives and demonstration projects that can be measured as to their overall effectiveness. Since 1992, we have been recommending that mechanisms be put in place to collect data from hospital emergency rooms and outpatient departments in order to identify high pool users and urge them to join case management programs.

While we understand that new taxes are unpopular, we believe that the recent referendum may have been an expression of how the voters feel about government, not how they feel about each other and that targeted fees devoted to expanding health care coverage would be acceptable. In particular, we would like to point out that the Medical Security Fund employer tax of .0012 on the first $14,000 of income per year was set at that level in 1988.

In summary, the Massachusetts League of Community Health Center's proposal is for this Commission to continue to recognize and validate the important role community health centers play in keeping Uncompensated Care Pool costs under control, and to continue to authorize and encourage the continued growth of community health center services as a major component of care for the most vulnerable people in the Commonwealth.

Thank you for this opportunity to address the Commission. I shall be happy to respond to any questions or concerns.

Division of Health Care Finance and Policy Staff

Date: November 27, 2002

To: The Management Sub-Committee of the 2002 Uncompensated Care Pool Commission

From: Division of Health Care Finance and Policy Staff

Cc: Co-Chairs of the Commission

At its meeting on November 12, 2002, the Management Sub-Committee asked DHCFP staff to submit to the sub-committee for consideration at its next meeting ideas for changes that might be made to the Uncompensated Care Pool.. This memo is in response to that request.

These proposed changes are designed to change some of the ways the Pool is administered so as to bring demand for Pool funds more in line with available funding and to improve equity. Not all of the changes can be made without some additional costs being incurred; however, any increase in costs associated with these proposed changes to Pool administration would be marginal.

Accountability would be increased for both providers and the patients who access care through the Pool. These proposed changes will enable the Pool to more effectively achieve its statutory requirement of ensuring that the Pool is the payer of last resort. Patients may find that the increased screening requirements and more limited scope of services reduce their access to care that is not urgently needed at a particular time. The Commonwealth could see an increase in expenses for MassHealth if more people are identified who can be enrolled in MassHealth due to the more stringent free care eligibility screening requirements, but there is not a dollar-for-dollar shift.

Ideas for Regulatory Change

The first group of suggestions contains those that can be implemented in a relatively short time frame at relatively low cost. The proposed regulatory changes regarding free care eligibility, the scope of services of the Pool, and the Pool payment level can be effected within ninety days, and therefore would have an effect in the current Pool Fiscal Year (2003). The proposed change to adjust cost-to-charge ratios prospectively could also be implemented within ninety days, but would affect only interim payments and cash flow. This change would have no long-term effect on demand for Pool funds.

1. Rationalize Payment Level
   a. Implement an efficiency standard on outpatient services to bring the payment level for outpatient services closer to that paid by MassHealth. Certain hospitals could be exempted from the efficiency standard or not (MassHealth does not).
      Savings: Up to $30 Million if Public Service Hospitals are exempt, up to $80 Million if no hospitals are exempt.

   b. Cap allowable costs for providers currently exempt from efficiency standards, including Public Service Hospitals.
      Savings: Capping at 150% of efficiency standard would save up to $4 Million. Holding allowable free care costs to a reasonable annual increase would prevent extraordinary increases over time.

   c. Adjust cost-to-charge ratios prospectively for the effect of expected changes so that estimated monthly payments are closer to the expected final settlement amount. This change would reduce the magnitude of payment adjustments at final settlement, but not eliminate these adjustments.
      Savings: $15-20 Million in interim payments only; no change in final payments. (While this affects cash flow only, it does provide for some interim relief.)

2. Reduce Inappropriate Utilization
   a. Do not pay for services for insured patients where payment was denied by the patient's private or public insurer because the service was determined to be not medically necessary, or for not following program rules, (e.g. not obtaining prior authorization, not obtaining care within a network), or because the care/procedure was not a covered by the applicable contract, or for incorrect billing.
      Savings: Up to $10 Million

   b. Do not pay for services not covered by the MassHealth Standard program.
      Savings: Up to $10 Million

   c. Manage pharmacy utilization by implementing a formulary and using DMA's strategies, including the DMA/DMH polydrug initiative. Contract with a vendor to manage pharmacy utilization.
      Savings: Up to $3 Million

3. Implement Eligibility Reforms
   a. Do not allow patients to apply for free care if, based on screening criteria, they appear to be MassHealth eligible, unless they have already completed a MassHealth application.
      Savings: $10-15 Million savings for Pool, increase for MassHealth

   b. Tighten residency requirements. For example, require 6 months residency for eligibility for free care for non-urgent services, and terminate eligibility for undocumented aliens.
      Savings: Up to $5 Million

NOTE: "Savings" = estimated reduction in allowable free care costs. Note that these are rough estimates only, and may depend on how the provision is implemented. In addition, the estimated savings from the various options may overlap, and they are not necessarily additive. None of these options has an impact on FFP, unless Congress raises the statewide DSH cap significantly.

4. Increase Accountability

a. Disallow payment where the provider has not met DHCFP standards for submitting electronic data documenting patient eligibility and services provided. (Currently, payment is withheld, but released when the provider meets standards.)
Savings: Up to $10 Million

NOTE: "Savings" = estimated reduction in allowable free care costs. Note that these are rough estimates only, and may depend on how the provision is implemented. In addition, the estimated savings from the various options may overlap, and they are not necessarily additive. None of these options has an impact on FFP, unless Congress raises the statewide DSH cap significantly.

Ideas for statutory change

The following ideas would require statutory change, and are therefore are dependent upon the actions of the Legislature and the Governor. They could be implemented by Pool Fiscal Year 2004, which begins October 1, 2003.

1. Rationalize Payment Level
   a. Establish a pricing method for outpatient pharmaceuticals. Set prices at the 340B cost for 340B eligible pharmacies and at the Medicaid rate for others, plus a corresponding dispensing fee. (340B refers to a section of the federal Veterans Health Care Act of 1992 that limits the cost of drugs for certain grantees of federal agencies.)
      Savings: Up to $7 Million

2. Increase Accountability
   a. Use per discharge, per diem, or per visit rates for full free care patients who have UCP as primary payer; use cost-to-charge ratio for patients who use UCP as a secondary payer
      Budget neutral.

3. Adjust Pool Funding and Structure
   a. Adjust annually the hospital assessment and payer surcharge based on a standard index such as: Medicare update factor, PPS hospital market basket, Medicaid update factor, CPI, etc.
      Increases Pool funding $4-30 Million per year

   b. Assess hospitals based on total charges less Medicare, Medicaid, and free care (but not other public payers, which are excluded from the current assessment), in order to improve compliance with federal provider tax regulations.
      Budget neutral.

   c. Allocate any shortfall in Pool funds to CHCs as well as hospitals to help foster cost and usage containment.
      Budget neutral.
      OR
      Cap total payments to freestanding CHCs.
      Savings: Up to $5 Million

4. Increase Access to Certain Curative Pharmaceuticals
   a. Allow the Pool to pay for selected curative pharmaceuticals provided to uninsured free care patients by independent pharmacies (in addition to provider-based pharmacies) under the protocols included in the proposed regulatory actions above.
      Cost: $20-40 Million.

   b. Allow the Pool to pay for selected curative pharmaceuticals provided to uninsured free care patients by mail order pharmacies (in addition to provider-based pharmacies) under the protocols included in the proposed regulatory actions above.
      Cost: $10-20 Million

MHA Response

At a meeting of the Management Sub-Committee of the Special Commission on Uncompensated Care, Division of Health Care Finance and Policy staff presented a number of proposed changes to the administration of the pool designed to "bring demand for Pool funds more in line with available funding and to improve equity." MHA is responding to those proposals which fell into two broad categories: Regulatory Change and Statutory Change.

First, it is important to have some policy principles or goals that should be met by any changes in pool administration and accountability measures. We propose the following:

1. Any administrative or accountability measure should improve the efficiency of the health care system as a whole. For example, any change to decrease pool expenses should not increase the costs borne by hospitals and health centers either by increasing administrative expense. Changes should result in real savings to the whole system.
2. Every effort should be made to reduce pool administrative burden on hospitals and health centers—every dollar spent on administration is a dollar taken away from necessary care.
3. Changes should be based on sound, data-based analysis and follow a public consultation process before implementation. It is important that any changes in the way the pool operates are well researched and vetted so as to avoid unintended consequences or dislocation of needed care.

DHCFP Ideas for Regulatory Change

1. Rationalize Payment Level
    a. Outpatient Medicaid "efficiency standard"
    MHA Response: Basically this proposal would reduce payments to hospitals to the Medicaid payment level. Unfortunately, on average the Medicaid outpatient payment level is 42 percent below hospital costs. Virtually no Massachusetts hospital would be paid its costs under the proposed standard. This proposal doesn't reduce system costs, it reduces pool payments—shifting more costs to be borne by hospitals.
    b. **MHA Response:** Cap exemption from efficiency standards
    To the extent that so called "efficiency standards" are used by the pool, it is inequitable to exempt any provider from their application. More to the matter, such standards must be sound and credible, and based on data. They can not be divorced from the goal of actually promoting efficiency in a fair and rationale manner and they cannot be used as an artificial and arbitrary device that primarily seeks to reduce payments.
    c. **MHA Response:** Prospective adjustment in cost to charge ratios
    This makes sense in concept, however it is difficult to implement. This could result in large, unpredicted shifts from one hospital to another during settlement, and could adversely affect hospital finances in the short run. This should be explored in a DHCFP working group including hospitals.

2. Reduce Inappropriate utilization
    a. Non-payment of third party denials
    MHA Response: Our understanding is that this proposal is current pool policy. Of course, we do have concerns that if a low-income patient fails to follow

insurance prior authorization or network rules, and can not pay for the service, it is the hospital that must "eat" the cost of care provided.

b. Non-payment for services not covered by MassHealth Standard
MHA Response: This proposal may make sense, but should be carefully vetted with providers.

c. Pharmacy management
MHA Response: This proposal makes sense.

3. Implement Eligibility Reforms
   a. Mandatory screening and MassHealth applications
   MHA Response: Mandatory screening is already pool policy. However, it is a fact that certain patients refuse to apply for MassHealth. It is untenable to make hospitals and health centers bear the full cost of care for patients who are afraid for some reason to apply to MassHealth. Note that DMA has removed its "outstationed workers" from hospitals so eligibility screening and referral is much more difficult for hospitals and patients. This effort by the state to save money adds to cost and risk of hospitals.
   b. Tighten residency requirements—6 months/disallow undocumented aliens
   MHA Response: MHA opposes these measures, especially the disallowance for free care for undocumented aliens. Our hospitals can not and will not refuse needed services to these patients. To force all their care into overcrowded emergency rooms is bad health policy for all of us.
4. Increase Accountability
   a. Deny payment to providers not meeting DHCFP electronic submission standards
   MHA Response: Its hard to understand the rationale for this proposal. How does this serve the mission of the uncompensated care pool? It's common knowledge that electronic data submission can be complicated and difficult to implement and that it requires careful work, collaboration and compromise by both sender and receiver. The goal should be cooperative and comprehensive transmission, not punitive denial of legitimate reimbursement.

DHCFP Ideas for Statutory Change

1. Rationalize Payment Level – Set prices for outpatient pharmaceuticals
MHA Response: This makes sense but the details need to be worked out in consultation with provides.
2. Increase Accountability – Use per discharge, per diem or per visit rates
MHA Response: We certainly don't understand this one--No "savings" but a significant increase in administrative costs for hospitals and DHCFP. This idea needs a great deal more study before it is given serious consideration.

3. Adjust Pool Funding and Structure
   a. Annual adjustment to assessment and surcharge
   MHA Response: Annual adjustments to the surcharge should be considered, but increasing the hospital assessment is different. Since hospitals already bear the entire burden of the shortfall, increasing the assessment would merely shift the burden among exacerbating current inequities.
   b. Change the hospital assessment base
   MHA Response: In the context of fundamental pool reform, changing the hospital assessment base from private sector charges to another more relevant base makes excellent sense. Our thinking is that net patient service revenue as a measure of a hospital's ability to pay makes sense, but careful attention has to be given to the transition for such a change.

c. Allocate shortfall to or cap CHCs
MHA Response: While this would tend to level the playing for hospitals and their health centers, it certainly makes much more sense to reduce the shortfall by restoring MassHealth Basic and funding the remaining pool shortfall. The Division should investigate the fairness of this proposal and the current allocation of the shortfall solely on hospitals. The distribution of this burden should be place on all parties including insurers and state government.

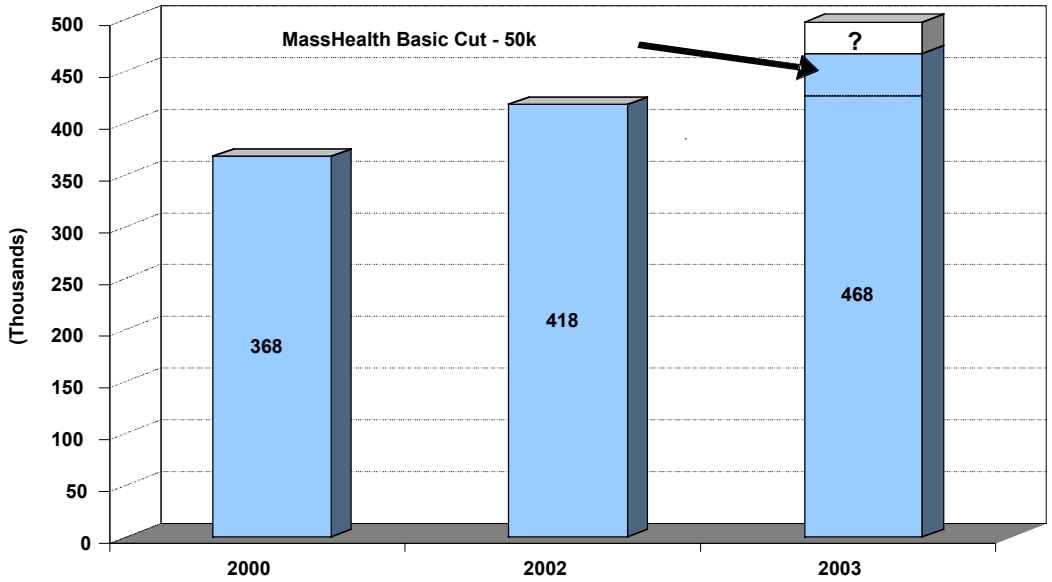
4. Increase Access to Curative Pharmaceuticals (a & b)
MHA Response: While this proposal merits further consideration, it would be difficult for us to support such a change until financing for uncompensated care is restructured in a more equitable way. There currently is insufficient funding to support current demand and this added cost, estimated at $30-$60 million, would not realize savings until many years later.

Special Commission on Uncompensated Care

Presentation by the Massachusetts Hospital Association

November 25, 2002

The Numbers of Uninsured is on the Rise . . .



. . . And is expected to continue to increase.

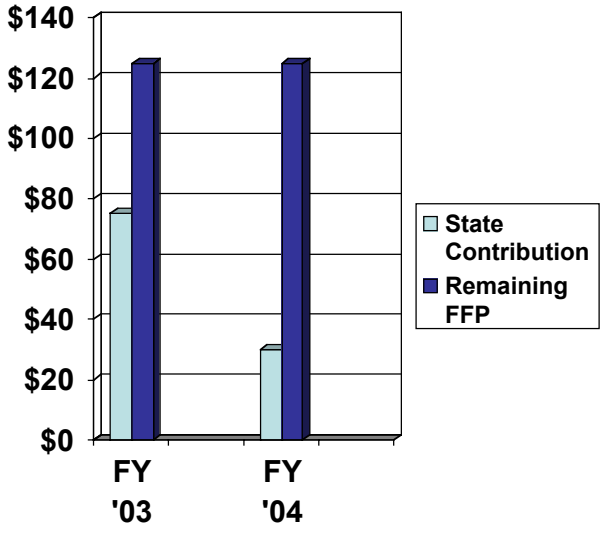
What we need to do

- Bridge the gap for ’03 and ’04
- Fundamentally Re-Structure in ’05

Needed: Temporary Funding to “Restore” Basic and Fill the Pool’s Underfunding Gap

Possible sources of temporary funding:

- Pool FFP?
- Tobacco Funds?
- Brandeis Recommendations?
- New Revenue?
- Other new sources?

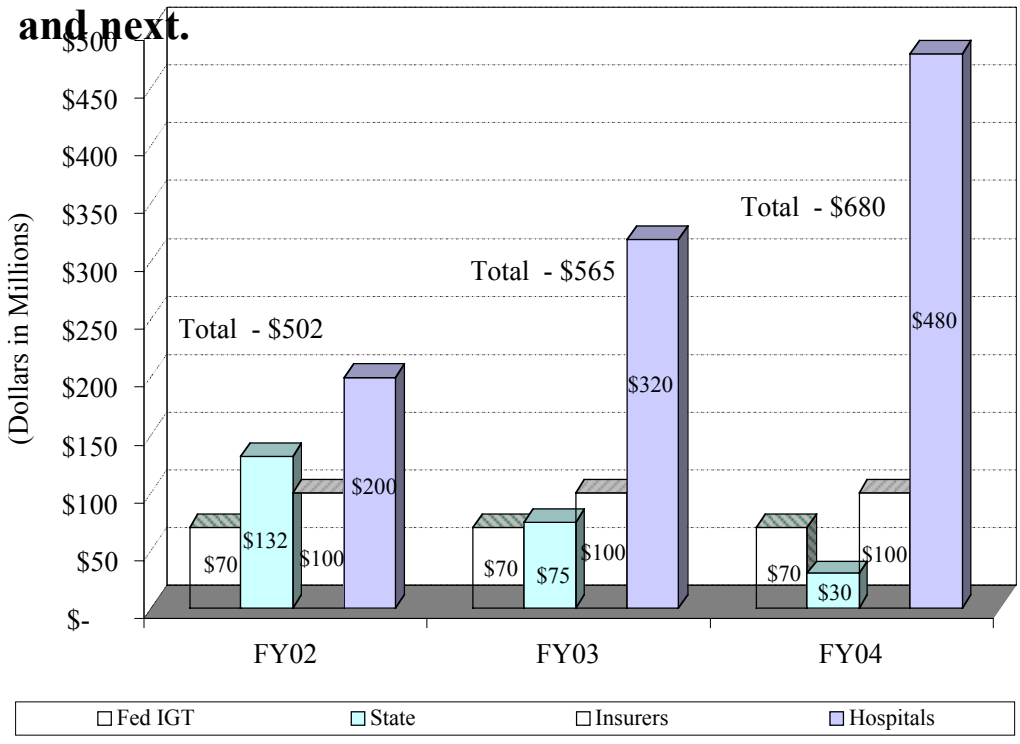


Reform Principles

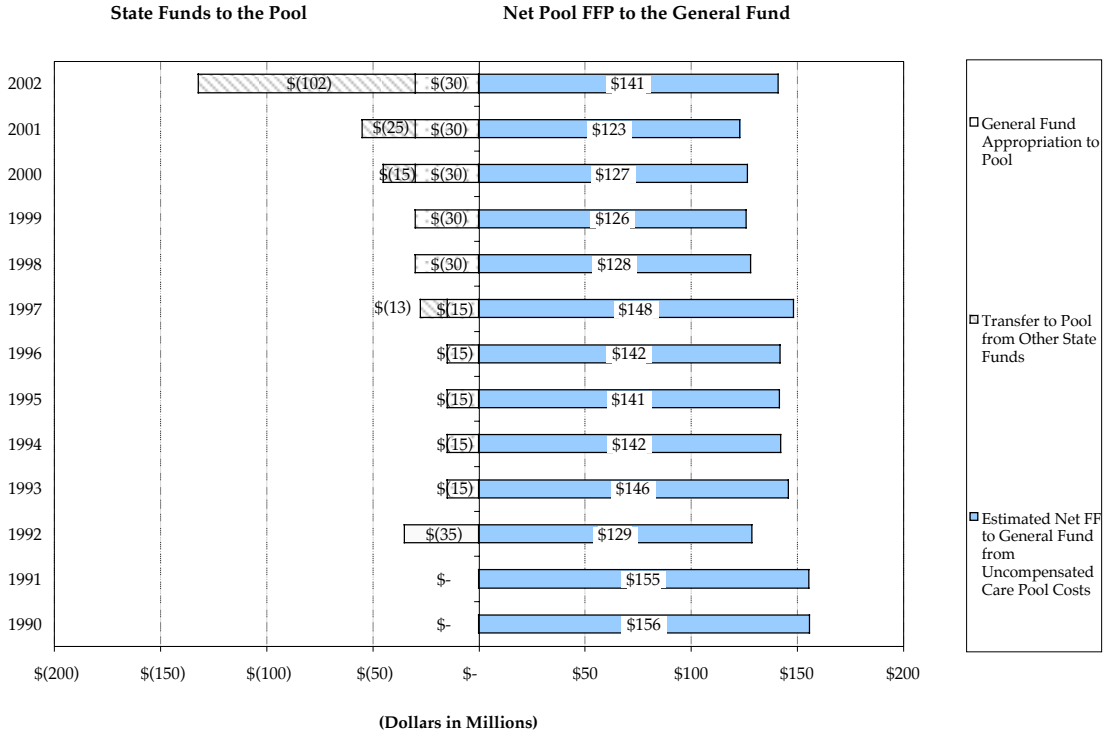
- Maximize, Protect Coverage
- Broad Funding Source: Free Care
- Equity: Hospitals, Payers
- Efficient Use of Resources

Uncompensated Care Pool Burden

Hospitals are facing an unsustainable burden this year and next.



State Funding for Uncompensated Care vs. Federal Financial Participation (FFP) to the State General Fund



Funding Principles for the Health Care Safety Net

- Funding the health care Safety Net is a societal responsibility and funding should be broad based.

- Any adequate and equitable funding proposal should address both pillars of the health care Safety Net: Medicaid & Uncompensated Care.

- Any funding plan for the health care Safety Net must be sustainable and reliable, particularly during hard economic times when the Safety Net is most needed.

- In order to sustain the health care Safety Net, payment for providing health care services for the Safety Net must be sufficient to cover the reasonable cost of providing efficient and quality care.

- The government, as a representative of all residents of the Commonwealth and as guardian of the public health, should be the payer of last resort for those dependent on the health care Safety Net.

- Any stable and reliable funding proposal should seek to maximize federal government funding for the health care Safety Net.

- As a matter of public policy, funding health care coverage, as opposed to funding only he cost of episodic care, is preferable in terms of both quality and cost efficiency.

- As private sector coverage expands, dependence upon the health care Safety Net diminishes; therefore, every reasonable opportunity to protect and expand private coverage must be pursued.

- The design of any funding mechanism for the Safety Net should be developed through a collaborative process that involves providers, government, payers and beneficiaries.

- To the extent that funding responsibility is not shared with all members of society, then among those who shoulder the funding responsibility there must be fairness and reasonableness in sharing the responsibility.

Massachusetts Hospital Association, Massachusetts League of Community Health Centers, Health Care for All, Massachusetts Nurses Association, Massachusetts Council of Community Hospitals

December 16, 2002

Robert P. Gittens
Secretary
Executive Office of Health and Human Services
1 Ashburton Place, 11th Floor
Boston, MA 02108-1518

Dear Senator Moore, Representative Keenan and Secretary Gittens:

The Special Commission on Uncompensated Care is about to end, but it is a long way from finishing its business. The consequences are dire for the commonwealth's health care safety net, for the truly sick who rely upon it, and for all the communities across the state that will feel the repercussions from its failure. It is no longer a question of the potential risk to people which will occur if the safety net fails, rather it is the reality of 50,000 patients removed from Medicaid, along with the growing number of uninsured and underinsured, looking to a safety net that is destined to fail.

It is unfortunate that as we attempt to right the long-standing structural problems with the Uncompensated Care Pool, we are faced with a significant pool funding crisis at a point when the state's budget is also facing a crisis and when there are significant questions about the state's economy. In fact, the well-being of the state's economy and the well-being of the health care system are linked. Ten percent of Massachusetts jobs are directly in health care and another 24 percent are tied to health care by multiplier effects.

So, we are certainly sensitive to the commonwealth's fiscal distress. Yet the problems we are charged to examine must be addressed. Maintenance of the health care safety net and the state's health care system has to be a priority. It is now, during such hard times, that a health care safety net is most needed.

By starting so late, the Commission was left with inadequate time for full deliberation of very complex public policy issues. While discussion of the scope of services provided by the pool is legitimate, there has not be sufficient discussion or understanding of what it will mean in terms of denial of care and increased cost to limit services to "emergency and urgent care." Such changes alter the historical mission of the pool. Such limitations would eliminate most continuing cancer and heart treatments, as well as diabetes follow-up and other crucial services generally not available outside hospitals for most uninsured patients. While much attention was given to detailed administrative issues, very little was given to the equally important subjects of how the pool's financial instability will affect the vulnerable population the pool serves and the health care system that serves all our residents. While studying historical uncompensated care trends was useful, it should never be done at the expense of taking time away from confronting the current uncompensated care crisis. While it is understandable that there was much discussion of the safety net's costs, there was virtually no discussion of how to equitably share such cost.

Now that we've reached the deadline for the Commission we're far from a real solution to the massive problems that the commonwealth and its residents are facing in trying to save the safety net. Shifting costs to hospitals from the state budget doesn't save money – it costs more, it destabilizes the safety net, and it threatens other services hospitals provide to the communities they serve.

The Division of Health Care Finance and Policy projects that this year's pool deficit will exceed $152 million, and that deficit is projected to more than double within two years to well over $300 million. The elimination of MassHealth Basic, which will leave 50,000 long-term unemployed adults without health coverage, and reductions in many other state health programs have contributed significantly to the deficit, as have the growing numbers of uninsured and underinsured employees in our commonwealth.

We all recognize that the pool has lost the confidence of many groups – but its mission remains vital. Payers are not the only members of the Commission that support improved management and cost effectiveness. And providers question the adequacy and appropriateness of its funding mechanism. And those who rely upon the pool for their care worry about its stability.

Providers cannot and will not turn their backs on those who need care as long as those providers have the resources to provide care. But there is no such thing as free care. It takes adequate funds to provide care to the growing number of safety net patients. And providers are not immune from the disturbing fiscal realities that haunt the state and the private sector. A comprehensive reform of the current financing, delivery and access aspects of the health care system may alleviate some of the current pressures on the system. But until that happens, it would be irresponsible to pretend that there will be no repercussions for the health care delivery system if new funding is not provided. Proposed savings schemes – some with merit, some speculative, some raising more problems than solutions – will take time to be implemented. But such savings, even if fully realized over time, cannot adequately address the present crisis.

With that harsh reality in mind, we put forward the following recommendations for your consideration and for the consideration of the other commission members:

1. **Restore MassHealth Basic.** The elimination of this program just does not make sense. Those covered by the program will continue to have significant health care needs that hospitals and health centers will have to meet. The elimination of the Basic program will "save" state government much less than the amount by which the elimination will increase the pool's deficit which hospitals must fund; and the commonwealth will lose millions of dollars in federal funds that can be used to defray half the cost of the program. MassHealth, which brings in a greater than 50 percent federal share, should be supported as the first option for coverage for low income state residents. Re-invigoration of the Division of Medical Assistance eligibility support and restoration of adult "optional" services will both result in savings to the pool. *Changes* in the program may be necessary to improve its cost-effectiveness, but the commonwealth can't afford to let its elimination stand. Consideration should be given to all sources of funding for the program, including the use of tobacco funds.

2. **Fund the pool shortfall.** Even after restoration of the MassHealth Basic program, DHCFP projects a significant pool shortfall. While reasonable administrative reforms may reduce the deficit, the shortfall should be funded. Given the magnitude and significance of a pool failure resulting from the shortfall, no funding source should be taken off the table without being given adequate consideration. One source of funding the

state should consider is federal matching revenue received for pool payments to hospitals, a large portion of which is currently diverted for other state uses unrelated to uncompensated care. The responsibility of employers who do not provide coverage and the adequacy of the surcharge should also be examined, as well as tobacco funds.

3. **Establish Principles for Reform.** There is a growing recognition that there is need to address reform of the health care system beyond the safety net, but while working toward such reform the safety net must be addressed now. While time apparently has run out for this commission to design a comprehensive reform of the safety net, we should establish principles to guide future reform. The principles should include:
    - protection and encouragement of private and public health care coverage for all the state's residents;
    - adequate incentives for the private sector to maintain and expand coverage, as well as appropriate and reasonable consequences for members of the private sector who do not provide coverage and thus shift the cost of care to the public sector;
    - implementation of a broad-based and stable funding source for the provision of care to the low-income and uninsured;
    - adequate funding for the efficient provision of quality care; and
    - equity among participants in the provision of care.

We respectfully request that you and the other members of the commission adopt these recommendations so the process of designing and implementing a comprehensive and lasting reform of the uncompensated care system can proceed in a timely fashion.

Sincerely,

Massachusetts League of Community Health Centers

Massachusetts Nurses Association

Health Care for All

Massachusetts Hospital Association

Massachusetts Council of Community Hospitals

Children's Hospital

December 12, 2002

Dear Secretary Gittens, Senator Moore, Representative Keenan and Members of the Commission:

I have approached my service on the Pool Commission with an abiding commitment to serving the health care needs of the disadvantaged in Massachusetts, a value that lies at the very core of Children's Hospital's mission. As health care organizations, advocates, policymakers and clinicians, we are all fundamentally committed to preserving the health care safety net for our citizens, and maintaining a strong network of hospitals and community health centers. I am convinced that this safety net is in peril. Due to the serious budget pressures resulting from the economic slowdown, the Commonwealth is finding it increasingly difficult to maintain its current commitment to indigent care. At the same time, the number of individuals without health insurance and the costs of caring for them continue to grow. All this comes at a time when federal funds for uninsured care are declining significantly.

Like all of you, I have spent the past several months trying to come to grips with the complicated set of issues surrounding reform of the Uncompensated Care Pool. My work on this Commission and the opportunities I have had to "meet my neighbors" have both broadened my perspective and solidified my pragmatic instincts. In this spirit, I would like to share a few thoughts with you before completing our work together. I expect no one will be entirely happy with my suggestions. However, we were charged at our first meeting with developing a framework for Pool reform. I offer these ideas as an impetus to more concrete discussion about next steps. I have divided them into a conceptual framework, and a set of specific recommendations.

1. We have not adequately addressed the fundamental questions of the mission and size of the Uncompensated Care Pool.

Arriving at some common understanding of the mission of the Uncompensated Care Pool and the resources needed to achieve its purposes should be the starting point for any discussion of reform. I understand that these are extremely difficult fiscal times, and that additional funds will be hard to access.

Certainly, this is implicit in the letter we have all received from several of our fellow Commission members, which makes some useful suggestions about ways to restructure Pool management. At the same time, I do not believe that one can divorce the question of the size of the Pool and the services covered by it from the question of the unmet health care needs of Massachusetts citizens and what we as a Commonwealth are prepared to provide. Starting by defining some services as "not free care reimbursable" does not solve the problem. It simply shifts costs to providers and to patients, and not necessarily in the most cost-effective and efficient manner.

Impending cuts to MassHealth Basic will further exacerbate this situation. We do not see a lot of MassHealth Basic enrollees at Children's, but I understand all too well the implications of this cut for my sister institutions and for the 50,000 enrollees slated to lose coverage. Many of the enrollees are mentally ill and/or homeless. Removing coverage will simply add to the burden on the Pool. I think most of us have acknowledged that this problem must be directly addressed; yet we have failed to offer any constructive suggestions. We need to find a way to restore MassHealth Basic using whatever payment and management reforms are necessary to appropriately control costs.

My belief is that the Pool needs more funding than the $345M it was guaranteed as a result of the last Pool reforms. Even the higher amounts that have been devoted to the Pool in recent years through special legislation – totaling $472M in 2002 – are inadequate, and will surely be too low if Basic is eliminated. The current projection of Pool demand in 2003, assuming no changes other than the Basic cut, is approximately $567 million according to the Division of Health Care Finance and Policy (DHCFP). This leads me to believe that the appropriate size of the Pool is between $475 and $600M. Others of you will undoubtedly differ in you own assessments. But I believe that we can and must work collectively to come to agreement on a methodology we can use to arrive at the level of demand for uncompensated care.

2. We should at a minimum search for equity in distributing the burden of paying for the care of our least fortunate.

While I assume that we will not have available sufficient funds to meet all our needs, I do not believe that this relieves our obligation to distribute equitably the burden of financing care for the uninsured.

We should look at the balance of funding between and among hospitals, insurers, and the state.

- Hospitals currently pay the greatest share ($170-215 million) of the net funds allotted by statute to the Pool for providing free care. Hospitals also bear the entire burden of any shortfall in Pool funding, and provide hundreds of millions of dollars in charity care in excess of their Free Care allowable costs. By comparison, insurers contribute $100 million to the Pool. In recent years, the state supplemented the $30 million in mandated funding with one-time transfers from the Medical Security Trust, a funding source now depleted. Meanwhile, approximately $160 million per year in federal funds generated by pool assessments are not deposited into the Pool. In essence, the Uncompensated Care Pool has become a system where hospitals are, by and large, redistributing their own money. After we have determined the total amount of appropriate uninsured and underinsured care, the relative shares of funding for that care should be balanced in order to relieve at least some of the burden on the hospital community. To the extent we still have a shortfall, the burden should be shared among all constituencies.

- Among hospitals, I continue to find it nonsensical that we tax a hospital's private sector charges rather than its net patient revenues. This formula reflects a bygone era when hospitals could pass the assessment on to private insurers directly because hospital rates were regulated by the state. Today, the health of an institution is not determined by what it charges

from private payors, but by its net patient revenues from all payors. My institution is particularly disadvantaged by this outdated and unfair system of taxation and stands to benefit from this change, but I believe the general principle of fairness in taxation should be upheld.

3. We should find appropriate mechanisms to control costs and limit distributions from the Uncompensated Care Pool.

Several Commission members have rightly pointed out that we must look at the "payout" side of the Uncompensated Care Pool. I share their concern, although I have different ideas about where we should draw the line in making these determinations.

- On the distribution side, I find the current mechanism for distributing funds outdated. We essentially use a cost-driven "fee for service" framework to distribute limited Pool funds; the only way an institution can hope to be paid is to load as many claims as possible into its invoice. As a practicing physician and hospital administrator, I would prefer to see incentives that ask us to manage care wisely, in the best interests of our patients. Just as we must ensure that the Pool has sufficient revenues to pay for unsponsored care, we must also ensure that Pool funds are used efficiently. I believe we would be better served if we could find a way to predictably fund providers at the beginning of the year (perhaps based upon total free care provided in past years), or otherwise set limits in terms of their expected Pool disbursements. Providers would then have an incentive to manage the free care that they deliver within their budgeted amounts.

- Given our limited funds, I do believe that we should try to standardize the kinds of services that the Pool will pay for. I do not agree with limiting services to urgent and emergent care, because I believe that this definition eliminates a whole category of treatment and care (chemotherapy has been mentioned as a particularly stark example) that will have enormous health repercussions if not delivered. At the same time, we simply cannot support a system in which we define the scope of reimbursable services as anything a hospital is willing to provide under its license. There must be some intermediate ground. We should be clear about what we will and will not pay for, and about the implications these decisions will have for the amount of Pool funding required.

- Children's Hospital is a major safety net provider for children, so I fully appreciate the role Boston Medical Center and Cambridge Hospital play in serving our most vulnerable citizens. I also have some understanding of the complexity of the ways in which they are funded. These institutions are part of our collective solution to the problem of the uninsured, both in terms of the care they deliver and the federal financial arrangements that they make accessible. As we seek to craft an equitable distribution formula, I believe we must account for their needs, while at the same time understanding the breadth and opportunities provided by their complicated financial arrangements.

With these ideas in mind, I offer the following recommendations:

1. First and most importantly, we must work to immediately restore MassHealth Basic coverage. The reasons are obvious. It has implications for the recommendations above, but it matters more to those who stand to lose this coverage.

2. DHCFP should immediately undertake an audit of all pool participants' uninsured and underinsured costs. The audit should determine the number of uninsured and underinsured individuals treated by each hospital and the nature of the services provided.

3. DHCFP should determine the costs of these services based upon Medicaid payment rates. This amount should form the basis of our decisions regarding necessary pool funding.

4. Having accomplished the preceding steps, we can make more rational choices about categories of care we are able to support. This total amount of unreimbursed care should be allocated equitably among hospitals, insurers and the Commonwealth, with each paying a third of the total costs. The tax rate among hospitals should be revised to apply to total net patient revenue.

5. Allocated payments in future years should be indexed to the medical inflation rate. In this way, hospitals will have an incentive to control uninsured costs, but they will not bear the total risks of increases in these costs.

6. DHCFP should undertake an annual review of program utilization. While this type of retroactive review of the program will mean that reimbursement for uninsured care lags economic conditions, it will ensure that increases in uninsured costs due to economic downturns will not be borne solely by hospitals (or that hospitals are overcompensated when economic conditions are more favorable).

In conclusion, the Commonwealth has a long and enviable history of providing health care services for its most vulnerable citizens. Hospitals and insurers have been partners with the Commonwealth in this effort. Together we have built a broad safety net of which the Pool is a critical part. This safety net is in serious jeopardy, and there are a huge number of other complicated fiscal issues confronting our state. If the Pool is to survive, then we must fundamentally rethink it and reform it to face the perils ahead. We need to be smart, committed, and willing to compromise if we are going to move forward constructively.

Sincerely,

James Mandell, M.D.
President and Chief Executive Officer

Health Care for All

December 16, 2002

Dear Secretary Gittens, Senator Moore, Representative Keenan and Members of the Commission:

The Uncompensated Care Pool is the foundation of the health care safety net in Massachusetts. Its statutory purpose, to provide access to health care for low-income, uninsured and underinsured residents of the Commonwealth, is one of which the people of the Commonwealth should be proud. The Special Commission on Uncompensated Care is coming to a close without a plan that would guarantee that the Pool will continue to be the safety net that low-income uninsured and underinsured residents of the Commonwealth need and deserve. At the same time, the state budget crisis has led to cuts in the MassHealth program that threaten to overwhelm the Pool with new demands and undermine the health of thousands of current MassHealth members and those who now depend on the Pool.

There is no easy solution to the dilemma we face, but in our view the Commission has not sufficiently focused its attention on solving this central problem or on exploring the overall health access crisis we face. The excellent data that has been presented to the Commission by the Division of Health Care Finance and Policy demonstrates that the underlying problem we face is that the available funds in the Pool do not meet the essential medical needs of the low-income uninsured residents who must rely upon it. It is fundamentally wrong to respond to this funding crisis by proposing to cut back on the medically necessary care provided by the Pool, as has been recently suggested by some members of the Commission. Such a change would shift much of the cost to hospitals and health centers, while many patients would receive less care or more poorly organized care. Although there are administrative changes and care management improvements that should be implemented to save the Pool money, we believe the Commission should recommend to the new administration and the legislature that the Pool's statutory purpose be maintained and that the Pool crisis be solved by restoring MassHealth Basic and finding new means of funding to eliminate the shortfall.

Restore MassHealth Basic

The most important recommendation this Commission can make regarding the health care safety net is to restore the planned cuts to the MassHealth Basic program. The 50,000 people who will lose their health care coverage next April 1 will still need health care, and the burden of financing that care – estimated to be about $160 million per year – will fall to the Pool. More precisely, because this added expense will exacerbate the Pool shortfall, the burden will be distributed among hospitals and health centers, many of which are already in precarious financial positions, as well as private physicians and others who are not eligible for Pool reimbursement.

The loss of MassHealth Basic will also create an access crisis for those who lose coverage, who often have recurring or chronic mental health and other medical incapacities and, therefore, a high need for health care services. It is well documented that people with chronic conditions who do not have health insurance fare poorly in the health care system relative to their insured counterparts. The availability of the Pool somewhat mitigates but does not eliminate this inequity. In short, the loss of MassHealth Basic is a threat to the health of some of the neediest residents of the Commonwealth.

The reductions in MassHealth Basic eligibility are imprudent both in terms of access and financial strategy – in addition to simply shifting costs from one sector to the other, the Commonwealth is sacrificing nearly $150M annually in federal matching funds. This Commission should come out strongly for a repeal of the cuts, and propose a means to fund MassHealth Basic.

Health Care For All has produced two recent reports on MassHealth ("The Facts on MassHealth: What It Is. Why It Works.", March 28, 2002, and "The MassHealth Cuts: What They Are. Why They Don't Work. What We Can Do.", November 13, 2002), which we have requested be included in the record of the Commission. These reports analyze the history of the MassHealth expansions of 1996-7 and their important role in reducing the demand for and costs of the Pool, which were escalating dramatically by 1996. By using a 25-cent tobacco tax, existing program funds and federal matching funds, these expansions extended MassHealth coverage to 300,000 children, parents, people with disabilities and the long-term unemployed, without the use of any new money from the General Fund. MassHealth Basic was one of these successful new programs, which had the added benefit of covering in a managed care program with preventive and primary care a group who were identified as "predominant pool users". Cutting these members from MassHealth will be a significant step backward from that important initiative, which was prudent from both a fiscal and medical care standpoint.

Broaden the Pool's Funding Base

Currently, hospitals and health plans contribute directly to the Pool. These contributions are subsidized by, among others, the premiums paid by employers who provide health coverage to their employees and the employees themselves. Through this mechanism, as well as the state's contribution to the Pool, the cost of uncompensated care is shared fairly broadly among people in the Commonwealth. We believe that this reflects a societal commitment to preserving the health care safety net.

Employers who do not provide health insurance for their employees do not contribute, either directly or indirectly, to the financing of uncompensated care. This is a situation that should be corrected for two reasons. First, this group of employers does not share in the broad social commitment to the safety net that Pool funding otherwise represents. And second, employers who do provide coverage are also subsidizing employers who do not, by funding the Pool to which uninsured, low-wage workers may turn for their health care. This creates an inequity among employers that should be corrected.

Health Care For All supports the bill sponsored by Senator McGee and Representative O'Brien titled "An Act to Fairly Share the Cost of Funding Uncompensated Care in the Commonwealth." The legislation would assess employers $300 per year for each full-time employee without coverage, to be paid to the Pool. We estimate that the assessment would generate up to $70 million annually for the Pool.

Passing this legislation would correct some of the imbalance that exists in how the responsibility for uncompensated care funding is now distributed. It would also help to shore up the Pool's finances and significantly reduce its shortfall (assuming the shortfall is not bloated by MassHealth Basic costs). We believe this is a fair and modest financing proposal and urge the Commission to support it.

Preserve Access

Maintain current scope of Pool services and site of care

The Pool's regulations promise eligible patients that the Pool will reimburse providers for "medically necessary care". This phrase is specifically defined, and comprises a broader range of services than "emergent and urgent care". The Division of Health Care Finance and Policy points out the reality that "elective surgery does not mean optional, but rather medically necessary but not an emergency, such as a hip replacement or removal of a cancerous tumor that can be delayed for a period of time." (From a DHCFP fact sheet given to the Commission). Preventive care is also considered medically necessary

according to regulation. Proposals to reform the Pool should take as a baseline the need to preserve this level of access.

There is much to be said for the financial and health care benefits of encouraging care to be provided in the most appropriate settings. Appropriateness must take into consideration availability, however. Restricting hospitals to providing only urgent and emergent care services in situations where there are no other providers of less intensive but medically necessary care creates a potentially very serious access barrier. In addition, there are types of care that may not be considered "urgent" or "emergent" that are only provided in hospitals (cancer surgery, chemotherapy, angioplasty and hip replacement, to name a few).

As one of the three voting members of the Scope of Services Sub-Committee, I specifically object to the recommendations submitted on 12/13/02 by some sub-committee members that would redefine Free Care to "emergency and urgent care services provided by acute hospitals to low-income uninsured individuals" and "medically necessary services provided by community health centers to low-income uninsured individuals". Restricting access in this way would establish a dual system in which some people, by virtue of their public or private health insurance, are deserving of needed care, while others with characteristics or incomes that exclude them from coverage are undeserving. *Needed care should be judged on the basis of generally accepted standards of care that apply to all patients.* Rigid formulations of what care may be provided where preclude this principle.

We also object to recommendations of these members of the Sub-committee on Scope of Services that the Pool not pay for services not covered by MassHealth Standard. MassHealth has eliminated benefits such as adult dental and prosthetics, which are clearly medically necessary. To deny patients any opportunity to obtain such services through the Pool undermines the very notion of a safety net.

These proposals were first made to the full Commission by some members, immediately before our sub-committee met. The sub-committee members were given no prior notice or materials before the meeting. This was the only vote taken in the entire Commission process (I voted against the proposal), and Health Care For All does not believe that the implications of such a drastic change in the mission of the Pool were fully researched, discussed or understood by the Commission members.

Implement appropriate management of care

It is entirely appropriate, however, to analyze past and present patterns of health care use by Pool-eligible patients and to institute utilization management processes in order to encourage, with sufficiently flexible criteria, that care be provided both appropriately and effectively. Such a policy would potentially have the added benefit of providing better continuity of care, by primary care providers outside of hospitals, to uninsured individuals. It is significant, however, that there are many areas of the state that do not have community health centers or outpatient clinics in their community hospitals. Therefore, the tools to provide preventive and primary care as well as early treatment do not exist in those areas. There have been demonstration projects (Ecu-HealthCare and Hampshire Health Access) funded by the Pool that have provided administrative and outreach funding to organize networks of private physicians willing to provide care with no reimbursement. Another model is to expand outpatient capacity for free care patients in community hospitals if there is no community health center or no other place to provide specialty physician services for uninsured residents. Both models provide more cost-effective early treatment and prevent hospitalizations for more serious conditions. If we are to encourage free care to be provided in community hospitals rather than more expensive teaching hospitals, such models should be expanded. Rigid restrictions on scope and site of care would undermine such cost-effective arrangements.

Maintain existing residency requirements and eligibility for undocumented aliens
The Division of Health Care Finance and Policy in its memo to the Management Sub-Committee recommends that the Pool require 6 months residency for non-urgent services and that eligibility be terminated for undocumented aliens. We believe this is an unacceptable restriction on access, and we commend the Massachusetts Hospital Association, in its response, for committing to providing care for these patients. Such restrictions would therefore be a cost burden to hospitals and health centers. This restriction would further undermine the trust within immigrant communities that is needed to ensure that people seek necessary care as early as possible.

Do not inappropriately restrict access through the eligibility determination process
We have strong reservations about the suggestion that the Division of Medical Assistance doing eligibility determination for the Pool. Though DMA has the infrastructure to do this, we fear that another access barrier would be erected for people who, for various reasons, do not want to interact with a state agency. Further, people who believe themselves ineligible for MassHealth, such as some immigrants, might also be discouraged from applying for support from the Pool because the common application process might obscure differences in eligibility standards for the two programs.

Implement appropriate cost savings and revenue maximization strategies
In the two reports on MassHealth mentioned previously, Health Care For All proposed several changes to MassHealth that would save or generate new dollars to help maintain MassHealth eligibility and benefits, including Basic. These proposals included controlling pharmaceutical costs in all state programs, encouraging care in less expensive settings, enhancing federal matching funds, avoiding preventable hospitalizations, and supporting targeted fraud and overpayment initiatives. These cost savings could help the Pool as well by helping restore cuts in MassHealth. Some similar cost savings and revenue generating strategies could be applied to the Pool itself. For example:

- We urge the Commission, the administration and the legislature to explore all opportunities for new DSH funds for the Pool and to consider allocating to the Pool more of the existing DSH funds generated by the Pool, which currently go to the General Fund.
- We support expanding the Pool demonstration projects which have provided targeted case management for chronic conditions and pharmacy services to free care patients in order to reduce emergency room use and preventable hospitalizations (for instance medications for diabetes, asthma and mental illness can reduce ER use and hospitalizations even in the very short run). The Division of Health Care Finance and Policy also recommended providing curative pharmaceuticals through the Pool. ("Ideas for Statutory Change"). Adequate funding for the Pool must be secured concurrently, however, so that such changes do not result in expanding the shortfall.
- We support the recommendations of the Massachusetts League of Community Health Centers to restore to DMA its previous capacity for outreach and for expedited eligibility determinations, since delays are currently increasing the use of the Pool by those likely to be eligible for MassHealth.

Expand Coverage Through Employers and Public Programs
The long term answer to Pool financing and access to care is the expansion of coverage to more uninsured Massachusetts residents. For the last two years Health Care For All, the American Cancer Society, the Massachusetts Medical Society and 70 other organizations in the HealthNow! Coalition, many on this Commission, worked to pass a new tobacco tax to fund expansions of MassHealth. This tax was passed in the spring, yet we are faced with reductions in MassHealth; HealthNow! supports legislation for the restoration of MassHealth Basic and for targeted programs to reduce health disparities by covering prevention and treatment of cancer, heart disease and diabetes. (sponsored by Representative Kaprielian and Senator Barrios).

Health Care For All also recommends support for the bill filed by Senator Tom McGee and Representative Tom O'Brien, "An Act to Strengthen Employer-Provided Health Care in the Commonwealth." This bill would encourage large employers of 100 or more employees to provide health coverage for their employees by assessing them one-half the cost of an individual health plan for each full-time employee without coverage. Expanding coverage by these employers will reduce demand for the Pool. In addition, the revenues raised from those employers who do not provide insurance would be used in part to fund improvements to the Insurance Partnership, which subsidizes employers of 50 or fewer employees and their low-wage workers if the employer provides health insurance. The bill would increase eligibility for the employees and enhance the subsidies for employers. The bill would also direct the DMA and DHCFP to prepare a plan to cover, through a MassHealth buy-in, low-wage employees of private human services providers who deliver human and social services under contract with the state's Executive Office of Health and Human Services. Revenues raised by the bill would also be allocated to the Pool directly and to MassHealth, which currently cover many low-wage uninsured workers in these large firms.

Conclusion

Massachusetts has succeeded in the last decade in reducing the numbers of uninsured in the state to one of the lowest in the nation through the expansion of MassHealth and other public programs like the Children's Medical Security Program. Yet 420,000 people remain ineligible for public programs or unable to obtain coverage through work and are dependent on the Uncompensated Care Pool as their basic safety net. As employer based coverage continues to erode and health care needs and costs continue to rise, the crisis in MassHealth and the Pool will only get worse. We cannot afford to go backward. Uninsured Massachusetts residents deserve more not less. The Commission and others who will be addressing the crisis in our system should more thoroughly investigate the health and economic implications of the gaps in the current system**.** For example, in a recent study by the Institute of Medicine, "Care Without Coverage: Too Little, Too Late" (5/31/02), the authors found that uninsured adults are less likely than adults with any kind of coverage to receive preventive and screening services, that uninsured cancer patients are in poorer health and more likely to die prematurely and that uninsured persons with chronic illnesses are less likely to receive appropriate care and have consistently worse clinical outcomes. (see attached Executive Summary). Studies by the Boston Public Health Commission (see attached) show wide disparities in health among racial and ethnic minorities, which is consistent with national studies. Low rates of insurance among racial and ethnic minorities contribute significantly to these disparities, in addition to problems in the delivery of culturally competent health care.

As we come to grips with these larger challenges, we hope that we can work together to maintain the Pool, MassHealth and our other safety net programs. They are not only key to the health of the people of the Commonwealth, but to our health care infrastructure and to the Massachusetts economy.

Sincerely yours,

Robert Restuccia
Executive Director

Massachusetts Nurses Association

VIA FACSIMILE
December 16, 2002

Robert P. Gittens, Secretary
Commonwealth of MA – Executive Office
1 Ashburton Place, 11th Floor
Boston, MA 02108-1518

Dear Senator Moore, Representative Keenan, and Secretary Gittens:

This letter will provide the Massachusetts Nurses Association's position regarding the Special Commission on Uncompensated Care. The Uncompensated Care Pool (UCP) was devised as a fair and equitable allocation of the burden of uncompensated care and free care among affected participants in the health care delivery system so that no single participant or group of participants bears a disproportionate burden of the cost of providing such care. The legislation creating the special commission on the UCP was specific in purpose: "*(a) to develop a suitable plan to establish a fair and equitable assessment to pay for the uncompensated care and equitable distribution of any such assessment, including maximizing the amount of federal financial participation to which the commonwealth may be entitled; (b) to develop a plan that includes incentives for the utilization of insurance programs, including programs operated by the division of medical assistance, wherever possible, such as payment methodologies that are not more favorable than those used by such insurance programs, as well as recommendations for more efficient and effective administration of the uncompensated care pool; and (c) to prepare legislation necessary to effectuate the recommendations of the commission."*

While this speaks to the financing of the pool, the pool was created to help pay the costs of providing care to the uninsured and underinsured, there is an expectation, as there should be, that those in need of care will get care regardless of existing funding sources. What care is necessary is best left for clinical providers; what care is reimbursed is already well defined.

Everyone is loathe to suggest taxes, particularly due to the recent ballot initiatives advocating the reduction of taxes and more recently advocating the elimination of the income tax, yet everyone is equally loathe to champion a reduction in services.

But if you ask the public whether it would be acceptable for an individual who does not have insurance, if it would be appropriate to deny treatment whether in a hospital or a clinic, the answer would be no. The question that remains unanswered is how do we pay for it?

Revenues need to be generated to increase funding to the pool and maximize federal dollars. No change in the current system of allocation has been suggested that would not otherwise be disruptive to services. If revenues can be reallocated without tax increases and without equally devastating cuts in other services, that would be most desirable. But in the event this is not possible any tax should be targeted to the pool and the method should be equally applied – inclusive of those not currently funding the pool.

With regard to specific recommendations:

- Mass Health Basic must be restored. The elimination of this program knowingly inflicts harm on citizens of the commonwealth.
- Utilization management recommendations regarding pharmacy utilization should be adopted.
- Do not alter current scope definitions – the unintended consequences are not known though it is highly likely this would result in greater use of already burdened ER's for medical needs and harm the well being of individuals in need of chronic care services.

While initial and necessary steps to maintain our health care safety net are needed, the MNA firmly believes that more fundamental reform of the health care system is required to address the health care needs of the commonwealth.

Thank you for the opportunity of participating on this commission.

Sincerely,

Julie Pinkham, RN
Executive Director

Memorandum

To: Special Commission on Uncompensated Care

From: Scope of Services Sub-Committee Members

Date: 12/17/02

Re: Recommendations for the Uncompensated Care Pool Report

As we have all discovered, the Uncompensated Care Pool faces multi-year deficits ranging from $152 million in PFY03, to $265 million in PFY04, and $305 million in PFY05. In light of this current fiscal situation the Special Commission asked the Scope of Services Sub-Committee to review the current scope of services available through the pool. Specifically we attempted to examine the factors contributing to projected deficits in the pool.

In attempting to carry out our charge, we held informational meetings and solicited input from all interested parties. Among those that participated are:

Special Commission Members
The Division of Health Care Finance and Policy
Attorney Michael Spivey, a principal with Spivey/Harris, and a nationally recognized Medicaid Disproportionate Share Funding expert

Our analysis indicates that a combination of factors are responsible for the significant projected deficits in the pool, but that the broad array of services eligible for pool funding are a contributing factor to the deficit situation.

The following recommendations are not intended to be an exclusive list reached by unanimous vote of the sub-committee, but rather as potential measures that should be considered in light of the current fiscal situation. These recommendations recognize that the Uncompensated Care Pool is an important part of the health care safety net, but that the Pool is an inefficient mechanism for allocation of the limited resources available to provide access to health care for citizens of the Commonwealth. These recommendations also recognize that hospitals are required to treat all individuals who present for emergency services regardless of their insurance status, and that community health centers are generally a more appropriate setting than hospital outpatient departments for other non-emergent services. These changes are intended to be consistent with the maximization of the Federal financial participation.

RECOMMENDATIONS

Voting in favor: Dan Keenan, State Representative
Rick Lord, Associated Industries of Massachusetts

Voting in opposition: Robert Restuccia, Health Care for All

Refine the definition of "Pool Eligible Payments"

"Free Care" be redefined so as to include only the following services:

- Emergency and urgent care services provided by acute hospitals to low-income, uninsured individuals;

- Medically necessary services provided by community health centers to low-income, uninsured individuals (provided under a consistent payment methodology for all community health centers)

- Bad debt associated with emergency services provided by acute care hospitals to uninsured individuals (other than low-income individuals).

Reduce Inappropriate Utilization

- Do not pay for services for insured patients where payment was denied by the patient's private or public insurer because the service was determined to be not medically necessary, or for not following program rules, (e.g. not obtaining prior authorization, not obtaining care within a network), or because the care/procedure was not covered by the applicable contract, or for incorrect billing.

- Do not pay for services not covered by the MassHealth Standard program.

1. Manage pharmacy utilization by implementing a formulary and using DMA's strategies, including the DMA/DMH polydrug initiative. Contract with a vendor to manage pharmacy utilization.

Management Sub-committee

OPTIONS FOR CONSIDERATION

The Management Sub-Committee has reached a consensus regarding the following options for consideration by the Uncompensated Care Pool Commission. The following members were present for the discussion: Senator Moore (Chair), Peter Meade, James Hunt, Alan Macdonald and Dale Lodge.

Ideas for Regulatory Change

The first group of suggestions contains those that can be implemented in a relatively short time frame at relatively low cost. The proposed regulatory options regarding free care eligibility, the scope of services of the Pool, and the Pool payment level can be effected within ninety days, and therefore would have an effect in the current Pool Fiscal Year (2003). The proposed option to adjust cost-to-charge ratios prospectively could also be implemented within ninety days, but would affect only interim payments and cash flow. This change would have no long-term effect on demand for Pool funds.

1. Rationalize Payment Level
   a. Implement an efficiency standard on outpatient services to bring the payment level for outpatient services closer to that paid by MassHealth. Certain hospitals could be exempted from the efficiency standard or not (MassHealth does not).
      Cost: Short-term savings of up to $30 Million by phasing in such efficiency standard over a two year period for all hospitals except Public Service Hospitals (as defined in regulation). Long-term savings of up to $80 Million by applying such efficiency standard to all hospitals, including Public Service Hospitals, over a five year period.

   b. Adjust cost-to-charge ratios prospectively for the effect of expected changes so that estimated monthly payments are closer to the expected final settlement amount. This change would reduce the magnitude of payment adjustments at final settlement, but not eliminate these adjustments.
      Cost: Savings of $15-20 Million in interim payments only; no change in final payments. (While this affects cash flow only, it does provide for some interim relief.)

2. Reduce Inappropriate Utilization
   a. Do not pay for services for insured patients where payment was denied by the patient's private or public insurer because the service was determined to be not medically necessary, or for not following program rules, (e.g. not obtaining prior authorization, not obtaining care within a network), or because the care/procedure was not a covered by the applicable contract, or for incorrect billing; provided however that there are no significant administrative hospital costs and there is the use of an appeal process similar to Chapter 141 of the Acts of 2000.
      Cost: Savings Up to $10 Million

   b. Manage pharmacy utilization by implementing a formulary and using DMA's strategies, including the DMA/DMH polydrug initiative. Contract with a vendor to manage pharmacy utilization.
      Cost: Savings Up to $3 Million

NOTE: "Savings"=estimated reduction in allowable free care costs. Note that these are rough estimates only, and may depend on how the provision is implemented. In addition, the estimated savings from the various options may overlap, and they are not necessarily additive. None of these options has an impact on FFP, unless Congress raises the statewide DSH cap significantly.

3. Increase Accountability
   a. Disallow payment where the provider has not met DHCFP standards for submitting electronic data documenting patient eligibility and services provided. (Currently, payment is withheld, but released when the provider meets standards.)
      Cost: Savings Up to $10 Million with a phase-in period of two years.

Ideas for statutory change

The following ideas would require statutory change, and are therefore are dependent upon the actions of the Legislature and the Governor. They could be implemented by Pool Fiscal Year 2004, which begins October 1, 2003.

1. Rationalize Payment Level
   a. Establish a pricing method for outpatient pharmaceuticals. Set prices at the 340B cost for 340B eligible pharmacies and at the Medicaid rate for others, plus a corresponding dispensing fee. (340B refers to a section of the federal Veterans Health Care Act of 1992 that limits the cost of drugs for certain grantees of federal agencies.)
      Cost: Savings Up to $7 Million

2. Increase Accountability
   a. Use per discharge, per diem, or per visit rates for full free care patients who have UCP as primary payer; use cost-to-charge ratio for patients who use UCP as a secondary payer
      Cost: Budget neutral with phase-in over a two year period.

3. Expand the Insurance Partnership
   a. Allow the Division of Medical Assistance to adjust the eligibility requirements for participation in the Insurance Partnership by increasing employer size from 50 to 100; employee eligibility income from 200%FPL to 250%FPL; increase subsidy amount for employers; design plan where an individual can participate in the Insurance Partnership where said individual's employer does not opt to participate in Insurance Partnership.
      Cost: Varies depending on action taken.

4. Contract Pool Functions to Third Party Administrator
   a. Allow the administration of the Pool to be administered by a non-state agency third party, similar to the pool administrative functions established in Chapter 574 of the Acts of 1985. Or outsource claims processing.
      Cost: Unknown.

Other Ideas

1. Technology Improvement at the Division of Medical Assistance
   a. Aggressively pursue federal matching monies for the upgrade and/or implementation of new technology at the Division.
      Cost: Unknown.

NOTE: "Savings"=estimated reduction in allowable free care costs. Note that these are rough estimates only, and may depend on how the provision is implemented. In addition, the estimated savings from the various options may overlap, and they are not necessarily additive. None of these options has an impact on FFP, unless Congress raises the statewide DSH cap significantly.

Conclusion

These proposed options are designed to change some of the ways the Pool is administered so as to bring demand for Pool funds more in line with available funding and to improve equity. Not all of the changes can be made without some additional costs being incurred; however, any increase in costs associated with these proposed changes to Pool administration would be marginal.

Accountability would be increased for both providers and the patients who access care through the Pool. These proposed changes will enable the Pool to more effectively achieve its statutory requirement of ensuring that the Pool is the payer of last resort. Patients may find that the increased screening requirements and more limited scope of services reduce their access to care that is not urgently needed at a particular time. The Commonwealth could see an increase in expenses for MassHealth if more people are identified who can be enrolled in MassHealth due to the more stringent free care eligibility screening requirements, but there is not a dollar-for-dollar shift.

NOTE: "Savings"=estimated reduction in allowable free care costs. Note that these are rough estimates only, and may depend on how the provision is implemented. In addition, the estimated savings from the various options may overlap, and they are not necessarily additive. None of these options has an impact on FFP, unless Congress raises the statewide DSH cap significantly.

Funding Sub-committee

Voting members of the Funding Sub-committee were Secretary Robert Gittens, Executive Office of Health and Human Services; Bruce Bullen, representing the Massachusetts Association of Health Plans; and Ron Hollander, Massachusetts Hospital Association. The non-voting member was Michael Widmer, Massachusetts Taxpayers Foundation.

On December 16, 2002, the Funding Sub-committee discussed and voted upon the following recommendations for consideration by the Special Commission on Uncompensated Care:

1. General Recommendations
   a. First, adopt the management and mission changes in the 12/2 letter to the chairs from Lord, Bullen, Widmer, Meade, and MacDonald as well as the proposed DHCFP regulatory and statutory changes of 11/27 that are consistent with the approach outlined in the 12/2 letter to the chairs in order to create funding capacity within the existing Pool.

      Voted in Favor: Bruce Bullen,
      Robert Gittens
      Voted in Opposition: Ron Hollander

   b. Authorize DOR to recover bad debt payments from individuals with incomes above 200% FPL whose care is billed to the Pool.

      Voted in Favor: Bruce Bullen,
      Robert Gittens
      Abstained: Ron Hollander

2. Support coverage mechanisms to encourage insurance coverage and discourage the dropping of insurance coverage (such as the Insurance Partnership). These mechanisms should not be funded by the Uncompensated Care Pool.

      Voted in Favor: Bruce Bullen,
      Robert Gittens
      Ron Hollander

3. To avoid eliminating MassHealth Basic
   a. Pursue aggressively additional federal Medicaid reimbursement under the MassHealth waiver.

      Voted in Favor: Bruce Bullen,
      Robert Gittens
      Ron Hollander

   b. Join with other states in aggressively pursuing Medicaid relief from the federal government.

      Voted in Favor: Bruce Bullen,
      Robert Gittens
      Ron Hollander

APPENDICES

Materials Submitted by the Massachusetts Hospital Association

Massachusetts Health Policy Forum Issue Brief
(Pleaseclick link to .pdf file - http://sihp.brandeis.edu/mhpf/Pool_Issue_Brief.pdf)

Materials Submitted by Health Care for All

The Facts on MassHealth: What It Is. Why It Works.
The MassHealth Cuts: What They Are. Why They Don't Work. What We Can Do.
Care Without Coverage: Too Little, Too Late
Cancer and Cardiovascular Disease Disparities Among Boston Residents

The Facts on MassHealth:
What It Is. Why It Works.

Josh Greenberg
Health Care For All
30 Winter Street, Suite 1010
Boston, MA 02108

March 28, 2002

Also available on the Web at www.hcfama.org/masshealthreport.html

Executive Summary

- ***MassHealth Provides Vital Care for Massachusetts Residents***

MassHealth is the Medicaid program, which provides **health coverage for 1,000,000 Massachusetts residents.** One in four children (and one in six residents overall) in the Commonwealth receive their medical insurance through MassHealth. MassHealth provides coverage to a broad range of people, including children, low-income parents, the disabled, and seniors.

In 1996 and 1997, the state received a federal waiver to expand Medicaid coverage, using funding from a dedicated tobacco tax and federal matching funds. As a result, the number of MassHealth members increased, allowing coverage for more of our neediest populations. Today, approximately 108,000 additional children are insured, as are 88,000 low-income parents and 87,000 disabled/ chronically unemployed adults (see chart, page 4). **To date, coverage for nearly 300,000 citizens of the Commonwealth has been provided with no additional contribution from the General Fund.**

- ***MassHealth Generates Billions of Dollars in Federal Revenues***

The MassHealth program receives Federal Financial Participation (FFP) for qualified expenditures. The availability of FFP has made the MassHealth program a valuable mechanism for increasing state revenues for the Commonwealth. **MassHealth receives fifty cents in federal reimbursement for every dollar the state expends on MassHealth.** The federal State Child Health Insurance Program (SCHIP) provides an enhanced match rate for certain children. In these cases, MassHealth receives sixty-five cents in reimbursement for every dollar expended.

- ***The Expansion Programs Have Been Funded without General Fund Contributions***

The expansions of 1996/97 have been funded without additional General Fund contributions. A vital financing source for the expansions has been the twenty-five cent per package tobacco tax. These funds are deposited in a separate state account, the Children's and Seniors' Assistance Fund (CSAF). Another key source of funding for expansion has been the FFP related to expanded services, which has been re-deposited in the CSAF. Funding from the Uncompensated Care Pool has been diverted to the CSAF as more people become insured. Lastly, funding for a small segment of welfare recipients previously served by Emergency Aid to the Elderly, Disabled and Children, was also moved into the expanded programs.

- ***MassHealth Cost Increases are Largely Due to Medical Inflation***

Recent MassHealth cost increases are attributable to two primary, separate causes:

- Medical inflation primarily in nursing home, pharmaceutical, community-based long term care and hospital expenditures.

- Caseload increases largely in the expansion populations. **These have been budget neutral to the General Fund because caseload and tobacco tax predictions have been accurate.**

- ***Cutting MassHealth Hurts the Economy and Destabilizes the Health Care System***

Because the federal government reimburses more than one-half of MassHealth costs, every dollar cut from the state budget will reduce federal revenues unnecessarily.

If coverage is lost, recipients would be forced to rely more on other state-funded services, such as the Uncompensated Care Pool, further reducing savings.

Cutting MassHealth means cutting jobs**.** The health service sector is the single largest employment sector in Massachusetts, accounting for 10% of all employees in the Commonwealth. Health care ranks as the #1 employer in nine counties and as the #2 employer in three more counties (see graphic, page 13).

- ***Recommendations to Save Costs and Stabilize Funding***

Approve "Health Now!" (S. 1703).
We recommend passing this legislation, which would raise tobacco taxes and dedicate the funding to the Children's and Seniors' Assistance Fund. The "Health Now!" Proposal would stabilize funding for the expansion programs, maintaining critical health coverage to hundreds of thousands of our neediest residents.

Maximize Federal Revenue.
While many major revenue maximization strategies have already been implemented, further projects should be lshifted out of the Division of Medical Assistance's jurisdiction and into an Executive Branch office (either the Health and Human Services or Administration and Finance). This would minimize inter-agency disputes and assure a comprehensive perspective on budget issues.

Avoid Preventable Hospitalization.
Targeted initiatives should be encouraged to decrease preventable hospitalizations. Diverting "stuck kids" (those in psychiatric beds but ready for discharge and receiving hospital-level care) into community-based services is one possibility. The Minigrants program also has proven effective in linking people to community providers.

Control Pharmaceutical Costs.
With pharmacy costs growing at an unsustainable rate, a variety of measures, some in progress, should be taken to restrain cost increases in this area. Such measures include bringing the cost of the Pharmacy Advantage program under Mass Health for low-income seniors, and exploring whether or not fair prices are being paid for pharmaceuticals.

Support Targeted Fraud and Overpayment Initiatives.
Overpayment and fraud hurt all citizens. The legislative task force and the Attorney General should be supported in their pursuit of stopping these practices, but should assure that providers are not harassed.

Instituting Copayments and Broad Cuts in Eligibility and Services Won't Work.
Both strategies are simplistic solutions unlikely to achieve their stated objective of saving money. Copays and eligibility cuts undermine patients' ability to get preventive care, leading to higher costs elsewhere. Both would also signal an unnecessary retreat from our moral commitment to serving the health care needs of the most vulnerable.

I. Introduction

The Commonwealth is currently in the midst of a significant, deep budget crisis. As state leaders look to trim costs and enhance revenues, the Massachusetts Medicaid program (known as MassHealth) has garnered a lot of attention.

House Speaker Thomas Finneran has appointed a Medicaid working group to make recommendations about cost saving measures. This is a welcome opportunity to examine the program in detail, and to propose strategies for ensuring its future.

There is a great deal at stake. MassHealth insures one in four children, and one in six residents of the Commonwealth. It pays for the nursing home costs of the vast majority of institutionalized elders. As a program, it has worked well. We have experienced significant reductions in the number of uninsured residents of the Commonwealth as a result of our efforts. Massachusetts is seen as a national leader, and rightfully so.

This paper is intended to provide basic information about, and offer analysis of, the MassHealth program, including:

- A brief overview of the MassHealth program, including coverage categories. MassHealth is a well-designed program. The expansions made in 1996/97 were well considered, and had strong policy and financial rationales;

- An introduction to the financing mechanisms utilized for each program component. MassHealth is a good financial deal for the state. The availability of federal funds makes cutting the program a poor choice from a fiscal perspective;

- A breakdown of cost increases in terms of caseload growth and medical inflation. The reasons for cost increases vary between caseload segments and between services. Policymakers must be strategic in seeking to rein in costs;

- An estimate of the likely economic impact of cutting eligibility or services. Through the federal matching funds available, MassHealth provides substantial economic benefits to the state, which is critical because health services is the leading employment sector statewide;

- Suggested measures to control costs and ensure program stability. Changes can be made to the MassHealth program that will control costs and stabilize funding. However, some reforms are likely to do more harm than good.

This paper was prepared by Health Care For All. In general, the MassHealth Defense Coalition is supportive of the views and recommendations contained in the report, but not every member necessarily embraces every point it contains.

Blaming the MassHealth program for the Commonwealth's budget problems is far too simplistic, and will likely produce recommendations that don't achieve their objectives. We hope that a more comprehensive look at MassHealth will generate a better-tailored response, one that protects our most vulnerable residents and ensures a healthy future.

II. Overview of the MassHealth Program

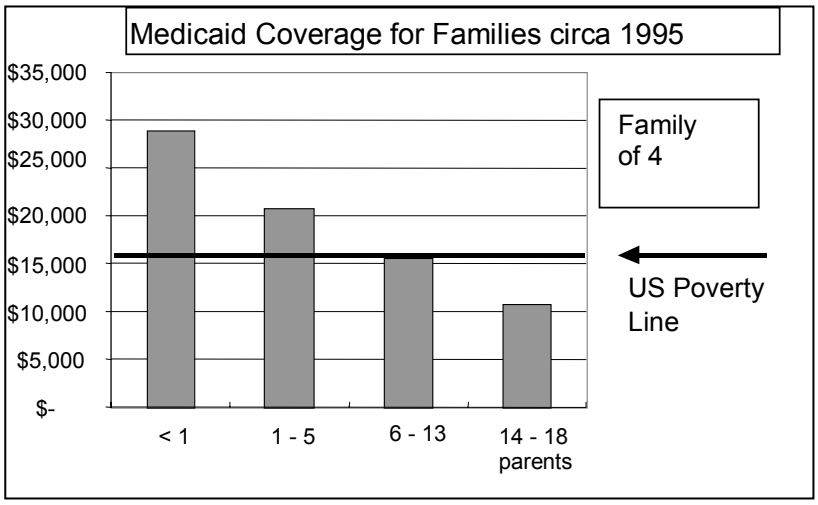
In Massachusetts, the Medicaid Program is referred to as MassHealth. Medicaid is a state-federal partnership. Under federal law, if the state operates a Medicaid program consistent with federal standards, it is eligible to receive federal matching funds for the costs of its program. Some federal standards are *mandatory*, i.e. a state must provide certain services to certain categories of people. Other standards are *optional,* i.e. a state can choose to provide services to additional people; if it does provide these services it will receive matching funds for them.[1] Finally, states can ask the federal government for a *waiver* from some requirements; waivers allow states to reallocate dollars to which they are entitled in order to expand coverage, test creative strategies and tailor their health care programs to local conditions.

Massachusetts, like the majority of other states, currently operates much of its Medicaid program through a "waiver" from the federal government (elders and institutionalized recipients continue to receive Medicaid coverage under non-waiver rules). The federal waiver is a "living document" in the sense that it has been modified numerous times since it was first approved in 1996. The federal waiver is the document that defines the coverage expansions, financing arrangements, and service delivery structure for the MassHealth program. Understanding the waiver is critical to understanding the costs and benefits of the Medicaid program in Massachusetts.

A. Medicaid Coverage in Massachusetts Before and After Expansion

Family Coverage

Prior to 1996, Massachusetts operated a more traditional Medicaid program. While the Commonwealth provided coverage to children, parents, disabled people, and the elderly, it often did so in an uncoordinated and disruptive manner. Family coverage provides a good example of this phenomenon. In the early 1990s, our Medicaid program's coverage standards were largely governed by federal requirements. As a result, eligibility for children and their parents depended upon two primary factors, including the income level of the family and the age of the family member. Younger children were eligible at higher federal poverty levels, while the income threshold for older children and parents remained tied to the standard governing the Aid to Families with Dependent Children (AFDC) program.



[1] Once a state chooses to provide an optional service, there are some limits on how it may seek to restrict the benefit. Medicaid programs must provide services in an "amount, duration and scope" sufficient to achieve their intended purposes.

The impact of tying Medicaid eligibility to a combination of age and income level could be seen in individual families. In the same family, some children could have coverage while others were uninsured. Younger children lost coverage as they aged, frequently disrupting continuity of care. This was especially problematic for children with chronic conditions like asthma.

Disabled Coverage

There were different reasons for the changes made to coverage for individuals with severe disabilities. Prior to the expansions, coverage for those eligible on the basis of disability was fragmented in several programs. The programs utilized alternative, complicated eligibility determinations that were difficult for the state to administer and for recipients to understand. Traditionally, there were three separate program categories serving disabled residents, all of which were substantially altered and streamlined by the expansion legislation:

- Medicaid disabled coverage provided insurance to low-income residents who met Social Security Administration disability standards. It utilized a "net income test" in which gross income was totaled, and then a complex series of deductions and income disregards were applied. This program was simplified by raising the income standard to 133% of the Federal Poverty Line (FPL) but using a gross income test with no deductions. The result is a program that is easier to administer, easier to understand, and is unlikely to have increased coverage[2];

- Medicaid "spend down" coverage was designed to insure "medically needy" residents who were over-income for regular disabled coverage, but otherwise met disability standards. Eligibility for this group had to be recalculated every six months. Recipients often cycled in and out of coverage, disrupting continuity of care and reducing the efficacy of treatment. The administrative costs were substantial. This program was eliminated and replaced by an expansion to the CommonHealth program (see below);

- The CommonHealth program was a 100% state-funded mechanism for providing coverage to working disabled adults and disabled children. There were no income limits in the program. CommonHealth utilized a sliding scale premium structure to recoup program costs from higher-income enrollees. The expansion legislation made several changes. First, it created a new category of CommonHealth recipient: non-working disabled adults. These recipients qualify by meeting a one-time six-month spend down. Subsequently, they are charged a sliding scale premium based on income. Second, the full CommonHealth program was included under the federal waiver, allowing the state to reduce costs by accessing federal funds for these enrollees.

MassHealth Basic

The creation of the MassHealth Basic program was the third major change in the 1996/97 legislation. MassHealth Basic provides a less comprehensive package of benefits to chronically unemployed individuals. Many of these residents were previously served by the EAEDC Program at state cost (there were no federal funds available). Others tended to use the Uncompensated Care Pool or hospital emergency departments for care. The MassHealth Basic Program was designed to provide ongoing coverage in

[2] A net income of 100% FPL is roughly equivalent to a gross income of 133% FPL.

less expensive settings. It also allowed the Commonwealth to collect federal payments for this coverage group.

The following table summarizes the changes made in eligibility and the approximate number of additional MassHealth members added as a result of the 1996/97 expansions.

Children's and Seniors Assistance Fund Programs

Coverage Group	Before Expansions	Now	Approximate Number Covered
Children	Children's coverage depended on a combination of the age of the child and the family's income.	All children are covered up to 200% of the FPL ($29,260 per year for a family of three).	107,800 additional children
Parents	Parents were covered up to 133% of the AFDC payment rate (less than 100% FPL).	All parents are now covered up to 133% of the FPL ($19,458 for a family of three). If the family has access to employer-based coverage and is below 200% FPL, the MassHealth Premium Assistance program will pay for a family policy (thus providing coverage to the parents as well as the children).	88,400 additional parents
Disabled adults	Disabled adults were covered up to 100% of the FPL.	Disabled adults are covered up to 133% of the FPL ($11,425 for an individual) under the MassHealth Standard program, and have access to the CommonHealth program if they are over income.	40,500 adults with disabilities
Chronically unemployed adults who do not meet a specific disability definition	No coverage. Could use the Uncompensated Care Pool or other safety net programs funded with state dollars.	These adults are now covered up to 133% of the FPL under the MassHealth Basic program.	46,474 adults

B. Financing of the MassHealth Program

As noted in the introduction, the MassHealth program receives federal financial participation (FFP) for qualified expenditures. In general, the MassHealth Program receives fifty cents in reimbursement for every dollar expended. This "match rate" is applicable to most MassHealth expenses, including services provided to the majority of

children, adults, and elderly people in the Commonwealth. However, the federal State Child Health Insurance Program (SCHIP) program provides an enhanced match rate for those children covered by SCHIP; in this case, MassHealth receives sixty-five cents in reimbursement for every dollar expended.[3] Total federal revenues for FY2002 are projected to be $2.9 billion.

State funds used for matching purposes can come from a variety of sources. The General Fund has historically been used to provide the state share of the Medicaid program. However, it is also possible to use dedicated funding streams (e.g. dedicated taxes or tobacco settlement funds) for Medicaid matching purposes.[4]

The availability of FFP has made the MassHealth program an attractive mechanism for increasing federal revenues for the Commonwealth. Services previously paid for by "state only" dollars have been incorporated into the Medicaid program in order to receive the federal matching funds. An example of this type of effort is the increasing use of the Medicaid program to cover mental health costs for Massachusetts residents. This stratagem produces a two-fold effect. On one hand, the overall cost of the Medicaid program increases as additional services or benefits are incorporated under its financing umbrella. On the other hand, the state receives a cost-offset in federal reimbursement for these services that can be used for any purpose. This dynamic has had a profound impact on the MassHealth Program and contributes substantially to its increasing share of the state budget.

Health Coverage Programs Now Included under Masshealth	**Additional Revenues Collected Through Federal Reimbursement**
• EAEDC health coverage for low-income residents • CommonHealth program for people with disabilities • Medical Security Plan for people collecting unemployment insurance • Prescription Advantage program (in process) *NB: these programs were previously funded with "state only" dollars. They are now included in MassHealth line items in the state budget, but net cost is reduced due to federal matching funds.*	• Medical care provided to special education students in a school-based setting • Home and community based services waivers for mentally retarded (DMR), elders (EOEA), and traumatic brain injury (MRC) • Care provided in public hospitals (DPH, DMH, and DMR state schools) • Case management services • Residential rehabilitation services • Distressed hospital payments • Enhanced matching funds for CMS-approved IT projects (e.g. HIPAA)

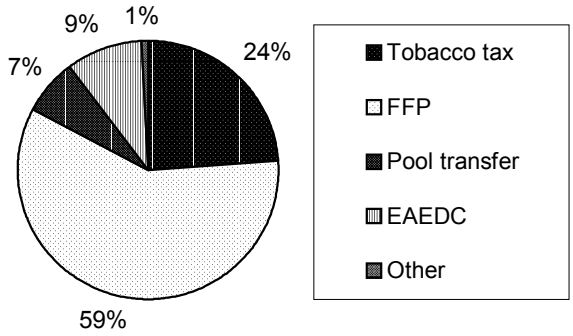
The expansions of 1996/97 created a new financial arrangement for the MassHealth program. The enabling legislation created the Children's and Seniors' Assistance Fund (CSAF) as a mechanism for tracking expansion-related revenues and expenditures. All revenues and expenditures for the expansion programs have been funneled through the

[3] SCHIP allowed states to either expand their Medicaid programs to cover children at income levels above federal Medicaid requirements, or to enact separate state health insurance programs for children. With federal permission, Massachusetts has implemented a blended program, combining the two approaches.

[4] A specific example of this strategy is the federal matching funds available for expenditures made by the Medical Security Plan (MSP). The MSP provides health coverage to unemployed residents. It is funded by an employer tax, currently set at $16.80 per employee per year. Thus, an employer tax is used to provide the state share for funding in this case.

CSAF. The expansions have been financed from four key sources. First, the legislature passed a twenty-five cent per package tobacco tax as a major source of new funding. Second, all FFP related to expansion expenditures have been redeposited in the CSAF (typically Medicaid FFP is returned to the General Fund). This includes federal matching dollars available through both the Medicaid and SCHIP funding streams. Third, the expansion legislation anticipated that transfers would be made from the Uncompensated Care Pool to the CSAF. The rationale for these transfers was that increased insurance coverage would result in diminished Pool utilization. Lastly, the legislature moved health care costs for a small segment of welfare recipients – those receiving Emergency Aid to the Elderly, Disabled and Children – into the expansion programs. As a result, a transfer is made each year from the General Fund to the CSAF to cover these expenses.

To date, we have provided coverage for 300,000 people with no additional contribution from the General Fund. The CSAF expenditures were budgeted over a five-year period in order to account for the predictable impact of caseload growth over time. The legislature understood that the program would gradually enroll additional members over time. Thus, in the early years of the expansions revenues significantly exceeded expenditures, while in the out years expenses were expected to outstrip revenues. The legislature expected that over the five-year period the two sides of the balance sheet would line up; i.e. that the programs created would be budget neutral to the state General Fund. This requirement is commonly referred to as **"state budget neutrality."**[5]



In Millions

Tobacco tax	470.7
FFP	1,166.4
Pool transfer	136.0
EAEDC	184.8
Other	19.2

III. Understanding MassHealth Expenditure Increases

	FY98	FY99	FY00	FY01	FY02
Total State Budget (in Millions)	$18,069.0	$19,045.0	$20,416.0	$22,110.0	$23,017.0
Medicaid Spending Less Expansion Costs	$3,568.1	$3,777.2	$3,986.0	$4,311.4	$4,927.7
General Fund Spending as a Percent of State Budget	19.75%	19.83%	19.52%	19.50%	21.41%

The MassHealth budget has been growing at a significant rate, **but until FY02 General Fund contributions to the MassHealth program have not.** In fact, General Fund contributions to the MassHealth Program as a percentage of overall state budget expenditures have remained fairly flat from FY1998-2002.[6] Indeed, the FY98-01 data show a slight decline in this ratio. There is an increase for FY02 that

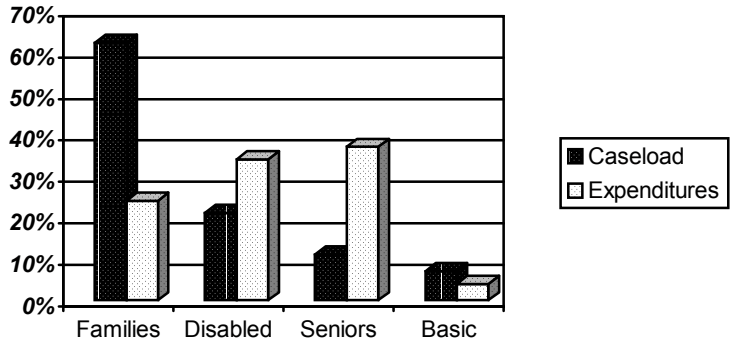
[5] There is also a "federal budget neutrality" requirement for all programs seeking approval for federal waivers. Under this requirement, a waiver cannot cost the federal government more than it would have paid without the waiver. The actual negotiation involves complicated discussions about medical inflation rates and the relevant base cost of the program.

[6] For this calculation, we used state budget projections from the Massachusetts Taxpayers Foundation; see Massachusetts Taxpayers Foundation. State Budget '02: Heading For a Crash. Boston: January 2002 (available at www.masstaxpayers.org).

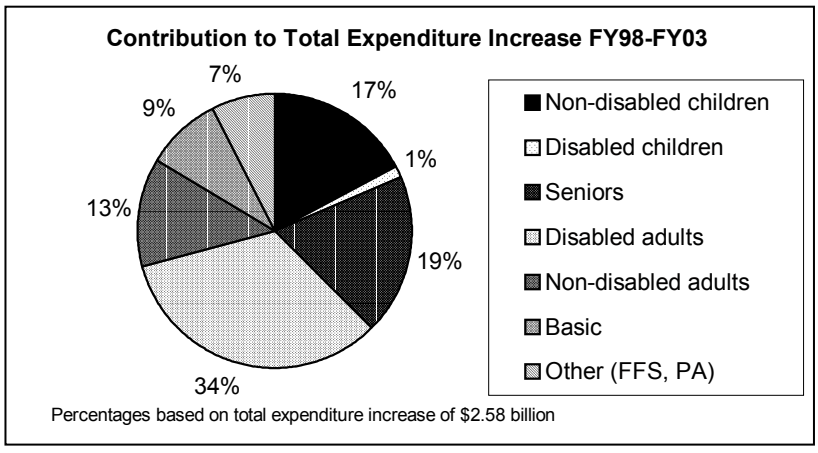
may be explained by several factors, primarily recession-related caseload increases combined with slower overall budget growth.

Total expenditure increases originate from a combination of caseload growth and medical inflation. The more people on the program, the more it costs. Similarly, even if enrollment stays flat, expenditures can rise due to increases in service costs. Within the MassHealth Program, these dynamics are specific to individual sub-populations of recipients. For some sub-populations, like elders and people with disabilities, service costs are a more significant factor because these groups are relatively high users of medical services. For other, relatively inexpensive sub-populations like children and parents, enrollment growth may contribute more to overall cost increases.

The following chart illustrates the relative balance of caseload and expenditures for four different population groups within the MassHealth program. While children and their parents make up nearly two-thirds (62%) of enrollment, they account for less than 25% of all expenditures. In contrast, elders comprise only 11% of the MassHealth population but contribute to over one-third of all costs (37%).



Thus, growth rates are inextricably linked with average per-member-per-month (PMPM) costs. The PMPM rate for elders is nearly 10 times that for children and parents ($1,460 per elder vs. $168 for non-disabled children and parents). Growth rates in program expenditures thus follow a predictable pattern: higher cost populations have been more responsible for overall expenditure growth on a per capita basis. Elders and adults and children with disabilities account for 54% of all expenditure growth during the past five years. The following chart summarizes expenditure growth by population since 1998.



A. Growth in Enrollment

Since 1996, we have added approximately 300,000 people into the MassHealth program. This is one of the primary statistics cited in support of the claim that the program is a "budget buster"; it is therefore important to understand the causes of enrollment growth and whether these causes were anticipated or unexpected.

MassHealth enrollment growth can be influenced in three distinct ways. First, enrollment can grow because eligibility criteria are changed. The expansions of 1996/97 are an obvious example of this factor—making more people eligible resulted in additional people signing up for the program. Second, the economic environment can impact MassHealth enrollment because eligibility for all MassHealth programs is tied to people's income levels. If incomes rise during good economic times, fewer people will be eligible for coverage. In contrast, during a recession, more people will become eligible. Recent growth in the MassHealth program is likely attributable to this cause, and should reverse itself upon an economic upturn.[7] Finally, MassHealth's relationship to the broader health care system can impact enrollment. If employers drop coverage, more people may rely on public options for their insurance. From all indications, this factor (called crowd-out) has not been a significant contributing factor to caseload increases.[8]

The 1996/97 expansions have provided the most significant contributions to enrollment increases over this period, **but have been entirely funded by tobacco taxes, federal revenues, and contributions from the Uncompensated Care Pool.** About 300,000 people have been added to the MassHealth program. This level of new enrollment was anticipated by the original projections made in 1998; however, especially on the adult side, enrollment in individual components of the program has differed from projections.[9] Some of the new enrollees would have been eligible for coverage under the previous rules; however, their costs have been charged to the Children's and Seniors' Assistance Fund through an accounting formula.[10]

The CSAF is expected to run a deficit at the end of FY2002 of $112M. The shortfall has resulted from the decision of the legislature not to make budgeted transfers from the Uncompensated Care Pool at the level anticipated by the original budget projections.[11] The expansions have, however, saved the Uncompensated Care Pool a great deal of money (probably $100-150M per year), as shown by the following chart.

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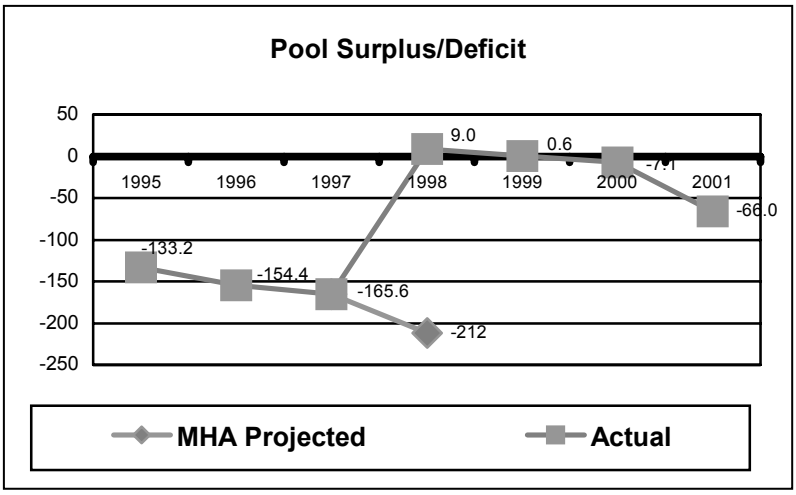
[7] Holohan, John. Rising Unemployment and Medicaid. Washington, DC: Urban Institute, September, 2001.
[8] Lutzky and Hill. Has the Jury Reached a Verdict? States Early Experiences with Crowd-out Under SCHIP. Washington, DC: Urban Institute, June 2001; Blumberg, Dubay and Norton. "Did the Medicaid Expansions for Children Displace Private Insurance? An Analysis Using SIPP." Journal of Health Economics 19 (2000).
[9] Massachusetts has enrolled fewer adults than anticipated in the insurance subsidy programs, and more than expected in MassHealth Basic and MassHealth Disabled/Commonhealth coverage.
[10] There are complicated arguments about the appropriateness of charging people to the CSAF who would have been eligible under old rules. On one hand, their costs would have been paid by the General Fund, and arguably should have been charged there. On the other hand, it is likely that the streamlining and marketing of the MassHealth Program encouraged some previously eligible people to apply for coverage who would not otherwise have done so (the "woodwork effect").
[11] Expected Pool transfers have fallen short by $128M (more than the overall deficit of $112M). Predicted tobacco tax revenues have been extremely accurate over the five year period. Both enrollment and total cost have been slightly lower than anticipated.



In contrast, enrollment in traditional coverage programs (e.g. Medicaid coverage that was available prior to expansion) has remained flat. For example, the number of elders receiving coverage through MassHealth has been virtually unchanged over the past five years, averaging around 100,000 members.

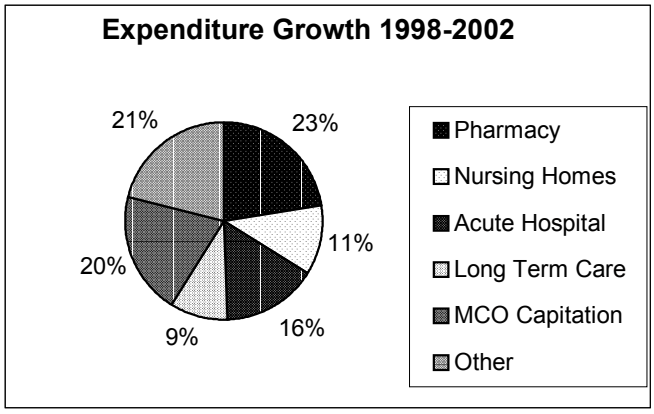
In recent months, it is likely that the economic downturn has impacted caseloads significantly. DMA estimates that application volume has increased by about 15% since September 2001. However, it is likely that enrollment increases are more substantial than cost increases. Family coverage tends to be most sensitive to economic conditions, but is also the least expensive in terms of per-member-per-month costs.

B. Growth in Service Costs

The second area to examine in terms of expenditure growth is specific services. Over the past five years (1998-2002), five areas have been responsible for much of the cost growth in the MassHealth program. These include pharmacy, managed care capitation, nursing home, services delivered at acute care hospitals (both inpatient and outpatient), and community-based long term care services.

Service Type	Change
Pharmacy	$409.9M
Nursing homes	$207.9M
Community long term care	$171.2M
(Acute) hospital care	$283.5M
MCO capitation	$366.1M
Other	$384.2M

The chart to the right provides a visual snapshot of the composition of service factors.



It is important to note that capitation payments for the managed care program account for 20% of the expenditure growth. The MassHealth program provides care to a significant percentage (about 16% or

145,000 members)[12] of the non-elderly population by contracting with four managed care organizations (MCOs).[13] To the extent that cost increases to MCO providers reflect inflation in the same service areas, the above chart understates the impact of these cost sectors.[14]

As with enrollment growth, it is important to understand the dynamics driving cost increases in specific service areas. As with cost growth generally, overall increases are the product of the base cost of the service in the initial year and the inflation rate for that service over the period in question. Thus, service areas that have high price tags to begin with can grow at relatively slow rates and still contribute significantly to overall cost inflation. In addition, specific services may be disproportionately utilized by a specific population, or may have internal dynamics which warrant further explanation. For this reason, the remaining four cost drivers outlined above will be considered in turn.

Pharmacy expenditures account for 16% of the overall MassHealth budget and are one of the fastest growing segments of the budget. Since 1998, pharmacy costs have increased by an average of 16.7% per year. This experience is consistent with overall trends in the health care marketplace. As might be expected, seniors and people with severe disabilities disproportionately utilize pharmacy benefits. Fully eighty-two percent (82%) of all pharmacy expenditures serve these two populations. Within pharmacy expenditures, the top three classes of medication are psychiatric drugs, cardiovascular drugs, and pain medications. Psychiatric medications account for fully one-third of all pharmacy costs, while the top three classes combined comprise nearly sixty percent (60%) of expenditures.

As an area of cost growth, pharmacy expenditures provide a logical area for savings. They are growing rapidly and are a significant component of the MassHealth budget. At the same time, this service is overwhelmingly utilized by particularly vulnerable segments of the MassHealth population. Moreover, the top three expenditure classes typify the problems with controlling pharmacy costs generally – if cost controls lead to inadequate access or poorer quality care, substitution of more expensive services (in this case hospitalization) will result.

Nursing home expenditures paid by MassHealth have increased substantially since 1998, but the growth rate in nursing home costs has averaged only four percent (4%) per year. The increase in expenditures here results from the fact that nursing home services are relatively expensive to provide. The base cost of nursing home care in 1998 was $1.27B out of a $3.73B overall Medicaid budget, or just over one-third of overall expenditures. Over the past five years, nursing home costs as a percentage of the overall MassHealth budget have actually declined. Nursing homes primarily serve elders, with almost 90% of all MassHealth nursing home benefits provided to older residents of the Commonwealth. There are approximately 37,000 elders on MassHealth residing in nursing homes.

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[12] Division of Medical Assistance. MassHealth 1115 Demonstration Project Annual Report SFY2000. Boston: 2001 (available at http://www.state.ma.us/dma/researchers/res_pdf/1115_2000-demoAR.pdf).

[13] Neighborhood Health Plan, the Boston HealthNet Plan, Network Health and Fallon Community Health Plan currently participate in the program.

[14] For example, assuming that the MCOs have experienced inflation in pharmacy costs at the same rate as the rest of the MassHealth program, pharmacy cost increases would account for 28% of overall cost increases. Excluding MCO costs, overall increases have been $1,456.7M, of which pharmacy accounts for $409.9M ($409.9M / $1,456.7M = 28.1%).

Unlike pharmacy benefits, nursing home costs cannot be easily controlled through reducing rates of payment. Nursing home providers complain that MassHealth currently pays them on average $10 to $15 a day less than the actual cost of care, and bankruptcies and facility closures have escalated in recent years.[15] Any cost savings would therefore need to be achieved through the increased provision of lower-cost alternatives in the community. This has begun to occur with the development of programs within the Executive Office of Elder Affairs that provide intensive services to elders at risk of institutionalization, and through the growth of alternative housing and care programs such as assisted living. However, this strategy is easier to state in theory than implement in practice. Elders that have already been placed in nursing homes confront significant barriers to returning to community settings. In the first place, elders in nursing homes tend to be the frailest and most medically needy members of their age groups. Because of the way in which eligibility criteria are structured for nursing home care, they would confront significant financial hurdles even if lower-cost, quality care were available in the community.[16] In addition, there is no guarantee that the provision of home-based care to severely incapacitated elders will save money, given the level of care they may require. Finally, elders in nursing homes have often severed ties with existing community resources (e.g. they have lost their previous housing), making return to the community a complex task requiring significant coordination of a broad range of social services.

A more promising alternative would be to expand the provision of diversionary programs to try to prevent or delay elders' entry into nursing homes where high quality community-based services are available. This would require the creation of additional capacity of community-based long-term care options, and targeted identification of elders in danger of nursing home placement.[17]

Community-based long-term care expenditures are largely made on behalf of adults and children with disabilities. The caseload growth for adults with disabilities is driving a significant percentage of the cost increase in this area. The kinds of services provided – personal care attendants, visiting nurses, etc. – keep recipients with chronic health conditions from requiring more expensive and less appropriate services. Indeed, these services have been identified by the Supreme Court in the *Olmstead* case as essential to allow the provision of care in the most "integrated" setting, a requirement of the Americans with Disabilities Act.

Lastly, **hospital costs** have increased significantly over the past five years. These increases in part reflect how the delivery system in Massachusetts is structured and

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[15] Massachusetts Health Care Task Force. Draft Final Report. Boston: January 25, 2002 (available at www.state.ma.us/healthcare/index.htm).

[16] The community income eligibility level for MassHealth is 100% of the FPL. Nursing home income eligibility is based on the monthly cost of care, with elders paying most of their income to the nursing home and MassHealth paying the balance. In addition, we require elders to "spend down" their assets in order to qualify for care, leaving them with few financial resources to draw upon. Moreover, elders with community-based spouses might lose eligibility for coverage because of the way income is "deemed" in the MassHealth program. Elders who live in the community must count a portion of their spouse's income as available to them when determining whether they qualify for MassHealth coverage. When they are institutionalized, this income is not counted. Consequently, some elders would lose eligibility for coverage were they moved from nursing homes to the community.

[17] Alecxih, Lisa Marie, et al. Estimated Cost Savings from the Use of Home and Community-Based Alternatives to Nursing Facilities in Three States. Washington, DC: AARP Public Policy Institute, 1996.

financed.[18] First, relative to the rest of the country, Massachusetts is over-reliant on acute care hospitals as the place where medical services are delivered for outpatient care. Second, our cost structure for hospital care is relatively expensive due to the disproportionate use of academic teaching hospitals by Massachusetts residents. Third, hospitals have experienced cost pressures from both private payors (through managed care contracting) and Medicare (as the result of the federal Balanced Budget Act). The consequence has been increased attention paid to Medicaid rates and billing.

At the same time, hospital rates have not increased substantially over the past five years. Unlike some of the other services, hospital usage tends to be more evenly distributed across the MassHealth population. As a result, the expansions are more responsible for overall increases in the hospital budget (but these costs have been paid for without General Fund contributions). The issues are complicated and contentious, and are not likely to be resolved in the short term through changes to the MassHealth program.

IV. The Economic Impact of Cuts to the MassHealth Program

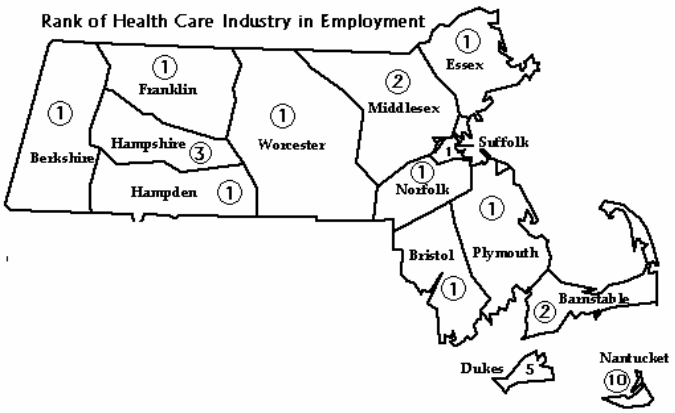
Cutting costs from the MassHealth program can frequently result in adverse consequences, including negative economic impacts. Health care is the single most important employment sector in the Commonwealth. Thus, overall cuts to health care services can reverberate throughout the broader economy. In a nutshell, reduced health care spending directly translates into job loss.

A quick review of health care's place in the Massachusetts economy is in order. Health services are the single most important employment sector in the state. According to

County	Employees	% Workforce
Barnstable	9,949	10.4%
Berkshire	6,842	11.1%
Bristol	22,529	9.0%
Dukes	535	7.5%
Essex	31,482	8.9%
Franklin	2,199	6.0%
Hampden	25,204	12.0%
Hampshire	4,304	5.4%
Middlesex	61,830	7.7%
Nantucket	221	5.3%
Norfolk	30,976	8.9%
Plymouth	16,654	7.0%
Suffolk	80,175	24.5%
Worcester	37,290	10.5%

[18] The "Lewin Report" on Medicaid hospital issues provides an overview of many of these issues. http://www.mhalink.org/News/Newsdir/News01/Lewin_Contents.htm. In addition, the Blue Ribbon Commission's consideration of the report raised significant questions. See, http://www.state.ma.us/healthcare/pages/pdf/lewreport.pdf

1998 data, 341,000 people in Massachusetts are employed in health services out of a total working population of 3,414,000, fully 10% of the total employed population. They are distributed throughout the state. Health care ranks as the most important employment sector in Suffolk, Essex, Norfolk, Bristol, Plymouth, Worcester, Franklin, Hampden and Berkshire counties; it ranks second in Middlesex, Barnstable and Dukes counties.



As evident from earlier discussion, MassHealth has its own form of "fiscal math." Cutting Medicaid dollars poses three inter-related problems to the health care sector and the economy more broadly:

- Cuts in MassHealth result in less federal revenue available to the state. This is a direct reduction in funds flowing overwhelmingly from out of state into Massachusetts[19];

- Cuts in MassHealth will result in increased demand on the Uncompensated Care Pool, which covers hospital costs for the uninsured.[20] The Pool has a fixed amount of funds available, including a capped amount of federal dollars. Thus, any unreimbursed increase in demand on the Pool amounts to a net economic drain because health providers will have to deliver additional services with the same overall funding. Alternatively, uncompensated care costs will be shifted to private insurers and employers raising health insurance premiums;

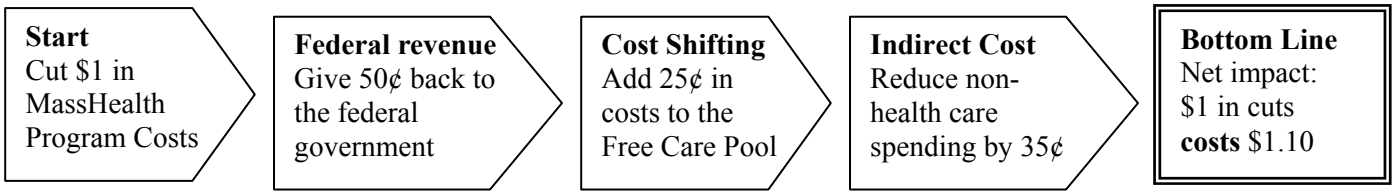
- The loss of federal revenue is amplified because the federal dollars are no longer available to circulate through the state economy. Fewer federal dollars results in diminished in-state expenditures by health workers and health providers. In addition, recipients who lose eligibility or benefits as the result of cuts will have less available disposable income to make non-health related purchases. Researchers at the University of South Carolina have estimated the "indirect" economic impact of reductions in federal Medicaid funds to be an additional 70% of the total reduction.[21]

[19] This idea should be distinguished from state budget cuts. State dollars are "redistributive." Cutting them will impact services, but the net economic impact to the state will be minimal because they come largely from in-state sources. In contrast, the federal funding leveraged through the Medicaid program is "free money."

[20] Approximately 25% of all health care costs in Massachusetts are attributable to hospital charges; thus a $1 cut is likely to lead to 25¢ in additional Pool charges.

[21] Division of Research, Moore School of Business. Economic Impact of Medicaid on South Carolina. Columbia: University of South Carolina, 2001.

The first three items listed have relatively predictable price tags given the current structure of federal and state financing mechanisms. The following graphic illustrates the dilemma:



V. Proposed Solutions: What Works and What Doesn't

As evident from the prior discussion, finding cost savings in the MassHealth Program will be a complex process, where careful consideration must be given to the cost ramifications of any proposed changes. In many cases, the cure will be worse than the disease. In others, cost controls will require careful planning and a long-term commitment to implementation that are unlikely to result in short-term savings. Below is a brief analysis of possible strategies.

A. Approve the Health Now! Tobacco Tax Proposal

The legislature has been considering a proposal known as "Health Now!" sponsored by Representative Kaprielian and Senators Montigny, Melconian, and Moore that would raise tobacco taxes and dedicate the funding to the Children's and Seniors Assistance Fund. The Health Now! proposal would stabilize funding for the expansion programs for several years, providing critical health coverage to hundreds of thousands of residents. A significant majority of Massachusetts residents support raising tobacco taxes if they are used to fund health care. The legislature should pass this bill, and earmark the proceeds to the CSAF, where they can leverage federal funds. The legislature should act quickly – each day that they wait, the Commonwealth loses over $500,000 in additional revenue. Moreover, other revenue sources should be found to support the non-expansion components of the MassHealth program.

B. Control Pharmaceutical Costs

Pharmacy costs are growing at an unsustainable rate. There are a variety of measures, some already in progress, that should serve to restrain cost increases in this area. The legislature should be careful, however, to assure that cost-control measures do not backfire. Medications are essential to treatment for many chronic diseases; measures that are based purely on cost, and do not take into account efficacy, are likely to be unsuccessful.

With respect to pharmacy costs:

- Cost savings from the Division of Medical Assistance's (DMA's) shift to generic medications should be given time to accrue. This past fall, the MassHealth program made significant changes to its prescription drug program, and placed prior approval requirements on the use of brand name medications if generic alternatives are available. The benefit from these cost controls has not yet accrued to DMA due to changes in the pharmacy vendor. Savings should be accounted for, while assuring

that these more restrictive policies have not had unintended health impacts on beneficiaries;

- DMA should implement bulk purchasing strategies, particularly in conjunction with other state agencies. While savings on the MassHealth side may be limited, the purchasing power of MassHealth may reduce costs for other agencies like the Department of Public Health and the Department of Mental Retardation;

- DMA should pursue a federal waiver to bring the costs of the Pharmacy Advantage program under MassHealth for low-income seniors and individuals with disabilities. Savings in state funds from this strategy should be understood to originate with the MassHealth program (and thus be seen as one way MassHealth is helping balance the state budget in difficult fiscal times), although doing so will ultimately increase the overall size of MassHealth;

- DMA should actively explore whether it is paying fair prices for pharmaceuticals. Currently, DMA utilizes a formula which bases individual drug prices on the wholesale acquisition cost (WAC) of pharmacies plus 10%. The Inspector General of the United States Department of Health and Human Services found that these prices are manipulated by pharmaceutical companies, and tend to overstate acquisition costs.[22] We recommend uniformly decreasing costs by a small percentage (perhaps to WAC + 7.5%) across the board. However, in order to protect small pharmacies from undue impact of such a change, state policymakers should explore the creation of a small pharmacy purchasing cooperative which would enable these businesses to compete fairly with larger pharmacy chains;

- DMA should aggressively educate physicians and other prescribers about the medical efficacy and cost of medications in order to counter the marketing strategies of pharmaceutical companies.

The legislature should be cautious in embracing all cost controls, however. DMA is planning to use a more restrictive formulary, where certain "tiers" of medications are preferred over others. Prior approval processes would attempt to prevent the use of non-preferred medications. This process should be explored but should carefully analyzed before being implemented. First, a careful assessment of efficacy should be undertaken, and should involve experts from outside DMA. This structure must save money throughout the MassHealth program (not just in pharmacy costs), and cannot have unanticipated cost consequences.[23] Second, certain classes of medications should be exempted from the proposed formulary, including psychiatric drugs, cancer medications, medications used to treat HIV disease, etc. Third, the prior approval process should assure deference to the clinical judgment of the treating physician. DMA could then encourage the use of medications that work better and cost less in terms of overall (not simply medication) costs. Patients who needed medications not included on

[22] Department of Health and Human Services, Office of the Inspector General. Medicaid Pharmacy – Actual Acquisition Cost of Brand Name Prescription Drug Products. Washington, DC: August 10, 2001.

[23] As one telling example of the problem, the cost of AIDS drugs for patients newly enrolled in the Community Medical Alliance Program increases on average after enrollment by about $400 per month. However, other medical costs decrease on average by more than this amount. Good pharmaceutical management combined with the use of "cutting edge" drug treatments actually saves money. Personal communication with Robert Master, M.D.

the preferred formulary would need sufficient, simple mechanisms to assure continued access to these pharmaceuticals.

C. Encourage Care in Less Expensive Settings

Copayments are often seen as an obvious means to direct people to more appropriate settings, but there are other mechanisms that achieve the same effect in a more targeted and less disruptive manner. Using the example of outpatient departments (OPDs) is helpful. As noted above, Massachusetts disproportionately provides care in relatively expensive outpatient settings rather than community settings (such as health centers and physician offices). Assuming it makes sense to shift people from OPDs to these community settings, the threshhold problem is the availability (both in terms of proximity and capacity) of alternatives. It makes far more sense to create economic incentives for *providers* to see MassHealth patients in these settings – e.g. by enhancing rates of payment for providers when they see patients outside OPDs.

Patient behavior is better influenced by enhanced member education initiatives. One strategy would be to redirect and/or enhance the current Minigrants funding for community outreach organizations to assist members with finding cost-effective care settings. The community organizations could also assist patients in accessing and maintaining regular preventive care. Similarly, many elders enter nursing homes as private paying clients only to "spend down" to Medicaid eligibility within a few months. By offering voluntary screening and counseling to these individuals, some could access home and community-based services delaying or eliminating their need for more costly nursing home care. The legislature should explore this and other options to expand access to home and community-based long term care as a means of reducing nursing home costs.

D. Enhance Revenue Maximization Efforts

As is clear from the previous discussion, MassHealth has actually provided substantial economic benefit to the Commonwealth by shifting costs to the federal government. While many major revenue maximization strategies have already been implemented, there are likely areas for additional efforts. In order to facilitate this process, further projects should be shifted out of DMA's jurisdiction and into an Executive Branch office (either EOHHS or A&F). This would assure a comprehensive perspective on budget issues, and would minimize inter-agency disputes. Through the establishment of an advisory committee of knowledgeable parties from outside state government, DMA could create a structure that tapped expertise in a more formal way.

E. Avoid Preventable Hospitalization

Hospital care is expensive and often preventable. DMA should be encouraged to undertake targeted initiatives to decrease preventable hospitalizations. Several ideas should be explored:

- "Stuck kids" in psychiatric beds have received a lot of attention over the past several years. These children are ready for discharge, but are receiving hospital-level care for lack of alternative placements. The solution lies in both diverting youth likely to need hospitalization to intensive community-based services, and creating step-down levels of service once they are discharged. The House I budget proposal includes $2M for inter-agency implementation of such intensive services in six cities

statewide. The idea is based on the success of the MHSPY Program in Cambridge/Somerville and the Worcester Communities of Care Program. Under MHSPY (which serves acutely ill children) average costs of care have declined from $100,000 per year to about $40,000 per year per child.[24] This is one area where greater spending in the short term may lead to significant savings and improved care down the road;

- DMA should reorient service delivery for people with disabilities to maximize community-based care and minimize hospitalizations. The Community Medical Alliance Program (CMA), a managed care plan that serves MassHealth recipients with very severe disabilities, has demonstrated substantial cost savings through reorganizing care. CMA's approach uses a case capitation rate that is adjusted to reflect the level of disability of the consumer (e.g. it is higher than the traditional MassHealth capitation rate but lower than what these consumers tend to "cost" the program on a fee-for-service basis). Care is then reorganized using a strong case management system, with well-organized and integrated service delivery. On average, CMA has decreased costs for the care of these patients by 10-25%. The model could be expanded to serve a population with less acute disabilities, including pediatric cases. This strategy is currently being piloted in Springfield with good results; serving a group of 800 patients, average yearly days of hospitalization have decreased from 1150 days/1000 patients to 722 days/1000 patients;

- The Minigrants program has proven an effective mechanism for enrolling individuals statewide into MassHealth. Given the current budget crisis, some of its emphasis should be redirected towards assisting with member education activities. In particular, the Minigrants are ideally suited to linking members with community providers in a cost-effective way.

F. Support Targeted Fraud and Overpayment Initiatives

It is difficult to know the exact extent of fraud and overpayment. The GAO estimated that overpayment amounted to about 8% of the Medicare fee-for-service program and that no state is maximizing available federal matching funds for Medicaid fraud control.[25] However, the extent to which Medicaid parallels the Medicare experience is unknown. Also, improving payment accuracy might reveal significant underpayment. Finally, fraud is difficult to detect and thus, difficult to estimate.

To the extent that fraud does occur, it hurts everyone. Therefore we believe that the fraud and overpayment efforts of the legislative task force and the Attorney General's Office should be supported, and the cost effectiveness of enhancing fraud control efforts should be explored. An important caveat is that reasonable efforts to recover improper payments should not be confused with a license to engage in provider harassment. An

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[24] Master, Robert. "Massachusetts Medicaid and the Community Medical Alliance: A New Approach to Contracting and Care Delivery for Medicaid-Eligible Populations with AIDS and Severe Physical Disability." The American Journal of Managed Care 4 (June 25, 1998); Master, Robert, and Eng, Catherine. "Integrating Acute And Long-Term Care for High-Cost Populations." Health Affairs 20 (November/December 2001).

[25] General Accounting Office. Medicaid: State Efforts to Control Improper Payments Vary. Washington, DC: July 11, 2001. See also, General Accounting Office. Medicare Improper Payments: Challenges for Measuring Potential Fraud and Abuse Remain. Washington, DC: July 12, 2000.

overly punitive or bureaucratic approach risks damaging access by driving providers out of the program.

G. Avoid Broad Cuts in Eligibility or Services

These cuts are unlikely to result in cost savings. They will destabilize the health care system and will result in very low-income residents going without essential care or utilizing more expensive services. Because of the federal matching system, Massachusetts will forego significant federal funding, and will drive people into the Uncompensated Care Pool. Loss of state and federal revenue will weaken an already fragile health care delivery system which will reduce the ability of the system to care for everyone (both MassHealth members and the general population). Similarly, increased reliance by the newly uninsured on emergency rooms would exacerbate existing problems with overcrowding and diversions, to the detriment of all. As detailed, the economic impact is significant. In addition, when specific services are eliminated, they are often replaced by more expensive, less tailored alternatives. We should avoid dismantling a program that works well and provides critical services to a million Massachusetts residents.

H. Increasing Copayments Will Not Work

Increasing copayments to MassHealth recipients seems like a simple mechanism for controlling costs, but it is a bad idea. There are two theoretical rationales for copayments:

- They discourage the use of unnecessary care;
- They are a mechanism that creates beneficiary-level economic incentives to use more appropriate and cost effective types of care.

The problem with the first rationale ("copayments discourage the use of unnecessary care") is that it is not well targeted. While some people may overutilize services, far more consumers utilize services appropriately. Many studies have found that copayments serve to deny people necessary services. This problem is heightened in a Medicaid population. Even modest increases in copayments have been shown to result in adverse outcomes for low-income people, and have actually cost states more money.[26] In addition, they disproportionately impact the sickest individuals who tend to use the most services and thus incur the most copayments.

Insofar as copayments are collected by providers, they should also be seen as an indirect rate reduction – when people don't pay them the provider absorbs the cost. They are a particularly inefficient means to accomplish this doubtful end, and lead to more administrative work for overburdened providers.

With respect to creating incentives, we have proposed several preferable strategies in Section C, above.

[26] Newhouse, et al. "Copayments and the Demand for Medical Care: the California Medicaid Experience." Bell Journal of Economics (Spring 1978). See also, Stuart and Zacker. "Who Bears the Burden of Medicaid Drug Copayment Policies." Health Affairs (March-April, 1999.)

VI. Conclusion

The MassHealth program is an important part of the health care system and critical to the health care needs of our most vulnerable citizens. The legislature can make reforms that achieve dual purposes: long-term stability of the program and improved health outcomes for consumers. Passing the tobacco tax, gaining federal reimbursement for the Prescription Advantage program, and reducing pharmacy costs are short-term strategies that will help stabilize MassHealth. Over the next year, DMA should pursue additional strategies that seek to control costs and improve care, including coordination of care for people with disabilities and development of incentives to seek care in lower cost community-based care settings. The Commonwealth should assure that it is cost-conscious in purchasing care by minimizing inappropriate overpayments and negotiating reduced pharmacy prices. The legislature should not make choices likely to constrain economic growth, lead to job loss, or to have unintended negative cost consequences. At a time of difficult fiscal choices, the Commonwealth must reaffirm its commitment to the health care needs of our residents, not eviscerate its successes.

The MassHealth Cuts:

What They Are.
Why They Don't Work.
What We Can Do.

Health Care For All
30 Winter Street, Suite 1010
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November 13, 2002

Also available on the Web at www.hcfama.org/masshealthreport.html

I. Executive Summary

As the economy falters, Massachusetts is struggling to address both a sharp decrease in state revenues and an increased demand for social services. The response to the state budget crisis by the legislature and the administration has been to cut the services and eligibility of MassHealth, the state Medicaid program.

Administered by the Massachusetts Division of Medical Assistance, MassHealth provides health care coverage to nearly one million residents. It provides comprehensive benefits for eligible low and middle income people, including children under 19, parents, pregnant women, people with disabilities, people who are HIV positive, long-term unemployed, adults who work for qualified employers and people in nursing homes.

MassHealth is funded by both state and federal funds. For most MassHealth programs, Massachusetts receives fifty-cents for every dollar it spends on services. For others, e.g. the State Children's Health Insurance Program (SCHIP), the Commonwealth receives sixty five-cents for every dollar spent. These federal funds – $2.9 billion of the total $5.38 billion MassHealth budget – go to the state's General Fund and make MassHealth the largest revenue generator for the Commonwealth.

In October 2002, Governor Jane Swift announced the elimination of several benefits and programs for the nearly 600,000 adults enrolled in MassHealth. The eliminated benefits are:

- Dentures
- Prosthetics
- Orthotics
- Chiropractic Therapy
- Eyeglasses

The estimated savings from eliminating these services totals approximately $22 million, or $11 million in state costs.[1] Ultimately, these are not cost-saving measures because the needs that they serve will not go away. Instead, the result will be sicker people who require more expensive care in hospital emergency departments or nursing homes. Further, MassHealth recipients who rely on these critical services will be far less able to work without them.

These cuts to MassHealth come in the wake of a series of devastating cuts to health and human service programs. In January 2002, Governor Swift eliminated nearly all dental benefits for adults covered by MassHealth. The Governor also imposed increased cost-sharing in several MassHealth programs, which will discourage members from seeking care and shift costs to providers.

In its Fiscal Year 2003 budget, the legislature voted to eliminate eligibility for 50,000 MassHealth Basic members as of April 1, 2003. MassHealth Basic serves very low-income, unemployed adults with high health needs who will have few options for care except emergency rooms. Costs will be shifted to other state programs, including the

[1] based on Fiscal Year 2002 expenditures

Department of Mental Health and the Department of Corrections, as well as "off-budget" to the Uncompensated Care Pool, hospitals and health centers. In her announcement last month, Governor Swift asked the legislature to move the closure of the MassHealth Basic program to February 1, 2003, to save an additional $11.5 million.

As this report was being written, the administration closed the Children's Medical Security Plan (CMSP) to new enrollees. Administered by the Department of Public Health, this November 4th closure effectively ends the Commonwealth's claim that every child – regardless of family income, age, or disability – will have access to health care coverage.

Instead of instituting these cuts that will condemn vulnerable populations to antiquated or non-existent care, this paper recommends the following alternative cost-saving measures:

- Maximize currently available Medicaid federal matching funds (FFP) for state programs
- Support an enhanced Federal Medical Assistance Percentage (FMAP)
- Implement better care coordination and early treatment to avoid preventable hospitalizations to reduce costs in MassHealth.
- Control Pharmaceutical Costs in MassHealth and other state programs.
- Support targeted fraud and overpayment initiatives.

We believe that these recommendations would address much of the gap in funding for MassHealth. The next few months are critical and will determine the future direction of the MassHealth program. It is a time for action. During the election campaign, Governor-elect Romney expressed his desire to restore the MassHealth Basic program. He also called for new federal revenue for the Medicaid program. Clearly he is in a strong position to provide leadership and we look forward to hearing the Governor-elect's plans for how we can avoid this impending crisis. We call on him to move forward quickly.

II. Introduction

The Commonwealth continues to grapple with an ongoing budget crisis. During Fiscal Year 2002, Governor Swift used her authority to reduce funding for many programs. During the budget deliberations for Fiscal Year 2003, more cuts in programs and services were instituted, including the scheduled elimination of a key MassHealth program for 50,000 very low-income unemployed, often homeless, adults with high medical needs.

Now, the Governor has proposed making further cuts in the MassHealth program for adults, effective January 1, 2003. These benefit cuts will do little to address the Commonwealth's fiscal problems, yet they will be devastating to the individuals who are deprived of necessary services. In some cases, cuts could lead to increased institutionalization, erasing any savings that might be generated. In other instances, the services that are eliminated are essential for "worker readiness." Without them, MassHealth recipients may be trapped indefinitely on public assistance.

For example, taking away eyeglasses from working poor, elderly, and disabled adults will save less than $2.59 million total and only $1.3 million in state funds (half or more of MassHealth is funded federally). Thousands of MassHealth members will be left without a basic necessity that enables them to work and take part in daily living activities. Eliminating prosthetics and orthotics will save the MassHealth budget $5.54 million total or about $2.77 million in state funds in this year. However, it will still cost the state money. People with severe health care needs will require longer stays in hospitals and may be forced into more expensive settings, such as nursing homes, if they cannot take care of themselves. These are not cost-saving measures because the needs of sick people will still be addressed. These are cost-shifting measures.

Governor Swift also asked the legislature to move the implementation of the MassHealth Basic cut from April 1, 2003 to February 1, 2003. The impact of this cut, which will eliminate coverage for 50,000 people and undermine the state's Uncompensated Care Pool, will cause major disruptions in care for low and middle- income people, and we hope that the legislature will not act to move up the implementation. In his campaign, Governor-elect Romney spoke in favor of restoring this program, and his administration must find the time necessary to develop solutions to this critical problem.

This briefing paper provides:

- A brief overview of the MassHealth program, including coverage categories and financing.

- A description of the proposed cuts in benefits to the MassHealth program and the nominal savings.

- An analysis of the impact of cutting eligibility and services on beneficiaries, on other areas of state spending and on other parts of the health care system.

MassHealth has been called a "budget buster", but blaming the program for the Commonwealth's budget problems is far too simplistic. While the program spent $5.38 billion in Fiscal Year 2002, over half of those expenditures are paid for with federal matching funds. MassHealth generated $2.9 billion in federal matching dollars. These

critical dollars are needed to sustain both Massachusetts' health care system and its economy. Additionally, the expansions in MassHealth have significantly reduced the number of uninsured in Massachusetts.

We hope that a look at MassHealth, and the impact of these proposed cuts, will generate a better-tailored response to the current budget crisis – one that protects our most vulnerable residents and ensures a healthy future for them and the Commonwealth.

III. Overview of the MassHealth Program

The following is a brief description of the MassHealth Program. For a full analysis, please refer to Health Care For All's previous report, **The Facts on MassHealth**, released in March 2002 and available at www.hcfama.org.

In Massachusetts, the Medicaid Program is referred to as MassHealth. Medicaid is a state-federal partnership. Under federal law, if a state operates a Medicaid program consistent with federal standards, it is eligible to receive federal matching funds for the costs of its program. Some federal standards are *mandatory*, i.e. a state must provide certain services to certain categories of people. Other standards are *optional,* i.e. a state can choose to provide services to additional people; if it does provide these services it will receive matching funds for them.[2] Finally, states can ask the federal government for a *waiver* from some requirements; waivers allow states to reallocate dollars to which they are entitled in order to expand coverage, test creative strategies and tailor their health care programs to local conditions.

Massachusetts, like many other states, currently operates much of its Medicaid program through a "waiver" from the federal government (elders and institutionalized recipients continue to receive Medicaid coverage under non-waiver rules). The federal waiver is a "living document" in the sense that it has been modified numerous times since it was first approved in 1996. The federal waiver is the document that defines the coverage expansions, financing arrangements, and service delivery structure for the MassHealth program. Understanding the waiver is critical to understanding the costs and benefits of the Medicaid program in Massachusetts.

A. Medicaid Coverage in Massachusetts

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The MassHealth program is administered by the Division of Medical Assistance and currently covers a total of 995,679 low and middle-income Massachusetts residents who are citizens or qualified immigrants. It provides comprehensive health benefits for eligible low and middle-income people who are under age 65, including families with children under 19, children under age 19, pregnant women, long-term unemployed, people with disabilities, adults who work with qualified employers, and people who are HIV positive. Medicaid also covers low-income residents 65 and older, as well as low and middle-income individuals of any age, who need long term care services.

Table I summarizes eligibility and the approximate number of MassHealth members.

[2] Once a state chooses to provide an optional service, there are some limits on how it may seek to restrict the benefit. Medicaid programs must provide services in an "amount, duration and scope" sufficient to achieve their intended purposes.

Table I: MassHealth Enrollment as of August 31, 2002

Coverage Group	Eligibility	Number Covered as of 8/31/02
Parents and Children	All children under age 19 are covered up to 200% of the FPL ($30,048 per year for a family of three). All parents are covered up to 133% of the FPL ($19,980 for a family of three). Pregnant women and infants are covered up to 200% FPL. For families under 200% FPL with employer based insurance, MassHealth will purchase the employer's family plan.	403,495 Children 216,864 Parents 620,359 Total
People with Disabilities	Disabled adults are covered up to 133% of the FPL ($11,784 for an individual) under the MassHealth Standard program. The CommonHealth program covers all working disabled adults as well as other adults over 133% FPL and children over 200% FPL. (Sliding scale premiums are required for higher income members)	21,811 Children 176,530 Adults 198,341 Total
Seniors	Income limit of $9,108 for an individual if they are residing in the community. The income eligibility is higher for those in a nursing home, but they must contribute some or most of their income to the costs of care.*	116,599
Long Term Unemployed	These adults are now covered up to 133% of the FPL under the MassHealth Basic program, but according to the Division of Medical Assistance, most enrollees have incomes of 40% of the FPL ($3,544) or less.	60,380

Source: Massachusetts Division of Medical Assistance

**Medicaid is the only public program that provides long-term care for low and middle-income people. Medicare only covers limited stays in nursing homes following a hospitalization.*

B. Financing of the MassHealth Program

The MassHealth program accounted for one-quarter of the General Fund spending in Fiscal Year 2001. However, if we look at state spending on MassHealth, the percentage drops to 9.7% of the state budget. By comparison, state aid for local education in Fiscal Year 2002 will be $4,092 billion, nearly double the $2.466 billion spent for the state share of Medicaid.[3]

The MassHealth program receives Federal Financial Participation (FFP) for qualified expenditures. In general, the MassHealth Program receives fifty-cents in reimbursement for every dollar expended. This "match rate" is applicable to most MassHealth expenses, including services provided to the majority of children, adults, and elderly people in the Commonwealth. However, there is an enhanced match rate of sixty-five cents on the dollar for those children covered by SCHIP, which is a part of MassHealth.[4] Total federal revenues for Fiscal Year 2002 are projected to be $2.9 billion.

[3] MassHealth: Dispelling Myths and Preserving Progress, Massachusetts Health Policy Forum. 2002.
[4] SCHIP allowed states to either expand their Medicaid programs to cover children at income levels above federal Medicaid requirements, or to enact separate state health insurance programs for children. With federal permission, Massachusetts has implemented a blended program, combining the two approaches.

State funds used for matching purposes can come from a variety of sources. The General Fund has historically been used to provide the state share of the Medicaid program. However, it is also possible to use dedicated funding streams (e.g. dedicated taxes or tobacco settlement funds) for Medicaid matching purposes.[5]

MassHealth cost increases are largely due to medical inflation, including nursing home, pharmaceutical, community-based long-term care and hospital expenditures. The cost increases are primarily for elders and adults and children with disabilities, which account for 54% of all expenditure growth during the past five years. This is not surprising, since these are the members who need the most care. Growth rates are inextricably linked with average per-member-per-month (PMPM) costs. For instance the costs for seniors is nearly 10 times the costs for children and parents.[6]

There has been much debate about the effect on MassHealth costs of expanding eligibility to nearly 300,000 new members since1996-7. However, as we discussed in detail in HCFA's March 2002 report, these expansions were accomplished without any new contribution from the General Fund. The new programs were financed by the 25-cent tobacco tax passed in 1996, by federal matching funds, by transfers from the Uncompensated Care Pool, and by an existing, small amount of funding from Emergency Aid to the Elderly, Disabled and Children (EAEDC).

Table II: Massachusetts Maximization of Federal Reimbursement through MassHealth

Health Coverage Programs Now Included under MassHealth	Additional Revenues Collected Through Federal Reimbursement
• EAEDC health coverage for low-income residents • CommonHealth program for people with disabilities • Medical Security Plan for people collecting unemployment insurance • Prescription Advantage program for seniors and people with disabilities (in process) *NB: these programs were previously funded with "state only" dollars. They are now included in MassHealth line items in the state budget, but net cost is reduced due to federal matching funds.*	• Medical care provided to special education students in a school-based setting • Home and community based services waivers for mentally retarded (DMR), elders (EOEA), and traumatic brain injury (MRC) • Care provided in public hospitals (DPH, DMH, and DMR state schools) • Case management services • Residential rehabilitation services • Distressed hospital payments • Enhanced matching funds for federally-approved Information Technology projects (e.g. HIPAA)

Source: Massachusetts Division of Medical Assistance

The MassHealth program has also grown because the availability of federal matching funds has made the MassHealth program an attractive mechanism for increasing revenues for the Commonwealth (see Table II). Services previously paid for by "state

[5] A specific example of this strategy is the federal matching funds available for expenditures made by the Medical Security Plan (MSP). The MSP provides health coverage to unemployed residents. It is funded by an employer tax, currently set at $16.80 per employee per year. Thus, an employer tax is used to provide the state share for funding in this case.

[6] The Facts on MassHealth, HCFA, March 28, 2002.

only" dollars have been incorporated into the Medicaid program in order to receive the federal matching funds. An example of this type of effort is the increasing use of the Medicaid program to cover mental health costs for Massachusetts residents. The state receives a cost-offset in federal reimbursement for these services that can be used for any purpose. This dynamic has had a profound impact on the MassHealth Program and contributes substantially to its increasing share of the state budget.

IV. The Cuts in the MassHealth Program

A. Overview

Over the last year, the legislature and governor have made debilitating cuts in public insurance programs that affect the hundreds of thousands of Massachusetts residents who rely on MassHealth and the Children's Medical Security Plan. These cuts will be felt throughout the Commonwealth by our friends and neighbors, health centers, doctors and local hospitals.

In January 2002, Governor Swift cut nearly all dental benefits for the 600,000 adults on MassHealth, eliminating their ability to have a cavity filled or dental cleanings. During the Fiscal Year 2003 budget debate, the legislature eliminated the MassHealth Basic program, which provides health coverage for 50,000 very low-income adults.

On October 10, 2002, Governor Jane Swift announced a series of broad cuts in health and human service programs using her constitutional powers under section 9C. Under this section, a governor can make unilateral decisions to reduce spending or eliminate programs if there is an apparent shortfall in needed funds. The Swift administration predicts that tax revenues for Fiscal Year 2003 will be $2.5 billion below projections.[7]

With these predictions, Governor Swift announced the elimination of the following health care benefits for the nearly 600,000 adults enrolled in the MassHealth program:

- Dentures
- Prosthetics
- Orthotics
- Chiropractic Therapy
- Eyeglasses

Cutting benefits like eyeglasses, prosthetics and orthotics will impede the ability of MassHealth recipients to obtain or maintain employment, thus reducing the likelihood of recipient income rising above MassHealth income limits through employment. This lack of stable employment also reduces the likelihood of recipients maintaining employer-based insurance as a primary payer of health costs. The cuts could increase costs to cash assistance programs such as Transitional Aid to Families with Dependent Children (TAFDC) and place additional burdens on the Massachusetts Rehabilitation Commission. Neither of these programs is funded to take on additional recipients.

[7] Kevin J. Sullivan, Secretary, Executive Office of Administration and Finance, August 29, 2002 letter to Cabinet/Agency Heads.

These benefit cuts also seem counterintuitive in light of known strategies to keep health care costs down. Providing people with the benefits needed to keep them healthy, at home or in a less restrictive setting, will avoid unnecessary hospitalizations or nursing home care. The cuts could therefore increase costs in Medicaid for these other services.

The previous cuts in adult dental services have already increased demand on the underfunded Uncompensated Care Pool, which pays health centers and hospitals to provide care to the uninsured or the underinsured.

In addition, the Governor proposes changes in the following programs:

- Increasing premiums for the SCHIP program (Family Assistance) – The Governor proposes removing limits on the amount families can be charged in both premiums and co-pays;
- Creating new premiums for the HIV waiver program;
- Increased co-payments for medications from fifty cents to two dollars per prescription;
- Establishing one dollar co-payments for other MassHealth services.

Most recently, on November 4, 2002, the Children's Medical Security Plan closed enrollment, forcing children to wait two to three months before granting them access to health care. Children will have to rely on emergency departments for care.

B. The MassHealth Basic Program

Nearly 50,000 adults are scheduled to lose their health care coverage on April 1, 2003. Governor Swift requested that the legislature return for a special session to accelerate this elimination to February 1, 2003. During his campaign, Governor-elect Romney stated that he supported restoring this important program, and we believe that the legislature should not act to move implementation to February. We call on the new administration to develop a plan to avoid closing this critical program.

MassHealth Basic provides health care to uninsured, long-term unemployed adults, many of whom have serious illnesses. People who get Basic benefits often have recurring or chronic mental health, substance abuse and other medical incapacities, which make it difficult for them to maintain employment. When the MassHealth Basic program was implemented in 1997, it was predicted that many of the high cost "predominant pool users" would be eligible for this program. "Predominant pool users" were disproportionately male and had particularly high rates of circulatory disease, mental illness and substance abuse.[8]

The MassHealth Basic population has indeed proved to be a high need group whose ongoing care cannot be well maintained by the Uncompensated Care Pool, which only covers services delivered in hospitals and health centers. For instance, MassHealth Basic members are more dependent on mental health services than any other MassHealth group. DMA estimates that 35,000 are enrolled in the Massachusetts Behavior Health Partnership (MBHP) and 18,000 are actively using mental health and

[8] Report of the Special Commission on Uncompensated Care, February 3, 1997.

substance abuse services through the MBHP.[9] Without access to prescription drugs and other services, many of these people will deteriorate and be forced into hospitals. Some will receive care in Department of Mental Health psychiatric hospitals, in designated beds in acute care hospitals, or in other state-funded health programs within DPH and DMH, all without federal reimbursement. Some of the current $86.2 million behavioral health costs for MassHealth Basic recipients will be forced back into the Department of Mental Health at 100% state expense and some will fall on the Pool through outpatient hospital services and acute care hospital psychiatric inpatient admissions. Additionally, without access to health and mental health services and prescriptions, some MassHealth Basic members will end up in the courts and prison system at a far greater state expense.

Only 11,000 of the approximately 60,000 people currently on MassHealth Basic will continue to be eligible for the program. Those receiving EAEDC from the Department of Transitional Assistance or those who are clients of the Department of Mental Health and who have an income below 100% federal poverty level (currently $8,860) will continue to receive coverage. For those no longer eligible, the loss of pharmacy and preventative services available under the Basic program will most likely cause their conditions to worsen, increasing the likelihood of them being determined disabled and qualifying them for MassHealth Standard.

MassHealth Basic members use over $90 million each year in inpatient and outpatient hospital services (see Table III). Much of this cost will be shifted onto the Uncompensated Care Pool (UCP), which is capped at $415 million. The Division of Health Care Finance and Policy estimates that the elimination of MassHealth Basic will add $76 million in Pool costs, resulting in a $153 million Pool deficit in FY03. The former MassHealth Basic members are expected to cost the Pool $160 million in FY04. These shortfalls will result in lower reimbursement rates for hospitals and community health centers that provide free care to the 420,000 Massachusetts residents who are already uninsured. The estimated annual savings to the state budget for cutting MassHealth Basic is only $137 million, or half of the annual cost of the program since the state will lose federal matching funds. The Pool cannot get federal matching funds for the new costs it will incur from this cut.

Table III: FY2002 Estimated MassHealth Basic Expenditures

Provider Type	**Estimated Expenditure ($million)**
Behavioral Health	$86.2
Pharmacy	$48.6
Outpatient Acute	$41.2
Inpatient Acute*	$28.5
Physician	$21.4
Community Health Center	$8.1
Dentist	$7.4
All Other	$12.1
Total	$253.6

Source: Massachusetts Division of Medical Assistance

* For a complete list of MassHealth Basic expenditures by hospital, see Appendix II.

[9] Massachusetts Division of Medical Assistance

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In addition to higher pool costs, a higher proportion of all services to this population will be delivered through emergency rooms, raising costs and increasing emergency room crowding. Without access to primary care and prescription drugs, Basic enrollees will also be hospitalized at higher rates. Massachusetts already has a severe problem with access to emergency care. Elimination of MassHealth Basic will make this already serious problem worse. Studies have shown that the uninsured are more likely to rely on the emergency room for care that could be treated elsewhere. For example, a study of people in Oregon who lost eligibility for Medicaid found that they were more than four times as likely to use the emergency room as their primary source of care than were Medicaid enrollees.[10] Studies have also found that the uninsured spend more time in the hospital for conditions that could be treated elsewhere than does the Medicaid population.[11]

C. Dental Services and Dentures

This spring, Governor Swift eliminated most adult dental benefits under MassHealth. Extractions – the removal of teeth – became the only alternative for most tooth problems. Now, without access to dentures, these adults will have no way to cope with the loss of their teeth.

The importance of oral health as a public health issue is largely misunderstood and undervalued. Oral health affects the ability to eat, speak, and sleep.[12] Poor dental health can lead to increasingly serious physical ailments. Dental problems can lead to a poor nutritional diet because of chewing difficulties.[13] Untreated gum and oral tissue disease can damage insulin production and result in diabetes.[14] Dental disease also impacts cancer treatment – it may complicate the delivery of both chemotherapy and head and neck irradiation.[15] Poor oral health can even cause a woman to deliver a pre-term, low birth weight baby.[16]

Oral health is linked to heart disease, lung disease, stroke, low birth weight babies and other major health conditions. Oral cancer is more prevalent than melanoma, ovarian cancer and cervical cancer and can be detected during a routine dental visit. In the United States, approximately 3.6 million workdays are lost due to oral health problems.[17]

As in other medical services, preventative measures and early treatment are far less costly than emergency measures. An adult patient needing a filling can receive an oral exam, a cleaning and a filling for a total cost of $137. If a patient has to see a dentist in

[10] Oregon Health Plan Disenrollment Survey
[11] Guo et al, How are Age and Payors Related to Avoidable Hospitalization Conditions?, Managed Care Quarterly, 2001, 9(4):33-42.
[12] *Healthy People 2010: Oral Health*. Washington, DC: US Dept. of Health and Human Services; 2000.
[13] National Center for Education in Maternal and Child Health, *Oral Health and Learning*, Georgetown University, (2001).
[14] The Nation's Health, July 2001.
[15] David Satcher, *Preface to* U.S. Department of Health and Human Services, *Oral Health in America, A Report of the Surgeon General*, 4 (2000).
[16] American Academy of Periodontology, Press release, May 7, 2000.
[17] Report to the Special Legislative Commission on Oral Health, *The Oral Health Crisis in Massachusetts*, February, 2000.

an emergency, the exam, extraction, and partial dentures cost $343, a cost increase of two and a half times.[18]

Dentures, which include full and partial dentures, as well as bridges, are essential for those who have lost their teeth. Losing teeth is not a consequence of aging, as commonly believed, and affects many besides seniors.[19] This loss may also lead to a greater risk of cancer and heart disease.[20] Even people with dentures may eat fewer fruits and vegetables, foods known for protective benefits, and eat more processed foods with higher cholesterol. All of this will exacerbate existing conditions or create new health problems and ultimately increase MassHealth costs.

> *AB is an elder resident at a Boston-area nursing home and a MassHealth recipient. While she was recovering from an operation at a rehabilitation hospital, her dentures were removed and no longer fit after being out for several weeks. She entered a nursing home and after six months has finally qualified for Medicaid. She needs new dentures, but if she cannot see a dentist by January 1, 2003, Medicaid will not pay and AB will not be able to afford them.*

Comprehensive dental care is a critical part of quality health care. The administration should reverse this decision and restore adult dental benefits under MassHealth.

Table IV: MassHealth FY01 Expenditures for Dentures

Age	Expenditure
65 and older	$3,955,565
Age 21-64	$9,196,538
TOTAL	**$13,152,104**
TOTAL STATE SHARE	**$6,576,052**

Source: Massachusetts Division of Medical Assistance

D. Prosthetics and Orthotics

Prostheses are needed for people who lose a limb due to accident or illness or for those born without a limb. The average cost for a prosthetic leg is $6,000 for below the knee and $11,000 for above the knee. A prosthetic arm costs an average of $10,000. Prostheses also require serious maintenance. Prostheses must be replaced as the stump continues to change in size and shape, and they deteriorate from continual use. If prostheses are not properly cared for they can cause skin infections, which may result in decreased functionality and an increased need for medical care. Generally, prostheses are replaced every one to three years.

While the overall number of MassHealth beneficiaries receiving prostheses is small, their quality of life would be seriously compromised without them. Without proper prostheses a patient faces the prospect of increased disability, related hospitalizations, sores, infections, emergency department visits, increased use of medication, continuing pain and perhaps a loss of independence.

[18] Robert Alconada, Massachusetts Dental Society, Division of Health Care Finance and Policy hearing, April 9, 2002.
[19] Centers on Disease Control and Prevention.
[20] Journal of the American Dental Association, November, 2001 as cited on American Dental Association web site, April, 2002.

Orthotic braces range from foot insoles and ankle braces to neck and back braces. Some braces are custom fitted, for instance to treat scoliosis or a fractured spine. The need for orthotic braces may be short-term, during rehabilitation, or permanent for a chronic condition. Specialized braces are often made from special plastics and metals and can cost anywhere from $1,000 to over $3,000.

JB is a woman on CommonHealth who works part-time as an Avon representative. She depends on orthopedic braces with custom-made shoes to function. One foot is very crooked and the other foot is weak. Without the shoes she cannot stand. Each of the shoes costs $500, and she will not be able to afford the shoes after MassHealth stops covering them on January 1st. She feels that without her shoes it will be harder to keep working.

Table V: MassHealth FY01 Expenditures for Prosthetics and Orthotics based on Provider or Dispensing Agency

Provider/Dispensing Agency	Age	Expenditure
Prosthetics Supplier	65 and older	$245,705
	Ages 21 – 64	$2,077,038
	Total	$2,322,744
Physician	65 and older	$53
	Ages 21 – 64	$103
	Total	$156
Pharmacist	65 and older	$1,141,194
	Ages 21 – 64	$1,423,081
	Total	$2,564,275
Podiatrist	65 and older	$10,760
	Ages 21 – 64	$26,792
	Total	$37,552
Durable Medical Equipment Provider	65 and older	$30,733
	Ages 21 – 64	$77,482
	Total	$108,216
Orthotics Supplier	65 and older	$115,082
	Ages 21 – 64	$393,438
	Total	$508,521
Group Practice	65 and older	$622
	Ages 21 – 64	$42
	Total	$665
TOTAL		**$5,542,129**
TOTAL STATE SHARE		**$2,771,064**

Source: Massachusetts Division of Medical Assistance

E. Chiropractic Therapy

MassHealth spent $763,000 on chiropractic services in Fiscal Year 2001. Chiropractic manipulation, also frequently called chiropractic adjustment, is the manipulation of the spine to treat a variety of musculoskeletal problems. It has been recommended by the Agency for Health Care Policy as the only safe, effective and drugless form of initial treatment for lower back problems in adults.[21] Lower back problems affect half of all working Americans and are the leading cause of temporary disability in people under age 45. Additionally, work-related neuromusculoskeletal disorders make up more than one third of worker compensation costs and are responsible for a third of all workday losses.[22]

It is estimated that the cost of the care given by medical professionals to sufferers of back problems is $50 billion a year.[23] Because chiropractors can offer in-house x-rays, ultrasounds and treatment, they tend to provide less costly care than doctors and surgeons. Additionally, hospitalization and medication costs are lower for chiropractic care than medical care, patients are diagnosed and treated in less time by chiropractors than by medical doctors, and patients treated by chiropractors miss fewer days of work than those treated by medical doctors.[24]

Table VI: MassHealth FY01 Expenditures for Chiropractic Services

Age	Expenditure
65 and older	$25,004
Age 21-64	$737,890
TOTAL	**$762,894**
TOTAL STATE SHARE	**$381,447**

Source: Massachusetts Division of Medical Assistance

F. Eyeglasses

Eyeglasses are the primary means to correct vision problems, including diabetes, glaucoma or other aging related vision issues. While MassHealth beneficiaries will continue to cover vision screening and medical eye care, eyeglasses, the main prescription for vision care, will no longer be available.

There are several illnesses which cause vision to deteriorate, including diabetes and glaucoma. Eyeglasses in both instances can help mitigate the impact of vision loss.

Decreased vision capacity can increase utilization of emergency rooms due to falls and confusion from lack of sight.[25] The injuries or lack of independence can also lead to increased nursing home or long term care placements.

[21] American Chiropractic Association; www.amerchiro.org.
[22] A Rudimentary Shift in Health Care Delivery and Demand, pg. 1.
[23] American Chiropractic Association; www.amerchiro.org.
[24] A Rudimentary Shift in Health Care and Demand, pg. 2.
[25] Mass Society of Optometrists

Table VII: MassHealth FY01 Expenditures for Eyeglasses

Age	Expenditure
65 and older	$309,022
Age 21-64	$1,133,287
TOTAL	**$1,442,309**
TOTAL STATE SHARE	**$721,154**

Source: Massachusetts Division of Medical Assistance

Table VIII: MassHealth FY01 Expenditures for Dispensing Fees for Eyeglasses

Provider/Dispensing Agency	Age	Expenditure
Optometrist	65 and older	$317,528
	Ages 21 – 64	$740,074
	Total	$1,057,602
Optician	65 and older	$8,808
	Ages 21 – 64	$59,893
	Total	$68,702
Optometry School	65 and older	$3,819
	Ages 21 – 64	$19,916
	Total	$23,736
TOTAL		**$1,150,040**
TOTAL STATE SHARE		**$575,020**

Source: Massachusetts Division of Medical Assistance

G. Increased co-payments

Increasing co-payments is often suggested as a strategy for reducing MassHealth spending and as an alternative to reducing eligibility or eliminating benefits. However, increasing co-payments in low-income populations is likely to reduce the efficiency and efficacy of the health care system and place an additional burden on health care providers while saving nothing, or even increasing costs, for the state.

Increasing co-payments to MassHealth recipients seems like a simple mechanism for controlling costs, but it not likely to be successful. Many studies have found that co-payments result in low-income people not utilizing necessary services. Even modest increases in co-payments have been shown to result in adverse outcomes for low-income people, and have actually cost states more money, as people forgo necessary and effective care.[26]

The specific effect of co-payments on MassHealth may be to increase spending. An analysis by the RAND Corporation found just this effect as a result of increased cost sharing for physician services in the CA Medicaid program. While co-payments did reduce the utilization of physician services, utilization of hospital care increased, leading to a net increase in spending overall. In New Hampshire, increasing co-payments and

[26] Newhouse, et al. "Copayments and the Demand for Medical Care: the California Medicaid Experience." Bell Journal of Economics (Spring 1978). See also, Stuart and Zacker. "Who Bears the Burden of Medicaid Drug Copayment Policies." Health Affairs (March-April, 1999).

creating other barriers to prescription drug access led to increased use of mental health and long term care services. A study of the effect of cost sharing in Quebec province on the elderly and the poor also found that adverse effects associated with reductions in use of essential drugs doubled and led to a significant increase in emergency room use. In addition, they disproportionately impact the sickest individuals who tend to use the most services and thus incur the most co-payments.

Insofar as co-payments are collected by providers, they can be viewed as an indirect rate reduction – when people don't pay them the provider absorbs the cost. They are a particularly inefficient means to accomplish this doubtful end, and lead to more administrative work for overburdened providers.

Increasing co-payments have the potential to harm a patients' health without doing any good for the state budget. In addition, co-payments impose additional costs on providers, both in the form of more administrative hassle and because services must be provided whether a co-payment is made or not.

V. Children's Medical Security Plan

In the FY03 budget, the legislature did not provide adequate funding to the Children's Medical Security Plan (CMSP), administered by the Department of Public Health. In addition enrollment has increased faster than anticipated due to the downturn in the economy. More families seek out coverage from CMSP when they either lose their jobs or their employers drop coverage or increase cost-sharing. As a result, the program closed enrollment on November 4, 2002 and will remain capped at 26,000 enrollees. At the end of October, the program was covering 27,600 children. Further, the program eliminated coverage of emergency services for all children enrolled.

The Children's Medical Security Plan was originally the Healthy Kids program. Created in the early 1990's as a basic preventive health program for children ages 0-6, it has expanded over the years to be somewhat more comprehensive – limited prescription, dental, and mental health coverage along with well-child and sick care visits – and include children through age 18. Children with family incomes below 200% of the federal poverty level (FPL) pay nothing for this coverage, children between 200-400% FPL pay for part of their coverage through monthly premiums and co-pays and children with family incomes over 400% FPL pay the full amount for coverage. CMSP members receive their hospitalization through the Uncompensated Care Pool.

Closing CMSP marks the end of Massachusetts' commitment to making health insurance available to all of the Commonwealth's children. CMSP is the program that grants all children, regardless of age, income or disability, access to health insurance. Any family calling to enroll in the program will be placed on a waiting list until the number served drops below 26,000. Once this occurs, children will be enrolled only as others withdraw. Without this insurance, children through the age of 18 will no longer be able to go to the doctor when they have an ear infection, see a dentist or access vision care.

VI. Recommendations to Save Costs and Stabilize Funding

We call on the new Administration to work toward solutions that could reverse the actions taken by Governor Swift to eliminate essential services for MassHealth members. The income eligibility limits for MassHealth—generally about $11,784 for an individual or $30,038 for a family of three—mean that these beneficiaries cannot pay out of pocket for dentures, prostheses and other expensive services that have been eliminated. We also ask that the new administration work with the legislature to find alternatives to closing the MassHealth Basic program to 50,000 members.

We offer the following recommendations, some of which are discussed in detail in Health Care For All's report, "The Facts on MassHealth: What it is. Why it works." (www.hcfama.org/masshealthreport.html).

Seek more federal dollars to support Medicaid.
In his campaign, Governor-elect Romney proposed to seek additional federal matching funds for MassHealth. There is currently a proposal in Congress to temporarily increase the Federal Medical Assistance Percentage (FMAP)—the federal match rate--to address the current downturn in states' budget revenues. The new administration could play an important role in supporting action by Congress and the Bush administration to pass this federal initiative, which could bring in an estimated $164.5 million to Massachusetts over the next year. Massachusetts would benefit from additional and continuing efforts in this arena to stabilize MassHealth.

Maximize MassHealth Federal Financial Participation Revenue.
While many major revenue maximization strategies to increase Federal Financial Participation funds have already been implemented, further projects should be shifted out of the Division of Medical Assistance's jurisdiction and into an Executive Branch office (either the Health and Human Services or Administration and Finance). This would minimize inter-agency disputes and assure a comprehensive perspective on budget issues.

Avoid Preventable Hospitalization.
Targeted initiatives should be encouraged to decrease preventable hospitalizations. Diverting "stuck kids" (those in psychiatric beds but ready for discharge and receiving hospital-level care) into community-based services is one possibility. The Mini-grants program, which supports community based outreach and enrollment activities, has also proven effective in linking people to community providers. Care coordination models that better organize quality care for high-risk or high-cost patients should also be explored.

Control Pharmaceutical Costs.
With pharmacy costs growing at an unsustainable rate, a variety of measures, some in progress, should be taken to restrain cost increases in this area. Such measures include bringing the cost of the Pharmacy Advantage program under Mass Health for low-income seniors, and exploring whether or not fair prices are being paid for pharmaceuticals.

Support Targeted Fraud and Overpayment Initiatives.
Overpayment and fraud hurt all citizens. The legislative task force and the Attorney General should be supported in their pursuit of stopping these practices, but should assure that providers are not harassed.

VII. Conclusion

These cuts in benefits and increases in cost-sharing are unlikely to result in significant cost savings. They have the potential to destabilize the health care system and result in very low-income residents going without essential care or utilizing more expensive services. Because of the federal matching system, Massachusetts will forgo significant federal funding, and will drive people into the Uncompensated Care Pool, which receives only a capped federal contribution. This cost-shifting will weaken an already fragile health care delivery system and will reduce the ability of the system to care for everyone, both MassHealth members and the general population. Similarly, increased reliance by the newly uninsured on emergency rooms will exacerbate existing problems with overcrowding and diversions, to the detriment of all. As detailed, the economic impact is significant. In addition, when specific services are eliminated, they are often replaced by more expensive, less tailored alternatives. We should avoid dismantling as a whole or in pieces a program that works well and provides critical services to a million Massachusetts residents.

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Questions regarding this briefing paper or Health Care For All's efforts to defend MassHealth and other access programs can be directed to Allison Staton, Manager, State-Wide Division at either 617-275-2927 or staton@hcfama.org.

BOX ES-1
Review of Committee Findings

This is a brief overview of the Committee's specific findings regarding the effects of insurance on the health of American adults. The Committee's overall conclusions are presented at the end of the Executive Summary.

Prevention and Screening

• Uninsured adults are less likely than adults with any kind of health coverage to receive preventive and screening services and to receive them on a timely basis. Health insurance that provides coverage of preventive and screening services is likely to result in greater and more appropriate use of these services.
• Health insurance would likely reduce racial and ethnic disparities in the recelpt of preventive and screening services.

Cancer

• Uninsured cancer patients generally are in poorer health and are more likely to die prematurely than persons with insurance, largely because of delayed diagnosis. This finding is supported by population-based studies of persons with breast, cervical, colorectal, and prostate cancer and melanoma.

Chronic Illness

• Uninsured adults living with chronic diseases are less likely to receive appropriate care to manage their health conditions than an- those who have health insurance. For the five disease conditions that the Committee examined (diabetes, cardiovascular disease, end-stage renal disease, HIV infection, and mental illness), uninsured patients have consistently worse clinical outcomes than insured patients.
• Uninsured adults with diabetes are less likely to receive recommended services. Lacking health insurance for longer periods increases the risk of inadequate care for this condition and can lead to uncontrolled blood sugar levels, which, over time, put diabetics at risk for additional chronic disease and disability.
• Uninsured adults with hypertension or high blood cholesterol have diminished access to care, are less likely to be screened, are less likely to take prescription medication if diagnosed, and experience worse health outcomes.
• Uninsured patients with end-stage renal disease begin dialysis with more severe disease than do those who had insurance before beginning dialysis.
• Uninsured adults with HIV infection are less likely to receive highly effective medications that have been shown to improve survival and die sooner than those with coverage.
• Adults with health insurance that covers any mental health treatment are more likely to receive mental health services and care consistent with clinical practice guidelines than are those without any health insurance or with insurance that does not cover mental health conditions.

Hospital-Based Care

• Uninsured patients who are hospitalized for a range of conditions are more likely to die in the hospital, to receive fewer services when admitted, and to experience substandard care and resultant injury than are insured patients.
• Uninsured persons with trauma are less likely to be admitted to the hospital, more likely to receive fewer services when admitted, and are more likely to die than are insured trauma victims.
• Uninsured patients with acute cardiovascular disease are less likely to be admitted to a hospital that performs angiography or revascularization procedures, are less likely to receive these diagnostic and treatment procedures, and are more likely to die in the short term. Health insurance reduces the disparity in receipt of these services by members of racial and ethnic minority groups.

General Health Status

• Relatively short (one- to four-year) longitudinal studies document relatively greater decreases in general health status measures for uninsured adults and for those who lost insurance coverage during the period studied than for those with continuous coverage.
• Longitudinal population-based studies of the mortality of uninsured and privately insured adults reveal a higher risk of dying prematurely for those who were uninsured at the beginning of the study than for those who initially had private coverage.

Executive Summary

This report, the second in a series of six planned by the Institute of Medicine (TOM) Committee on the Consequences of Uninsurance, examines the relationship between being insured or uninsured and the health of American adults. Care *Without Coverage: Too Little, Too Late* follows the issuance last October of Coverage *Matters: Insurance and Health Care,* which provided an overview of health insurance in the United States, described the dynamic and frequently unstable nature of coverage, and delineated the extent of uninsurance and the characteristics of Americans who are most likely to be uninsured. Over the next 15 months the Committee will issue reports on family, community, and economic impacts of uninsurance and, last, a report that identifies models and strategies for addressing the problem of uninsurance.

Contrary to popular belief, Americans who do not have health insurance are at risk for poorer health as a result of their lack of coverage, In its first report, *Coverage Matters: Insurance and Health Care,* the Committee presented several popular myths about the lack of health insurance that indicated considerable public misunderstanding about the importance of coverage, which has hampered efforts to advance solutions. in 1999 almost 60 percent of the public believed that uninsured people get the health care they need from doctors and hospitals. The reality is that those without health insurance are much more likely to go without care than are people who have insurance (TOM, 2001 a). In this report, the Committee examines whether this reduced access to care results in less appropriate care and poor health consequences.

Ascertaining whether health insurance improves health outcomes is critical to shaping public policy about health insurance and the financing of health care more generally. The strongest research studies consistently show that working-age Americans (those between 18 and 65) who do not have health insurance have

poorer health and die prematurely. The Committee concludes that if these roughly 30 million working-age Americans were to become insured on a continuous basis, their health would be expected to improve.

Increasingly, clinical and health services research provides evidence that receiving too little medical care or receiving it too late has harmful effects for those without health insurance. These effects could be ameliorated through the enhanced access to care that insurance provides. In this report the Cointnittee weighs the evidence of the effect of being uninsured on health-related outcomes for adults and considers the potential benefits of extending health insurance to adults without it. In a subsequent report, the Committee will examine comparable studies focused on children.

Being uninsured is associated with a variety of worse health-related outcomes, including the following:

- less frequent or no use of cancer screening tests resulting in delayed diagnosis and premature mortality for cancer patients (Ayanian et al., 1993; Roetzheim et al., 1999, 2000a, 2000b; Ferrante et al., 2000; Breen et al., 2001; Perkins et al., 2001);
- care that does not meet professionally recommended standards for the rnanagement of chronic disease, for example, the failure of persons with diabetes to receive timely eye and foot exams to prevent blindness and amputations (Beckles et al., 1998; Ayanian et al., 2000);
- lack of access to and maintenance of appropriate medication regimens for persons with hypertension or HIV infection (W.E. Cunningham et al., 1995, 1999, 2000; Shapiro et al., 1999; Huttin et al., 2000; Goldman et al., 2001); and
- fewer diagnostic and treatment services for trauma or heart attacks and an increased risk of death when in the hospital (Haas and Goldman, 1994; Blustein et al., 1995; Canto et al., 1999, 2000; Doyle, 2001).

The health benefits of having insurance are even stronger when continuity of coverage is taken into account. Being uninsured for relatively short periods (one to four years) appear' to result in a decrease in genet-al health status. When followed over longer periods of time, uninsured adults have been found to be at higher risk of premature death than are persons with private coverage (Lurie et al., 1984, 1986; Franks et al., 1993a; Sorlie et al., 1994; Baker et al., 2001).

Additionally, the potential health benefits of having insurance are magnified when vulnerable populations, already at increased risk of worse health, receive coverage. These vulnerable groups include adults who are

- chronically ill (especially between the ages of 55 and 64 years),
- living with severe mental illness,
- members of racial and ethnic minority groups, and
- of lower socioeconomic status.

Based on the preponderance of evidence, the Committee concludes that

• the health of uninsured adults is worse than it would otherwise be if they were insured,

• providing health insurance to uninsured adults would result in improved health, including greater life expectancy, and

• increased rates of health insurance coverage would especially improve the health of those in the poorest health and most disadvantaged in terms of access to care and thus would likely reduce health disparities among racial and ethnic groups.

ASSESSING THE IMPACT OF HEALTH INSURANCE ON HEALTH

The Committee reached these conclusions after a review that used explicit criteria to select and evaluate the best-designed research studies investigating the health of working-age adults with arid without health insurance. To be selected, studies had to consider (1) an individual's health insurance status as an independent variable or "predictor," and (2) the effect of insurance status oil one or inure health-related outcomes for adults ages 18 through 64. A subsequent report will review the effects of health insurance coverage oil children arid oil pregnant women. Studies that focus primarily on adults 65 years and older were excluded because virtually all in this age group have health insurance coverage through the federal Medicare program.[1]

This report uses specific definitions of insurance and of the terms of coverage. "Insured adults" means those with general medical and hospitalization insurance, while "uninsured adults" are persons without any health insurance. The Committee has not explicitly considered those who may be inadequately insured ("underinsured"). Although the Committee did not examine studies comparing benefit packages among those with insurance or set out to analyze distinctions among kinds of health insurance, the literature led it to consider some features of health insurance that appear to affect health outcomes. For example, distinctive results from studies that compared those with private and public health insurance point to characteristics such as continuity of coverage and coverage of prescription drugs as important factors. The Committee paid particular attention to studies that examined the length of time participants were uninsured to determine whether and how that factor affected health.

[1] 'While Medicare: covers hospitalisations, physician, and other outpatient services including rehabilitative therapies and home health care, it does not cover most outpatiet prescription drugs near does it comer nonrehabilitative long-terra care.

Because most of the evidence comes from studies that are observational rather than experimental, interpreting the evidence about the value of coverage for health outcomes requires application of careful standards of analysis arid review. Consequently, analytical adjustments are required to account for potential biases related to variation among study subjects in lengths of tithe uninsured, types of health insurance coverage, and characteristics of study participants that correlate with health insurance status whose effects can be confused or confounded with those of insurance.

Three characteristics of individuals are closely related to health insurance status and, :u a result, require analytic adjustment: health status, rice and ethnicity, and socioeconomic status. The strongest observational studies use adjustments to separate the effects of these characteristics from those of health insurance coverage. The Committee believes that the research literature likely understates the differences in health outcomes between insured and uninsured adults that can be attributed to health insurance. One of the shortcomings in the literature is a lack of information about the experience of those adults who do not seek care, whether insured or uninsured. Research that relies on administrative or clinical documentation of health care use cannot account for the experience of those who do not seek treatment, and uninsured adults are less likely to seek treatment than are insured adults. Thus, studies that rely on health care records to compare groups may actually overstate the utilization of services by uninsured populations.

Finding: Health insurance coverage is associated with better health outcomes for adults. It is also associated with having a regular source of care and with greater and more appropriate use of health services. These factors, in turn, improve the likelihood of disease screening and early detection, the management of chronic illness, and the effective treatment of acute conditions such as traumatic injury and heart attacks. The ultimate result is improved health outcomes.

Health insurance makes a difference in receipt of services arid health outcomes. Direct measures of health examined in studies include self-reported health status, morality, stage of disease at time of diagnosis, and physiologic measures (e.g., controlled blood pressure in persons with hypertension). Because direct measures of health outcomes are often hard to obtain inexpensively in large-scale studies, intermediate measures of health care processes are commonly used as proxies to assess the effect of health insurance on health. This report examines receipt of recommended services, for example, dilated eye exams annually for persons with diabetes and regular blood pressure checks for those with hypertension, that have been validated by professional guidelines and clinical effectiveness research.

Finding: Health insurance is most likely to improve health outcomes if it is continuous and links people to appropriate health care. When health insurance includes preventive and screening services, prescription drugs, and mental health care, it is more strongly associated with the receipt of appropriate care than when insurance does not have these features.

Adults without health insurance face serious shortcomings in access to care. The quality and length of life are distinctly different for insured and uninsured populations, with worse health status and shortened lives among uninsured adults. While having health insurance demonstrably increases use of services, more importantly, it also facilitates snore appropriate use of health care services. In prevention and chronic disease rnanagement for example, having health insurance greatly increases the likelihood of a regular source of care and of continuity in care, which in turn can improve health outcomes.

Finding: Increased health insurance coverage would likely reduce racial and ethnic disparities in the use of appropriate health care services and may also reduce disparities in morbidity and mortality among ethnic groups.

Members of different racial and ethnic groups differ in terms of health status, the likelihood of having health insurance, and the care that they receive (Haas and Adler, 2001; TOM, 2001 a, 2002; Mills, 2001). Health insurance does not eliminate all disparities among population groups in access to care or remediate all deficits in health status among minority populations. It does, however, facilitate receipt of preventive services, having a regular source of care, and improved quality of care.

EFFECTS OF HEALTH INSURANCE ON SPECIFIC HEALTH CONDITIONS

In the following discussion of health services and conditions, the evidence reviewed by the Committee is presented as follows:

- primary prevention and screening services;
- cancer care and outcomes;
- chronic disease care and outcomes (including diabetes, cardiovascular disease, end-stage renal disease, HIV infection, and mental illness);
- hospital-based care (including trauma care and care for coronary artery disease);
- general health outcomes.

Primary Prevention and Screening Services

Finding: Uninsured adults are less likely than adults with any kind of health coverage to receive preventive and screening services and to receive these services on a timely basis. Health insurance that provides more extensive coverage of preventive and screening services is likely to result in greater and more appropriate use of **these services.**

Uninsured adults are less likely than those with health insurance to receive preventive services such as mammograms, clinical breast exams, Pap tests, and colorectal screening (Powell-Griner et al., 1999; Ayanian et al., 2(100, Breen et al., 2001). The positive effect of having insurance is more evident with relatively costly services such as mammograms (Zambrans et al., 1999; Cununings cc al., 2000). Studies of particular ethnic groups find that health insurance is associated with the increased receipt of preventive services and an increased likelihood of having a regular source of care (Mandelblatt et al., 1999).

Generally, insurance benefits are less likely to include preventive and screening services than physician visits for acute care or diagnostic tests for symptomatic conditions. The more extensive the coverage of preventive services, the snore likely are health plan enrollees to receive these services (Faulkner and Schauffler, 1997). Yet even if people have health insurance that does not cover preventive services, they are snore likely to receive appropriate services than are those without any form of health insurance, partly because they are more likely to have a regular source of care or a primary provider.

Even after adjustments for age, race, education, and regular source of care, uninsured adults are less likely to receive timely screening for breast, cervical, or colorectal cancer. Once discovered, their cancer is likely to be at a more advanced stage.

Cancer Care and Outcomes

Finding: Uninsured cancer patients die sooner, on **average, than do persons with insurance, largely because of delayed diagnosis. This finding is supported by population-based studies of breast, cervical, colorectal, and prostate cancer and melanoma.**

Uninsured cancer patients more often fare poorly than do patients with coverage. A relatively advanced, often fatal, late stage of disease at the time of diagnosis is snore common among persons without insurance coverage, reflecting their reduced use of timely screening services. Uninsured persons with breast, colorectal, or prostate cancer are more likely to die prematurely from their disease than are patients with private health insurance. For example, uninsured women with breast cancer have a risk of dying that is between 30 and 50 percent higher

than the risk for women with private health insurance (Ayaniann et al., 1993; LeeFeldstein et al., 2000; Roetzheim et al., 2000x), and uninsured patients with colorectal cancer are about 50 percent more likely to die than are patients with private coverage, even when the cancer is diagnosed at similar stages (Roetzheirn et al., 2000b). This evidence comes from research using area or statewide cancer registries.

Uninsured adults with cancer might experience differences in treatment. For example, uninsured women with breast cancer are less likely than privately insured women to receive breast-conserving surgery (Roetzheim et al., 2000x). It should be noted, however, that disparities in treatment persist among racial and ethnic groups even if all have insurance (IOM, 2002).

Chronic Disease Care and Outcomes

Finding: Uninsured adults living with chronic diseases are less likely to receive appropriate care to manage their health conditions than are those who have health insurance. For all five disease conditions (in addition to cancer) that the Committee examined (diabetes, cardiovascular disease, end-stage renal disease, HIV infection and mental illness), uninsured patients have consistently worse clinical outcomes than do insured patients.

For persons living with a chronic illness, health insurance may be most important in enhancing opportunities to acquire a regular source of care and receive appropriate management of their condition. Identifying; chronic conditions early acrd providing; professionally recommended, cost-effective interventions on an ongoing and coordinated basis can improve health outcomes. Yet uninsured adults with chronic conditions are less likely to have a usual source of care or regular check-ups than are chronically ill persons with coverage (Ayanian et al., 2000; Fish-Parcharn, 2001).

Diabetes

Uninsured persons with diabetes are less likely to receive recommended services. Lacking health insurance for longer periods increases the risk of inadequate care for this condition and can lead to uncontrolled blood sugar levels, which, over time, put diabetics at risk for additional chronic disease and disability. Despite the demanding and costly care regimen that persons with diabetes face, adults with diabetes are almost as likely to be uninsured as adults without this disease (12 percent are uninsured compared to the general population uninsured rate of 15 percent [Harris, 19991.)

Uninsured adults with diabetes are less likely to receive the recommended professional standard of care than those with health insurance. For example, they are less likely to receive regular foot or dilated eye exams that are important in the

prevention of foot ulcers and blindness. Twenty-five percent of adults with diabetes who were uninsured for a year or more went without a checkup within the past two years, compared to 7 percent of diabetics who were uninsured for less than a year and 5 percent of diabetics with health insurance (Beckles et al., 1998; Ayanian et al., 2000).

Cardiovascular Disease

Uninsured adults with hypertension or high cholesterol have diminished access to care, are less likely to be screened, are less likely to take prescription medication if diagnosed, and experience worse health.

According to analyses of national health survey data, 19 percent of uninsured adults with heart disease and 13 percent with hypertension lack a usual source of care, compared to 8 and 4 percent, respectively, of their insured counterparts (Fish-Parchan, 2001). Uninsured adults have less frequent monitoring of blood pressure once they are diagnosed with hypertension and are less likely to stay on drug therapy than are insured adults who have hypertension (Huttin et al., 2000; Fish-Parchan, 2001).

Loss of insurance coverage disrupts therapeutic relationships arid worsens blood pressure control (Lurie et al., 1984, 1986). Deficits in care for uninsured adults with hypertension or high cholesterol place them at risk of complications and deterioration of their condition. For example, patients admitted to emergency departments with severe uncontrolled hypertension were more likely to be uninsured than socio-demographically similar patients with any insurance (Shea et al., 1992a, 1992b).

End-Stage Renal Disease

Uninsured patients have more severe renal failure when they begin dialysis than insured patients (Kausz et al., 2000). The clinical goals for patients with kidney disease are to slow the progression of renal failure, manage complications, and prevent or manage coexisting disease effectively. Uninsured patients are less likely than insured patients to have received treatment for related anemia before initiating dialysis, and their health status is already compromised by a greater likelihood of more severe anemia (Obrador et al., 1999).

The virtually universal qualification of end-stage renal disease (ESRD) patients for Medicare once dialysis or transplantation becomes necessary erases previously existing gender and racial or ethnic disparities in access to hospital-based care for ESRD patients with heart disease (Daumit et al., 1999, 2000).

Human Immunodeficiency Virus Infection

Uninsured adults, once diagnosed with HIV, face greater delays ill accessing appropriate care than those with health insurance and are more likely to forgo

needed care. Persons without health insurance have been shown to wait more than three months after diagnosis to have their first office visit and to wait an average of four months longer than privately insured patients to receive newer drug therapies (Turner et al., 2000). Furthermore, the uninsured with HIV are less likely to be able to maintain a recommended drug regimen over time (Cunningham et al., 2000).

Uninsured adults with HIV infection are less likely to receive highly effective medications that have become the standard of treatment within the past five years and been shown to improve survival (Carpenter et al., 19)6, 1998; Goldman et al., 2001). Having health insurance of any kind has been found to reduce mortality in HIV-infected adults by 71-85 percent over a six-month period, with the greater reduction found more recently when effective drug therapies were in more widespread use (Goldman et al., 2001).

Mental Illness

Adults with health insurance that covers any mental health treatment are more likely to receive mental health services and care consistent with clinical practice guidelines than are those without airy health insurance or with insurance that does not cover mental health conditions.

Mental illness represents a major but often underestimated source of disability and is equivalent to heart disease and cancer in terms of its impact. Depression and :anxiety disorders are often treatable in the general medical sector arid primarily require outpatient services. Severe mental illnesses (schizophrenia, other psychoses, and bipolar depression) require the attention of specialty mental health professionals arid may require more extensive services (e.g., inpatient services, partial or day hospitalization).

Receipt of appropriate care has been associated with improved functional outcomes for depression and anxiety disorders, yet the uninsured are less likely to receive this degree of care. Patients without health insurance for mental health visits who were diagnosed with depression, panic disorder, or generalized anxiety disorder were less likely to receive mental health services (Dross arid Rosenheck, 1998; Cooper-Patrick et al., 1999). When they did receive care, it was less likely to be appropriate (concordant with professional practice guidelines) (Wang et al., 2000; Young et al., 2001). Uninsured adults with severe mental illnesses also receive less appropriate care or medications and experience delays in receiving services until they gain public insurance coverage (Rabinowitz et al., 1998, 2001; McAlpine and Mechanic, 2000).

Even when health insurance does not specifically cover mental health services, having it increases the likelihood that someone with depression or anxiety will receive some care for the condition. Persons with a severe mental illness such as schizophrenia or bipolar disorder face difficulties in obtaining and then keeping health insurance after diagnosis. When they do have health insurance, especially public insurance (Medicare or Medicaid), they are more likely to receive specialty

mental health services than are severely ill persons without any health insurance or even patients with private insurance.

Hospital-Based Care

Finding: Uninsured patients who are hospitalized for a range of conditions are more likely to die in the hospital, to receive fewer services, and, when admitted, are more likely to experience substandard care and resultant injury than are insured patients.

Poorer health status for uninsured adults when they are hospitalized is compounded by their experiences as inpatients. Being uninsured is associated with the receipt of fewer needed services, worse quality care, and greater risk of dying in the hospital or shortly after discharge (Hadley et al., 1991; Burstin et al., 1992; Haas and Goldman, 1994; B1ustein et al., 1995; Doyle, 2001). Being uninsured and not having a regular source of care are also associated with delays in seeking care from the *emergency department* for a variety of conditions, delays that may compromise outcomes (e.g., rupture in acute appendicitis) (Braveman et al., 1994). *Because most* hospital-based studies are biased by the inclusion of self-selected patients who "show up" for care, the Committee decided to focus on two conditions-traumatic injuries arid acute cardiac events-for which roost people receive hospital care whether or not they are insured.

Traumatic Injuries

Uninsured persons with traumatic injuries are less likely to be admitted to the hospital, receive *fewer services* when admitted, and are more likely to die than are insured tratuna victims.

Provider response to traumatic injury can be influenced by insurance status. In one statewide study of uninsured auto accident victims, uninsured patients were found to receive less care and had a 37 percent higher mortality rate than did privately insured accident victims (Doyle, 2001). Another statewide study showed while uninsured trauma patients were as likely to receive intensive care unit services as privately insured patients, they were less likely to undergo operative procedures or receive physical therapy (Haas and Goldman, 1994).

Acute Cardiovascular Disease

Uninsured patients with acute cardiovascular disease are less likely to be admitted to a hospital that performs angiography or revascularization procedures, are less likely to receive these diagnostic and treatment procedures, and are snore likely to die in the short tern. Health insurance reduces the disparity in receipt of these services for women relative to men and for members of racial and ethnic minority groups (Carlisle et al., 1997; Daumit et al., 1999, 2000).

Insurance status influences the receipt of hospital-based treatments for cardiovascular disease (specifically, coronary artery disease). Uninsured patients hospitalized for acute myocardial infarction (heart attack) experience a greater risk of dying during their hospital stay or shortly thereafter than do patients with private insurance (Young and Cohen, 1991; Blustein et al., 1995; Canto et al., 2000).

The choice of hospital itself has significant effects on diagnosis, treatment, and health-related outcomes. Uninsured patients are less likely to be admitted to a hospital that performs angiography or cardiac revascularization (Leape et al., 1999) and are less likely to receive these diagnostic and treatment procedures regardless of hospital facilities (Canto et al., 1999). Insurance status has also been shown to influence access to transfer for revascularization (Blustein et al., 1995).

GENERAL HEALTH OUTCOMES

An uninsured adult's experiences with ambulatory and hospital care influence his or her health status in important ways over the short term and may lead to a premature death.

Health Status

Finding: Relatively short (one- to four-year) longitudinal studies document decreases in general health status measures for uninsured adults and for those who lost insurance coverage compared to persons with continuous coverage.

Like those with chronic health conditions, adults in late middle age are more likely to experience declines in function and health status if they lack or lose health insurance coverage (Baker et al., 2001). Changes in health status might include worsening control of blood pressure, decreased ability to walk or climb stairs, or decline of general self-perceived wellness and functioning. The effect of being uninsured oil self-reported health measures is greater for lower-income persons (Franks et al., 1993b).

Mortality

Finding: Longitudinal population-based studies of the mortality of uninsured and privately insured adults reveal a higher risk of dying for those who were uninsured at the beginning of the study than for those who initially had private coverage.

Longer-term population-based studies (from 5 to 17 year) find a 25 percent higher risk of dying for adults who were uninsured at the beginning of the study (Franks et al., 1993a; Sortie et al., 1994). These analyses of overall mortality are corroborated by the mortality experience of insured and uninsured patients with

heart attack, cancer, traumatic injury, and HIV infection (B1ustein et **ail., 1995;** Canto et al., 2000; Ayanian et al., 1993; Roetzheim et al., 2000a; Doyle, 2001; Goldman et al., 2001).

THE DIFFERENCE COVERAGE COULD MAKE TO THE HEALTH OF UNINSURED ADULTS

Particular groups of uninsured adults are more likely to experience poor health or barriers to care and thus can be expected to benefit more from gaining health insurance. These groups include uninsured adults who are chronically ill, persons with severe mental illness, members of some racial and ethnic minority groups, and persons with lower socioeconomic status. Many of the uninsured belong to one or more of these higher-risk groups.

The Committee bases the following summary conclusions on the substantial consistency of results among the methodologically strongest observational studies in its review and the coherence of these results with the behavioral research that informs the Committee's conceptual model of mechanisms by which health insurance affects health outcomes:

- **Having health insurance is associated with better health outcomes for adults and with their receipt of appropriate care across a range of preventive, chronic, and acute care services. Adults without health insurance coverage die sooner and experience greater declines in health status over time than do adults with continuous coverage.**
- **Adults with chronic conditions and those in late middle age stand to benefit the most from health insurance coverage in terms of improved health outcomes because of their high probability of needing health care services.**
- **. Population groups that most often lack stable health insurance coverage and that have worse health status, including racial and ethnic minorities and lower-income adults, would benefit most from increased health insurance coverage. Increased coverage would likely reduce some of the racial and ethnic disparities in the utilization of appropriate health care services and may also reduce disparities in morbidity and mortality among ethnic groups.**
- **Health insurance that affords access to providers and includes preventive and screening services, outpatient prescription drugs, and specialty mental health care is more likely to facilitate the receipt of appropriate care.**
- **Broad-based health insurance strategies across the entire uninsured population would be more likely to produce these benefits than would "rescue" programs aimed only at the seriously ill.**

What differences in health care utilization and outcomes would health insur-

ance make if the uninsured were provided with coverage? Despite the scarcity of experiments testing the impacts of providing health insurance to the previously uninsured, the Committee believes that the powerful and consistent observational evidence across a wide variety of populations and health conditions, corroborated by the few experimental and quasi-experimental studies that have been conducted, provides a reasonable basis for answering this question.

The key lies in the role health insurance can play in facilitating access to care and the timely and appropriate use of services. In addition, if uninsured adults were insured on a continuous basis, their health status would likely be better than it would be otherwise arid their risk of dying; prematurely would be reduced. The survival benefits derived from insurance coverage, however, can be achieved in full only when health insurance is acquired well before the development of advanced disease. The problem of later diagnosis and higher mortality among uninsured women with breast cancer, for example, cannot be solved by insuring; women once their disease is diagnosed (Perkins et al., 2001).

Finally, the evidence presented accounts only for some of the benefits and advantages that health insurance provides. Financial risk reduction and economic security are major benefits that accrue to everyone with coverage, whether or not they use it (IOM, 2001a). Patient satisfaction and the sense of being valued when professional and caring attention is provided in painful, stressful, or frightening circumstances are genuine, desirable outcomes. These qualities are more likely to be found in health care settings and healing relationships where one is confident of good access to health care providers' tune arid resources. Adults without health insurance are less likely to feel deserving of a physician's attention when they seek care, and indeed, uninsured adults are less likely to seek needed care than are those with health insurance. Financial security and stability, peace of mind, alleviation of pain and suffering, improved physical function, disabilities avoided or delayed, and gains in life expectancy constitute an array of health insurance benefits that accrue to members of our society who have health insurance. For many of the 40 million uninsured Americans, these benefits remain out of reach.

CANCER AND CARDIOVASCULAR DISEASE DISPARITIES AMONG BOSTON RESIDENTS

The Boston Public Health Commission
Thomas M. Menino, Mayor
John Auerbach, Executive Director

November 2002

Cancer and Cardiovascular Disease Disparities Among Boston Residents: Selected Behavioral Risk Factors

Percentage of Women Ages 40 and Over Who Ever Had a Mammogram, Boston 1997-1999

BOSTON	89.8%
White	90.4%
Black	93.6%
Hispanic	75.4%
Asian	*

*Insufficient sample size

Percentage of Women Ages 50 and Over Who Had a Mammogram in the Past 2 Years, Boston 1997-1999

BOSTON	85.5%
White	83.2%
Black	94.1%
Hispanic	86.2%
Asian	*

*Insufficient sample size

Percentage of Adults Ages 50 and Over Who Had a Blood Stool Test in Past 2 Years

BOSTON	33.9%
White	34.8%
Black	33.8%
Hispanic	30.9%
Asian	*

*Insufficient sample size

Percentage of Adults Ages 50 and Over Who Had a Sigmoidoscopy or Colonoscopy in Past 5 Years

BOSTON	32.9%
White	33.8%
Black	34.7%
Hispanic	22.2%
Asian	*

*Insufficient sample size

Percentage of Adults** Ever Told Had High Cholesterol
Boston, 1997 and 1999

BOSTON	20.9%
White	21.3%
Black	24.1%
Hispanic	19.1%
Asian	14.8%

**Among adults who were ever screened

Percentage of Adults Who Had Blood Cholesterol
Checked in the Past 5 Years, Boston 1997 and 1999

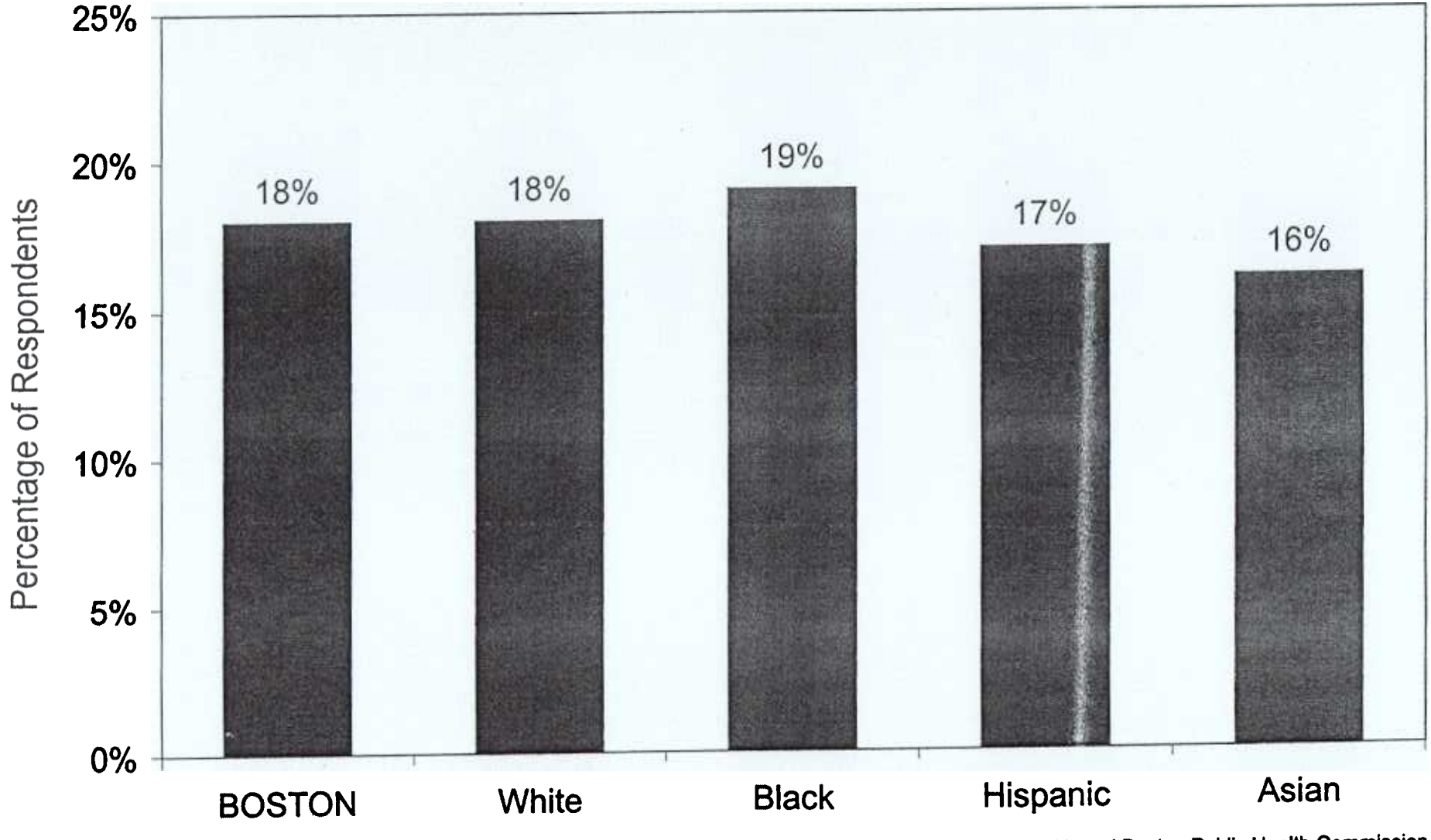
BOSTON	75.9%
White	77.9%
Black	74.7%
Hispanic	74.3%
Asian	65.2%

Percentage of Adults Ever Diagnosed with Heart Disease
Boston, 1997-1999

BOSTON	4.6%
White	5.4%
Black	4.2%
Hispanic	3.0%
Asian	1.7%

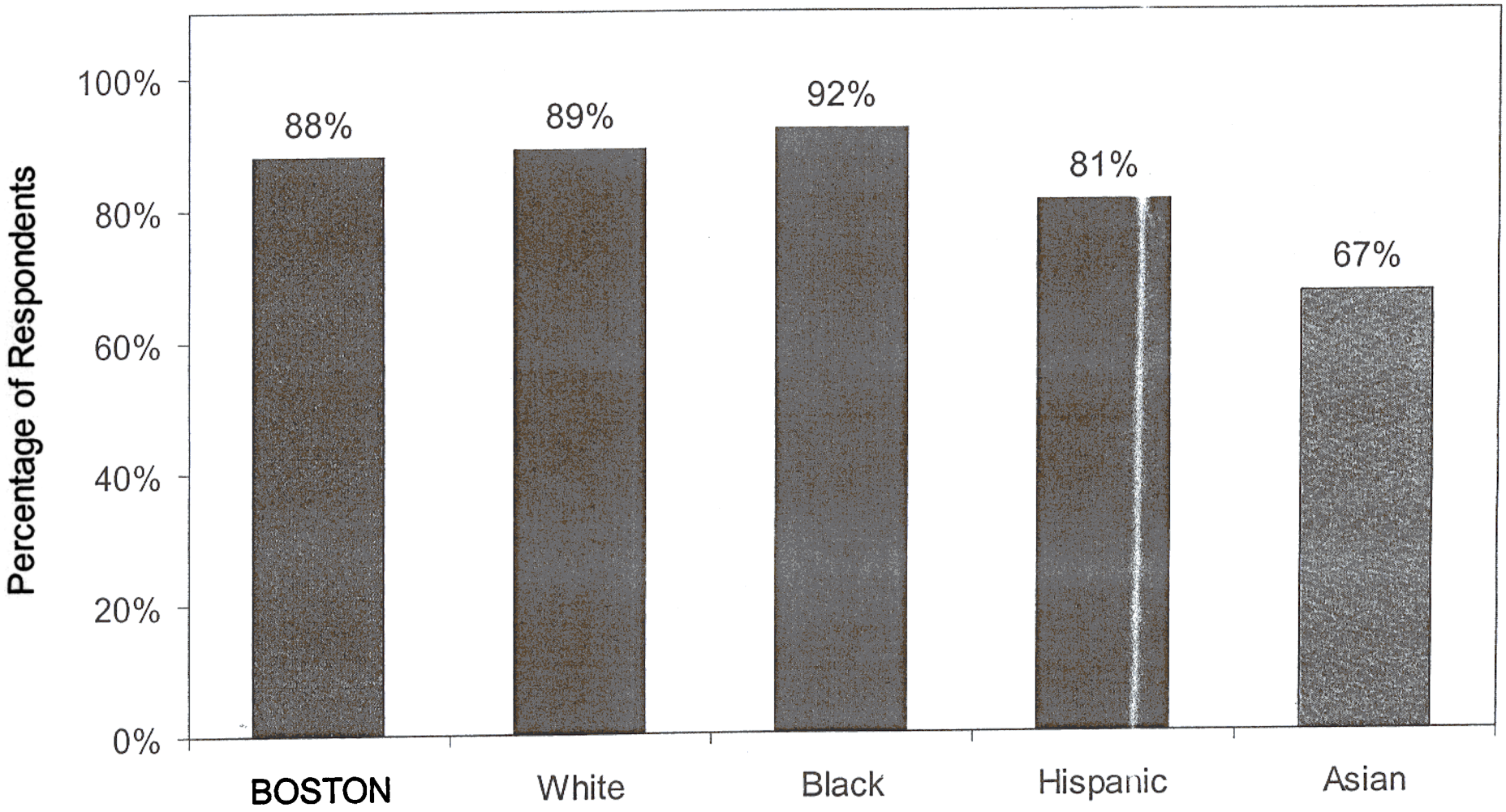
DATA SOURCE: Behavioral Risk Factor Surveillance System, 1997-1999,
Massachusetts Department of Public Health and Boston Public Health Commission

Percentage of Adults Who Are Current Smokers By Race/Ethnicity, Boston, 1997-1999



DATA SOURCE: Behavioral Risk Factor Surveillance System, 1998-1999, Massachusetts Department of Public Health and Boston Public Health Commission
GRAPHIC: Boston Public Health Commission, Research Office

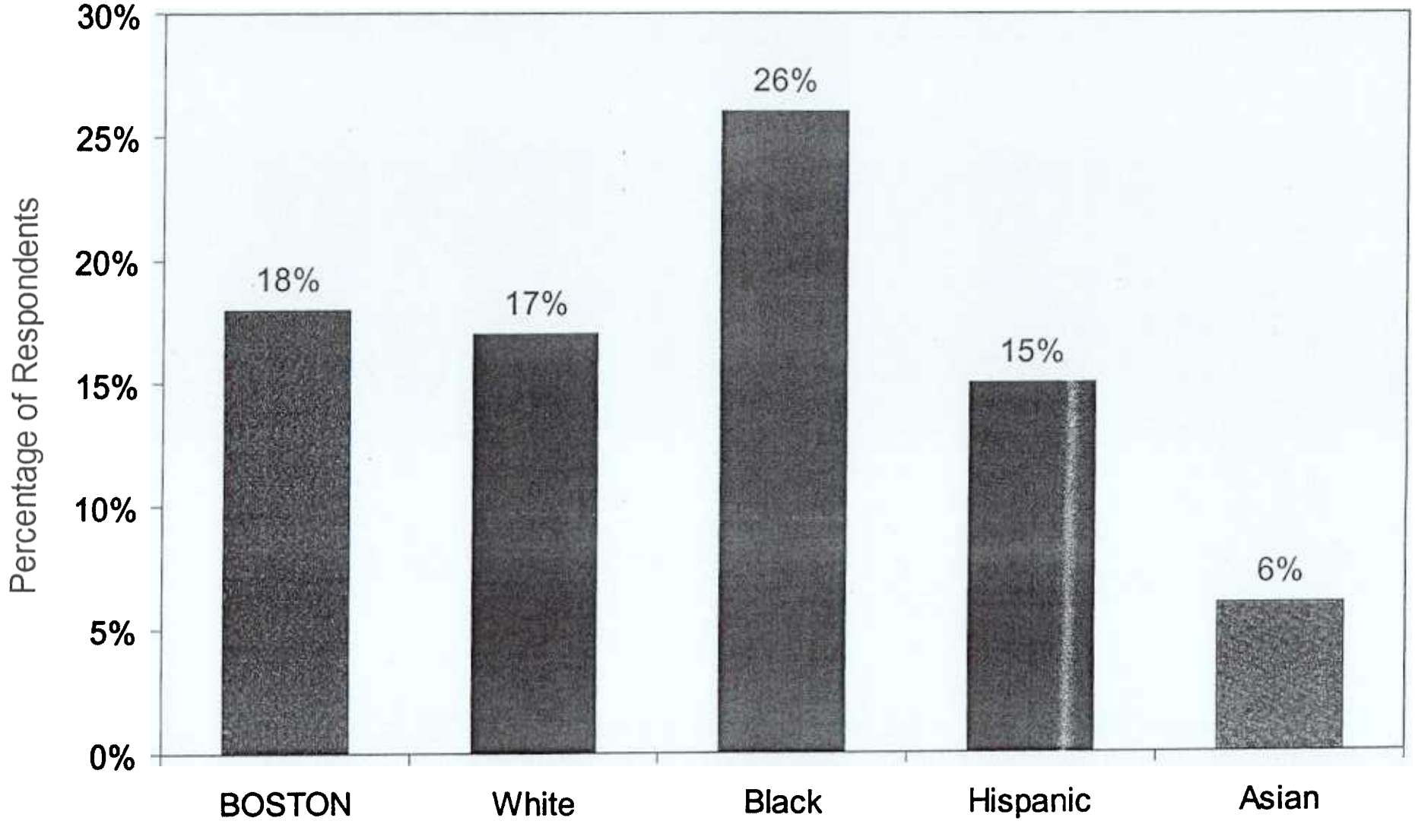
Percentage of Women Who had Cervica Cancer Screening In the Past Three Years By Race/Ethnicity, Boston, 1997-1999



DATA SOURCE: Behavioral Risk Factor Surveillance System, 1998-1999, Massachusetts Department of Public Health and Boston Public Health Commission

GRAPHIC: Boston Public Health Commission, Research Office

Percentage of Adults Ever Diagnosed with High Blood Pressure By Race/Ethnicity, Boston, 1997 and 1999



DATA SOURCE: Behavioral Risk Factor Surveillance System, 1998-1999, Massachusetts Department of Public Health and Boston Public Health Commission

GRAPHIC: Boston Public Health Commission, Research Office

Leading Causes of Death Age-Adjusted Rates by Race/Ethnicity, Boston, 2000

White

Leading Causes	Deaths per 100,000 Population
Cancer (All)	240.8
Heart Disease	230.6
Stroke	52.8
COPD	43.0
All Injuries Combined	42.0

Black

Leading Causes	Deaths per 100,000 Population
Cancer (All)	276.9
Heart Disease	224.8
Stroke	59.9
All Injuries Combined	55.4
Nephritis/Nephrosis	49.6

Hispanic

Leading Causes	Deaths per 100,000 Population
Cancer (All)	128.1
Heart Disease	63.3
Stroke	62.9
Diabetes	52.2
All Injuries Combined	20.8

Asian

Leading Causes	Deaths per 100,000 Population
Cancer (All)	112.8
Heart Disease	85.6
Stroke	53.6
COPD	21.7
All Injuries Combined	16.6

DATA SOURCE: Boston resident deaths, Massachusetts Department of Public Health. Rates are calculated using the US Census 2000 for resident population.

DATA ANALYSIS: Boston Public Health Commission, Research Office

Number of Deaths For the Leading Causes of Death by Race/Ethnicity, Boston, 2000

White

Leading Causes	Number of Deaths
Cancer (All)	764
Heart Disease	802
Stroke	190
COPD	148
All Injuries Combined	130

Black

Leading Causes	Number of Deaths
Cancer (All)	273
Heart Disease	216
Stroke	52
All Injuries Combined	72
Nephritis/Nephrosis	46

Hispanic

Leading Causes	Number of Deaths
Cancer (All)	39
Heart Disease	20
Stroke	13
Diabetes	14
All Injuries Combined	17

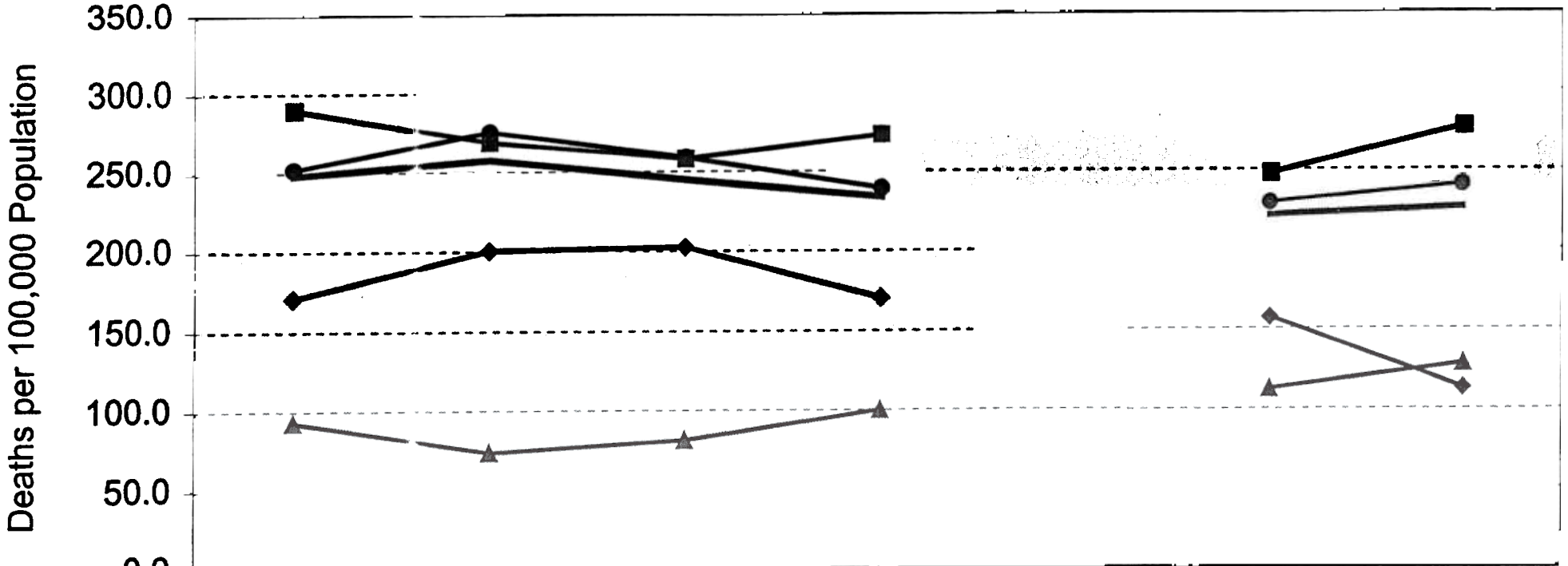
Asian

Leading Causes	Number of Deaths
Cancer (All)	33
Heart Disease	25
Stroke	15
COPD	6
All Injuries Combined	6

DATA SOURCE: Boston resident deaths, Massachusetts Department of Public Health. Rates are calculated using the US Census 2000 for resident population.

DATA ANALYSIS: Boston Public Health Commission, Research Office

Cancer Mortality Age-Adjusted Rates by Race/Ethnicity, Boston, 1995-2000



	1995	1996	1997	1998		1999	2000
White	251.7	274.8	258.6	239.0		229.8	240.8
Black	289.6	268.4	257.9	272.6		247.3	276.9
Hispanic	92.8	73.6	81.2	99.9		112.3	128.1
Asian	170.7	200.3	202.4	170.2		156.8	112.8
BOSTON	248.1	257.3	244.7	233.7		221.9	226.9

DATA SOURCE: Boston resident deaths, Massachusetts Department of Public Health. Rates are calculated using resident population estimates from MISER for 1991-1998, Massachusetts Department of Public Health 1999 Preliminary Population Estimates, and the US Census 2000 for resident population.

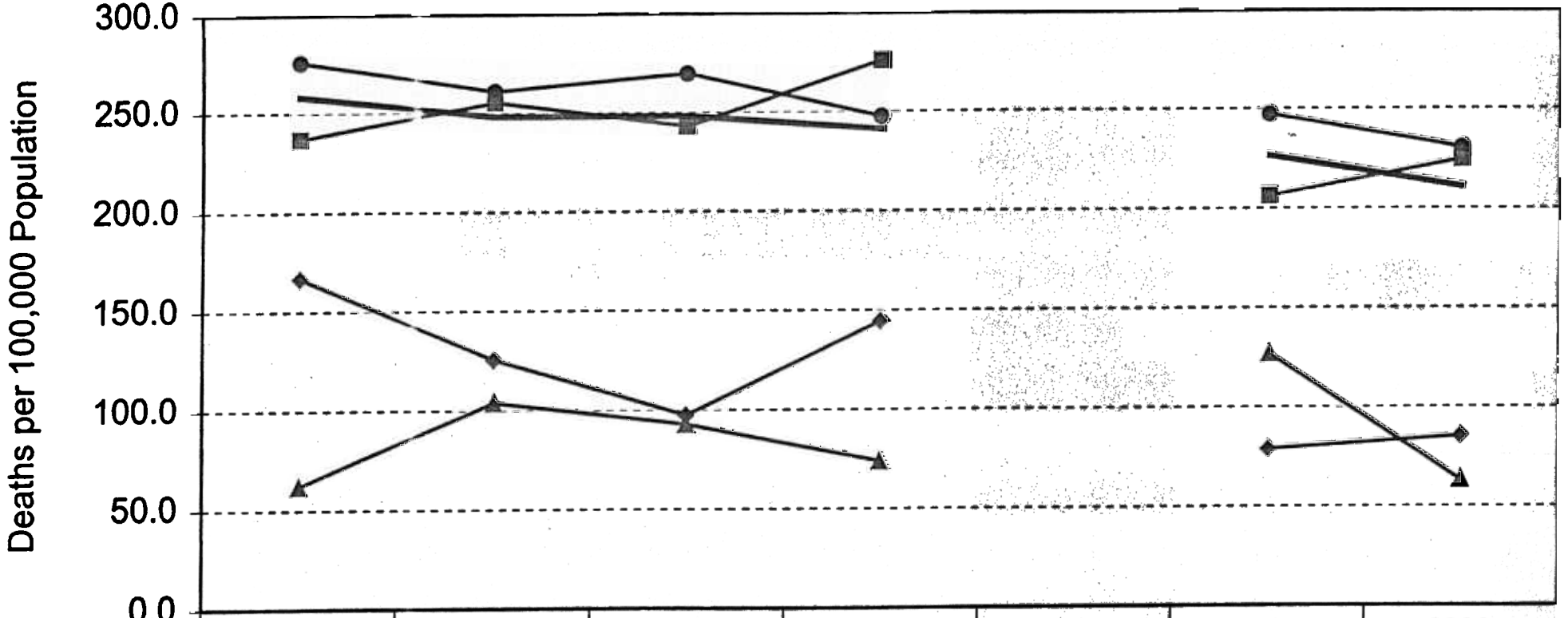
DATA ANALYSIS: Boston Public Health Commission, Research Office

Numbers

Number of deaths due to cancer by race/ethnicity, Boston, 1995-2000

White	820	861	801	742	740	764
Black	244	230	221	241	238	273
Hispanic	28	26	30	33	37	39
Asian	34	41	41	40	42	33
BOSTON	1128	1158	1094	1058	1057	1109

Heart Disease Mortality Age-Adjusted Rates by Race/Ethnicity, Boston, 1995-2000



	1995	1996	1997	1998		1999	2000
White	275.6	260.5	269.3	247.6		247.3	230.6
Black	236.9	255.1	242.8	275.7		206.6	224.8
Hispanic	62.1	103.8	92.8	73.9		126.7	63.3
Asian	166.5	125.3	97.4	144.2		79.0	85.6
BOSTON	258.2	247.9	248.0	241.2		226.6	211.1

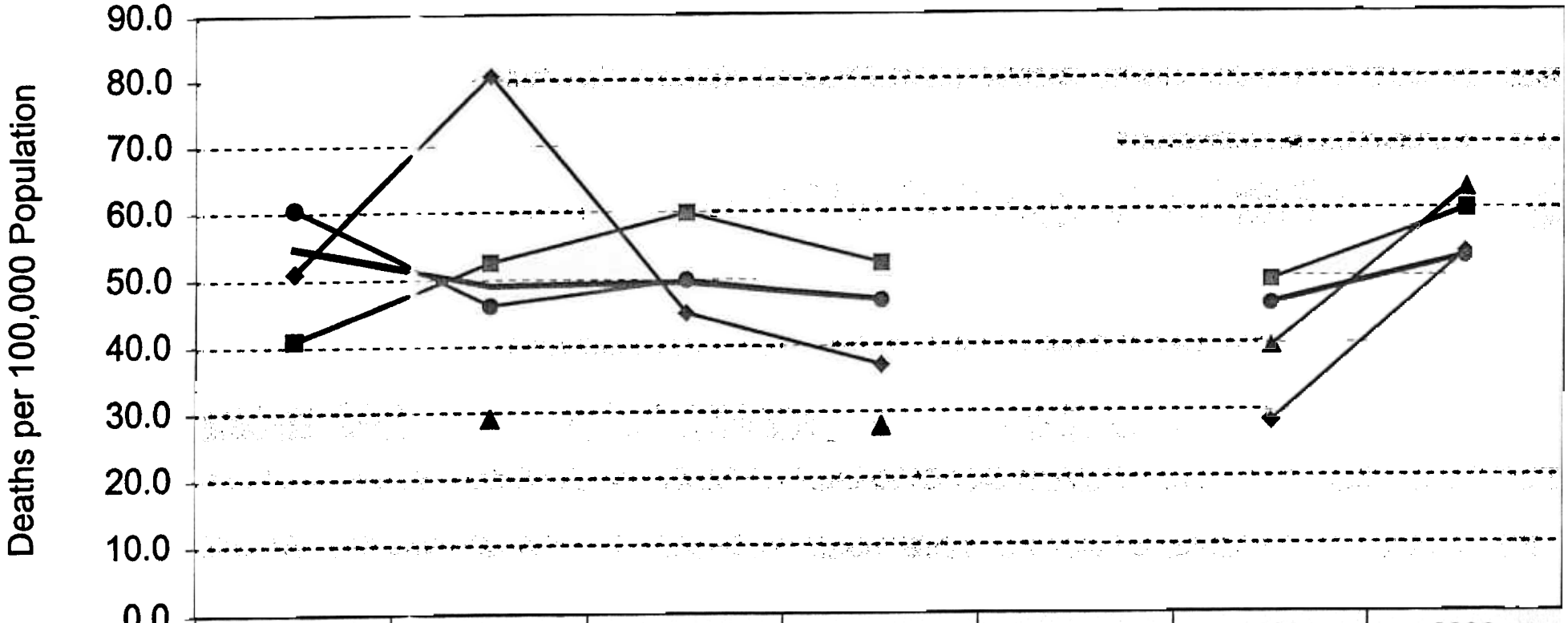
DATA SOURCE: Boston resident deaths, Massachusetts Department of Public Health. Rates are calculated using resident population estimates from MISER for 1991-1998, Massachusetts Department of Public Health 1999 Preliminary Population Estimates, and the US Census 2000 for resident population.

DATA ANALYSIS: Boston Public Health Commission, Research Office

Number of deaths due to heart disease by race/ethnicity, Boston, 1995-2000

			1997			
White	999	933	948	887	888	802
Black	199	209	204	241	190	216
Hispanic	19	30	29	26	39	20
Asian	30	24	20	31	21	25
BOSTON	1,247	1,196	1,201	1,185	1,138	1,067

Stroke Mortality Age-Adjusted Rates by Race/Ethnicity, Boston, 1995-2000



	1995	1996	1997	1998		1999	2000
White	60.5	46.1	49.9	46.8		46.0	52.8
Black	41.0	52.5	59.8	52.2		49.5	59.9
Hispanic	n<5	29.0	n<5	27.6		39.5	62.9
Asian	51.0	80.5	45.0	37.1		28.4	53.6
BOSTON	54.7	49.1	49.5	46.9		46.1	52.9

DATA SOURCE: Boston resident deaths, Massachusetts Department of Public Health. Rates are calculated using resident population estimates from MISER for 1991-1998, Massachusetts Department of Public Health 1999 Preliminary Population Estimates, and the US Census 2000 for resident population.

DATA ANALYSIS: Boston Public Health Commission, Research Office

Number of deaths due to stroke by race/ethnicity, Boston, 1995-2000

	1995	1996	1997	1998	1999	2000
White	230	180	182	177	177	190
Black	33	41	51	44	43	52
Hispanic	2	8	4	9	12	13
Asian	9	15	9	8	7	15
BOSTON	274	245	246	238	239	270

Cervical cancer mortality age-adjusted rates by race/ethnicity, Boston, 1999-2000

	Number	Age-adjusted rate (deaths per 100,000 population)
White, non-Hispanic	7	2.2
Black, non-Hispanic	11	8.4
Hispanic	0	0.0
Asian/Pacific Islander	1	n<5
Boston	19	3.3

NOTE: Cause of death based on ICD-10 codes. Age-adjusted to the 2000 US standard population
DATA SOURCE: Boston resident deaths, Massachusetts Department of Public Health
DATA ANALYSIS: Boston Public Health Commission, Research Office

Colorectal cancer mortality, age-adjusted rates (deaths per 100,000 population), by race/ethnicity, Boston, 1995-2000

	1995	1996	1997	1998	1999	2000
White	32.6	25.4	34.1	23.2	21.7	26.0
Black	28.6	34.4	35.0	28.5	28.1	24.4
Hispanic	23.6	---	---	17.2	15.1	---
Asian	---	---	---	---	---	---
BOSTON	30.9	25.2	31.7	23.8	22.4	23.0

NOTE: If there were less than five deaths, a rate was not calculated.

DATA SOURCE: Boston resident deaths, Massachusetts Department of Public Health. Rates are calculated using resident population estimates from MISER for 1991-1998, Massachusetts Department of Public Health 1999 Preliminary Population Estimates, and the US Census 2000 for resident population.

DATA ANALYSIS: Boston Public Health Commission, Research Office

Number of deaths due to colorectal cancer by race/ethnicity, Boston, 1995-2000

	1995					
White	113	84	112	76	75	87
Black	23	28	29	25	26	22
Hispanic	6	1	2	5	5	3
Asian	2	3	2	4	4	1
BOSTON	144	116	145	110	110	113

Breast cancer mortality, age-adjusted rates (deaths per 100,000 population), by race/ethnicity, Boston, 1995-2000

	1995	1996	1997	1998	1999	2000
White	32.4	40.0	41.9	30.5	23.5	30.1
Black	39.5	30.7	29.1	36.1	21.0	34.7
Hispanic	---	---	---	---	---	---
Asian	---	---	---	---	---	---
BOSTON	32.6	36.6	36.7	29.0	23.6	29.0

NOTE: If there were less than five deaths, a rate was not calculated.

DATA SOURCE: Boston resident deaths, Massachusetts Department of Public Health. Rates are calculated using resident population estimates from MISER for 1991-1998, Massachusetts Department of Public Health 1999 Preliminary Population Estimates, and the US Census 2000 for resident population.
DATA ANALYSIS: Boston Public Health Commission, Research Office

Number of deaths due to breast cancer by race/ethnicity, Boston, 1995-2000

	1995	1996	1997	1998	1999	2000
White	64	79	71	52	48	55
Black	21	17	16	20	13	22
Hispanic	4	2	2	0	4	3
Asian	0	3	4	4	3	3
BOSTON	89	101	93	76	68	83

Prostate cancer mortality, age-adjusted rates (deaths per 100,000 population), by race/ethnicity, Boston, 1995-2000

	1995	1996	1997	1998	1999	2000
White	21.9	38.9	32.3	17.3	27.2	29.9
Black	65.2	61.8	81.9	73.4	52.5	78.3
Hispanic	---	---	---	46.2	---	---
Asian	---	---	---	---	---	---
BOSTON	28.6	40.2	39.2	29.1	30.0	34.2

NOTE: If there were less than five deaths, a rate was not calculated.

DATA SOURCE: Boston resident deaths, Massachusetts Department of Public Health. Rates are calculated using resident population estimates from MISER for 1991-1998, Massachusetts Department of Public Health 1999 Preliminary Population Estimates, and the US Census 2000 for resident population.
DATA ANALYSIS: Boston Public Health Commission, Research Office

Number of deaths due to prostate cancer by race/ethnicity, Boston, 1995-2000

	1995	1996	1997	1998	1999	2000
White	27	47	39	22	34	36
Black	17	18	24	22	15	21
Hispanic	2	1	3	5	1	1
Asian	1	1	0	1	2	1
BOSTON	47	67	66	51	52	59

ADDENDA

The following materials were received during the seven-day period allowed for interested parties to submit additional materials for inclusion as part of the record.

1. Senator Richard T. Moore
2. Massachusetts Law Reform Institute
3. Blue Cross/Blue Shield of Massachusetts, Massachusetts Business Roundtable, Associated Industries of Massachusetts, Massachusetts Association of Health Plans, Massachusetts Taxpayers Foundation
4. Massachusetts Council of Community Hospitals
5. Massachusetts League of Community Health Centers

December 19, 2002

Special Commission on the Uncompensated Care Pool
ATTN: Secretary Robert Gittens
Executive Office of Health and Human Services
One Ashburton Place
Boston, MA

To the Special Commission:

As of today, the Uncompensated Care Pool Commission report is three days late. The time authorized by law for the Special Commission on the Uncompensated Care Pool expired on December 16, 2002.

In is common knowledge that the time expired without an opportunity by members to fully and fairly discuss the suggestions of the Commission subcommittees, to discuss other suggestions presented to the Commission by individual commissioners and groups of commissioners, or to allow the full commission to debate these or any other suggestions for reform of the Pool.

While I recognize that every Commissioner would like to have seen the process of the last several months result in specific recommendations for the Governor and Legislature, the calendar did not allow sufficient time to discuss, debate and thoughtfully act upon any of the various, sometimes competing, proposals that have been raised during our review of the Pool history, current operations, and projected increases in cost.

In my view, it would have been unconscionable to ask Commissioners to vote on any of the proposals without an opportunity for full discussion of each issue. It would also have been inappropriate to vote on some proposals, but fail to consider others simply because time ran out for the Commission. In either case, the merits of any recommendations that might have been adopted would have been tainted by their adoption through such a flawed and undemocratic process.

In the absence of that comprehensive discussion, the Commissioners, on a five to four split vote, concluded that they could not "adopt or accept" any specific proposals. Consequently, the Commission unanimously voted to simply transmit the subcommittee reports, additional proposals and statistical information to the Governor and the Legislature for further consideration, review and action.

The significance of the debate on December 16th regarding the difference between the parliamentary motions to "accept" versus "transmit" should not be minimized. The term "accept," would mean that Commissioners agreed with and supported the proposals, while "transmit" does not imply agreement, but simply willingness to allow the concepts to be forwarded to appropriate authorities for further consideration.

As a co-chair of the Commission, on the part of the Senate, I would urge that the Governor and Legislature develop legislation to reform the Uncompensated Care Pool that includes the following concepts:

1) The Pool should support improvements in the Insurance Partnership that encourage more employers and employees to have access to health insurance. Those improvements ought to include:
   a) Increasing the size of businesses eligible for participation in the Partnership from 50 employees to 100.
   b) Increasing the subsidy for employers and/or minimizing administrative costs.
   c) Increasing eligibility for participation from 200% of the Federal Poverty Level (FPL) to at least 250% of the FPL.
   d) Providing a mechanism for employees to join the Partnership whose employers are eligible for Partnership participation, but decline to participate.

2) The current formula for supporting the Pool needs to recognize that health care costs have increased by 18 percent since the passage of legislation authorizing that formula in Chapter 47 of the Acts of 1997. (Source: Bureau of Labor Statistics, U.S. Department of Labor, 12/14/02). The state share and the private sector share need to be adjusted to accommodate that increase and include a formula for annual indexing the share to health care inflation. Private health plans have all increased their premiums in that time period, and it is unrealistic to leave the assessment for Pool costs at 1997 levels.

3) The cost of care billed to the Pool for anyone who had employer supported insurance during the preceding two years prior to becoming uninsured and Pool-eligible, should be billed to that individual's employer of record.

4) The Pool should be administered by an independent third-party and the administration of the Pool should be improved to assure a cost-effective management system that ensures consistent eligibility and benefits for all Massachusetts residents who are accepted by the Pool.

5) Any monies that the Division of Health Care Finance and Policy receives from collecting outstanding debt should go to the uncompensated care pool fund and not to the General Fund.

6) The Pool should recognize and reward hospitals and health centers that have demonstrated that they have adopted evidence-based best practices for ensuring patient safety such as those identified by the "Leap Frog Initiative" so-called. Since improved safety and quality have been demonstrated to save money, as well as improve health of patients, they must be included as a key factor in Pool management.

7) The Division of Medical Assistance and the Division of Health Care Finance and Policy should be provided with technology that allows them to provide information necessary to the highest standards of data collection and analysis for effective Pool and Medicaid management. Despite the state's current fiscal problems, this expense could be handled by the combination of the federal Medicaid reimbursement for Information Technology (IT) of 90% and obtaining the state match, including the costs of conversion, through the state's IT Bond. In that way, there should be no adverse impact on the operating budget, but long-term benefits to managing both the Pool and Medicaid programs.

Some of these concepts are contained in the Commission report and there may be other suggestions within the report that also merit the attention of the Administration and the Legislature that could be included in any final legislative proposal. Yet, I want to take this opportunity to underscore the urgency of action with regard to reform of the Uncompensated Care Pool.

Recent 9C cuts that affect the eligibility and benefits offered through Medicaid and the planned April 1st changes to MassHealth eligibility for some 50,000 individuals, are having, and will continue to have, dramatic shifting of costs to the Pool. These cuts in Medicaid need to be reviewed and reconsidered. The Pool needs to be reformed without regard to the Medicaid cuts, but the urgency of reform is significantly greater, if the cuts are allowed to stand.

Therefore, the report should be transmitted, as it was voted upon by the Commission, to the General Court Clerks, the Governor and the Ways and Means Committees post haste.

Sincerely,

RICHARD T. MOORE,
Senate Chair, Committee on Health Care and
Co-Chair, Uncompensated Care Pool Commission

MNA
MASSACHUSETTS NURSES ASSOCIATION

VIA FACSIMILE
December 16, 2002

Robert P. Gittens, Secretary
Commonwealth of MA – Executive Office
1 Ashburton Place, 11th Floor
Boston, MA 02108-1518

Dear Senator Moore, Representative Keenan, and Secretary Gittens:

This letter will provide the Massachusetts Nurses Association's position regarding the Special Commission on Uncompensated Care. The Uncompensated Care Pool (UCP) was devised as a fair and equitable allocation of the burden of uncompensated care and free care among affected participants in the health care delivery system so that no single participant or group of participants bears a disproportionate burden of the cost of providing such care. The legislation creating the special commission on the UCP was specific in purpose: "*(a) to develop a suitable plan to establish a fair and equitable assessment to pay for the uncompensated care and equitable distribution of any such assessment, including maximizing the amount of federal financial participation to which the commonwealth may be entitled; (b) to develop a plan that includes incentives for the utilization of insurance programs, including programs operated by the division of medical assistance, wherever possible, such as payment methodologies that are not more favorable than those used by such insurance programs, as well as recommendations for more efficient and effective administration of the uncompensated care pool; and (c) to prepare legislation necessary to effectuate the recommendations of the commission.*"

While this speaks to the financing of the pool, the pool was created to help pay the costs of providing care to the uninsured and underinsured, there is an expectation, as there should be, that those in need of care will get care regardless of existing funding sources. What care is necessary is best left for clinical providers; what care is reimbursed is already well defined.

Everyone is loathe to suggest taxes, particularly due to the recent ballot initiatives advocating the reduction of taxes and more recently advocating the elimination of the income tax, yet everyone is equally loathe to champion a reduction in services.

But if you ask the public whether it would be acceptable for an individual who does not have insurance, if it would be appropriate to deny treatment whether in a hospital or a clinic, the answer would be no. The question that remains unanswered is how do we pay for it?

Revenues need to be generated to increase funding to the pool and maximize federal dollars. No change in the current system of allocation has been suggested that would not otherwise be disruptive to services. If revenues can be reallocated without tax increases and without equally devastating cuts in other services, that would be most desirable. But in the event this is not possible any tax should be targeted to the pool and the method should be equally applied – inclusive of those not currently funding the pool.

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781-821-4625 ■ FAX 781.821.4445 ■ *www.massnurses.org*

With regard to specific recommendations:

- Mass Health Basic must be restored. The elimination of this program knowingly inflicts harm on citizens of the commonwealth.
- Utilization management recommendations regarding pharmacy utilization should be adopted.
- Do not alter current scope definitions – the unintended consequences are not known though it is highly likely this would result in greater use of already burdened ER's for medical needs and harm the well being of individuals in need of chronic care services.

While initial and necessary steps to maintain our health care safety net are needed, the MNA firmly believes that more fundamental reform of the health care system is required to address the health care needs of the commonwealth.

Thank you for the opportunity of participating on this commission.

Sincerely,

Julie Pinkham, RN
Executive Director

Massachusetts Law Reform Institute

99 Chauncy Street, Suite 500, Boston, MA 02111-1703
(617) 357-0700 ■ FAX (617) 357-0777

December 20, 2002

35581

Senator Richard T. Moore
Representative Daniel Keenan, and
Secretary Robert Gittens, Co-chairs,
Special Commission on Uncompensated Care
c/o Division of Health Care Finance and Policy
Two Boylston Street
Boston, MA 02116-3100

Re: Submission of additional materials to the Final Report of the Special Commission on Uncompensated Care

Dear Commission Chairmen and Members,

This additional information is submitted by the Massachusetts Law Reform Institute, a non-profit legal advocacy organization representing the interests of low-income residents of Massachusetts and the Massachusetts Immigrant and Refugee Advocacy Coalition, a statewide network of more than 160 community agencies, religious groups, labor unions, human service organizations, legal service providers and activists committed to protecting the rights and welfare of immigrant and refugee communities.

The Uncompensated Care Pool is a vital component of the health care safety net for all low income uninsured and underinsured residents of Massachusetts. Several proposals included in the Final Report of the Special Commission in the interests of reducing costs to the Pool will have serious unintended consequences of which policy makers should be aware.

The November 27, 2002 memorandum from the DHCFP staff suggest that the eligibility criteria for free care "tighten residency requirements [f]or example, require 6 months residency for non-urgent services, and terminate eligibility for undocumented aliens." Responsible policy makers should consider neither of these proposals.

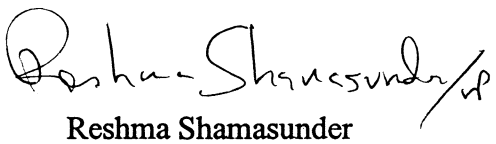
A durational residency requirement for the receipt of public benefits is unconstitutional. A few years ago California attempted to limit new residents to California to the same level of cash welfare benefits available in their state of prior residence. The United States Supreme Court struck down the residency restriction as a violation of the constitutionally protected right to travel that embraces the right to be treated equally in a new state of residence. Saenz v. Roe, 119 S. Ct. 1518 (1999). There is little question that the more drastic proposal to impose a 6-month residency requirement would also be found unconstitutional. Nor does this proposal make sense from a health policy perspective. Non-urgent care consists of care that can be deferred for more than 24-hours without unreasonable risk of harm, that is a far cry from deferring care for a six month period. 114.6 C.M.R. 10.02 (definition of urgent care).

The proposal to eliminate coverage for "undocumented aliens" is similarly unwise. The

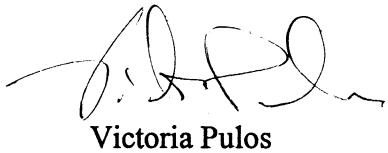
federal Emergency Medical Treatment and Active Labor Act prohibits hospitals that accept Medicare and maintain emergency departments from refusing emergency treatment. 42 U.S.C. 1395dd. This duty extends to all individuals in need of emergency treatment regardless of citizenship or immigration status. Excluding this population from the pool would violate one of the pool's basic functions --equalizing the costs of caring for the uninsured. Further, exclusion of the undocumented from the free care pool will leave many people with no source of care except the hospital emergency department. Shifting care to this expensive and already over-crowded setting is bad for everyone. Finally, it would be an administrative nightmare for hospital personnel to be expected to understand the intricacies of immigration law in order to correctly identify "undocumented aliens." Is an individual who has overstayed a visa but has a petition for adjustment of status pending undocumented? Is an individual who qualifies for registry status but has not applied undocumented? These are questions that hospital administrative personnel are unlikely to get right and should not be required to ask. This kind of questioning creates a hostile environment for "documented" immigrants who make up a key component of the Massachusetts labor market, particularly the health care work force.

We also oppose the suggestion made by some insurers and employer groups and two members of the Scope Subcommittee that hospital services covered by the pool be restricted to emergency and urgent care only. This restriction leaves a gaping hole in the safety net for uninsured residents who need care that cannot be provided by community health centers or who live in areas of the state without access to community health centers. A far better way to strengthen the pool is to maximize federal revenue by restoring funding for the MassHealth Basic population, and engaging in more effective outreach for free care patients who are potentially eligible for MassHealth. According to the analysis of pool users prepared by DHCFP, 30 percent are potentially eligible for MassHealth, and of the potentially eligible group, 74 percent are potentially eligible for MassHealth Basic. See pp. 32 of Final Report.

Thank you for the opportunity to submit this additional material.



Reshma Shamasunder
MIRA Coaltion



Victoria Pulos
M.L.R I.

BlueCross BlueShield of Massachusetts

MBR MASSACHUSETTS BUSINESS ROUNDTABLE

AIM ASSOCIATED INDUSTRIES OF MASSACHUSETTS

mahp MASSACHUSETTS ASSOCIATION of HEALTH PLANS

Massachusetts Taxpayers Foundation

December 23, 2002

Robert P. Gittens
Secretary
Executive Office of Health & Human Services
1 Ashburton Place, Room 1109
Boston, MA 02108-1518

Dear Senator Moore, Representative Keenan and Secretary Gittens:

We are writing to provide some additional clarity around recommendations made in our December 2, 2002 letter to the Uncompensated Care Pool Commission and ask that this letter serve as an addendum to our earlier correspondence.

Our recommendations, which were adopted in whole or in part by the various pool subcommittees, are intended to serve as a framework for ensuring better administration and management of pool functions. Our intention always was that our recommendations would serve as principles to help guide the Legislature relative to pool reform. We would look to the Legislature to provide the details needed to establish and implement these recommendations. While we have stated orally at Commission and subcommittee meetings the intent of our recommendations, we feel it is important to communicate them in writing, so that our intentions relative to pool reform are clear and are not misconstrued.

The thrust of our recommendations relative to the definition of "free care" is that medically necessary services that can be provided in community health centers should be provided in community health centers, as opposed to more costly hospital outpatient departments. We recognize that there are some services, such as chemotherapy, which are critical components of the safety net but that are not typically provided in community health centers. Our intent is that the pool would continue to cover these services. Finally, we note that the reference in our recommendations to emergency and urgent care is intended to include inpatient admissions arising from emergency and urgent medical conditions.

Our goal continues to be ensuring that low income, uninsured individuals receive the care they need. It is essential, however, that the Commonwealth, in these difficult fiscal times, ensures that pool dollars are used wisely and that care be provided in the most cost-effective setting. We believe that our recommendations embrace these important objectives.

Sincerely,

Richard C. Lord
President and CEO
Associated Industries of Massachusetts

Peter G. Meade
Executive Vice President
Blue Cross Blue Shield of Massachusetts

Bruce M. Bullen
Chief Operating Officer
Harvard Pilgrim Health Care
Representing
Massachusetts Association of Health Plans

Alan G. Macdonald
Executive Director
Massachusetts Business Roundtable

Michael J. Widmer
President
Massachusetts Taxpayers Foundation

Massachusetts Council of Community Hospitals
45 Braintree Hill Office Park - Suite 300, Braintree, MA 02184
Telephone: (781) 356-5653 Fax: (781) 356-4494

Senator Richard T. Moore
Representative Daniel Keenan
Secretary Robert Gittens
Co-chairs
Uncompensated Care Pool Commission

Gentlemen,

The Massachusetts Council of Community Hospitals (MCCH) appreciated the opportunity to participate in the work of the Commission. We have learned much from the analyses presented and the ideas expressed. We recognize the time pressures the Commission was under to develop recommendations and are disappointed more actionable items were not agreed to.

We have emphasized the urgent need for community hospitals to be restored to a higher standard of financial viability than currently exists and how important it is to avoid what appears to be a major financial blow to the community hospital system due to the impending shortfall in pool funding.

MCCH believes, along with others, that the pool requires a much more broadened base of funding than currently exists. Neither the hospitals that provide the care, or the insured patients that receive the care, nor the employers who provide insurance to their employees should be disproportionately carrying the burden for costs needed to care for the uninsured. It is simply unfair. We will continue to work with others to find ways to broaden funding.

MCCH also believes we can take action to resolve very immediate inequities and force a higher standard of performance on the whole hospital system. We argue that a standardized fee payment system that can take available pool funding and redistribute it will create both equity and a more efficient system to care for the uninsured. The current method of disproportionate reimbursement to certain hospitals had previous utility but now aggravates inequities that harm everyone. This avenue deserves greater exploration as a short term transitional step as more secure and broadened funding sources are sought.

We look forward to working with you and the new administration on this most important issue. Please contact me at 781-424-0930 with any questions.

Sincerely,

Donald J. Thieme

Donald J. Thieme
Executive Director

MASSACHUSETTS LEAGUE of COMMUNITY HEALTH CENTERS

100 Boylston Street, Suite 700, Boston, MA 02116 • 617-426-2225 • 800-475-8455 • Fax 617-426-0097

December 24, 2002

Her Excellency the Governor
The Honorable Mark Montigny, Chair, Senate Ways and Means Committee
The Honorable John H. Rogers, Chair, House Ways and Means Committee
Patrick F. Scanlan, Clerk of the Senate
Steven T. James, Clerk of the House
The State House
Boston, MA 02133

Dear Governor Swift, Senator Montigny, Representative Rogers, Mr. Scanlan and Mr. James:

With respect to the Report of the Uncompensated Care Pool Commission filed with you on December 16, 2002, the Massachusetts League of Community Health Centers would like to acknowledge the fine work of the staff to the Commission who were able to process and present a great deal of useful information in a short period of time. As stated in the preface to the Report, this information, as well as the broad recommendations should be useful in further decision making on your part.

We are, however, concerned that a number of the proposals included in the Report, including but not limited to many of the staff recommendations, were not in fact processed through the Commission's subcommittees, nor were they fully discussed and acted upon by the Commission as a whole. With this in mind, we would welcome the opportunity to continue to provide input to a process which needs to continue in order to insure that the essential services provided under the Pool are to remain available.

Very truly yours,

James W. Hunt, Jr.
President and CEO