Massachusetts Health Centers – Insurance and Other Clarification Memo

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To Massachusetts Health Centers:

Below outlines the UDS reporting instructions for the above categories:

Dental Only Patients

For individuals who do not utilize medical services at your health center (e.g., dental-only patients or behavioral health patients), your health center is expected to track and report their MEDICAL insurance on Table 4 lines 7-11. These individuals may not have insurance for dental services but they may have insurance for primary care and other medical/behavioral health services. Table 4 lines 7-12 records Principal Third Party **Medical** Insurance Source. A patient seen in the dental clinic with Medicaid, Private, or Other Public dental insurance who did not use medical services may be presumed to have the same kind of medical insurance. If a patient does not have dental insurance, you may not assume that they are uninsured for medical care, and the health center must obtain this information from the patient.

Health Safety Net

The Health Safety Net is categorized as a state or local safety net program. These are programs which pay for a wide range of clinical services for uninsured patients, generally those under some income limit set by the program. They may pay based on a negotiated fee-for-service, or fee-per-visit. They may also pay "cents on the dollar" based on a cost report, in which case they are generally referred to as an "uncompensated care" program. Most are generally "capped" at a maximum total amount, and payments are often paid in a different fiscal year. The following are how your data should be reported across tables 4, 9d, and 9e.

Tables Affected	Treatment
Table 4	• While patients may need to qualify for eligibility, these programs are not considered to be public insurance. • Patients served are to be counted on Line 7 as uninsured.
Table 9D	• The health center's usual charges for each service are to be considered charges directly to the patient (reported on Line 13, Column A). • If the patient pays any co-payment, it is reported in Column B. • If they are responsible for a co-payment but do not pay it, it remains a receivable until it is collected or is written off as a bad-debt in Column F. • All the rest of the charge (or all of the charge if there is no required co-payment) is reported as a sliding discount in Column E.
Table 9E	A. The total amount received during the calendar year from the State or local indigent care program is reported on Line 6a.

CHIP

It is currently unrealistic for health centers to differentiate between SCHIP and MassHealth. Thus, all individuals covered by MassHealth and SCHIP should be reported on line 8a of Table 4, lines 13a and 13b column A for capitation and managed care fee for service, respectively, and lines 1, 2a, 2b on Table 9D. If at some point it differentiating between MassHealth and SCHIP becomes more straightforward, health centers will be expected to report SCHIP on line 8b on Table 4.

MassHealth Limited

Report as uninsured on Table 4 line 7.
If you are able to distinguish these charges and collections from regular Medicaid, report on Table 9D line 7. If you are not able to distinguish, report on line 1 of Table 9D.

CarePlus

Report all CarePlus as Medicaid on line 8a in Table 4.

Qualified Health Plans purchased through the Health Connector (including ConnectorCare)

The UDS does not distinguish between Gold, Silver or Bronze plans. As the manual states, all of these subsidized plans are reported as Private Insurance on Table 4 Line 11. Charges and revenues are reported on Table 9D Line 10 (unless the plan is a managed care plan then it is reported on 11a or 11b for capitated and FFS plans, respectively). It is important that grantees reassign the patient portion of third party charges to self-pay Table 9D Line 13 to reflect co-pays and deductibles.

Healthy Start Women

Report as uninsured on Table 4 (line 7) and on Table 9D other public (line 7).

Children's Medical Security Plan (CMSP)

CMSP is not considered SCHIP by the Bureau of Primary Health Care as it is funded solely with State dollars and does not receive the federal match. It has limited coverage – outpatient only – and children who require inpatient services are linked into/'covered' through the Health Safety Net Trust Fund.

CMSP is to be reported on line 10a of Table 4. On Table 9D, you should report the revenue, cash, etc. on lines 7, 8a and 8b (other public).

As of July 1, 2017, changes were implemented to CMSP's billing process (elimination of UniCare as the administrator); however, they do not effect UDS categorization of CMSP. It is a state Medicaid program but does not receive any federal reimbursement.

Managed Care

A. Neighborhood Health Plan – most (if not all) of NHP is managed care. For UDS purposes, NHP has three categories – commercial (private), and Medicaid. You need to track these managed care enrollees and their corresponding charges and member months separately.

B. Network Health – the same as NHP, you must track the enrollees by the type of coverage and category

C. HealthNet – the same as NHP, you must track the enrollees by the type of coverage and category.

D. BMC's HealthNet – for those health centers that continue to participate in Boston Medical Center's HealthNet network whereby individuals are given a 'card' that gives them access to all services within the medical center. Technically, these individuals are not "insured" however, after a lengthy discussion with Art Stickgold, we agreed that these individuals should be reported on line 10A of Table 4.

E. CeltiCare – as CeltiCare's market penetration increases you need to pay attention to the categories that are offered by CeltiCare and report member months accordingly on lines 13a and 13b. You need to track CeltiCare managed care enrollees and their corresponding charges and member months separately by category.

F. Fallon Community Health Plan – the same as NHP, you must track the enrollees by the type of coverage and category.

See the Table below for details/summary:

	Table 4 – Medical Insurance Source	**Table 4 – Managed Care Utilization**	**Table 9D**
Commercial including but not limited to NHP, Network Health, HealthNet, (possibly CeltiCare). Includes all QHPs purchased through the Connector.	Line 11	Line 13a column D for capitation; line 13b column D for fee for service (ffs)	Lines 11a for capitation, line 11b for managed care ffs, line 10 for straight ffs
Medicaid Managed Care including but not limited to NHP, Network Health, HealthNet, CeltiCare, CarePlus plans	Line 8a	Line 13a column A for capitation; line 13b column A for ffs	Lines 2a for capitation, line 2b for managed care ffs, line 1 for straight ffs
Indemnity Medicaid (straight fee-for-service, non-managed care)	Line 8a	Not applicable	Line 1
SCHIP Including but not limited to NHP, Network Health, HealthNet	Line 8a	Line 13a column A for capitation; line 13b column A for ffs	Lines 2a for capitation, line 2b for managed care ffs, line 1 for straight ffs
The 'original' BMC HealthNet	Line 10A	Line 13a column C for capitation; line 13b column C for ffs	Lines 8a for capitation, line 8b for managed care ffs, line 7 for straight ffs

Senior Care Options (SCOs)

On Table 4 the patient would be reported as a Medicare patient (line 9). On Table 9D the collection would be from both Medicare and Medicaid. There should be some rational division of the charges which should be Medicare up to the amount that Medicare pays and then all the rest would go up to Medicaid. This would apply for straight fee-for-service (line 4 and lines 1 for Medicare and Medicaid, respectively), managed care capitation (lines 5a and 2a for Medicare and Medicaid, respectively) and managed care fee-for-service (lines 5b and 2b for Medicare and Medicaid, respectively).

Please get in touch with the SCOs with which you have a contract and determine the gross ratio of Medicaid and Medicare – a gross ratio Medicare to Medicaid is acceptable, or outpatient allocation of Medicare to Medicaid would work as well. Use this on Table 9D and allocate between Medicare and Medicaid proportionally.

NOTE: Commonwealth Care Alliance (CCA) and Senior Whole Health are both SCOs, and therefore should be categorized as above. However, CCA and United serve dual eligibles under age 65 in the One Care Program, which could be counted as Medicare managed care since it is for duals. As a reminder, One Care is for disabled adults between 21 and 64 who are dually eligible due to their disability status. SCOs are only for 65+ persons who are eligible for MassHealth, and are therefore dually eligible too.

Program of All-inclusive Care for the Elderly (PACE)

Report all clinicians associated with the PACE program on lines 1-11 of Table 5 and line 1 of Table 8A. Count medical visits provided by these clinicians if they meet the UDS criteria (i.e., face to face, documented in the patient's chart, independent clinical judgment is rendered, provided by a licensed clinicians). You may include nursing FTEs on line 11 but do not include nursing visits on line 11. Report charges for these visits and collections (take some reasonable portion of PMPM) on Table 9D – you will need to determine the split between Medicare and Medicaid. NOTE: What we are trying to determine is the reasonable part of your PACE reimbursement that is due to outpatient care. It is acceptable for you to work 'backwards' by determining the medical costs and using this amount as the payments on Table 9D column B (with corresponding gross charges in column A).

For ancillary and wrap services, including the personnel providing these services, report them on line 29a of Table 5, the costs for them on line 12 of Table 8A, and the income received for the portion of the non-clinician-provided services goes on line 10 of Table 9E.

For the ancillary and wrap services, PACE programs are shown as an expense on line 12 Table 8a. You do not include any visits from the PACE program on Table 5. Staff for the PACE program should be counted on line 29a of Table 5. The income is shown on table 9E line 10.

If patients enrolled in PACE come into the health center and see a physician who is part of your 330 staff with legitimate medical visits (face to face, documented in the patient's chart at the health center, independent clinical judgment, etc.), then the physicians and mid-levels providing this care at the health center would be counted on lines 1-11 of Table 5 along with the medical visits in column b and the patient on line 15 column c. Do not include nursing visits that are incidental to custodial care (so, do not include these visits on line 11 of Table 5, but include the FTEs).

- Count all the medical visits
- Count all FTEs

If Medicare pays you for the visits (in which the PACE enrollee saw a 330 clinician) above the PACE PMPM, then you would show the charges and collections for that visit on Table 9D. If Medicare does not reimburse you for this 330 visit, then you would show a reasonable medical PMPM on Table 9D line 4a and reduce the amount on Table 8a.

Primary Care Payment Reform (PCPRi)

Primary Care Payment Reform initiative (PCPRi) was an alternative payment methodology that worked to improve access to primary care, enhance patient experience, quality, and efficiency through care

management and coordination. PCPRi combined a shared savings/risk arrangement with quality incentives.

In this model, participants contract with MassHealth, and committed to delivering primary care consistent with the Commonwealth's definition of a patient-centered medical home with a focus on behavioral health integration. As a result, participants were provided a managed care capitated amount per patient per month to provide the full breadth of primary care and behavioral health services. Services not covered under the capitated payment were paid on a managed care FFS basis. The following is how patients covered by PCPRi should be captured on the UDS.

Tables Affected	Treatment
Table 4	• People covered by this plan are considered as Medicaid Managed Care and are insured on table 4 • It is considered to be managed care and all member months should be counted and included as a capitated Medicaid program
Table 9D	• The health center's usual charges for each service for those covered by this plan are to be considered Medicaid Managed Care Capitated charges (Column A). • The capitated payments from MassHealth should be reported as revenues in Column B. • The difference between the Charges and the capitated payment should be considered as the allowance. • The health center's usual charges for services not covered under the capitated payment should be considered as Managed Care Fee for Service. Payments and allowances related to these charges should be handled as you would normally handle these on the UDS. • Any retroactive payments (Wrap-around payments) related to charges that are covered under the cap or not should be handled as you would normally handle these on the UDS.

NOTE: PCPRi ended on December 31, 2016.

Reclassification of the Self-Pay Portion of Third Party Charges

Those of you who underwent a system conversion to NextGen have experienced some difficulty identifying and moving the charges associated with copayments and deductibles to line 13 column A of Table 9D.

Per Art Stickgold regarding NextGen, if issues still persist:
Run a listing of all adjustments and find the adjustments that state transfer copayment, deductible, and responsibility. The worst case is that you have a code that has a code that says self-pay (as opposed to

from Medicare to self-pay). If this is the case, then they have to run a report by payor class. What charges were Medicare, Medicaid, down to self-pay.

Self-pay Sliding Discounts

On Table 9D, line 13, column e, report only slides for individuals who are low income (200% FPL).

a. Report gross charges for all individuals on line 13 column A

b. Report cash received for patients on line 13 column B

c. Report cash from HSN on line 6a T9E

The 'extra slides' (i.e., slides for individuals above 200% FPL) are not reported anywhere on the UDS.

Patient Centered Medical Home - A number of health plans in Massachusetts are providing PMPM dollars for the health centers to pilot PCMH.

d. Should these be counted as MM on Table 4? No

e. The income from this PMPM should be by payor on T9D column B. The payment should be listed in column C3.

Boston Public Health Commission

There has been some inconsistency regarding the categorization of the funds received from the Boston Public Health Commission. The funds are public. Therefore, funds received from the Boston Public Health Commission should be reported on line 7 (local government) of Table 9E.

ACA Funds

ACA funds received from MassHealth that are not paid on a FFS basis and/or are not tied to direct patient services should be reported on Table 9e line 6: State Government Grants and Contracts (specify: _), not on Table 9d. Please use the specify box and indicate that a portion of the total on this line is from this source.

Community Health Workers

Community Health Workers can perform many functions at a health center and thus can be classified across many lines on Table 5 in the Enabling Services section. Per the instructions, care should be taken to distribute an individual staff members time across 1 or more columns reflecting what functions they provide at the health center. The manual specifically states that:

> **Community Health Workers (Line 27c) are** lay members of communities who work in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve. Staff may be called community health workers, community health advisors, lay health advocates, promotoras, community health representatives, peer health promoters, or peer health educators.

Specific consideration should be made to ensuring that CHWs who provide Case Management or Patient/Community Health Education services are categorized on these lines so that their visits can be appropriately reported.

Counting Nurse Triage Visits

Nurse triage visits are one of the most common visits reported on the UDS on Table 5, line 11 and as long as patients who are seen by the nurse during a triage encounter are not referred to and seen by another medical provider on the same day, they can typically be counted on the line 11 on Table 5 as a nurse visit. Whether you bill for these services or not does not have a bearing on whether they should or should not be counted on your UDS Report.