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 and on the Zip Code Table. 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 and the Zip Code Table record Principal Third Party **Medical** Insurance Source. For example, a patient seen for dental services only should be asked about their medical insurance during registration. If that has not occurred and the patient has Medicaid, Private, or Other Public dental insurance, you 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	• 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 Medicaid (MassHealth). Thus, all individuals covered by Medicaid 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 (FFS), respectively, and lines 1, 2a, 2b on Table 9D. If at some point it differentiating between Medicaid 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 and line 1 in Table 9D.

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.

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).

Medicaid Managed Care, including Accountable Care Organizations

MassHealth introduced Accountable Care Organizations (ACOs) for many of its members in March 2018. The goals of an ACO are to deliver better care to members, improve the population's health, and control costs through care management and coordination. ACOs combine a shared savings/risk arrangement with quality incentives.

For the fully at-risk, primary care-exclusive Medicaid ACOs, ACO revenue for your assigned patients should be reported as Managed Care Fee-for-Service (as the health centers are still paid on a fee-for-service basis) on Line 2b. Excerpt below:

"Report charges for services provided to patients who are assigned to the health center and must receive their primary care from the health center—hence the managed care inclusion—but for whom no monthly fee is paid."

MCOs post-ACO implementation:

1. BMC HealthNet Plan – you must track the enrollees by the type of coverage and category
2. Tufts Health Together – you must track the enrollees by the type of coverage and category

For a **full list of MassHealth ACOs and MCOs**, visit: https://www.mass.gov/service-details/full-list-of-masshealth-acos-and-mcos

See the Table below for details/summary:

	Table 4 – Medical Insurance Source	**Table 4 – Managed Care Utilization**	**Table 9D**
Commercial. Includes all QHPs purchased through the Connector	Line 11	Line 13a column D for capitation; line 13b column D for FFS	Lines 11a for capitation, line 11b for managed care FFS, line 10 for straight FFS
Medicaid Managed Care. Includes ACOs	Line 8a	Line 13a column A for capitation; line 13b column A for FFS	Line 1 for straight FFS, line 2a for capitation, line 2b for managed care FFS (ACOs)
Straight Medicaid (Fee For Service including PCC plans, non-managed care)[1]	Line 8a	Not applicable	Line 1
SCHIP Including but not limited to NHP/AllWays Health Partners, Network Health, Boston 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

DSRIP

DSRIP funding to pay for technical assistance and other Medicaid transformation activities that are not tied directly to patient services should be counted on Table 9E, line 8: Foundation/Private Grants and Contracts.

[1] Primary care case management plans that pay PCPs a small fee to manage patient but all services are otherwise paid as straight Medicaid (line 1) on a FFS basis are not MC patients according to UDS instructions. All charges and payments, including CM fee are on line 1.

Senior Care Options (SCOs)

On Table 4, generally the patient would be reported as a Medicare patient (line 9). However, some patients may be considered dual-eligibles, and therefore should be reported on Line 9a. Note that some may be 65+ and only qualify for MassHealth/Medicaid; it is not a requirement to have Medicare to enroll in a SCO. SCOs are distinct from One Care Plans, which do require someone to have Medicaid and Medicare. SCO FAQ here: https://www.mass.gov/service-details/senior-care-options-sco-provider-billing-frequently-asked-questions-faqs.

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 Medicaid, 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). Note:

- 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.

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 Table 9E line 6a

The 'extra slides' (i.e., slides for individuals greater than 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 Table 9E line 7 (local government).

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 ensure 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. Also note that CHWs cannot generate countable UDS visits. If a CHW is categorized 100% FTE on line 27c, visits should not be reported as case management without a corresponding FTE.

Counting Nurse Triage Visits

Triage visits are one of the most common type of nurse visits reported on the UDS on Table 5, Line 11. To be a countable nursing visit, the encounter must meet all visit criteria and the patient is not seen by another provider at the same service delivery site on the same date of service.

It is recommended that the health center track the countable, reportable visits using this code with either a zero charge or a fixed fee schedule charge with a corresponding sliding fee discount, if applicable, and/or bad debt write-off, based on the health center's policies and procedures.

COVID-19 Funding – 8a Financial Costs, 9d Patient-related Revenue, 9e Other Revenues

During COVID-19 public health emergency, health centers may have received targeted funding to prevent, prepare, and respond to coronavirus disease. Below is a list of where these funds should be listed:

COVID Costs and Revenues Sources	Table and Line for Reporting

8a – Financial Costs	• **Accrued costs for staffing and other direct costs** by service line, reporting primarily, perhaps exclusively on medical and enabling service lines • **Donated services and supplies** related to COVID-19 on line 18
9d – Patient Related Revenues	• **Table 9d, line 8c: Other Public**. - **COVID-19 Uninsured Program** Testing and treatment associated with caring for uninsured patients with suspected or actual COVID-19 administered by HRSA under the COVID-19 Uninsured Program on Line 8c., including charges, collections

For Table 9e – Other Revenues, see the crosswalk below. For additional funding streams, reference: https://bphc.hrsa.gov/sites/default/files/bphc/datareporting/reporting/uds-covid-19-funding-guidance.pdf

Funds	Table	Comment
HRSA COVID Supplementals	Table 9E, Lines 1l-p • Coronavirus Preparedness and Response Supplemental Appropriations Act (activity code H8C) on Line 1l • Coronavirus Aid, Relief, and Economic Security (CARES) Act (activity code H8D) on Line 1m • Expanding Capacity for Coronavirus Testing (activity code H8E) on line 1n • American Rescue Plan (activity code C8E) on line 1o • Other COVID-19-related funding from BPHC on Line 1p	This includes H8C, H8D, H8E and C8E funding. Report *drawdowns* received during the reporting period. **ALL** health centers should report funds on 1o, American Rescue Plan. **NO** health centers should report funds on Line 1p, Other COVID-19 funding from BPHC
Federal Communications Commission (FCC) Telehealth Expansion Grant	• If you received the award directly from FCC, it should be listed as other federal grant on T9E, line 3 • If you received the award through C3, it should be listed as private on T9E, line 8	
HHS Provider Relief Funds	Table 9E, Line 3b	Note which PRF tranches you received
MassHealth Supplemental Payments	• Most health centers would have received bulk money directly from state (revenue) but not tied to visits on T8 and T9E, line 6 (state) • Some received funds through BMC, therefore it should be listed on T9E line 8 (private)	

Health Safety Net Supplemental	Table 9E, Line 6a	
Paycheck Protection Program	**NOT** reported on the UDS	This is a loan that may be forgiven and therefore becomes a grant but should not be reported on the UDS