

Massachusetts Health Centers – Insurance and Other Clarification Memo

Table of Contents

Dental Only Patients 2

Health Safety Net 2

CHIP 3

MassHealth Limited 3

CarePlus 3

Qualified Health Plans purchased through the Health Connector (including ConnectorCare)..... 3

Children’s Medical Security Plan (CMSP)..... 3

Medicaid Managed Care 3

DSRIP 5

Senior Care Options (SCOs)..... 5

Program of All-inclusive Care for the Elderly (PACE) 5

Reclassification of the Self-Pay Portion of Third Party Charges 6

Self-pay Sliding Discounts 6

Boston Public Health Commission 7

Community Health Workers 7

Counting Nurse Triage Visits..... 7

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	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• 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 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.

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).

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.

Medicaid Managed Care

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.

MCOs pre-ACO implementation date covering Jan. 1 – Feb. 28, 2018:

You need to track managed care enrollees and their corresponding charges and member months separately for the following for the first two months of the year only:

1. BMC HealthNet
2. CeltiCare
3. Fallon Community Health Plan
4. Health New England
5. Neighborhood Health Plan (*announcement in Fall 2018 that NHP will be rebranded as AllWays Health Partners on Jan. 1, 2019*)
6. Tufts Network Health

MCOs post-ACO implementation date covering Mar. 1 – Dec. 31, 2018:

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

NOTE: We recognize that many FQHCs may have already submitted their 2018 UDS report and used their best judgment as to where to place ACO revenue. During this transitional year, we have heard that some FQHCs have placed this funding on Table 9D Line 1: Medicaid Non-Managed Care and others have placed this funding on Line 2b: Medicaid Managed Care (fee-for-service). We will engage with FQHCs in 2019 to get input and further discuss this categorization, but for now the League’s guidance is for MassHealth ACOs to be counted as Medicaid Managed Care (fee-for-service) on Line 2b.

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, non-managed care).	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

We advise that DSRIP funding should be counted on Table 9E, line 6: State Government Grants and Contracts.

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 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).

- 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 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 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 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.