UDS Managed Care Reporting and Relationship across Tables 4 and 9D

There are two tables in the UDS Report that capture managed care information. These are Table 4, where managed care enrollment is reported as member months, and Table 9D, where managed care charges, revenue, supplemental payments, and adjustments made by third-party payers for patients enrolled or assigned in managed care plans are reported. The following instruction summarizes the reporting requirements for each, as well as how they relate to each other.

Definitions

Managed Care: A system in which a fee is paid under contract to a health center by a private or public organization to provide a defined range of services to patients assigned to the health center.
A managed care plan meets the UDS definition when all of the following criteria are met:

- There is a contract between the health center or a health center provider and an MCO where the health center assumes some risk (often monetarily or tied to quality and/or cost).
- Patients are assigned to the health center and/or a primary care provider (PCP) within the health center as managed care enrollees. The health center is held responsible for the comprehensive care of those assigned, attributed, or enrolled patients under the specified managed care service contract (e.g., medical, dental, and/or behavioral health).
- Monthly enrollee data (also sometimes called attribution lists, assigned lives, or membership data) are provided by or are available from the MCO, such as from an online portal or from an account manager.

Managed Care—Capitated: A payment model in which a health center contracts with a Managed Care Organization (MCO) to provide a list of services to patients assigned through the capitated plan. The MCO pays the health center a capitation fee (a set amount, usually paid monthly, for each enrolled patient assigned to the health center) regardless of whether any services were rendered during the month. No further direct payment is provided if the services rendered are on the list of services covered by the capitation fee in the agreement between the health center and the MCO.

Managed Care—Fee-for-Service: A payment model in which a health center contracts with an MCO, is assigned patients for whom the health center is responsible for providing primary care services and is reimbursed on a fee-for-service (or encounter-rate) basis for covered services.

Managed Care—Combined Capitation and Fee-for-Service: A payment model in which some of the services for which the health center contracts with an MCO are covered by a capitation payment and the remainder of covered services are "carved out" and reimbursed on a fee-for-service basis. Carve-outs may include treatment of specific diseases (e.g., HIV) or specific services (e.g., prenatal care, labor/delivery).

Member Month: One individual enrolled in a managed care plan for one month.

IMPACTED TABLES

Table 4, Selected Patient Characteristics

Managed care utilization is reported on Lines 13a–13c of Table 4, Selected Patient Characteristics. This section of Table 4 captures managed care enrollment during the calendar year for those patients *assigned to the health center* for medical or comprehensive managed care plans that include medical care.

These data are reported as member months in the relevant cells for the type of managed care (row) and the payer type (column). A full year of member months is the total count of assigned patients for each month over 12 months. To report this accurately, health centers must gather rosters of patients assigned through managed care plans during the year. The monthly counts are summed to get the total member months for the annual UDS Report.

If the health center sees patients who are enrolled in a managed care plan where the patient is NOT assigned to the health center or one of its providers or if the patient is assigned to another provider who is not a health center provider, then that is NOT a managed care patient assigned to the health center and NO member months are reported.

Note that there may be programs where patients are assigned to the health center or the health center receives a per member per month payment that are **not** to be reported as managed care **enrollees**. A few examples:

- DO NOT report in this section enrollees who are only in primary care case management (PCCM) programs, the Centers for Medicare & Medicaid Services (CMS) patient-centered medical home (PCMH) demonstration grants, or other third-party plans that pay a monthly fee (often as low as $5 to $10 per member per month) to manage patient care.
- DO NOT report member months for enrollees who are assigned to the health center in managed care plans that are specific to behavioral health or dental services only. (However, an enrollee who has medical *and* dental are to be included in the reported member months, on account of the medical managed care.)

Forms of Managed Care Plans

There are two forms of managed care plans: capitated and fee-for-service. On Table 4, each managed care enrollee's member months are reported as *either* capitated or fee-for-service, based on the contracting arrangement.

Capitated Member Months are reported on Line 13a. Report the total capitated member months by payer category (see Table 9D, below). This is derived by adding the total enrollment reported from each capitated plan for each month.

- A patient is in a capitated plan if the health center's contract with the MCO stipulates that, for a flat payment per month, the health center will provide the patient all the services on a negotiated list. This usually includes, at a minimum, all medical office visits. This is often called a per member per month payment plan.
- If a patient is assigned to the health center in a combined Capitation and Fee-for-Service managed care plan, as described in the definition section above, the member months for that patient are reported as capitated member months on Line 13a of Table 4. The member months for these patients are NOT reported on both capitated and fee-for-service lines.

Fee-for-Service Member Months are reported on Line 13b. Report the total fee-for-service member months by payer type. This is derived by adding the total enrollment reported from each fee-for-service plan for each month.

- A fee-for-service member month is defined as one patient being assigned to a health center or health center service delivery provider for one month through a managed care contract, during which time the patient way receive contractually defined basic primary care services only from the health center, and in which the services are paid on a fee-for-service basis.

- It is important to understand that this is not where *all* fee-for-service patients are reported, but rather only those patients who are assigned to the health center through a medical managed care plan that pays on a fee-for-service basis.

Example of Managed Care Reporting on Table 4:

- 721 members were assigned to the health center through a Medicaid MCO that pays fee-for-service for basic primary care, and also pays incentives for conducting certain screenings and achieving certain goals. Most members were assigned for the full year (12 months) but some were added to the health center's roster later in the year. The health center reviews the assignments for the year, and finds the following:
    - 652 members were assigned to the health center for the full year = 7,824 member months (652 members*12 months)
    - 69 members were assigned in October= 207 member months (69*3 months)
- The member months equal 8,031. This is the total number of months that patients were assigned to the health center in the year.
- The health center reports 8,031 on Line 13b, Column a.

Table 9D, Patient Service Revenue

On Table 9D, Patient Service Revenue, five major payer categories are listed: Medicaid, Medicare, Other Public, Private, and Self-Pay.

All categories except Self-Pay have a row for each of the two forms of managed care, as well as a row for non-managed care. On Table 9D, the two forms of managed care are reported on capitated

managed care lines (Lines 2a, 5a, 8a, and 11a, dependent on the payer) and fee-for-service managed care lines (Lines 2b, 5b, 8b, and 11b, dependent on the payer).

In order for charges, collections, and adjustments to be reported as managed care, managed care enrolled patients are assigned to the health center or PCP within the health center, where the health center is held responsible (and assumes some risk, whether upside only or upside and downside) for the comprehensive care of those attributed patients under the specified service contract.

There will generally be a close relationship between member months on Table 4 and managed care collections on Table 9D, but there are some examples of where managed care will be reported on Table 9D without member months on Table 4. Examples of instances where managed care charges, revenue, etc. are reported **without** member months on Table 4 include:

- Dental-only or behavioral health-only managed care plans where medical care is not part of the managed care plan. In the case of these plans, there are no managed care member months on Table 4 (because that is limited to managed care plans that encompass medical care), but there would be managed care charges, revenue, etc. reported on Table 9D.
- Carved-out services or services that are reimbursed on a fee-for-service basis under a capitated managed care plan. In this situation, the charges, collections, and adjustments for the carved-out services are reported on the managed care fee-for-service line, while the services covered by the capitation agreement are reported on the managed care capitation line.

Continuing the Example from Table 4 onto Reporting on Table 9D:

- 721 patients are assigned to the health center through a Medicaid MCO that pays fee-for-service for basic primary care, and also pays incentives for conducting certain screenings and achieving certain goals. These 721 patients have a total of 2,236 visits with the health center in the year. The charges for those 2,236 visits come to $382,356. The health center collects $390,273 from the MCO in the year, $15,094 of which is incentive payments and the remainder of which is fee-for-service reimbursement for visits.
- The charges, collections, and incentives for these patients from this Medicaid MCO would be reported on Line 2b, in Columns a, b, and c3, respectively. Adjustments would also be reported in Column d.

Cross-Table Relationships

- The capitated member months reported on Table 4, Line 13a relate to the capitated revenue reported on Table 9D, Lines 2a, 5a, 8a, and/or 11a.
    - If capitated member months are reported on Table 4, then there will be capitated revenue on the related line on Table 9D. Because capitation is paid regardless of services rendered, this is always the case.

- For example, if there are Medicaid Capitated Member Months reported on Table 4, Line 13a, Column a, then there will be, at a minimum, revenue in Column B on Line 2a of Table 9D.

- There is a relationship between the fee-for-service member months reported on Table 4, Line 13b and the revenue reported on Table 9D on Lines 2b, 5b, 8b, and/or 11b.
  - Unlike capitated managed care, it is possible to have managed care fee-for-service member months on Table 4 without related revenue on Table 9D. For example, if the patient who is enrolled in a managed care plan that is specifically for medical services is only seen for dental care, which is not part of the managed care plan they are enrolled in.
  - It is also possible to have no managed care fee-for-service member months on Table 4, but managed care fee-for-service revenue on Table 9D. For example, if the patient is enrolled in a capitated plan, but their labor/delivery is reimbursed fee-for-service, they may have managed care fee-for-service revenue on Table 9D, but no corresponding managed care fee-for-service member months on Table 4.