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 from managed care enrolled patients are reported. The following instruction summarizes the reporting requirements for each, as well as how they relate to each other.

Definitions

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

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 with an MCO where the MCO assumes some risk.
- Managed care enrollees are assigned to the health center and/or a primary care provider (PCP) within the health center and must obtain approval from the MCO to be reassigned to another PCP.
- Monthly enrollee data (also sometimes called attribution lists or membership data) are provided by or are available from the MCO, such as from an online portal or from an account manager.
- Enrollees must receive prior approval or referral from their PCP prior to being seen elsewhere for a reimbursable nonemergency care service or contracted specialty care.

Table 4

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 these cells. A member month is defined as one individual assigned to the health center through a managed care plan for one month. In order to report accurately, health centers must access rosters of assigned patients for managed care plans throughout the year. The patients assigned to the health center through those plans each month comprise the managed care member months for that particular month, and added together for the year, comprise the total member months to be reported on the annual UDS Report.

If the health center sees patients who are enrolled in a managed care plan that permits them to receive care from any number of providers (without being assigned to a specific provider or organization) or if the patient is assigned to another provider, not a provider at the health center, then that is NOT to be reported as managed care in the UDS, and NO member months are reported.

Note that there may be programs that enroll patients with the health center that are not to be reported as managed care enrollees. A few examples:

- DO NOT report in this section enrollees 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 include patients as enrollees here on Table 4 who are assigned to the health center in managed care plans that are specific to behavioral health or dental services. (However, an enrollee who has medical *and* dental would be included in the reported member months, on account of the medical managed care.)

There are two types of managed care plans: capitated and fee-for-service. 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.
- 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, during which time the patient may receive contractually defined basic primary care services only from the health center but for whom 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 managed care plan that pays on a fee-for-service basis.

Table 9D

On Table 9D, Patient Service Revenue, five major payer categories are listed: Medicaid, Medicare, Other Public, Private, and Self-Pay. All, but Self-Pay, have capitated managed care (2a, 5a, 8a, and 11a, respectively) and fee-for-service managed care (2b, 5b, 8b, and 11b, respectively) subcategories (in addition to a non-managed care subcategory). Remember that in order for charges, collections, and adjustments to be reported as managed care, the patient must be enrolled in a managed care plan, typically with member months reported 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's 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 are separately reported on the corresponding managed care lines—those that are for a defined set of services covered by the capitation and those that are reimbursed on a fee-for-service basis.

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. 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 is only seen for dental care, which is not part of the managed care plan they are enrolled in, they may only have self-pay charges and revenue on Table 9D.

- 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 fee-for-service revenue on Table 9D, but no corresponding fee-for-service member months.