

Module 7: Table 6

SLIDE #1: Introduction

This module will cover table 6, managed care. Prisons, Indian Health Service, Section 638, and Immigration and Nationalization Service sites do not report this table.

SLIDE #2: Table 6

As you can see table 6 is relatively simple, categorizing your managed care enrollment by two types of plans and by four types of categories.

SLIDE #3: Managed care enrollment

Table 6 requests year-end enrollment in managed care plans as of or as close as possible to December 31st of the calendar year being reported.

Because this is a year-end count, the number of enrollees may be greater or less than the number of total users participating in that plan during the year. Also not all enrollees actually become users. In many instances those enrolled in managed care plans may not have a visit during the calendar year. Therefore the counts reported on table 6 would be very unlikely to be the same as the user counts reported for the payer categories on table 2.

Columns A through D define the payer categories in terms of Medicaid, Medicare, other public and private. For full definitions of those payers and what would be counted in each, please refer to the module on table 2 for the discussion of users by payer class.

Line 1 of table 6 reports users in capitated plans, while line 2 of table 6 reports users in fee-for-service managed care plans.

It is important to note that not all of your users are enrolled in managed care plans and it would be unlikely for the combination of these two categories to equal or be near the total users of your health center as reported on Table 2.

For enrollees in combined plans or plans that have what are known as “carve outs”, their individual diagnoses or services may be taken out of a capitated payment and paid separately on a fee for service basis can only be counted in one of the categories. Because they're capitated plans, the user would still be considered a capitated user on table 6 even if a portion of the services were paid on a fee-for-service basis. Again, enrollees should be counted only once in one of the categories.

SLIDE #4: Managed care characteristics

To define what constitutes managed care, it's good to take a look at the definition.

Managed care typically involves these characteristics:

- An obligation to provide a defined set of covered services and for a defined period of time in which the patient is locked in and assigned to a specific primary care provider.
- The plans typically also require that provider to act as what's known as a “gatekeeper”, meaning that they perform the case management function of moving the patient through the medical care system and they make the referrals to outside providers when that patient needs additional specialized care or hospitalization.
- In a capitated plan the payment tends to be fixed for the enrollee. Capitated plans tend to be the easier plan to define in terms of managed care because of this. The payments are made on a regular basis and the payments cover a specific interval, typically what's known as a month or a member month.

Fee-for-service managed care, on the other hand, also requires a lock-in and care management on the part of the patient; however, because the payment is not directly linked to this it is often the case that you do not receive routine lists of how many patients are enrolled in those managed care plans.

It should, however, be possible to contact the plan at the end of the year, and request a count of the number of enrollees. If the plan is unable to provide a list of the enrollees, one should consider whether or not the plan in fact is managed care in that your management of the patients' service utilization is dependent on that payer knowing what time frame you are responsible for which patients. Because there is usually some risk involved, and that risk can be defined either in the downside in terms of withhold that may not be paid or in the upside in terms of a bonus payment or profit sharing it is important that the plan can determine which patients are involved at what time.

SLIDE #5: Managed care reporting

To further define what managed care constitutes, we'll look at some specific cases.

Case management plans or “primary care case management” plans where your site would be paid a small fee per user each month to obtain the case management services of the provider, but while not placing the provider at direct financial risk for the management of the care, would be counted as managed care;

However, it would counted as fee-for-service managed care even though a small monthly payment is added to that fee-for-service in that the majority of the payment is paid on that basis.

Preferred provider organizations (or PPO's) where patients are given a panel of providers to choose from but have the option of going outside that group and paying an additional fee would not be considered managed care in that the patient bears the risk and not the provider.

Also, managed care plans are not limited to medical, but may also include dental and mental health managed care either in addition to medical care or on their own.

Lastly, it must be your site and your organization that is directly involved in the managed care relationship. If referrals are being made to you from other providers that are in a managed care organization, but you are being paid on a fee-for-service basis that would again not be considered managed care. In some cases, a site may not have any users in managed care plans. In this situation, table 6 would be left blank.

SLIDE #6: Thank you

Thank you. If you are interested in learning more about the UDS reporting requirements and step-by-step instructions for completing the UDS tables, please visit the other modules available online. In addition, the UDS helpline is available to answer questions at 1-888-459-1080, or via e-mail at udshelp@nhscdata.net.