HRSA
Health Resources & Services Administration

Reporting Uniform Data System (UDS) Financial and Operational Tables

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Vision: Healthy Communities, Healthy People

Opening Remarks

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Health Resources and Services Administration (HRSA)

Agenda

- Review reporting requirements for UDS financial tables and related operational tables
- Review UDS terminology for financial and operational tables
- Review some common case examples
- Discuss common reporting questions

HRSA Health Center Program

Objectives of the Webinar

By the end of this webinar, participants will be able to:

- Understand reporting requirements for the UDS financial tables and related operational tables.
- Identify strategies to check data for accuracy.
- Access additional reporting support.

Poll

How familiar are you with the UDS financial tables?

A. I am not familiar. The basics will be helpful to learn.
B. I am not very familiar. Gaining a better understanding will be helpful.
C. I am somewhat familiar. Learning about the tables in more detail will be helpful.
D. I am very familiar with these tables. I would like to learn about any changes this year that impact UDS reporting.

Overview of Data Collected in UDS Tables

Patient Profile

Captures the demographic information of health center patients who received in-scope services.

ZIP Code Table and Tables 3A, 3B, and 4

Services and Clinical Outcomes

Captures personnel, visits, services, and outcomes related to all in-scope services provided to health center patients.

Tables 5, 6A, 6B, and 7

Costs and Revenues

Captures the financial costs and the revenues (both patient service generated and other) related to in-scope services.

Tables 8A, 9D, and 9E

All data is reported for the *full calendar year*, Jan. 1, 2022 through Dec. 31, 2022.

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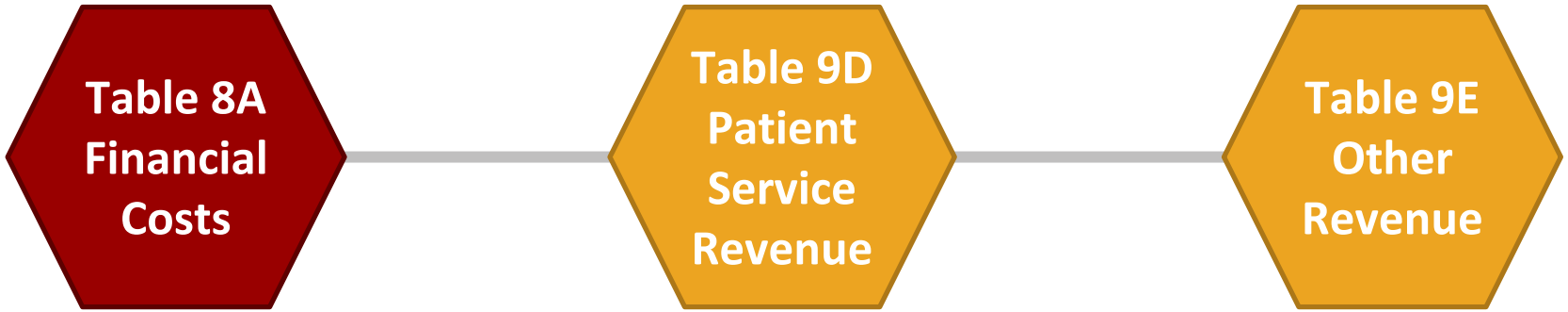
Overview of Financial Tables

Table 8A: Financial Costs	Table 9D: Patient Service Revenue	Table 9E: Other Revenue
Costs related to personnel, classified by cost center, aligned with service areas on Table 5	Charges, by payer, related to services provided to patients	Federal grant revenue, including health center funding and COVID-19 supplemental funding from HRSA BPHC
Costs related to services/contracts, by cost center, aligned with service areas on Table 5	Collections, by payer, related to services provided to patients	State/local grant revenue
Pharmaceutical costs	Adjustments, by third party payer, related to services provided to patients	Private/foundation revenue
Costs for facilities and non-clinical support services	Revenue, by third party payer, is classified as capitated managed care, fee-for-service managed care, and non-managed care	Cash donations
Value of donated facilities, services, and supplies	Sliding fee discount for patients and bad debt for patients	Receipts from indigent care programs

Key Terms in UDS Financial Tables

Cost Center	A grouping of costs by service type or function aligned with service area classifications used in Table 5
Accrued Cost	Expenses incurred during the calendar year
Overhead	Facility and non-clinical support service expenses
Charges	The value of services rendered to patients during the calendar year based on the center's fee schedule
Collections	Total cash received in the calendar year for services provided to patients, regardless of when those services were rendered
Adjustments	Contractual discounts granted as part of an agreement with a third-party payer
Third-Party Payer	Any entity, other than the patient, reimbursing the health center for patient services
Managed Care	Revenue from organizations that meet the UDS definition of managed care: payers with which the health center has a *contractual managed care agreement to provide a range of services to patients assigned to the health center*; paid fee-for-service or capitated

Table 8A: Costs



Financial Costs

Table 8A Columns

Column A

Accrued Cost

- Expenses incurred during the calendar year.
- Cost includes personnel and all costs other than personnel.
- Cost excludes bad debt and principal payments.

Column B

Allocation of Facility and Non-Clinical Support Services

- Allocation of facility and non-clinical support services (Column A, Lines 14 and 15) to each cost center in Column B, Lines 1-13.
- Note: Total of Column B must be equal to Column A, Line 16.

Column C

Total Cost After Allocation of Facility and Non-Clinical Support Services

- Includes all direct cost and the cost center's share of overhead cost. Represents total cost to operate services. Sum of Columns A + B (automated in EHBs).
- Can be used to calculate cost per visit and cost per patient.
- All in-kind non-cash donations are reported on Line 18.

Financial Costs: Accrued Cost

Table 8A, Column A

Accrued Cost

- Expenses incurred during the calendar year.
- Cost includes personnel and all costs other than personnel.
- Cost excludes bad debt and principal payments.

Allocation of Facility and Non-Clinical Support Services

- Allocation of facility and non-clinical support services (Column A, Lines 14 and 15) to each cost center in Column B, Lines 1-13.
- Note: Total of Column B must be equal to Column A, Line 16.

Total Cost After Allocation of Facility and Non-Clinical Support Services

- Includes all direct cost and the cost center's share of overhead cost. Represents total cost to operate services. Sum of Columns A + B (automated in EHBs).
- Can be used to calculate cost per visit and cost per patient.
- All in-kind non-cash donations are reported on Line 18.

Accrued Costs

Accrued costs are those costs incurred by a given cost center during the calendar year, including:

- Staff costs (salary, fringe benefits, continuing medical education [CME], etc.).
- Paid referred care.
- Supplies.
- Depreciation of equipment.
- Software or systems.
- Interest payments on any loans.
- Costs for contracted care, etc.

Accrued costs do not include:

- Costs for anything incurred outside the calendar year.
- Bad debt related to the provision of patient service.
- Loan principal payments.
- Costs for services the health center did not pay for directly (e.g., services that the health center referred, but were billed directly by the third-party provider).
- Gross costs for capitalized expenses.

Detailed guidance for where certain grants and revenue are to be reported is in the UDS Manual, beginning on page 153.

Table 8A Lines Aligned with Services on Table 5

FTEs and Visits Reported on Table 5, Line:	Have Costs Reported on Table 8A, Line:
1–12: Medical Personnel	1: Medical Personnel
13–14: Medical Lab and X-ray	2: Medical Lab and X-ray
16–18: Dental	5: Dental
20a–20c: Mental Health	6: Mental Health
21: Substance Use Disorder	7: Substance Use Disorder
22: Other Professional	9: Other Professional
22a–22c: Vision	9a: Vision
23: Pharmacy	8a: Pharmacy
24–28: Enabling	11a–11h: Enabling
24: Case Managers	11a: Case Management
25: Patient and Community Education Specialists	11d: Patient and Community Education
26: Outreach Workers	11c: Outreach
27: Transportation Personnel	11b: Transportation
27a: Eligibility Assistance Workers	11e: Eligibility Assistance
27b: Interpretation Personnel	11f: Interpretation Services
27c: Community Health Workers	11h: Community Health Workers
28: Other Enabling Services	11g: Other Enabling Services
29a: Other Programs and Services	12: Other Program-Related Services
29b: Quality Improvement Personnel	12a: Quality Improvement
30a–30c and 32: Non-Clinical Support Services	15: Non-Clinical Support Services
31: Facility Personnel	14: Facility

Takeaway: Each line on Table 5 has a *corresponding* line for related costs on Table 8A.

Full table and details are in **Appendix B** of the UDS Manual.

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Medical Cost Center
Table 8A, Lines 1–3, Column A

Line 1: **Medical personnel** salary and benefits

- **Includes** costs for all personnel directly attributable to medical department, including medical providers and medical assistants.
- **Includes** medical personnel under contract.
- Does **not** include value of volunteers.

Line 2: Medical **lab and X-ray** direct costs

- **Includes** medical lab and X-ray services provided directly by the health center and those provided by a referred care provider.
- Does **not** include costs that lab/radiology bills directly to the patient, unpaid medical lab and X-ray provided directly by a referred care provider, or dental lab and X-ray costs.

Line	Cost Center	Accrued Cost (a)
	Financial Costs of Medical Care	
1	Medical Personnel	
2	Lab and X-ray	
3	Medical/Other Direct	
4	**Total Medical Care Services** (Sum of Lines 1 through 3)	

Line 3: **Other than personnel direct medical** costs

- **Includes** costs for anything else directly attributable to the medical department.
- Does **not** include value of donated goods.
- Does **not** include any pharmacy or pharmaceutical. costs, such as cost of medications.

Other Cost Centers

Table 8A, Lines 5–8b, Column A

Line 5: Dental

- **Includes** dental personnel costs, contracted dental care, and electronic dental record costs.

Line 6: Mental Health

- **Includes** mental health personnel, supplies, and software used specifically by mental health department.

Line 7: Substance Use Disorder

- **Includes** substance use disorder services personnel, supplies, and software.

Line 8a: Pharmacy

- **Includes** pharmacy personnel and the dispensing and administrative fees for 340B contractors.
- Does **not** include cost of drugs.

Line 8b: Pharmaceuticals

- **Includes** the cost of medications administered in-house or via contract pharmacy.
- Does **not** include value of donated drugs or dispensing and administrative fees of contract pharmacy.

Do not include volunteer or donated personnel, supplies, or facilities on any of these lines.

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Key Considerations:
Reporting Various Costs Related to Pharmacy

Pharmacy and Pharmaceuticals are reported on Lines 8a and 8b; there are several consideration to be sure this is reported accurately:

- Dispensing and administrative fees for contract pharmacy (e.g., 340B) are reported on Line 8a, Pharmacy, separate from the cost of drugs.
- The cost of medications administered by in-house clinicians are reported on Line 8b, not in Medical.
- Administrative or overhead costs for the contract pharmacy program should be allocated to Line 8a, Pharmacy, in Column B.
- Report assistance establishing eligibility for pharmacy assistance programs on line 11e, not in Pharmacy.
- Donated drugs are reported on Line 18, Donated Facilities, Services, and Supplies; value at 340B prices.

Pharmacy Lines on Table 8A

Line	Cost Center	Accrued Cost (a)
	Financial Costs of Other Clinical Services	
8a	Pharmacy (not including pharmaceuticals)	
8b	Pharmaceuticals	

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Other Cost Centers

Table 8A, Lines 9 and 9a, Column A

Line 9: Other Professional

- **Includes** other professional and ancillary health care services costs like podiatry, chiropractic, acupuncture, naturopathy, speech and hearing pathology, or occupational and physical therapy.
- Does **not** include other professional costs that may be included in programs reported under "Other Program Related Services" (Line 12), such as WIC, Healthy Start, fitness centers, clinical trials, etc.

Line 9a: Vision

- **Includes** vision personnel and supplies.
- Does **not** include donated time of optometrists.

Other Cost Centers

Table 8A, Lines 11a–13, Column A

Lines 11a–11h, Line 11: Enabling Services

- **Includes** costs such as those for education materials, taxi vouchers, and translation/interpretation services, in addition to personnel costs.

Line 12: Other Program-Related

- **Includes** costs such as WIC, child care centers, housing, clinical trials, employment training, space leased to others, and retail pharmacy services provided to non-health-center patients.
- Describe the program costs using the "specify" field.

Line 12a: Quality Improvement (QI)

- **Includes** costs of personnel dedicated to the QI program and/or HIT/EHR system development.
- Do **not** include allocated portions of costs and time for QI personnel attending meetings, peer reviews, or designing or interpreting QI findings to other service categories. **QI costs go here.**

Line	Cost Center	Accrued Cost (a)
	Financial Costs of Enabling and Other Services	
11a	Case Management	
11b	Transportation	
11c	Outreach	
11d	Patient and Community Education	
11e	Eligibility Assistance	
11f	Interpretation Services	
11g	Other Enabling Services (specify___)	
11h	Community Health Workers	
11	**Total Enabling Services** (Sum of Lines 11a through 11h)	
12	Other Program-Related Services (specify___)	
12a	Quality Improvement	
13	**Total Enabling and Other Services** (Sum of Lines 11, 12, and 12a)	

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Knowledge Check: Accrued Costs

Which of these costs *will be* reported on Table 8A in the Calendar Year 2022 UDS Report?

A. Health center staffing costs that occurred in Federal Fiscal Year 2022.
B. A loan principal payment made by the health center in Calendar Year 2022.
C. Depreciation of the health center's medical equipment.
D. None of these are reported on Table 8A in 2022.

Answer to Knowledge Check: Accrued Costs

Which of these costs *will be* reported on Table 8A in the Calendar Year 2022 UDS Report?

A. Health center staffing costs that occurred in Federal Fiscal Year 2022.

B. A loan principal payment made by the health center in Calendar Year 2022.

C. Depreciation of the health center's medical equipment.

D. None of these are reported on Table 8A in 2022.

Remember:

The entire UDS is a calendar year report, so costs are not reported by fiscal year—they are reported by calendar year.

Principal payments on capitalized expenses (e.g., property or equipment) are not reported on the UDS; only interest and depreciation are reported on Table 8A.

Case Example

Ronald has been tasked with completing Table 8A for his health center. He has a list of each staff person and the total pay they received for the year.

What else does he need to accurately report total personnel costs by cost center?

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Case Example

Ronald has been tasked with completing Table 8A for his health center. He has a list of each staff person and the total pay they received for the calendar year.

What else does he need to accurately report total personnel costs by cost center?

Ronald will also need:

- Where each staff person is categorized on Table 5 (e.g., which service category) so that person's costs are in put in the related cost center on Table 8A.
- Fringe costs for each staff person, to be added to salary and wages to arrive at the full costs.
- Any other personnel costs, such as those for contracted personnel.

Ronald will also need to report all other accrued costs (those that are not personnel) in each cost center.

Frequently Asked Questions: Accrued Costs

? How do we allocate costs for clinical staff who split time in administrative/non-clinical duties? For example, a Chief Medical Officer who also sees patients.

Crosswalk Tables 5 and 8A for costs and FTE: Determine how this staff is reported on Table 5 and reflect that on Table 8A, too. Generally, a provider who is a CMO will have most of their time on a medical provider line on Table 5; then corporate time is reported on line 30a. Then here on Table 8A, a similar portion of their cost would be reported as non-clinical, for the corporate activities performed.

? Do community health workers (CHWs) go under Other Professional Services on Table 8A?

No, CHW costs are part of enabling services and have their own line in the Enabling section. On Table 8A, CHWs are reported on Line 11h; on Table 5, they are reported on Line 27c. Other Professional Services corresponds with Line 22 of Table 5 and includes dieticians, podiatrists, etc. not CHWs.

? Does the interpretation/ translation (on Line 11f) only include services provided by staff employed by the health

No, it is not ONLY health center personnel. Line 11f could include the cost for translation systems/ software, outsourced interpretation services, interpretation staff, or any combination of these.

Financial Costs: Allocation of Overhead

Table 8A, Column B

Column A

Accrued Cost

Expenses incurred during the calendar year.

Cost includes personnel and all costs other than personnel.

Cost excludes bad debt and principal payments.

Column B

Allocation of Facility and Non-Clinical Support Services

Allocation of facility and non-clinical support services (Column A, Lines 14 and 15) to each cost center in Column B, Lines 1-13.

Note: Total of Column B must be equal to Column A, Line 16.

Column C

Total Cost After Allocation of Facility and Non-Clinical Support Services

Includes all direct cost and the cost center's share of overhead cost. Represents total cost to operate services. Sum of Columns A + B (automated in EHBs).

Can be used to calculate cost per visit and cost per patient.

All in-kind non-cash donations are reported on Line 18.

Allocating Facility and Non-Clinical Support Services (Overhead) Table 8A

Facility and non-clinical support service expenses are referred to as overhead expenses. In the UDS, these are reported on Table 8A, Column A, in Lines 14 and 15 (Line 16 is the total).

Line	Cost Center	Accrued Cost (a)
	Facility and Non-Clinical Support Services and Totals	
14	Facility	
15	Non-Clinical Support Services	
16	**Total Facility and Non-Clinical Support Services** (Sum of Lines 14 and 15)	

Line 14: Facility-Related Expenses

- Includes facility personnel costs, rent or depreciation, mortgage interest payments, utilities, security, groundskeeping, janitorial services, maintenance, etc.

Line 15: Non-Clinical Support Services

- Includes personnel such as corporate administration, billing, revenue cycle, and medical records and intake personnel, as well as facility and liability insurance, legal fees, managing practice management system, and direct non-clinical support costs (travel, supplies, etc.).

Allocating Facility and Non-Clinical Support Services (Overhead) Table 8A, Column B

Line	Cost Center	Accrued Cost (a)
	Facility and Non-Clinical Support Services and Totals	
14	Facility	
15	Non-Clinical Support Services	
16	**Total Facility and Non-Clinical Support Services** (Sum of Lines 14 and 15)	

- All overhead costs are allocated to cost centers in Column B.
- Overhead costs that are directly associated with a cost center should be allocated first.
- The remaining overhead costs should be allocated using a proportional method, such as the proportion of square footage that each cost center uses (for facility costs) and percent of total accrued costs of each cost center (for non-clinical support costs).

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)
	Financial Costs of Medical Care		
1	Medical Personnel		
2	Lab and X-ray		
3	Medical/Other Direct		
4	**Total Medical Care Services** (Sum of Lines 1 through 3)		
	Financial Costs of Other Clinical Services		
5	Dental		
7	Substance Use Disorder		
8a	Pharmacy (not including pharmaceuticals)		
8b	Pharmaceuticals		
9	Other Professional (specify___)		
9a	Vision		
10	**Total Other Clinical Services** (Sum of Lines 5 through 9a)		
	Financial Costs of Enabling and Other Services		
11a	Case Management		
11b	Transportation		
11c	Outreach		
11d	Patient and Community Education		
11e	Eligibility Assistance		
11f	Interpretation Services		
11g	Other Enabling Services (specify___)		
11h	Community Health Workers		
11	**Total Enabling Services** (Sum of Lines 11a through 11h)		
12	Other Program-Related Services (specify___)		
12a	Quality Improvement		
13	**Total Enabling and Other Services** (Sum of Lines 11, 12, and 12a)		

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Allocating Facility and Non-Clinical Support Services (Overhead) to Cost Centers

Step 1

Allocate Line 14, Facility

- Allocate facility costs to each cost center based on either actual facility costs for that cost center or percentage of total square footage that the cost center uses.
- Any facility costs that are specific to non-clinical support services are allocated to Line 15.

Step 2

Allocate Line 15, Non-Clinical Support Services ascribable to specific cost center

- Allocate any non-clinical support costs attributable to a specific cost center to that cost center.
  - For example, decentralized front desk personnel, billing and collection systems and personnel, etc. are allocated to the service they work in.
- Consider lower allocation of overhead to contracted services.

Step 3

Remaining Costs

Allocate remaining costs using a consistent approach, commonly based on the proportion of direct costs or of visits.

Use the simplest allocation method that produces a result comparable to a more complex method. If possible, use at least a three-step allocation method.

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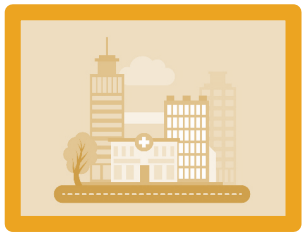
Overhead Allocation Example: First Step

Total Facility Costs on Line 14, Column A: $70,000

Site A
2,500 square feet
80% medical, 20% admin

Site B
3,500 square feet
57% medical, 29% mental health, 14% admin



Site C
6,500 square feet
31% medical, 31% dental, 15% mental health, 23% admin

	Medical (Lines 1–3)	Dental (Line 5)	Mental Health (Line 6)	Admin (Line 15)	Total Square Feet
Site A	2,000	-	-	500	2,500
Site B	-	2,000	1,000	500	3,500
Site C	2,000	2,000	1,000	1,500	6,500
Total Square Feet (SF)	4,000	4,000	2,000	2,500	12,500
% of total SF	32%	32%	16%	20%	100%
% total SF times total facility costs	32%*$70K	32%*$70K	16%*$70K	20%*$70K	100%*$70K
Facility Allocation	$22,400	$22,400	$11,200	$14,000	$70,000

Administration facility costs are allocated to non-clinical support and then allocated with non-clinical support services in second step.

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Overhead Allocation Example: Next Steps

Line 15: Non-Clinical Support Services are $250,000.

Plus $14,000 of allocated facilities costs (as shown in last slide).

Total of $264,000 of non-clinical support costs to be allocated.

First, distribute non-clinical support costs to the applicable service where possible.

Next, distribute remaining non-clinical support costs ($34,000).

Cost Center	Total to be allocated to cost center in Column b
Medical (Lines 1–3)	$75,000
Dental (Line 5)	$105,000
Mental Health (Line 6)	$50,000
Total Allocated in this Step	$230,000
Remaining Non-Clinical Support Costs to be allocated	$34,000

Cost Center	Percent of Costs in Column a	Allocation
Medical (Lines 1–3)	30.8%	$10,458.70
Dental (Line 5)	44.6%	$15,170.65
Mental Health (Line 6)	24.6%	$8,370.65
Total	100%	**$34,000**

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Overhead Allocation Example: Total of $320,000

Cost Center	Step 1 Allocated Facility Costs	Step 2 Allocated Non-Clinical Support Services	Step 3 Allocation of Remaining Costs	Total Overhead Costs to be Reported in Column B for Cost Center
Medical (Lines 1–3)	$22,400	$75,000	$10,458.70	$107,858.70
Dental (Line 5)	$22,400	$105,000	$15,170.65	$142,570.65
Mental Health (Line 6)	$11,200	$50,000	$8,370.65	$69,570.65

Knowledge Check: Allocating Costs on Table 8A

What costs are allocated in Column B of Table 8A?

A. Column B includes allocation of facility and non-clinical support services costs (Lines 14 and 15).
B. Column B includes allocation of total accrued costs (Line 17).
C. Column B includes allocation of facility, non-clinical support services costs, and value of donated facilities, services, and supplies (Lines 14, 15, and 18).

Answer: Allocating Costs on Table 8A

What costs are allocated in Column B of Table 8A?

A. **Column B includes allocation of facility and non-clinical support services costs (Lines 14 and 15).**
B. Column B includes allocation of total accrued costs (Line 17).
C. Column B includes allocation of facility, non-clinical support services costs, and value of donated facilities, services, and supplies (Lines 14, 15, and 18).

Frequently Asked Questions: Overhead Allocation

? What if contracted services are performed on site at our health center? Do we allocate overhead costs?

You would allocate a small amount of overhead to the contracted services, amounting to the cost for any space used for contracted services as well as any costs for administering the contracted care (e.g., accounting and contract management).

? Can we just allocate our facility and non-clinical support costs based on portion of costs or portion of visits?

While that is permitted, it is definitely not recommended! Using a single-step allocation method like this will not accurately reflect the total costs that a given service area uses to provide the services. Remember, the total costs (including overhead) are used to calculate cost per visit and cost per patient.

Financial Costs: Total Cost

Table 8A, Column C

Column A

Accrued Cost

Expenses incurred during the calendar year.

Cost includes personnel and all costs other than personnel.

Cost excludes bad debt and principal payments.

Column B

Allocation of Facility and Non-Clinical Support Services

Allocation of facility and non-clinical support services (Column A, Lines 14 and 15) to each cost center in Column B, Lines 1-13.

Note: Total of Column B must be equal to Column A, Line 16.

Column C

Total Cost After Allocation of Facility and Non-Clinical Support Services

Includes all direct cost and the cost center's share of overhead cost. Represents total cost to operate services. Sum of Columns A + B (automated in EHBs).

Can be used to calculate cost per visit and cost per patient.

All in-kind non-cash donations are reported on Line 18.

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Table 9D: Patient-Related Revenue

Table 9D: Patient Service Revenue

Lines 1–14

Revenue by five payer categories: Medicaid, Medicare, Other Public, Private, and Self-Pay.

All *except self-pay* include three sub-categories:

- Non-managed care
- Capitated managed care
- Fee-for-service managed care

				Retroactive Settlements, Receipts, and Paybacks (c)						
Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Collection of Reconciliation/ Wraparound Current Year (c1)	Collection of Reconciliation/ Wraparound Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty/ Payback (c4)	Adjustments (d)	Sliding Fee Discounts (e)	Bad Debt Write-Off (f)
1	Medicaid Non-Managed Care									
2a	Medicaid Managed Care (capitated)									
2b	Medicaid Managed Care (fee-for-service)									
3	**Total Medicaid** (Sum of Lines 1 + 2a + 2b)									
4	Medicare Non-Managed Care									
5a	Medicare Managed Care (capitated)									
5b	Medicare Managed Care (fee-for-service)									
6	**Total Medicare** (Sum of Lines 4 + 5a + 5b)									
7	Other Public, including Non-Medicaid CHIP, Non-Managed Care									
8a	Other Public, including Non-Medicaid CHIP, Managed Care (capitated)									
8b	Other Public, including Non-Medicaid CHIP, Managed Care (fee-for-service)									
8c	Other Public, including COVID-19 Uninsured Program									
9	**Total Other Public** (Sum of Lines 7 + 8a + 8b + 8c)									
10	Private Non-Managed Care									
11a	Private Managed Care (capitated)									
11b	Private Managed Care (fee-for-service)									
12	**Total Private** (Sum of Lines 10 + 11a + 11b)									
13	**Self-Pay**									
14	**TOTAL** (Sum of Lines 3 + 6 + 9 + 12 + 13)									

Report charges, collections, supplemental payments, contractual adjustments, sliding discounts, and bad debt for patients.

Table 9D at a Glance: Reporting Patient Service Revenue

Step 1: Patient Service Revenue (*Columns*)

- **Column A:** Charges for services in the year
- **Column B**: Collections on a cash basis
- **Column C1-C4**: Reconciliations
- **Column D**: Contractual Adjustments
- **Column E**: Self-pay sliding fee discounts
- **Column F**: Self-pay bad debt

Step 2: By Payer (*Rows*)

Lines 1-3: Medicaid

Lines 4-6: Medicare

Lines 7-9: Other Public

Lines 10-12: Private

Line 13: Self Pay

Step 3: By Form of Payment (Sub-lines a & b)

Non-Managed Care

Sub-line a: Managed care

Sub-line b: Non-managed care

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Patient Service Revenue

Table 9D, Columns A and B

Charges (a)

- Charges are the amount each service rendered to patients in the calendar year is valued at, **according to the health center's fee schedule**. Charges for any given procedure are recognized and reported at the same amount across all payers.
- Charges are captured by third-party and self-pay payer for all patient services rendered in the health center's scope of service in the calendar year (January 1 through December 31).
- Charges are reclassified in accordance with co-pay or co-insurance responsibility; for example, if a patient is responsible for 20% of the charge, then 80% of the charge is on the third-party payer line and 20% of the charge is moved to the self-pay line.

Collections (b)

Collections are the **total cash received in the calendar year** (January 1 through December 31) for services provided to patients, regardless of when those services were rendered.

Collections include:

- Reimbursement for services provided to patients from third-party payers and patients.
- Managed care or capitation payments.
- Payment for grant-covered services from public entities.
- Health center reconciliation or wrap payments.
- Quality bonuses or pay-for-performance bonuses.

Retroactive Settlements, Receipts, and Paybacks

Table 9D, Columns C1–C4

	Retroactive Settlements, Receipts, and Paychecks (c)			
Amount Collected This Period (b)	Collection of Reconciliation/ Wraparound *Current* Year (c1)	Collection of Reconciliation/ Wraparound *Previous* Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty/Payback (c4)
Payments reported in C1–C4 are part of Column B total, but do not equal Column B	FQHC prospective payment system (PPS) reconciliations and Wraparound payments for Current Year	FQHC prospective payment system (PPS) reconciliations and Wraparound payments for Prior Years (anytime before current year)	• Managed care pool distributions • Pay for performance (P4P) • Other incentive payments • Quality bonuses • Value-based payments	Paybacks or deductions by payers because of overpayments or penalty *(report as a positive number)*

Patient Service Revenue

Table 9D, Column D

Adjustments (d)

- Adjustments are **contractual discounts granted as part of an agreement with a third-party payer**.
- Virtually all insurance companies have a maximum amount they pay for a given service, and the health center agrees to write off the difference between what they charge and that contracted amount. These are considered contractual adjustments.
- On Table 9D, adjustments have the effect of reducing the amount to be collected and are generally reported in Column D as a positive number. However, reconciliation, wraparound, and incentive payments reported in Columns C1-C3 are subtracted from Column D, which may result in a negative number.
- Adjustments for third-party payers are reported in Column D.

For example, if a service has a fee schedule charge of $275 but a third party payer contract specifies that the payer will pay $225 for that service, then the charge is $275 (Column A) , the collection is $225 (Column B), and adjustment is $50 (Column D).

Third-Party Payers

A third-party payer is any entity, other than the patient, reimbursing the health center for patient services. The patient and the health center are parties directly involved with the service. An outside payer is a "third-party payer." In the UDS, these categories are:

Medicaid

- ✓ Any state Medicaid program, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Adult Day Health Care (ADHC), and Program of All-inclusive Care for the Elderly (PACE), if administered by Medicaid
- ✓ Medicaid managed care organizations (MCOs) or Medicaid programs administered by third-party or private payers
- ✓ Children's Health Insurance Program (CHIP), when administered by Medicaid

Medicare

- ✓ Any Medicare program or other program administered by Medicare
- ✓ Medicare managed care programs, including Medicare Advantage run by private payers
- ✓ ADHC or PACE, if administered by Medicare

Other Public

- ✓ CHIP, when paid for through private insurers
- ✓ State- or county-run insurance plans
- ✓ Service contracts with municipal or county jails, state prisons, public schools, or other public entities
- ✓ HRSA COVID-19 Uninsured Program

Private

- ✓ Insurance provided by employers
- ✓ Tricare, Trigon, Federal Employees Insurance Program
- ✓ Insurance purchased through state exchanges or by individuals
- ✓ ***NOT*** Medicaid or Medicare programs administered by private payers

HRSA Health Center Program

Managed Care

- **Managed care (either capitated or fee-for-service) refers to those payers with which the health center has a contractual managed care agreement to provide a range of services to patients assigned to the health center.**
  - Typically, these agreements include:
    - ✓ Responsibility for managing the care of a set of assigned patients.
    - ✓ Requirement for patients to receive specific care from the health center.
- This generally requires **regular review and reclassification of insurers in your system** to be sure that only those with whom you have contractual managed care agreements are categorized as managed care for UDS reporting.

Managed care does not refer to all managed care plans from which you received payment. Managed care refers to payments for patients *assigned to the health center through managed care plans*.

In other words, it is likely that services will be provided to and payment received for patients who are covered by a managed care plan but who are not assigned to one of your providers or with whose managed care plan you do not have a contract.

HRSA Health Center Program

Patient Service Revenue

Forms of Payment

Managed Care	Revenue from organizations that meet the UDS definition of managed care: payers with which the health center has a *contractual managed care agreement to provide a range of services to patients assigned to the health center*; paid fee-for-service or capitated.
Non-Managed Care	A payment model in which procedures and services are separately charged and paid. Third-party payers pay some or all of the bill, generally based on agreed-upon maximums or discounts.
Managed Care — Capitated	A managed care payment model in which a health center contracts with a managed care organization (MCO) for a specified set of services, for which the managed care plan pays the health center a set amount for each patient assigned to the health center. This is called a capitation fee and is typically paid per member per month.
Managed Care — Fee-for-Service	A managed care payment model in which a health center contracts with an MCO, is assigned patients for whom the health center is responsible for care through that MCO, and is reimbursed on a fee-for-service (or encounter-rate) basis for covered services.

Patient Service Revenue
Table 9D, Line 13

Self-Pay

- Self-pay refers to charges or the portion of charges that **are the responsibility of the patient** (rather than a third-party payer) and includes related collections and write-offs.
  - Includes charges incurred by uninsured patients, including those covered by indigent care programs, written off as sliding fee discounts, and/or written off as patient bad debt.
  - Includes co-payments, deductibles, and charges to insured individuals for uncovered services that become the patient's personal responsibility.
- **Self-Pay charges** (Column A) may then be paid by the patient and recorded as **Collections** (Column B), written off as **Sliding Fee Discounts** (Column E) based on patient income and family size, or written off as **Bad Debt** (Column F) when uncollectable (including inability to locate persons, patient's refusal, or inability to pay regardless of income).
  - Self-pay does NOT include third-party payer bad debt.
- Self-pay is reported on Line 13 of Table 9D.

Table 9D Revenue and Table 4 Insurance

Payer categories are generally aligned with patient insurance categories, but remember that payment may be received from a different payer than the patient's primary medical insurance.

Table 4	
Line	**Principal Medical Insurance**
7	**Uninsured**—No medical insurance at last visit
8a and 8b	**Medicaid** and Medicaid CHIP
9a and 9	Dually Eligible and **Medicare**
10a	**Other Public** non-CHIP—State and local government insurance
10b	**Other Public** CHIP (not paid by Medicaid)
11	**Private**

Table 9D	
Line	**Revenue Source**
13	**Self-Pay**—Include co-pays and deductibles, state and local indigent care programs
1–3	**Medicaid**
4–6	**Medicare**
7–9	**Other Public**—Include patient service revenue from programs with limited benefits
7–9	**Other Public**
10–12	**Private**

Case Example

A patient is seen five times at the health center in 2022. At the first visit of the year, the patient has Medicaid, but by the last visit of the year, the patient is uninsured.

Two of the visits are primary care visits that are paid by Medicaid, then the patient has two mental health visits that Medicaid does not cover. The last visit is a family planning visit, paid by Title X.

First, what is this patient's primary medical insurance on Table 4? Second, where is the patient service revenue for these visits reported?

Case Example

A patient is seen five times at the health center in 2022. At the first visit of the year, the patient has Medicaid, but by the last visit of the year, the patient is uninsured.

Two of the visits are primary care visits that are paid by Medicaid, then they patient has two mental health visits that Medicaid does not cover. The last visit is a family planning visit, paid by Title X.

First, what is this patient's primary medical insurance on Table 4? Second, where is the patient service revenue for these visits reported on Table 9D?

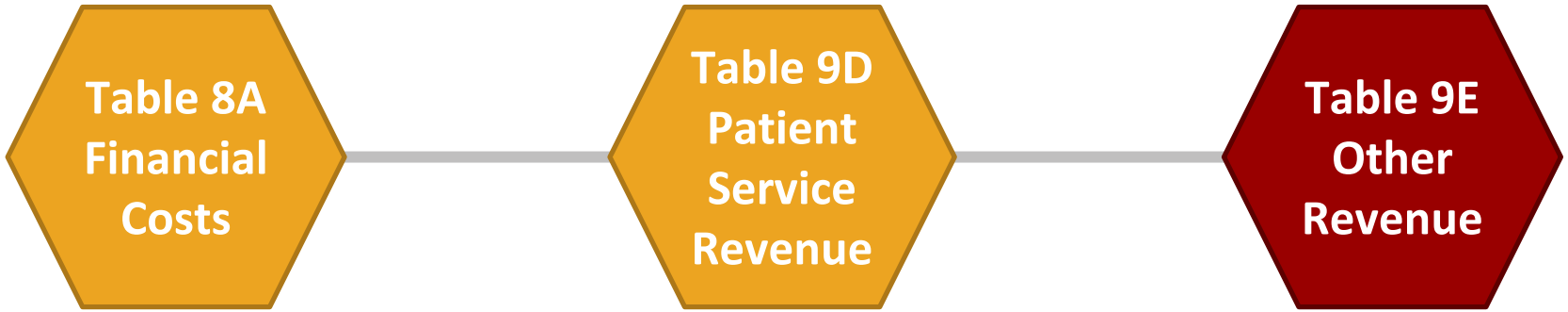
Table 4

- At their last visit of the year, the patient was uninsured, therefore the patient is reported as Uninsured on Table 4 (Line 7).

Table 9D

- The two primary care visits reimbursed by Medicaid are reported as Medicaid patient revenue, based on the type of payment.
- The two mental health visits that Medicaid did not cover (and therefore were the responsibility of the patient) are reported as Self-Pay on Line 13.
- The family planning visit is reported on Other Public (Line 7).

Table 9E: Other Revenue



Other Revenue

Table 9E

- This table is reported on a **cash basis:** amount drawn down (not award) in the year.
- Report based on the **entity dollars were received from** (called the last party rule).

Report **non-patient-service receipts** or funds drawn down in 2022.

- Include income that supported activities described in your health center scope of services.
- Report funds by the entity from which you received them.
- Complete “specify” fields.

The total amount reported on Tables 9E and 9D represents total revenue supporting the health center’s scope of services.

Find guidance for common health center funding awards related to the COVID-19 pandemic on the HRSA Training and Technical Assistance site.

HRSA Health Center Program

Revenue Categories

Table 9E, Lines 1a–3b

Lines 1a–1q

BPHC Grants: Funds your health center received directly from BPHC, including funds passed through to another agency.

- Include 330 grant(s) drawn down in the year.
- Include the amounts directly received under the various COVID-19 funding streams. *Only report amounts received in 2022.*

Lines 2–3b

Other Federal Grants: Grants you received directly from the federal government other than BPHC.

- Ryan White Part C.
- Other federal grants (e.g., HUD, CDC, SAMHSA).
- EHR Incentive Payments: Include Promoting Interoperability funds, including funds paid directly to providers and turned over to the health center (exception to last party rule).
- Provider Relief Fund.

Line	Source	Amount (a)
	BPHC Grants (Enter Amount Drawn Down—Consistent with PMS 272)	
1a	Migrant Health Center	
1b	Community Health Center	
1c	Health Care for the Homeless	
1e	Public Housing Primary Care	
1g	**Total Health Center** (Sum of Lines 1a through 1e)	
1k	**Capital Development Grants**, including School-Based Service Site Capital Grants	
1l	Coronavirus Preparedness and Response Supplemental Appropriations Act (H8C)	
1m	Coronavirus Aid, Relief, and Economic Security Act (CARES) (H8D)	
1n	Expanding Capacity for Coronavirus Testing (ECT) (H8E and LAL ECT)	
1o	American Rescue Plan (ARP) (H8F, L2C, C8E)	
1p	Other COVID-19-Related Funding from BPHC (specify_____)	
1q	**Total COVID-19 Supplemental** (Sum of Lines 1l through 1p)	
1	**Total BPHC Grants** (Sum of Lines 1g + 1k + 1q)	
	Other Federal Grants	
2	Ryan White Part C HIV Early Intervention	
3	Other Federal Grants (specify _____)	
3a	Medicare and Medicaid EHR Incentive Payments for Eligible Providers	
3b	Provider Relief Fund (specify _____)	
5	**Total Other Federal Grants** (Sum of Lines 2 through 3b)	

HRSA Health Center Program

BPHC COVID-19 Funding Lines

Table 9E, Lines 1l–1q

Line	Source	Amount (a)
	BPHC Grants (Enter Amount Drawn Down—Consistent with PMS 272)	
1a	Migrant Health Center	
1b	Community Health Center	
1c	Health Care for the Homeless	
1e	Public Housing Primary Care	
1g	**Total Health Center** (Sum of Lines 1a through 1e)	
1k	**Capital Development Grants**, including School-Based Service Site Capital Grants	
1l	Coronavirus Preparedness and Response Supplemental Appropriations Act (H8C)	
1m	Coronavirus Aid, Relief, and Economic Security Act (CARES) (H8D)	
1n	Expanding Capacity for Coronavirus Testing (ECT) (H8E and LAL ECT)	
1o	American Rescue Plan (ARP) (H8F, L2C, C8E)	
1p	Other COVID-19-Related Funding from BPHC (specify_____)	
1q	**Total COVID-19 Supplemental** (Sum of Lines 1l through 1p)	
1	**Total BPHC Grants** (Sum of Lines 1g + 1k + 1q)	

Lines 1l–1p capture COVID-related funding *from HRSA BPHC* and should only include amounts drawn down in 2022.

- **Report the amount drawn down in the year**; some of these funds may have been awarded in 2021, but if they were not drawn down until 2022, then they're reported in the calendar year 2022 UDS.
  - Lines 1l–1n were awarded in 2020.
  - Line 1o was awarded in 2021.
- At this time, there will be **no reporting on Line 1p**, as no other BPHC COVID-19 funding exists.
- See detailed guidance on COVID-19 funding.

HRSA Health Center Program

Non-Federal Grants Revenue Categories

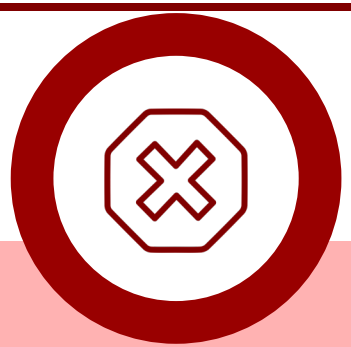
Table 9E, Lines 6–10

- **State and Local Government:** Funds received from a state or local government, taxing district, or sovereign tribal entity (e.g., state public health grant)
- **State/Local Indigent Care Programs**: Funds received from state/local indigent care programs that subsidize services rendered to patients who are uninsured (e.g., New Mexico Tobacco Tax Program)
- **Foundation/Private:** Funds from foundations and private organizations (e.g., hospital, United Way)
- **Other Revenue:** Miscellaneous non-patient-related revenues including fundraising, interest revenue, medical records revenue, *public* pharmacy, etc.

	Non-Federal Grants or Contracts	
6	State Government Grants and Contracts (specify_____)	
6a	State/Local Indigent Care Programs (specify_____)	
7	Local Government Grants and Contracts (specify_____)	
8	Foundation/Private Grants and Contracts (specify_____)	
9	**Total Non-Federal Grants and Contracts** (Sum of Lines 6 + 6a + 7 + 8)	
10	Other Revenue (non–patient service revenue not reported elsewhere) (specify _____)	
11	**Total Revenue** (Sum of Lines 1 + 5 + 9 + 10)	

Key Reminders for Other Revenue on Table 9E

- Report all grant funds and non-patient service payments received during the calendar year on Table 9E.
- Grants or loans forgiven are not reported on Table 9E.
- Be sure all revenue is reported based on who your health center received the money from, not where the funding originated.



- **Do not** report 340B or contract pharmacy revenue on Table 9E; report on Table 9D according to guidance on page 169 of the UDS Manual.
- **Do not** report pay-for-performance incentives or other incentives for patient care on Table 9E; report in Column C3.

Detailed guidance for where certain grants and revenue are to be reported is in the UDS Manual, beginning on page 153.

HRSA Health Center Program

Frequently Asked Questions: Table 9E

How does the UDS Table 9E financial reporting differ from our health center financial statements?

Table 9E reports all non-patient-service-related revenue on a cash basis, and health centers will recognize this revenue on an accrual basis in their financial statements.

How do we report grant funds for which we have only used (or drawn down) part of the award amount?

Table 9E collects information on cash receipts for the calendar year. For a grant, report the cash amount received during the calendar year. Do not report the award amount (unless the full award was paid/drawn down during the year).

How do we report funding that we receive from an organization that received a grant, which they "pass through" to our health center?

Use the "last party rule" to classify the receipts. Grant, contract, and other funds should always be reported based on the entity from which the health center received them, regardless of the source from which they originated.

Resources and Updates

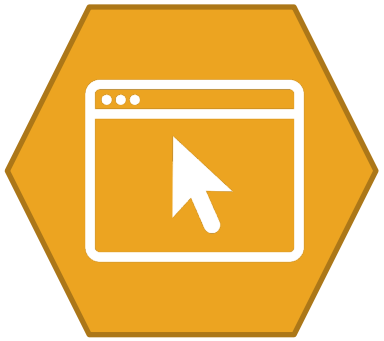
BPHC UDS Reporting Resources

- **UDS Training and Technical Assistance (TTA) Resources on the BPHC website**
- Resources now regrouped by topic to better align with UDS tables:
  - Special/Current Topics
  - Reporting Guidance
  - Staffing and Utilization
  - Clinical Care
  - **Financials**
  - Additional Reporting Topics
  - UDS Data

UDS TTA resources are available at https://bphc.hrsa.gov/datareporting/reporting/index.html

Follow UDS Guidance

Thoroughly read definitions and instructions in the 2022 UDS Manual.



Review resources on the Financials page of the HRSA UDS TTA site. This page includes:

- **Table-Specific Fact Sheets** are available for each table.
- **COVID-19 Funding UDS Reporting Guidance** outlines funding sources administered to health centers and provides guidance on where these funding sources should be reported in the UDS.
- **UDS Financial Tables Reporting Guidance** provides common reporting considerations and issues to consider when reporting UDS Tables 8A, 9D, and 9E, including tips and acronyms.
- **Reporting Donations on the UDS** explains how to report various donations a health center may receive throughout the reporting year. It clarifies where health centers should report donated services and supplies vs. monetary donations across Tables 8A: Financial Costs and 9E: Other Revenue.

HRSA Health Center Program

Available Assistance

Technical assistance materials, including local trainings, are available online:

- HRSA UDS Training and Technical Assistance site

UDS Support Center for assistance with UDS reporting questions:

- udshelp330@bphcdata.net
- 866-UDS-HELP (866-837-4357)

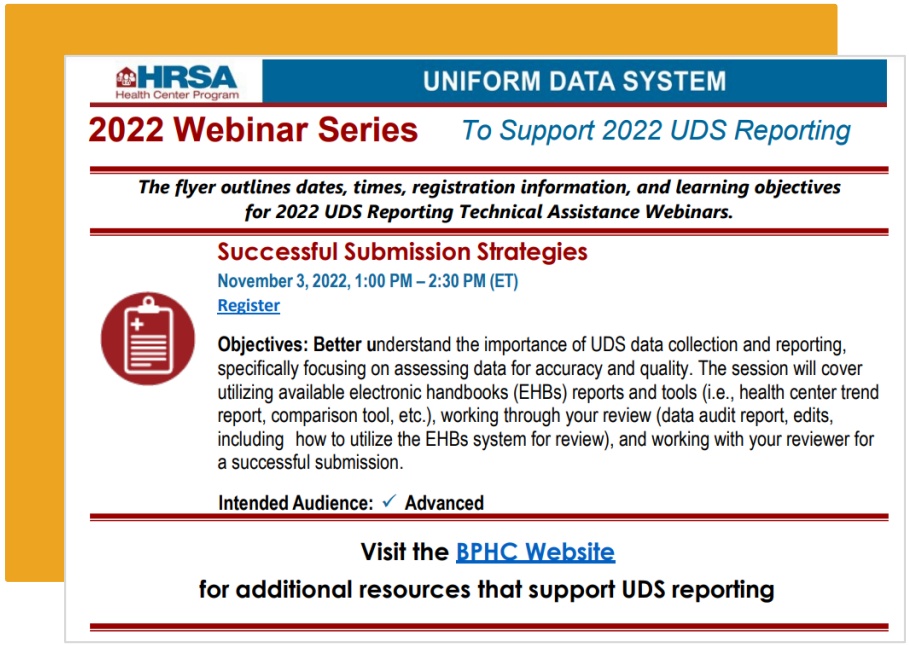
Health Center Program support for questions about the Health Center Program

EHBs support

- UDS Report and preliminary reporting environment access (in EHBs)
- EHBs system issues: 877-464-4772, Option 1
- EHBs account access and roles: 877-464-4772, Option 3

National Training and Technical Assistance Partners (NTTAPs)

Upcoming Webinars


HRSA Health Center Program

UNIFORM DATA SYSTEM

2022 Webinar Series *To Support 2022 UDS Reporting*

The flyer outlines dates, times, registration information, and learning objectives for 2022 UDS Reporting Technical Assistance Webinars.

Successful Submission Strategies

November 3, 2022, 1:00 PM – 2:30 PM (ET)

Register

Objectives: Better understand the importance of UDS data collection and reporting, specifically focusing on assessing data for accuracy and quality. The session will cover utilizing available electronic handbooks (EHBs) reports and tools (i.e., health center trend report, comparison tool, etc.), working through your review (data audit report, edits, including how to utilize the EHBs system for review), and working with your reviewer for a successful submission.

Intended Audience: ✓ **Advanced**

Visit the BPHC Website

for additional resources that support UDS reporting

- **One session left in the 2022 UDS Webinar series: Successful Submission Strategies on Nov. 3.**

- Past webinars can be accessed on the HRSA UDS TTA site, along with many other resources!

Preliminary Reporting Environment Coming Soon

- Access the Uniform Data System (UDS) Preliminary Reporting Environment (PRE) via the HRSA Electronic Handbooks starting October 28, 2022.
- Two offline reporting tools are also available to help health centers submit UDS data before the reporting period begins on January 1, 2023:
  - Offline Excel Files
  - Hyper Text Markup Language (HTML) Files
- Learn more about the PRE at this upcoming webinar:

UDS Training: PRE Webinar

November 10, 2022

1:00 – 3:00 PM ET

Register

Access Instructions to Access UDS Reporting Guidance on the Electronic Handbooks

HRSA Health Center Program

Community Health Quality Recognition Badges

Community Health Quality Recognition (CHQR) Badge Eligibility Criteria

- **CHQR badge eligibility criteria have been established for clinical quality measures (CQMs) that do not currently have established national benchmarks.**
  - Criteria will be used to award CHQR badges for the 2021–2023 UDS reporting periods
  - Provides health centers with clear targets to shape quality improvement strategies
- **Benchmarks, new badges, and criteria changes will take effect for the 2021 UDS reporting period, including:**
  - Incorporating Look-Alikes (LALs) into Adjusted Quartile Rankings. As a result, LALs will be eligible for Health Center Quality Leader badges.
  - Adding new CHQR badge categories: HIV, maternal and child health, and addressing social risk factors to health.
  - Awarding one COVID-19 response badge using UDS-reported data on COVID-19 testing and vaccinations.
  - Adopting updated criteria for the Health Disparities Reducer badge.

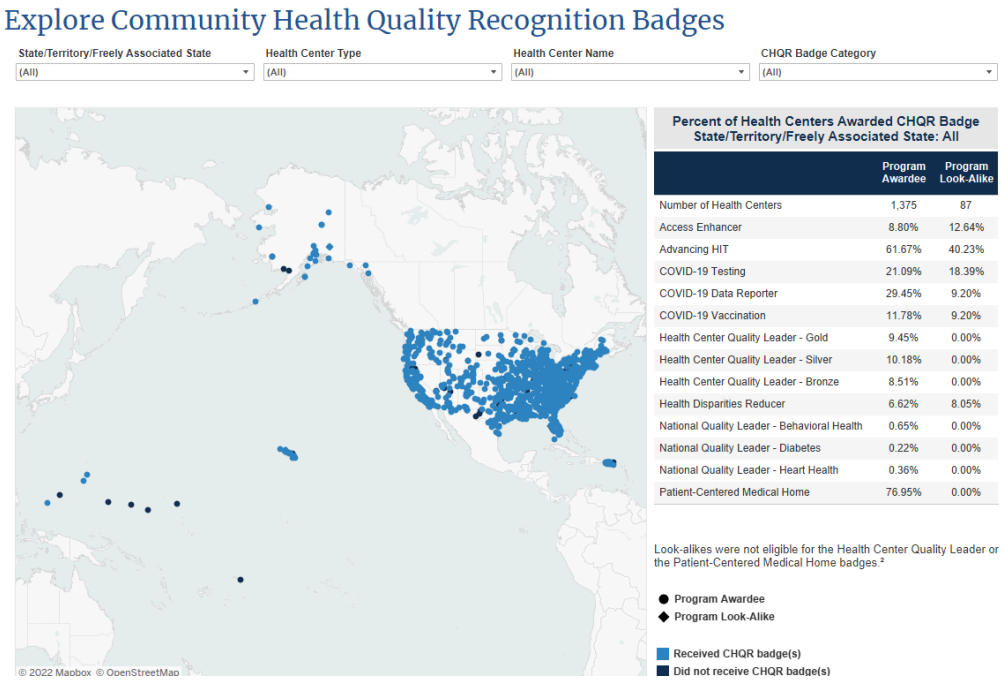
Access CHQR Overview and CHQR FAQ

HRSA Health Center Program

Access Community Health Quality Recognition Data

Community Health Quality Recognition (CHQR) Dashboard

- Dashboard available publicly on the data.hrsa.gov website.
- Provides visualization, national-level summary, state-level summaries of CHQR badges awarded.
- Identifies program awardees and look-alikes that have made notable quality improvement achievements.
- Updated annually with UDS data release.



Access CHQR Dashboard

Looking Forward to 2023 UDS Reporting

UDS Patient Level Submission (UDS+)

UDS+ is...

- Beginning with the 2023 UDS, BPHC will accept patient-level report data.
  - UDS Tables PBZC, 3A, 3B, 4, 6A, 6B, and 7

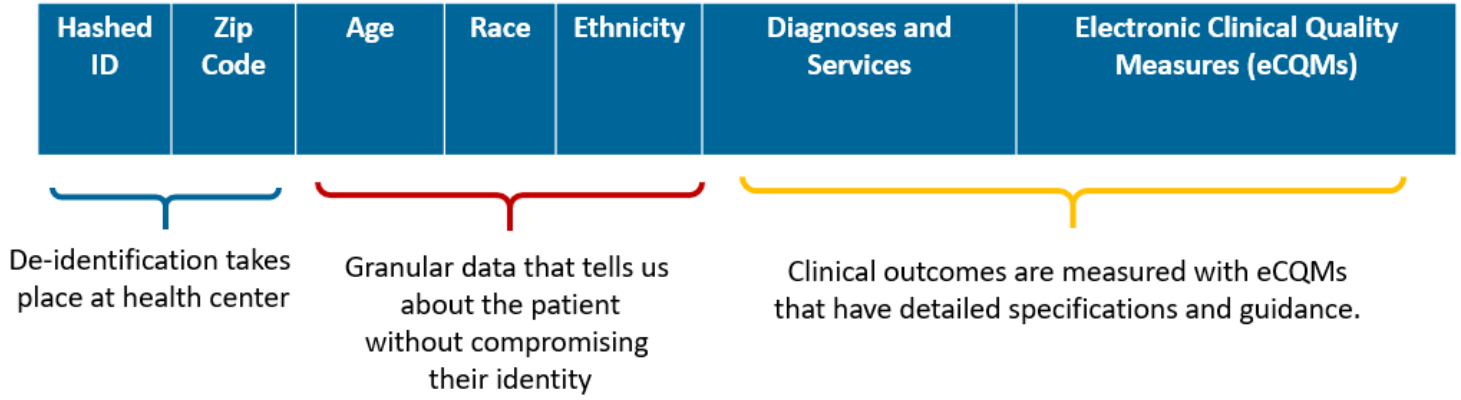
BPHC plans to accept UDS+ data in two ways:

- Manual file upload system & Fast Healthcare Interoperability Resources (FHIR)

UDS+ does not...

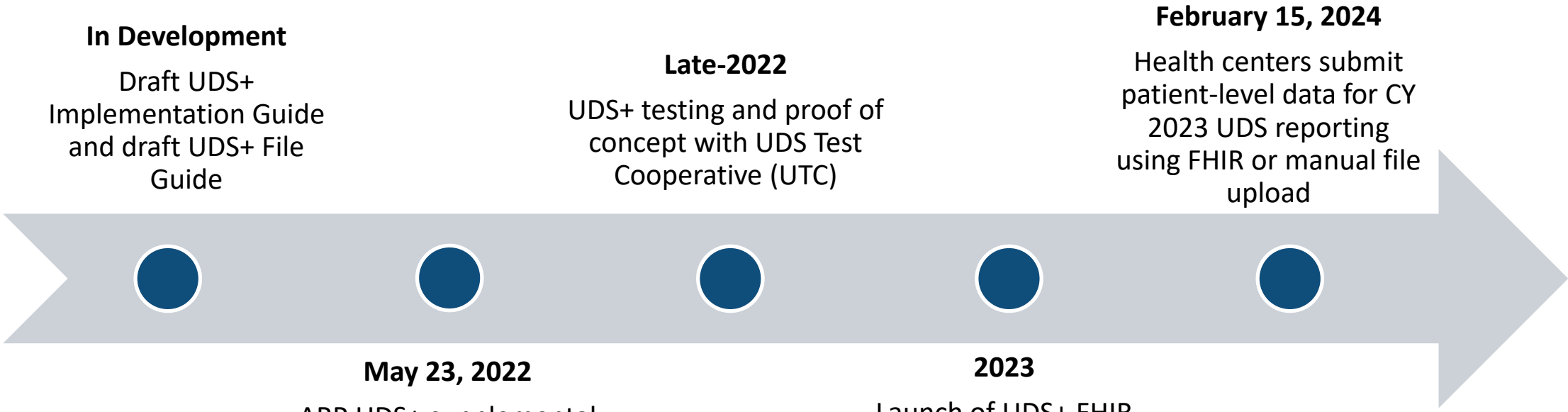
- Collect full copies of data directly from patients' electronic medical records
- Collect patient identifiers

For more information, visit: Uniform Data System (UDS) Modernization Initiative



HRSA Health Center Program

UDS+ Implementation Timeline



UDS Modernization FAQs

HRSA Health Center Program

Questions and Answers

Thank You!

Bureau of Primary Health Care (BPHC)

Health Resources and Services Administration (HRSA)

udshelp330@bphcdata.net or Health Center Program Support

1-866-837-4357

bphc.hrsa.gov

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www.HRSA.gov

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