Table 4: Selected Patient Characteristics

PURPOSE:

Table 4 is used to report on selected patient characteristics, including income, insurance status, managed care utilization, and membership in special populations. In combination with the other patient profile tables, it provides an understanding of the demographics of those receiving services.

CHANGES:

- In addition to submitting this table as described below within the EHBs, health centers may voluntarily submit de-identified patient-level report data using Health Level Seven (HL7®) Fast Healthcare Interoperability Resources (FHIR®) R4 standards for this table.

KEY TERMS:

INSURANCE AND MANAGED CARE:

- *Third Party Insurance:* Main source of insurance for primary medical care services. Report this as of the last visit of the reporting year.

- *Managed Care Member Month:* Defined as 1 individual being enrolled for 1 month in a managed care plan. Total number of member months equals the sum of the monthly enrollment for the reporting year.

SPECIAL POPULATIONS

- *Migratory or Seasonal Agricultural Worker:* A patient whose principal employment is in agriculture on a seasonal basis. Migratory describes those who establish a temporary home for such employment. Seasonal describes those who do not establish a temporary home for such employment.

- *Homeless Patient:* A patient who is homeless at the time of any service provided during the reporting year.

- *School-Based Service Site Patient:* A patient receiving health care services at a school-based service delivery site in their scope of project. This includes in-scope school-based health centers located on or near school grounds that provide on-site comprehensive health care services.

- *Veteran:* A patient who has been discharged or released from the uniformed services of the United States under conditions other than dishonorable.

- *Public Housing Patient:* A patient who is served at health center sites located in or immediately accessible to public housing, regardless of whether the health center site receives PHPC funding, or the individual physically resides in public housing.

HOW DATA ARE USED:

- **Patient Characteristics:** Describes patients by income and insurance.

- **Managed Care Utilization:** Describes managed care enrollment in terms of member months per payer.

- **Special Populations:** Provides information about special populations receiving services.

TABLE TIPS:

- Table 4 is completed for the Universal Report and the grant-specific report (if applicable).

INCOME

- Total patients by income must equal total patients by insurance and total patients in each section of Tables 3A and 3B and the Zip Code Table.

For more detailed information see UDS Reporting Requirements for 2023 Health Center Data, pages 41 – 54.

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- Income should be updated annually and collected from all patients (not only from patients applying for a sliding fee discount). The report should include the most current income information available.

- Income must be reported by the patient. Do not assume income (e.g., report a Medicaid-insured patient as low-income). The patient can self-declare income if it is consistent with health center policies and procedures.

- Official poverty guidelines are available online at *ASPE's website.*

- Use Line 5 (Unknown) to report patients whose information was not collected at or within 12 months of the last visit of the calendar year.

INSURANCE

- Breast and Cervical Cancer Control Program, Workers Comp, indigent care programs, and other programs that cover only a specific service are **not** considered insurance.

MANAGED CARE

- Enrollees in Primary Care Case Management (PCCM) programs, which pay a small monthly fee (usually less than $10 per member per month) that do not cover patient care, are **not** reported as managed care.

- Do not include managed care enrollees whose capitation or enrollment is limited to behavioral health or dental services only, though an enrollee who has medical and dental coverage is counted on the appropriate medical insurance line.

SPECIAL POPULATIONS

- All 330 programs report the total number of agricultural worker patients (Line 16), homeless patients (Line 23), school-based patients (Line 24), veterans (Line 25), and public housing patients (Line 26) served.

- Report the patient's shelter arrangements as of the first visit during the reporting period.

- *Migratory Agricultural Workers* (Line 14) are usually hired laborers who are paid piecework, hourly or daily wages and who establish a temporary home for the purposes of employment. Also include on Line 14, migratory workers who have had this work as their principal source of income within 24 months of their last visit and their dependent family members who have used the center.

- *Seasonal Agricultural Workers* (Line 15) are individuals whose principal employment is in agriculture on a seasonal basis (as opposed to year-round employment) and who do not establish a temporary home for purposes of employment. Seasonal agricultural workers who have had this work as their principal source of income within 24 months of their last visit are reported on Line 15 as are their dependent family members who have used the center.

- *Homeless* (Lines 17–22) are only reported by 330h grantees. These are patients who lack housing, including individuals whose primary residence during the night is a supervised public or private facility providing temporary living accommodations and individuals who reside in transitional housing. This information is recorded based on where they spent the previous/recent nights:

  - Shelter (Line 17)

  - Transitional Housing (Line 18)

  - Doubled Up (Line 19)

For more detailed information see UDS Reporting Requirements for 2023 Health Center Data, pages 41 – 54.

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- Street (Line 20)

- Other (Line 21)

- Permanent Supportive Housing (Line 21a)

- Unknown (Line 22)

- ***School-Based Service Site Patients*** (Line 24) are reported by all health centers that identified a school-based service site in their grant or designation application and scope-of-project description. The total number of patients who received health care services at the school service delivery site(s) is reported. Include patients who received countable visits within any of the service categories (medical, mental health, etc.). Services are targeted to the students at the school but may also be provided to siblings, or parents, as well as persons residing in the immediate vicinity of the school.

- ***Veterans*** (Line 25) are patients who have been discharged or released under conditions other than dishonorable from the uniformed services of the United States. Patients who are still in the uniformed services (including the National Guard or Reserves) are not considered veterans. This information is reported by all health centers.

- ***Public Housing Patients*** (Line 26) are individuals served at health center sites that are located in or immediately accessible to public housing, regardless of whether the health center site receives Public Housing Primary Care (PHPC) funding. Exclude scattered site Section 8 housing units that receive no public housing agency support other than Section 8 vouchers.

CROSS TABLE CONSIDERATIONS:

- The total patients reported by insurance type must match on Table 4 (Lines 7–12) and the Patients by ZIP Code Table. For example, total Medicare patients on Table 4 (Line 9) must match the total Medicare patients (Column D) on the Patients by ZIP Code Table.

- Reporting of charges and collections by payer on Table 9D relates to insurance enrollment on Table 4. For example, dividing Medicaid revenues on Table 9D, Line 3, Column B by Total Medicaid patients on Table 4 (Line 8) equals the average charge/average collection per Medicaid patient (see below).

- Reporting of managed care revenues on Table 9D relates to member months on Table 4. Dividing managed care capitation income by member months equals average capitation per member per month (PMPM). For example, dividing Medicaid capitated income (Table 9D, Line 2a, Column B) by Table 4, Line 13a, Column A equals Medicaid PMPM (see below).

SELECTED CALCULATIONS:

See next two pages for the examples described below:

- **Calculation of Average Charge per Medicaid Patient:** $26,744,788/(20,061+15,396) = $754/ Medicaid Patient

- **Calculation of Average Collection per Medicaid Enrollee:** $29,325,761/ (20,061+15,396) = $827/Medicaid Patient

For more detailed information see UDS Reporting Requirements for 2023 Health Center Data, pages 41 – 54.

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Table 4: Selected Patient Characteristics

TABLE 4 — SELECTED PATIENT CHARACTERISTICS			
Reporting Period: January 1, 2023 through December 31, 2023			
CHARACTERISTIC		**NUMBER OF PATIENTS**	
Line	Income as Percent of Poverty Guideline	Number of Patients (a)	
1	100% and below		
2	101-150%		
3	151-200%		
4	Over 200%		
5	Unknown		
6	TOTAL (Sum Lines 1-5)		

Line	Third Party Medical Insurance	0-17 years old (a)	18 and older (b)
7	None/Uninsured	4,958	19,257
8a	Medicaid (Title XIX)	20,061	15,396
8b	CHIP Medicaid		
8	Total Medicaid (Line 8a+8b)	20,061	15,396
9a	Dually Eligible (Medicare and Medicaid)		163
9	Medicare (Inclusive of dually eligible and other Title XVII beneficiaries)	2	6,860
10a	Other Public Insurance Non-CHIP (specify)	3	738
10b	Other Public Insurance CHIP		
10	Total Public Insurance (Line 10a+10b)	3	738
11	Private Insurance	2,460	4,713
12	TOTAL (Sum Lines 7+8+9+10+11)	27,484	46,964

Line	Managed Care Utilization Payer Category	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	TOTAL (e)
13a	Capitated Member Months	369,658				369,658
13b	Fee-for-service Member Months					
13c	Total Member Months (Sum Lines 13a+13b)	369,658				369,658

Table 4: Selected Patient Characteristics

				TABLE 9D — PATIENT SERVICE REVENUE				
					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)
1	Medicaid Non-Managed Care	5,028,253	3,890,883		1,135,473			1,166,506
2a	Medicaid Managed Care (capitated)	7,411,041	10,080,620	4,113,290		2,944,160		-2,669,579
2b	Medicaid Managed Care (fee-for-service)	14,305,494	15,354,258					-494,501
3	**Total Medicaid** (Lines 1+2a+2b)	**26,744,788**	**29,325,761**	**4,113,290**	**1,135,473**	**2,944,160**		**-1,997,574**
4	Medicare Non-Managed Care							
5a	Medicare Managed Care (capitated)							
5b	Medicare Managed Care (fee-for-service)							
6	**Total Medicare** (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)							
9	**Total Other Public** (Lines 7 + 8a + 8b + 8c)							