Table 9D: Patient Service Revenue

PURPOSE:

Table 9D collects patient service revenue information on charges, collections, retroactive settlements, receipts, paybacks, adjustments, self-pay sliding discounts, and self-pay bad debt write-offs attributable to the calendar year.

CHANGES:

- There are no major changes to Table 9D: Patient Service Revenue.
- Many of the requirements have been further clarified in this version of the UDS Manual.

HOW DATA ARE USED

- The data from Table 9D are used to understand health center patient service revenue and payer mix.
- These data are used to calculate average charge per visit, payer mix, and charge-to-cost ratio.

KEY TERMS:

FULL CHARGES: Report in Column A the total unadjusted gross charges to a payer for a billable service according to the health center's fee schedule. Charges should be reported based on the date of services and limited to the dates of service that occurred in 2024.

COLLECTIONS: Report in Column B the gross receipts for the calendar year from a payer regardless of the period in which the paid services were rendered. Collections and adjustments are reported based on posting date and limited to transactions posted in 2024.

FORM OF PAYMENT:

MANAGED CARE CAPITATED: Capitation fees paid, per patient or per assigned member, to the health center (usually monthly) regardless of whether services were rendered or not.

MANAGED CARE FEE-FOR-SERVICE: Charges and collections for patients assigned to the health center under a managed care arrangement and seen on a fee-for-service basis for covered services.

PAYERS:

MEDICAID: Includes all routine Medicaid and EPSDT under any name; Medicaid part of Medi-Medi or crossovers; CHIP if paid through Medicaid; may include fees for other state programs paid by the Medicaid intermediary.

MEDICARE: Includes all routine Medicare; Medicare Advantage; Medicare portion of Medi-Medi or crossovers.

OTHER PUBLIC: Includes state or local government programs; municipal or county jails and state prisons; public schools or public institutions that engage with the health center on a fee-for-service or other contractual arrangement; non-Medicaid CHIP; state-based programs which cover a specific service or disease such as Breast and Cervical Cancer Early Detection Program (BCCEDP), Title X, Title V, COVID-19 (testing and treatment administered by HRSA under the COVID-19 Uninsured Program). Does *not* include indigent care programs.

Note: Although family planning programs such as Title X programs, BCCEDPs, and other dedicated state or local programs are considered Other Public payers, patients are generally classified as Uninsured on Table 4 because these are not considered comprehensive health insurance plans.

For more detailed information see UDS Reporting Requirements for 2024 Health Center Data, pages 159 – 170.

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PRIVATE: Includes private and commercial insurance; Tricare, Trigon, Workers Comp, etc.; contracts with private schools, private jails, Head Start, etc., that are paid by the organization and based on patient visits. Insurance purchased through state exchanges are reported as "private", unless you can identify the patient as being enrolled through purchased subsidies from a Medicaid expansion program.

SELF-PAY: Charges for which patients are responsible and all associated collections. Includes co-pays and deductibles for which the patient is responsible. Also, includes payments for services covered by indigent care programs.

TABLE TIPS:

CHARGES (COLUMN A)

- Undiscounted, unadjusted charges based on a fee schedule, for services provided in the measurement year.
- Do not enter "charges" where no collection is attempted or expected, such as for enabling services or pharmacy samples.
- Under no circumstances should the actual amount paid by Medicare or Medicaid (e.g., FQHC, G code or T code rates) or the amount paid by any other payer be used as the actual charge amount in column A. Charges must come from the health center's schedule of fees, typically based on CPT codes, or retail charge (for pharmacy).
- For Medicare charges, if your system uses both the G-code charge and actual charge, you can remove G-code charges by running a report to get the total for G-code charges for the year, then subtract this number from total charges and report the difference in Column A.

COLLECTIONS (COLUMN B)

- Amount collected as payment for, or related to, the provision of services, including payments from third party payers, capitation payments, payments from patients, and collections for services provided in a prior year. Collections are reported on a cash basis.

RETROACTIVE SETTLEMENTS, RECEIPTS, OR PAYBACKS (COLUMNS C1 – C4)

- Columns c1 and c2 include payments for FQHC or S-CHIP settlements (difference between established per-visit rate and initial payments) and reconciliations (submission of a cost report) for current or prior year. These are often referred to as wrap payments.
- Column c3 or "Other Payments" includes risk pools, incentives, Pay for Performance (P4P), and quality bonuses.
- These amounts are also included in Column B.
- Column c4 or "Penalty/Payback" enter payments made by the health center to payers because of overpayments collected earlier. This could include Accountable Care Organization (ACO) downside risk payments.

ADJUSTMENTS (COLUMN D)

- Adjustments are payment reductions granted as part of an agreement with a third-party payer.
- Reduce the adjustments in Column D by the amount of FQHC adjustments (c1–c4).
- Allowances do not include:
  - Non-payment for services not covered by the third party.
  - Non-payment of bills which were not submitted in a timely fashion or properly signed/submitted.

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- Deductibles or co-payments that are not paid by a third party and not collected from a patient.
- For managed care capitated insurance *only*, the allowance is calculated as the difference between total charges and collections unless there are early or late capitation payments (Column D = Column A — Column B). This does not apply for fee-for-service payers.

SLIDING FEE DISCOUNTS (COLUMN E)

- Reduction in the amount due or paid for services rendered based solely on the patient's documented income and family/household size as it relates to federal poverty level.
- May be applied to co-payments, deductibles, and non-covered services for insured patients when the related charge has been moved to the self-pay line.
- Line 13 — self-pay line only.

BAD DEBT (COLUMN F)

- Amounts considered to be uncollectable from the patient and formally written off during the calendar year, regardless of when the service was provided.
- *Only self-pay bad debt* is reported, third-party bad debt is not reported.

RECLASSIFYING CHARGES:

- Co-payments and deductibles as well as charges for non-covered services rejected by third parties should be moved to the payer responsible for the charge.
- It is essential to reclassify these charges and portions of charges appropriately.
- Show collections of these reclassifications on the appropriate line.

REPORTING CHARGES AND COLLECTIONS FOR PHARMACEUTICALS DISPENSED AT CONTRACT PHARMACIES

- Full retail charges are reported by payer in Column A.
- The amount received from the patient (Line 13) or insurance company is reported in Column B.
- The amount disallowed by a third-party for the charge is reported in Column D.
- The amount written off for a patient as a sliding discount is reported in Column E.

CROSS TABLE CONSIDERATIONS:

- Table 4, Lines 7–12 and Table 9D: Table 4 reports primary medical insurance and Table 9D includes all charges and collections including those for other services such as dental. Charges and collections by payer type on Table 9D relate to insurance enrollment on Table 4.
- Table 4, Lines 13a–b and Table 9D: Capitated managed care revenue on Table 9D divided by capitated member months on Table 4 should approximate Per member, per month (PMPM).
- Table 5 and Table 9D: Billable visits on Table 5 should relate to charges on 9D (charge per visit).
- Table 8A and Table 9D: Reimbursable costs should relate to gross charges if fee schedule is designed to cover costs. See example on the next page.
- Table 9D, Line 13, Column E and Table 9E, Line 6a, Column A: If indigent care funds on Table 9E reimburse for services delivered to uninsured patients in the current year, they should not exceed sliding fee discount on Table 9D.

For more detailed information see UDS Reporting Requirements for 2024 Health Center Data, pages 159 – 170.

Table 9D: Patient Service Revenue

TABLE 9D — PATIENT SERVICE REVENUE

Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Retroactive Settlements, Receipts, and Paybacks (c)		
				Collection of Reconciliation/ Wrap Around Current Year (c1)	Collection of Reconciliation/ Wrap Around Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)
14	**TOTAL** (Lines 3+6+9+12+13)	52,440,869	41,010,494	4,113,290	1,306,596	2,944,160

TABLE 8A — FINANCIAL COSTS

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
FINANCIAL COSTS FOR MEDICAL CARE				
1	Medical Staff	20,287,757	9,641,909	30,029,666
2	Lab and X-ray	1,302,135	662,268	1,964,403
3	Medical/Other Direct	2,839,075	1,329,591	4,168,666
4	**TOTAL MEDICAL CARE SERVICES** (Sum Lines 1 through 3)	24,428,967	11,733,768	36,162,735
FINANCIAL COSTS OF OTHER CLINICAL SERVICES				
5	Dental	3,986,773	1,771,103	5,757,876
6	Mental Health	1,356,455	652,157	2,008,612
7	Substance Use Disorder	446,473	217,386	663,859
8a	Pharmacy (not including pharmaceuticals)	1,587,276	790,340	2,377,616
8b	Pharmaceuticals	2,177,064		2,177,064
9	Other Professional (Specify_____)	555,819	280,298	83,618
9a	Vision	1,111,640	560,597	167,236
10	**TOTAL OTHER CLINICAL SERVICES** (Sum Lines 5 through 9a)	11,221,500	4,271,881	13,235,881

The full charges for this example as reported on Table 9D, line 14, column (a) is $52,440, 869. Total medical costs of $31,162,735 reported on line 4, column (c) of Table 8A and total other clinical services reported on line 10, column (c) of Table 8A of $13,235,881. Adding these two totals from Table 8A that represent the costs of providing medical and other clinical services equals $44,398,616 which is less than the full charges of $52,440, 869.

For more detailed information see UDS Reporting Requirements for 2024 Health Center Data, pages 159 – 170.