



Reporting UDS (Uniform Data System) Financial and Operational Tables and Using Comparison Performance Metrics

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Opening Remarks

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Bureau of Primary Health Care

Health Resources and Services Administration



Agenda

- Overview
- Costs on Table 8A
- Patient Revenues on Table 9D
- Other Revenues on Table 9E
- Other Resources
- Conclusion



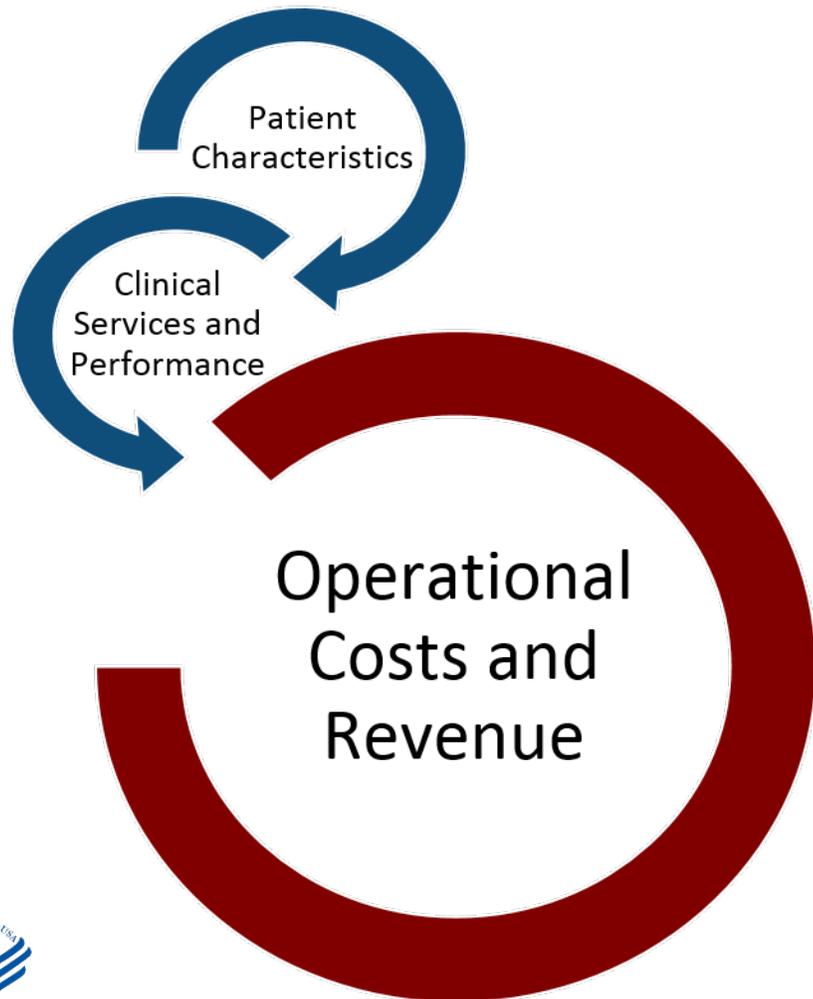
Objectives of the Webinar

- **Understand the financial tables for Calendar Year 2019 UDS data collection and reporting (to be reported by February 15, 2020)**
- **Clarify expectation for collecting and reporting financial elements of the UDS**
- **Discuss unique or specific examples to support accurate reporting**
- **Assess attendees knowledge to ensure understanding**



Operational Tables

Income & Insurance (Table 4), Staffing & Services (Table 5), and Finances (Tables 8A, 9D, & 9E)



Why these operational costs and revenue?

- Staffing levels by service type
- Program costs
- Patient income and insurance
- Patient revenues
- Non-patient revenue

All directly related; we cannot talk about *costs and revenues* without talking about patients and services!

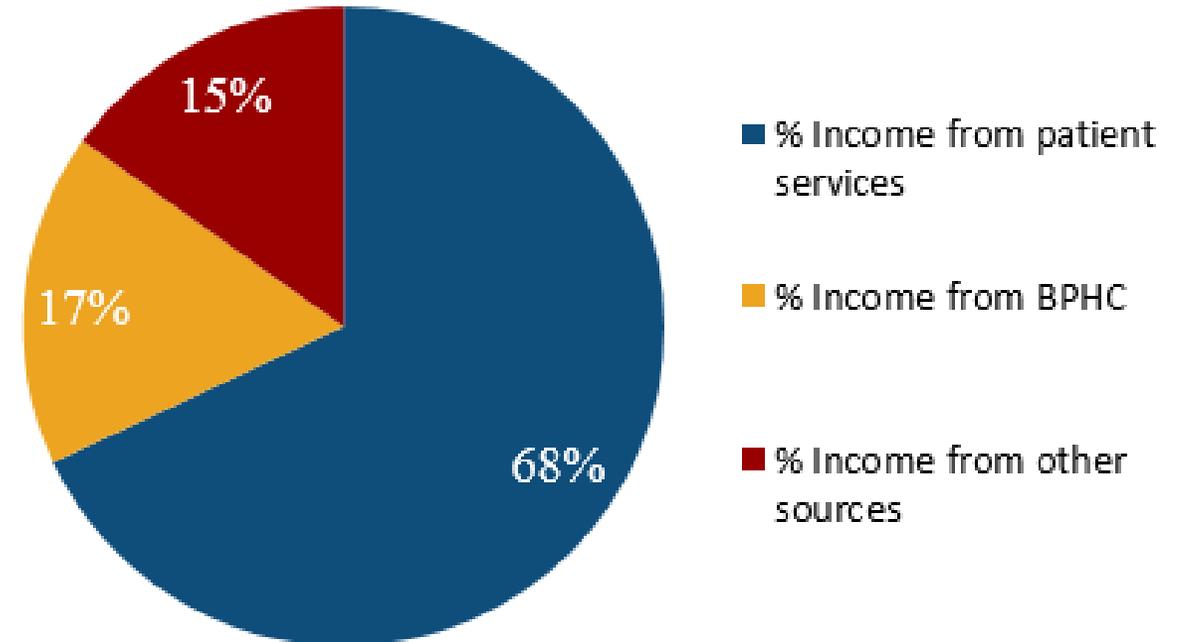
What the Numbers Say

2018 National Statistics

Staff and Financial Category	Average
Total cost per patient	\$990
Medical cost per medical visit	\$200
Charge per billable visit	\$297
Self-pay charges written off as sliding discounts	62%
Insurance adjustments as a percent of insurance charges	29%
Surplus as a percent of total cost	2%

Sources of Support

Health Center Program awardees are funded primarily through patient services.





Costs on Table 8A

Operating Costs

Tables 5 and 8A Crosswalk

Table 5

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1	Family Physicians	.25	12		
2	General Practitioners				
3	Internists				
4	Obstetrician/Gynecologists				
5	Pediatricians	1.0	13		
7	Other Specialty Physicians				
8	Total Physicians (Sum lines 1-7)	1.25	25		
9a	Nurse Practitioners	.6	3		
9b	Physician Assistants				
10	Certified Nurse Midwives				
10a	Total NP, PA, and CNMs (Sum lines 9a - 10)	.6	3		
11	Nurses	3.0			
12	Other Medical Personnel				
13	Laboratory Personnel	1.0			
14	X-Ray Personnel				
15	Total Medical (Sum lines 8+10a through 14)	5.85	28		10
16	Dentists		5		
17	Dental Hygienists		4		
17a	Dental Therapists				
18	Other Dental Personnel				
19	Total Dental Services (Sum lines 16-18)		9		5
20a	Psychiatrists				
20a1	Licensed Clinical Psychologists				
20a2	Licensed Clinical Social Workers				
20b	Other Licensed Mental Health Providers				
20c	Other Mental Health Staff				
20	Total Mental Health (Sum lines 20a-c)				

Table 8A

	Cost Center
	Financial Costs of Medical Care
1	Medical Staff
2	Lab and X-ray
3	Medical/Other Direct
4	Total Medical Care Services (Sum Lines 1- 3)
	Financial Costs of Other Clinical Services
5	Dental
6	Mental Health
7	Substance Use Disorder
8a	Pharmacy not including pharmaceuticals
8b	Pharmaceuticals
9	Other Professional (Specify: _____)
9a	Vision
10	Total Other Clinical Services (Sum Lines 5 through 9a)



Tables 5 and 8A Crosswalk Continued

Staff FTE on Table 5, Line:	Have Costs Reported on Table 8A, Line:
1–12: Medical Providers and Clinical Support Staff	1: Medical Staff
13–14: Lab and X-ray	2: Lab and X-ray
16–18: Dental (e.g., dentists, dental hygienists)	5: Dental
20a–20c: Mental Health	6: Mental Health
21: Substance Use Disorder	7: Substance Use Disorder
22: Other Professional (e.g., nutritionists, podiatrists)	9: Other Professional
22a–22c: Vision Services (ophthalmologists, optometrists, optometric assistants, other vision care)	9a: Vision
23: Pharmacy	8a: Pharmacy
24–28: Enabling (e.g., case management, outreach, eligibility)	11a–11h: Enabling <i>Note: Cost categories on Table 8A are not in the same sequential order as they appear on Table 5</i>
29a: Other Programs/Services (e.g., non-health-related services including WIC, job training, housing, child care)	12: Other Related Services
29b: Quality Improvement	12a: Quality Improvement
30a–30c and 32: Non-clinical Support Services and Patient Support (e.g., corporate, intake, medical records, billing, fiscal, IT staff)	15: Non-clinical Support Services
31: Facility (e.g., janitorial staff)	14: Facility



Financial Costs

Table 8A

Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
<p>Accrued direct costs</p> <p>Include costs of</p> <ul style="list-style-type: none"> Staff Fringe benefits Supplies Equipment Depreciation Related travel <p>Exclude bad debt</p>	<p>Allocation of facility and non-clinical support services</p> <ul style="list-style-type: none"> Allocate to all other cost centers (lines) <p>Must equal Line 16, column (a)</p>	<p>Sum of columns (a) + (b) (done automatically in EHBs)</p> <p>Represents cost to operate service</p> <p>Used to calculate cost per visit and cost per patient</p>

	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 of Medical Care				
1	Medical Staff			
2	Lab and X-ray			
3	Medical/Other Direct			
4	Total Medical Care Services (Sum Lines 1- 3)			
Financial Costs of Other Clinical Services				
5	Dental			
6	Mental Health			
7	Substance Use Disorder			
8a	Pharmacy not including pharmaceuticals			
8b	Pharmaceuticals			
9	Other Professional (Specify: _____)			
9a	Vision			
10	Total Other Clinical Services (Sum Lines 5 through 9a)			
Financial Costs of Enabling and Other Services				

Column (a), Lines 1–13

Table 8A

- **Line 1:** Medical staff salary and benefits, including
 - Paid medical interns or residents
 - Vouchered or contracted medical services
- **Line 2:** Medical lab and x-ray direct expense
- **Line 3:** Non-personnel including Health IT/EHR expenses
- **Lines 8a-8b:** Separate drug (8b) from other pharmacy costs (8a)
 - Dispensing fees on 8a
 - Pharmacy assistance program on 11e
- **Lines 5-13 (excluding 8a-8b):** Direct expenses, including personnel (employed + contracted), benefits, supplies, and equipment
 - Line 12: Other Related Services includes space rented out within the health center, WIC, retail pharmacy to non-patients, etc.
 - Line 12a: Staff dedicated to HIT/EHR design and QI

	Cost Center
	Financial Costs of Medical Care
1	Medical Staff
2	Lab and X-ray
3	Medical/Other Direct
4	Total Medical Care Services (Sum Lines 1- 3)
	Financial Costs of Other Clinical Services
5	Dental
6	Mental Health
7	Substance Use Disorder
8a	Pharmacy not including pharmaceuticals
8b	Pharmaceuticals
9	Other Professional (Specify: _____)
9a	Vision
10	Total Other Clinical Services (Sum 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 Cost (Sum Lines 11a through 11h)
12	Other Related Services (Specify: _____)
12a	Quality Improvement
13	Total Enabling and Other Services (Sum Lines 11, 12, and 12a)



Column (a), Lines 14-19

Table 8A

Indirect or Overhead Costs

- **Line 14:** Facility-related expenses including, rent or depreciation, mortgage interest payments, utilities, security, janitorial services, maintenance, etc.
- **Line 15:** Costs for all staff reported on Table 5, lines 30a-32, including corporate administration, billing collections, medical records and intake staff; board of directors cost; facility, liability, and D&O insurance; legal fees; managing practice management system; and direct non-clinical support costs (travel, supplies, etc.)
 - Include malpractice insurance in the service categories, not here

Line	Facility and Non-Clinical Support Services and Totals
14	Facility
15	Non-Clinical Support Services
16	Total Facility and Non-Clinical Support Services (Sum Lines 14 and 15)
17	Total Accrued Costs (Sum Lines 4 + 10 + 13 + 16)
18	Value of Donated Facilities, Services, and Supplies (specify: _____)
19	Total with Donations (Sum Lines 17 and 18)

- **Line 16:** Total indirect costs (Line 14 + Line 15) *to be allocated in column (b)*
- **Line 18:** “In-kind” services; donated facilities, supplies, and pharmaceuticals; and volunteer hours.
 - Value pharmaceuticals at 340B pricing
 - “In-kind” at replacement value



Recommended Steps to Improve Accuracy

- Use a two step allocation method for overhead (column b); one step often skews costs

Line 14: Facility

- For each facility, identify square footage utilized by each cost center and cost per square foot
- Distribute facility costs to each cost center
- Space shared by two cost centers (e.g. a medical/dental waiting room) is allocated to those two cost centers. General space (janitor's closet, lunch room) may be netted out of the total

Line 15: Non-Clinical Support Services

- Distribute non-clinical support costs to the applicable service
- Decentralized front desk staff, billing and collection systems and staff, etc.
- Consider lower allocation of overhead to contracted services and enabling services
- Allocate remaining costs using straight-line method (proportion of costs to each service category)





Cost Considerations on Table 8A

Are cost data reasonable?

Averages across Health Centers

- Nationally, medical staff costs are about **80%** of total medical costs, and about **45%** of total accrued costs (before donations)
- Pharmacy + pharmaceuticals average about **11%** of total costs
- Facility costs average about **8%** of total costs
- Non-clinical support services average about **25%** of total costs
- Costs must include salary plus fringe benefits for all FTEs and services (e.g., equipment) reported on Table 5:
 - Medical average: approx. **\$100K/FTE** (Line 15, column (a) on Table 5)
 - Dental average: approx. **\$125K/FTE** (Line 19, column (a) on Table 5)



UDS Health Center Performance Comparison Report:

Cost per Patient

Measures	Averages								National Percentiles		
	Health Center	State	National	Rural	Size	Sites ¹	Special population Agricultural Workers ²	Special population Homeless ³			
					10,000-19,999	6-10	Below 25%	Below 25%			
					n = 177	n = 1373	n = 765	n = 307			
COSTS											
Cost Per Patient											
Total Cost per Total Patient	\$797.36	\$1,128.99	\$941.97	\$977.74	\$894.18	\$874.78	\$943.13	\$929.11	\$676.52	\$855.88	\$1,130.63
Medical Cost per Medical Patient	\$514.38	\$749.37	\$601.51	\$614.26	\$574.36	\$561.94	\$599.99	\$595.64	\$479.67	\$587.00	\$732.44
Dental Cost per Dental Patient	\$368.77	\$584.39	\$513.03	\$498.31	\$482.57	\$507.54	\$510.26	\$511.62	\$393.93	\$512.22	\$689.16
Mental Health Cost per Mental Health Patient	\$1,028.99	\$1,099.10	\$823.66	\$829.31	\$853.53	\$725.68	\$829.31	\$815.43	\$423.16	\$723.78	\$1,166.74
Substance Abuse Cost per Substance Abuse Patient	-	\$1,153.70	\$1,165.88	\$1,228.25	\$1,126.68	\$1,031.61	\$1,173.24	\$1,126.00	\$439.24	\$999.25	\$2,024.09
Vision Cost per Vision Patient	\$118.86	\$219.21	\$223.07	\$214.87	\$220.87	\$233.38	\$220.05	\$222.95	\$110.60	\$188.34	\$285.15
Enabling Services Cost per Enabling Patient	\$959.81	\$682.33	\$731.20	\$790.79	\$641.55	\$623.62	\$755.93	\$731.48	\$407.34	\$973.69	\$2,398.99



Relationship Between Reporting Income and Insurance on Table 4 and Patient-Generated Revenue on Table 9D

Income

Table 4

Line	Characteristic	Number of Patients (a)
Income as Percent of Poverty Guideline		
1	100% and below	7
2	101 - 150%	1
3	151 - 200%	1
4	Over 200%	1
5	Unknown	2
6	Total (Sum lines 1-5)	12

- **Lines 1-4: Patients by income**

- Use income based on Federal Poverty Guidelines
 - ✓ Most recent income data collected during the measurement year
 - ✓ Can be based on documents submitted or self-reported per Board policy (consistent with the [Health Center Program Compliance Manual](#))
 - ✓ Do not use insurance or special population status as proxy for income
- Income is used determine eligibility for sliding fee (Reported on Table 9D), based on the health center's policies and procedures
- Income should be reasonable when considered along side Table 9D



Primary Medical Insurance Categories

Table 4

- **None/Uninsured:** Patient had no medical insurance at last visit - include uninsured patients for whom the health center may be reimbursed through grant, contract, or uncompensated care fund
- **Medicaid (Title XIX):** Medicaid and Medicaid-managed care programs, including those run by commercial insurers
- **CHIP Medicaid OR Other Public Insurance CHIP:**
 - If CHIP paid by Medicaid report on 8b; If CHIP reimbursed by commercial carrier outside of Medicaid report on 10b
- **Dually Eligible (patients enrolled in both Medicare and Medicaid):** Subset of Medicare patients who are dually eligible

Charges and collections for patients who are classified as uninsured may be classified as Self-Pay on Table 9D; may be Other Public if covered by grant funds, or another payer; if for example, the services were non-medical and covered by a payer.

Line	Principal Third Party Medical Insurance
7	None/Uninsured
8a	Medicaid (Title XIX)
8b	CHIP Medicaid
8	Total Medicaid (Line 8a + 8b)
9a	Dually Eligible (Medicare and Medicaid)
9	Medicare (Inclusive of dually eligible and other Title XVIII beneficiaries)
10a	Other Public Insurance (Non-CHIP) (specify)
10b	Other Public Insurance CHIP
10	Total Public Insurance (Line 10a + 10b)
11	Private Insurance
12	TOTAL (Sum Lines 7 + 8 + 9 + 10 + 11)



Primary Medical Insurance Categories

Table 4

- **Medicare:** Include Medicare, Medicare Advantage, and Dually Eligible
- **Other Public Insurance (Non-CHIP) (specify):** State and/or local government insurance that covers a broad set of services
 - **EXCLUDE** categorical grant programs reimbursing limited benefits (e.g., EPSDT, BCCCP)
- **Private Insurance:** Commercial insurance, insurance earned for public employees or retirees, insurance purchased on the federal or state exchanges

Patients receiving these services are often **uninsured** on Table 4, but are **Other Public** on Table 9D

Line	Principal Third Party Medical Insurance
7	None/Uninsured
8a	Medicaid (Title XIX)
8b	CHIP Medicaid
8	Total Medicaid (Line 8a + 8b)
9a	Dually Eligible (Medicare and Medicaid)
9	Medicare (Inclusive of dually eligible and other Title XVIII beneficiaries)
10a	Other Public Insurance (Non-CHIP) (specify)
10b	Other Public Insurance CHIP
10	Total Public Insurance (Line 10a + 10b)
11	Private Insurance
12	TOTAL (Sum Lines 7 + 8 + 9 + 10 + 11)



Crosswalk Between Table 4 and 9D

Table 4 – Principal Third Party Medical Insurance Lines	Table 9D – Primary Payer Revenue Lines
7: Uninsured – No medical insurance at last visit (includes patients whose service is reimbursed through grant, contract, or uncompensated care fund)	13: Self Pay –includes revenue data from full-pay self-pay, the patient liability for insured patients and sliding fee patients (<i>Do not include revenues from categorical grant programs –See Other Public, Lines 7-9</i>)
8a and 8b: Medicaid and Medicaid CHIP (includes Medicaid-managed care programs and all forms of state-expanded Medicaid)	1-3: Medicaid (includes Medicaid expansion)
9a and 9: Dually eligible and Medicare	1-6: Medicare and Medicaid
10a: Other Public non-CHIP – State and local government insurance that covers primary care	7-9: Other Public – Include patient revenue from programs with limited benefits, such as family planning (Title X), BCCCP, etc.
10b: Other Public CHIP	7-9: Other Public
11: Private – Commercial insurance, including insurance purchased of federal or state exchange (<i>Do not include worker’s compensation</i>)	10-12: Private – Charges and collections from contracts with commercial carriers, schools, jails, Head Start, tribes, and workers’ compensation, and state and federal exchanges
13a: Capitated managed care enrollees	“a” lines
13b: Fee-for-service managed care enrollees	“b” lines



Polling Question

Managed Care Utilization

Table 4

Report the sum of monthly enrollment for 12 months by type of insurance

A member month = one member enrolled for 1 month

Complete only for managed care contracts where the patient must go to health center for their primary care. Include:

Capitated plans: For a flat payment per month, services from a negotiated list are provided to patients

Fee-for-Service plans: Paid according to the fees established for primary care and other services rendered

There is generally a relationship between

Member months on Table 4

Example: $36,788 \text{ Medicaid member months} \div 12 = 3,066$

Insurance categories on Table 4

Example: 4,174 Medicaid patients

Managed care lines on Table 9D

Example: $\text{Medicaid net capitation } \$1,044,850 \div \text{member months } 36,788 = \28

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



Managed Care

- ***Managed Care Organizations (MCOs)*** have different names: MCO, Health Maintenance Organization (HMO), Accountable Care Organization (ACO), Coordinated Care Organization (CCO), etc.
- MCOs may have ***multiple plans with different payers*** (e.g., Medicaid and Private)
- Health center receives a monthly ***enrollment list*** of patients in the managed care plan
- MCOs may include ***financial risk***

Patients are considered managed care on the UDS if they must receive all of their primary care from the health center itself and/ or the health center must coordinate that patient's care.

Managed Care Reporting

Payment Model	How to Report on the UDS
Capitated managed care covering primary care	Enrollees on Table 4, Line 13a; revenue on Table 9D “a” line
Capitated managed care covering behavioral health or dental <i>only</i>	No enrollees on Table 4; revenue on Table 9D “a” line
Fee-for-service (FFS) managed care	Enrollees on Table 4, Line 13b; revenue on Table 9D “b” line
Managed care incentive payments	Revenue on Table 9D, columns (b) <u>and</u> (c3), and deduct from column (d)
Primary care case management (small fee paid per member per month [PMPM] for care coordination)	No enrollees on Table 4; revenue on Table 9D on <u>non-managed care</u> line
Capitated carve-out payments paid as fee-for-service (combined capitated/FFS)	Do not report enrollees on Table 4 as fee-for-service managed care (enrollees on capitated line); revenue as fee-for-service managed care on Table 9D “b” line

Patient-Related Revenue

Table 9D

Retroactive Settlements, Receipts, and Paybacks (c)										
Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	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)	Penalty/ Payback (c4)	Allowances (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 (Lines 1 + 2a + 2b)									
4	Medicare Non-Managed Care									
5a	Medicare Managed Care (capitated)									

Report (columns)

- > (a) Charges
- > (b) Collections (**cash** receipts)
- > (c1-c4) Supplemental payments
- > (d) Contractual adjustments
- > (e) Self-pay sliding discounts
- > (f) Self-pay bad debt write-off

By Payer (rows)

- > Lines 1-3 Medicaid
- > Lines 4-6 Medicare
- > Lines 7-9 Other Public
- > Lines 10-12 Private
- > Line 13 Self-pay

By Form of Payment

- > Non-managed care
- > a) Capitated managed care
- > b) Fee-for-service managed care



Column (a): Full Charges

Table 9D

Full Charges This Period (a)	Amount Collected This Period (b)	Retroactive Settlements, Receipts, and Paybacks (c)				Allowances (d)	Sliding Fee Discounts (e)	Bad Debt Write Off (f)
		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)	Penalty/ Payback (c4)			

- Report total **billed** charges by payer source
 - Undiscounted, unadjusted, gross charges for services based on fee schedule
 - ✓ Charges are full gross charges based upon the fee schedule before adjustments and reported uniformly across all pay groups
 - ✓ Include **charges for all services** (e.g., medical, dental, mental health, vision, pharmacy including contract 340b pharmacy)
 - Do not include “charges” where no collection is attempted or expected (e.g., enabling services, donated pharmaceuticals, or free vaccines)
 - Do not include capitation or negotiated rate as charge amount
 - Do not include charges for Medicare G-codes
 - ✓ To learn more about [CMS payment codes](#), visit the CMS website



Column (b): Collections

Table 9D

Full Charges This Period (a)	Amount Collected This Period (b)	Retroactive Settlements, Receipts, and Paybacks (c)				Allowances (d)	Sliding Fee Discounts (e)	Bad Debt Write Off (f)
		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)	Penalty/ Payback (c4)			

- Include ***all payments*** received in 2019 for services to patients
 - Capitation payments
 - Contracted payments
 - Payments from patients
 - Third-party insurance
 - Retroactive settlements, reconciliations, receipts, and payments
 - ✓ Include pay for performance, quality bonuses, and other incentive payments
- Do not include “Promoting Interoperability” or EHR incentive payments from Medicaid and Medicare here (report on Table 9E)



Columns (c1)-(c4): Retroactive Settlements, Receipts, and Paybacks

Table 9D

Amount Collected This Period (b)	Retroactive Settlements, Receipts, and Paybacks (c)			
	Collection of Reconciliation /Wrap-Around <i>Current</i> Year (c1)	Collection of Reconciliation /Wrap-Around <i>Previous</i> Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty/Payback (c4)
<ul style="list-style-type: none"> • Payments reported in c1 – c4 are <i>part of</i> column b total, but do <i>not equal</i> column b 	<ul style="list-style-type: none"> • Federally qualified health center (FQHC) prospective payment system (PPS) reconciliations (<i>based on filing of cost report</i>) 	<ul style="list-style-type: none"> • Wrap-around payments (<i>additional amount per visit to bring payment up to FQHC level</i>) 	<ul style="list-style-type: none"> • Managed care pool distributions • Pay for performance (P4P) • Other incentive payments • Quality bonuses • Court-ordered payments 	<ul style="list-style-type: none"> • Paybacks or payer deductions by payers because of over-payments (<i>report as a positive number</i>)

Pay for Performance

- Many health centers are in ***value-based payment*** contracts or contracts that pay performance bonuses. These are reported on the line of the payer you received the monies from in ***column (b): Collections*** as well as in ***column (c3): P4P***.



Column (d): Allowances

Table 9D

Full Charges This Period (a)	Amount Collected This Period (b)	Retroactive Settlements, Receipts, and Paybacks (c)				Allowances (d)	Sliding Fee Discounts (e)	Bad Debt Write Off (f)
		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)	Penalty/ Payback (c4)			

- Contractual adjustments or Allowances (column (d)) are agreed upon **reductions/write-offs** in payment by a third-party payer
 - Reduce by amount of retroactive payments in c1, c2, and c3
 - Add paybacks reported in c4
- May result in a negative number
- Non-payment for services not covered/rejected by a third party, deductibles, and co-payments due from patients are not allowances—reclassify to secondary payer
- For managed care capitated lines (2a, 5a, 8a, and 11a) only, allowances equal the difference between charges and collections (because they do not typically carry a balance) $\text{column (d)} = \text{(a)} - \text{(b)}$

Reclassification of Charges

Line	Payer Category	Reclassify Charge		Retroactive Settlements, Receipts, and Paybacks (c)				Allowances (d)	Sliding Fee Discounts (e)	Bad Debt Write Off (f)
		Full Charges This Period (a)	Amount Collected This Period (b)	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)	Penalty/ Payback (c4)			
10	Private Non-Managed Care	\$200 \$170	\$120					\$50		
13	Self Pay	\$30								

Reclassify co-payments, deductibles, and charges for non-covered services rejected by third-party payers

Example: An insured patient was seen at the health center. On the day of the service, the service charge for the visit was \$200. The insurer paid \$120 with an allowance of \$50.

- Post service charge for private payer = \$200 at time of service
- Post-payment of \$120 with a \$50 allowance on the private line when payment is received
- Reduce the initial charge of \$200 to private insurance by \$30—this is the co-pay owed by the patient
- Reclassify the \$30 co-pay to self-pay charges



Column (e): Sliding Fee Discounts

Table 9D

Full Charges This Period (a)	Amount Collected This Period (b)	Retroactive Settlements, Receipts, and Paybacks (c)				Allowances (d)	Sliding Fee Discounts (e)	Bad Debt Write Off (f)
		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)	Penalty/Payback (c4)			

- Report *reductions in patient charges based on their ability to pay* as a sliding-fee discount
 - Based on the patient’s documented income and family size (per federal poverty guidelines)
- May be applied
 - To insured patients’ co-payments, deductibles, and non-covered services
 - Only when charge has been reclassified from original charge line to self-pay
- May not be applied to past-due amounts



Sliding Fee Discounts Example

Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Retroactive Settlements, Receipts, and Paybacks (c)				Allowances (d)	Sliding Fee Discounts (e)	Bad Debt Write Off (f)
				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)	Penalty/ Payback (c4)			
13	Self Pay	\$200	\$10						\$180	\$10

An uninsured patient was seen at the health center. On the day of the service, the patient qualified for a sliding discount that required her to pay 10% of the service charge.

- The service's full charge from the fee schedule is \$200
- A fee of \$20 was charged to the patient (10% of full charge)
- The patient paid \$10
- The patient still owed \$10 and, after the health center determines this is uncollectable or the health center's bad debt policy is met, this amount is written off by the health center

Column (f): Bad Debt Write Off

Table 9D

Full Charges This Period (a)	Amount Collected This Period (b)	Retroactive Settlements, Receipts, and Paybacks (c)				Allowances (d)	Sliding Fee Discounts (e)	Bad Debt Write Off (f)
		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)	Penalty/ Payback (c4)			

- Only report **patient bad debt** (not third-party payer bad debt)
 - Report on Line 13
- Include amounts owed by patients considered to be uncollectable and formally written off during 2019, regardless of when service was provided
- Do not change bad debt to a sliding discount
- Discounts (e.g., to specific groups of patients, cash discounts) or forgiveness are not patient bad debt (or a sliding discount)



340(b) Contract Pharmacy

- To accurately report contract pharmacy dispensing to **clinic patients**, generally using 340(b) purchased drugs:

Table	Related Reporting/ Impact
8A (Costs)	<ul style="list-style-type: none"> Report the amount the pharmacy charges for managing dispensing of drugs on Line 8a. Report the full amount paid for pharmaceuticals, either directly by the clinic or indirectly by the pharmacy, on Line 8b. If the pharmacy buys prepackaged drugs, and there is no reasonable way to separate the pharmaceutical costs from the dispensing/administrative costs, report all costs on Line 8b. Associated non-clinical support services (overhead) costs go on Line 8a, Col B. Report payments to pharmacy benefit managers on Line 8a. Share of profits: Some pharmacies engage in fee splitting and keep a share of profit. Report this as a payment to the pharmacy on Line 8a.
9D (Patient revenue)	<ul style="list-style-type: none"> Charge (Column A) is the health center/contract pharmacy's full retail charge for the drugs dispensed. If retail is unknown, ask the pharmacy for retail prices for the drugs dispensed. Collection (Col B) is the amount received from patients or insurance companies. Health centers must collect this information from the contract pharmacy. (Note: Most health centers do not have this sort of arrangement for Medicaid patients, unless explicitly stated.) Allowance (Col D) is the amount disallowed by a third-party for the charge (if on Lines 1–12). Sliding Fee Discount (Column E) is the amount written off for eligible patients per health center policies (Line 13). Calculate as retail charge/ pharmacy charge, minus amount collected from patients (by pharmacy or health center), minus amount owed by patients.
9E (other rev.)	Do not report pharmacy income on Table 9E, and do not use Table 9E to report net income from the pharmacy. Report actual gross income on Table 9D.





Polling Question



Revenue Considerations for Reporting Table 9D Accurately

Payer Mix

- **Table 9D shows the best example on the UDS of complete or total payer mix; Table 4 only shows medical payer mix.**
 - On average, Medicaid and Medicare as a percent of total revenue is about 7% more than Medicaid and Medicare as a percent of total patients by primary medical insurance on Table 4.
 - ✓ Remember, Table 9D is reported by where the money came from (payer), and therefore a payer line may include services covered by a different payer than reflected on Table 4, such as dental coverage that is different from primary medical insurance.
 - ✓ The percentage can fluctuate depending on the types of services (higher priced care items, e.g., prenatal care/delivery).

Averages Across Health Centers

- **Adjustments and Patient Discounts:**
 - **62%** of self-pay charges written off as sliding discounts
 - **29%** of insured charges adjusted as allowances
 - Indigent care funds cover **11%** of self-pay charges

Test Your Understanding!

A few income, insurance, and payer edits



Short Description	Common Edit Flag
Member Months in Question	Table 4: A large number of Medicaid member months is reported compared with the total Medicaid enrollment served reported on Line 8
Patients Unknown Income Questioned	Table 4: More than 50% of total patients are reported as having Unknown income
Inter-year Change in Uninsured Patients	Table 4: The percentage of uninsured patients to total patients has significantly increased from prior year—(e.g., current year 33%; prior year = 14%)
Change in Collections in Question	Table 9D: A large change from the prior year in collections per medical + dental + mental health visit is reported
FQHC Medicaid Non-Managed Care Retroactive Payments Questioned	Table 9D: FQHC Medicaid Non-Managed Care retros exceed 50% of collections

Test Your Understanding!

More income, insurance, and payer edits



Short Description	Common Edit Flag
Possible Material Reclassification Problem	Table 9D: The self-pay collection rate (0.76) exceeds the combined collection rate for Medicare and Private Insurance (0.52)
Large Change in Accounts Receivable for Total Medicaid is Reported	Table 9D: Total Medicaid, Line 3: When we subtract collections (column (b)) and adjustments (column (d)) from your total Medicaid charges (column (a)) there is a large difference (53%)
Charge to Cost Ratio Questioned	Tables 8A and 9D: Total charge to cost ratio (0.7) is reported that suggests that charges are less than costs
Inter-year Capitation PMPM questioned	Tables 4 and 9D: The average Medicaid capitation PMPM reported on Line 2a \$56 is significantly different from the prior year \$24
Patient Revenue Reported in Question	Tables 4 and 9D: Private Managed Care Collections are reported on Table 9D with no matching Private Managed Care Member months on Table 4, Line 13c column (d)



Polling Question



Other Revenue, Table 9E

Other Revenue

Table 9E

- Report *non-patient receipts* received in 2019
 - *Cash receipts* – amount drawn down (not award)
 - Include income that supported activities described in your scope of services
 - Report cash receipts by the entity from which you received them
 - Complete “specify” fields
- Revenue reported on Tables 9E and 9D represent total income-related cash receipts that supported federal scope of services

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 Lines 1a through 1e)	
1k	Capital Development Grants, including School Based Health Center Capital Grants	
1	Total BHPC Grants (Sum Lines 1g + 1k)	
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	
5	Total Other Federal Grants (Sum Lines 2-3a)	
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 Lines 6 + 6a + 7 + 8)	
10	Other Revenue (non-patient related revenue not reported elsewhere) (specify:____)	
11	Total Revenue (Lines 1+5+9+10)	



Revenue Categories

- **BPHC Grants:** Funds received directly from BPHC, including funds passed through to another agency
- **Ryan White:** Report Part C (Part A is usually reported on line 7; Part B is usually reported on line 6)
- **Other Federal Grants:** Grants received directly from the federal government other than BPHC (e.g., Ryan White Part D, HUD, SAMHSA, CDC)
- **EHR Incentive Payments:** Report Meaningful Use/Promoting Interoperability funds, including funds paid directly to providers and turned over to the health center (exception to last party rule)

Line	Source
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 Lines 1a through 1e)
1j	Capital Improvement Program Grants
1k	Capital Development Grants, including School Based Health Center Capital Grants
1	Total BPHC Grants (Sum Lines 1g + 1j + 1k)
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
5	Total Other Federal Grants (Sum Lines 2-3a)



Revenue Categories

- **State and Local Government:** Funds received from a state or local government, taxing district, or sovereign tribal entity (e.g., WIC)– Do not include fee-for-service payments (e.g., BCCCP) or indigent care programs (see next slide) here
- **Foundation/Private:** Funds from foundations and private organizations (e.g., hospital, United Way)
- **Other Revenue:** Contributions, fundraising income, rents, sales, interest income, patient record fees, pharmacy sales to the public (i.e., non-health center patients), etc.
 - Do not report bad debt recovery or 340(b) payments here–these revenue are reported on Table 9D

Line	Source
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 Lines 6 + 6a + 7 + 8)
10	Other Revenue (non-patient related revenue not reported elsewhere) (specify:____)
11	Total Revenue (Lines 1+5+9+10)



Reporting Indigent Care Programs

Table	Line	Report
4	7	Patient as uninsured, not other public
9D	13	Charges, collections, bad debt (if any) as self-pay, balance not owed by patient as sliding fee
9E	6a	<p>Funds received from state and local program that subsidize/pay for health care (general) services to uninsured and IHS PL 93-638 Compact funds</p> <ul style="list-style-type: none"> • Based on a current or prior level of service or lump sum per visit (not fee-for-service) • Private contracts with tribes are to be reported as private, on Table 9D • Do not report these funds on both Tables 9D and 9E





Polling Question



Considerations for Reporting Table 9E Accurately

Considerations

- **Remember that Table 9E is reported on a cash basis**
 - Only include revenues that were received/drawn down in 2019, not full awards
- **Be sure that the following are NOT reported on this table:**
 - Do not include in-kind donations; those are reported on Table 8A
 - 340B pharmacy revenue; this is reported by payer on Table 9D
 - Patient-generated revenue of any kind; all patient generated revenue is reported on Table 9D
 - Write-offs of any type
- **Be sure to report grants based on the org. from whom *you received the funds***
 - For example, if you receive a grant from your state's CDC, from a U.S. CDC grant they received by the state and passed on to the center are reported as a state grant (Line 6).



Selected Table 9E Calculation

- From the Health Center Trend Report:

UDS Health Center Trend Report – 2018
1362 Health Centers - Universal

				2017 - 2018		2016 - 2018	
	2016	2017	2018	Change	%	Change	%
Financial Cost/Viability							
Total Accrued Costs per Total Patients	\$889.85	\$941.97	\$990.17	\$48.20	5.12%	\$100.32	11.27%
Medical Cost per Medical Visit	\$184.77	\$192.34	\$199.78	\$7.44	3.87%	\$15.01	8.12%
330 Grant Funds per Patient ¹	\$166.99	\$169.25	\$166.26	-\$2.99	-1.77%	-\$0.73	-0.44%

This is calculated by using the values reported for 330 Grant Funds (Lines 1a through 1e on Table 9E) per Patient (unduplicated patient count from Table 4, Line 6). This partially measures health center reliance on 330-grant funding and provides a useful trend.



Using Available Data and Report Outputs

- **Standard reports and publicly available UDS data discussed:**
 - Health Center Trend Report
 - Summary Report
 - Health Center Performance Comparison Report
 - Rollup Report
 - [HRSA Website Data Center](#) (Rollups, comparison data, health center profiles)
- **Uses:**
 - Used by HRSA to monitor program performance, report to Congress, and identify recipients of quality improvement awards
 - Used by health centers in reporting of grant applications, to monitor performance, and to identify opportunities for quality improvement activities and interventions
 - Evaluated by many* against state and national benchmarks and performance of health center peers
 - ✓ Compare health center changes to changes seen at the state and national levels or to other comparison groups (e.g., rural/urban, smaller/larger, special populations)
 - ✓ Establish goals and targets for program improvements

***HRSA, health centers, researchers, PCAs, HCCNs, etc.**



Resources to Support Financial and Operational Reporting

- [UDS Training Website](#)
 - Operational Costs and Revenue training module
 - [Reporting Donations guide](#)
 - [Table 8A Fact Sheet](#)
 - [Table 9D Fact Sheet](#)
 - [Table 9E Fact Sheet](#)
 - Financial Tables handout (common errors)
- [Reporting UDS Financial and Operational Tables and Using Comparison Performance Metrics webinar](#)



Webinars

- **Upcoming Webinars**

- Strategies for Successful UDS Reporting, October 17 from 1:00-2:30 p.m. ET
- UDS for Bureau of Health Workforce (BHW): Review of Reporting Requirements, November 14 from 1:00-3:00 p.m. ET

- **Past Webinars**

- Reporting Virtual Visits and the Mental Health and Substance Use Disorder Services Reporting Addendum, September 17, 2019, 1:00 – 2:30 p.m. ET
- Review of Clinical Tables and Measures to Support Quality Improvement, September 26, 2019, 1:00-2:30 p.m. ET
- Webinars will be archived on [HRSA's Health Center Program website](#)



Contact Information

Remember to call the UDS Support Line if you have additional
content questions:

1-866-UDS-HELP

or

1-866-837-4357

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