



# Using Comparison Performance Metrics from Uniform Data System (UDS) Tables 8A, 9D, and 9E

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**Jillian Maccini**  
**John Snow, Inc., Training and Technical Assistance Provider**  
**Bureau of Primacy Health Care (BPHC)**

**Vision: Healthy Communities, Healthy People**



# Opening Remarks

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**Daniel Duplantier**

**Team Lead, Data Production, Data and Evaluation Division**

**Office of Quality Improvement**

**Bureau of Primary Health Care (BPHC)**

**Health Resources and Services Administration (HRSA)**



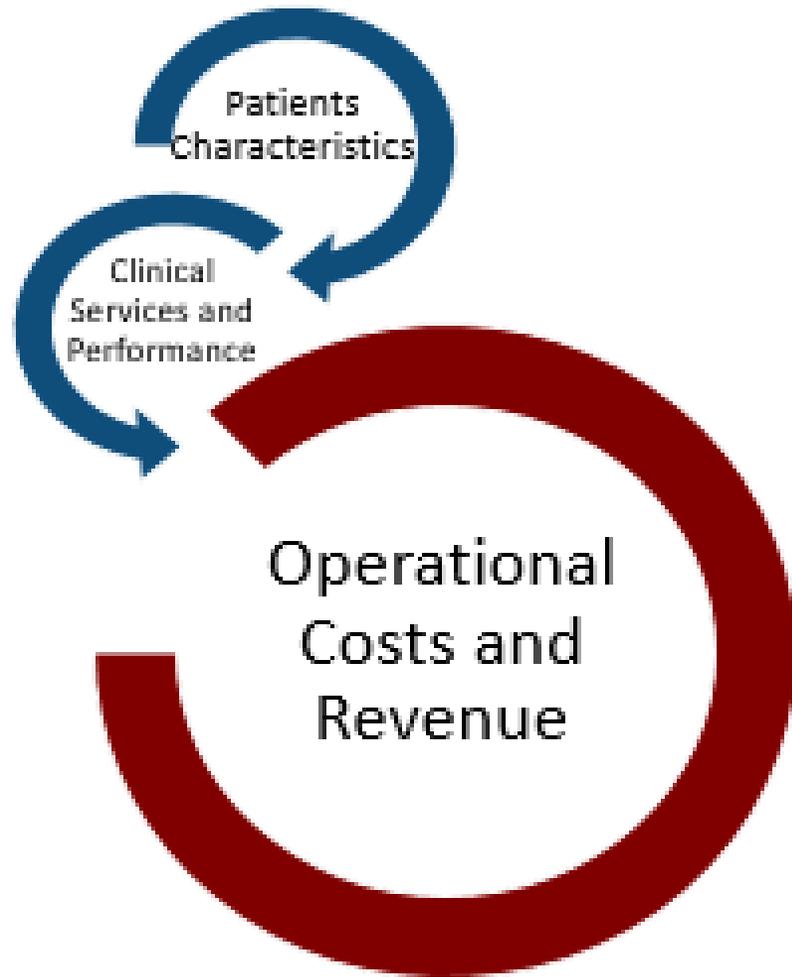
# Agenda

- Discuss strategies and tips for evaluating reported financial data and identify opportunities to assess financial performance
- Review common reporting mistakes including managed care and 340B pharmacy reporting
- Identify strategies and tips for checking data accuracy
- Address topic questions



# Operational Tables

Income & Insurance (Table 4), Staffing & Services (Table 5, 6A), and Finances (Tables 8A, 9D, & 9E)



## *Why these operational costs and revenue?*

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

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

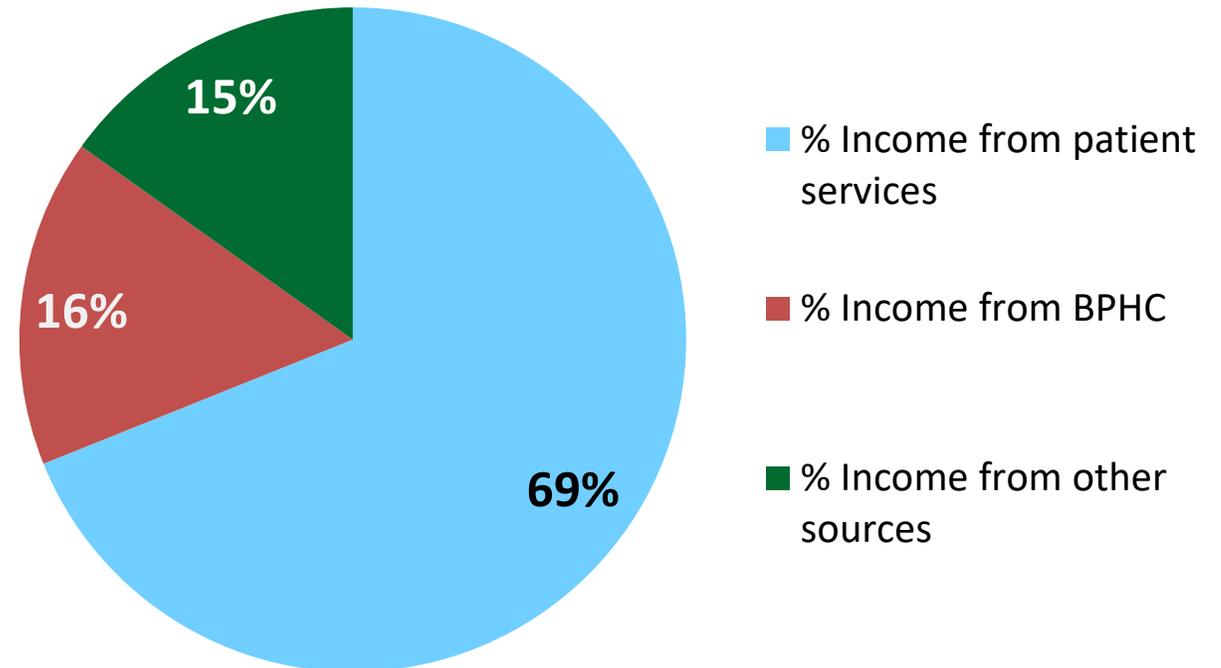
# How Are We Doing?

## 2019 National Statistics

Service and Financial Category	2019 Average
Total cost per total patient	\$1044
Medical cost per medical visit	\$206
Charge per billable visit	\$316
Self-pay charges written off as sliding discounts	62%
Insured charges adjusted as allowances	29%
Surplus/Deficit as % total cost	1%

### Sources of Financial Support

Health Center Program awardees are funded by payers primarily from 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	<b>Total Physicians (Lines 1–7)</b>	<b>1.25</b>	<b>25</b>		
9a	Nurse Practitioners	.6	3		
9b	Physician Assistants				
10	Certified Nurse Midwives				
10a	<b>Total NPs, Pas, and CNMs (Lines 9a–10)</b>	<b>.6</b>	<b>3</b>		
11	Nurses	3.0			
12	Other Medical Professional				
13	Laboratory Personnel	1.0			
14	X-ray Personnel				
15	<b>Total Medical Care Services (Lines 8 + 10a through 14)</b>	<b>5.85</b>	<b>28</b>		<b>10</b>
16	Dentists		5		
17	Dental Hygienists		4		
17a	Dental Therapists				
18	Other Dental Personnel				
19	<b>Total Dental Services (Lines 16–18)</b>		<b>9</b>		<b>5</b>

## Table 8A

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



# Tables 5 and 8A Crosswalk (Cont.)

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 and Services (e.g., non-health-related services including WIC, job training, housing, child care)	12: Other Program-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, and 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><b>Cost by function</b></p> <p>Include costs of:</p> <ul style="list-style-type: none"> <li>Staff</li> <li>Fringe benefits</li> <li>Supplies</li> <li>Equipment depreciation</li> <li>Related travel</li> </ul> <p>Exclude bad debt</p>	<p>Allocation of facility and non-clinical support services</p> <ul style="list-style-type: none"> <li>Allocate to all other cost centers (lines)</li> </ul> <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>

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



# 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 Information Technology (IT)/Electronic Health Record (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 (hired + contracted), benefits, supplies, and equipment
  - Line 12: Other Program- Related Services includes items and programs not classifiable elsewhere and those not exclusively tied to Health Center Program patients.
  - Line 12a: Staff dedicated to **HIT/EHR design** and quality improvement (QI)

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



# Column a, Lines 14-19

## Table 8A: 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; facility and liability 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	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)
<b>Facility and Non-Clinical Support Services and Totals</b>				
14	Facility			
15	Non-Clinical Support Services			
16	<b>Total Facility and Non-Clinical Support Services</b> (Sum of Lines 14 and 15)			
17	<b>Total Accrued Costs</b> (Sum of Lines 4 + 10 + 13 + 16)			
18	Value of Donated Facilities, Services, and Supplies (specify _____)			
19	<b>Total with Donations</b> (Sum of Lines 17 and 18)			

- **Line 16:** Total overhead 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
  - [Reporting donations in the UDS](#)



# Pharmacy Reporting on Table 8A

Health centers with pharmacy programs have many considerations for reporting on the UDS. Some tips for reporting Table 8A accurately:

- Dispensing fees for contract pharmacy (e.g., 340B are reported on Line 8a, Pharmacy, separate from the cost of drugs).
- Costs of pharmaceuticals (either for in-house pharmacy or contract pharmacy) are reported on Line 8b.
- Administrative or overhead costs for the contract pharmacy program, such as clinic's in-house 340B manager or contract manager, should be allocated to Line 8a, Pharmacy, in Column B.
- Report pharmacy assistance program on Line 11e, in the enabling section, not in pharmacy!
- Donated drugs are reported on Line 18, Donated Facilities, Services, and Supplies; value at 340B prices.



# Potential Impacts of COVID-19 on Table 8A

There may be staffing changes such as furloughs or addition of positions such as contact tracers or telehealth coordinators.

- Any service area that shows a notable change in FTEs or services on Table 5 should show change in related cost center on Table 8A.

The health center may have received donations of testing supplies, PPE, space for testing, or volunteer time.

- Any donations of goods, supplies, services, or staff time should be valued and reported on Line 18 of Table 8A.
- Do not report cash donations on Table 8A; those are reported on Table 9E.
- [Resource outlining how to report donation types.](#)

The health center may have purchased telehealth platforms or additional communication tools (e.g., tablets, webcams) to reach patients and staff at home.

- If a system is used by just one cost center, then the system or tool will be reported as an accrued cost for that cost center (Column A).
- If a system or tool is used across the clinic (e.g., by medical and behavioral health), then allocate across those cost centers.



# Cost Considerations on Table 8A

**Are cost data reasonable?**



# Averages across Health Centers

- Personnel costs average about **60-70%** of total costs
- Pharmacy + pharmaceuticals average about **13%** of total costs
- Facility costs average about **7%** of total costs
- Non-clinical support services average about **24%** of total costs
- Costs (including salary plus fringe, supplies, contracted care, etc.) per full time equivalent (FTE) reported in the service area on Table 5:
  - Medical avg.: approx. **\$100K/FTE** (Line 15, Col a on Table 5)
  - Dental avg.: approx. **\$125K/ FTE** (Line 19, Col a on Table 5)



# Recommended Steps to Improve Accuracy

Use a two-step overhead allocation method.

## Line 14: Facility

- For each facility, allocate the cost directly associated with a cost center to that cost center. Allocate the remaining facility cost based on percent distribution of square feet used by each cost center.
- Add administrative space and common spaces not dedicated to a specific cost center to non-clinical support costs and distribute.

## Line 15: Non-Clinical Support Services

- Allocate the non-clinical support cost directly associated with the cost center to those centers. Allocate remaining non-clinical support based on some reasonable method (such as proportion of direct costs).
- Consider lower allocation of overhead to contracted services and enabling services.
- Allocate remaining costs using proportion of costs to each service category.



# Risks of One Step Allocation Method

- **Using a one step method often means that overhead costs are allocated in proportion with costs, FTEs, or visits.**
- This means that if, for example, pharmacy is a significant cost (let's say 15% of total costs), even though it's contracted, using a one step process, it is allocated significant overhead (15% of total overhead).
  - ✓ In fact, any services that are contracted or otherwise incur less overhead should reflect that, so as to not inflate the costs of that cost center.
- Similarly, your medical or mental health clinic may have a new building with a much higher value than your dental clinic, for example.
  - ✓ Using a two step process better reflects the costs of facility and non-clinical support services that each cost center incurs, thereby more accurately reflecting cost per visit or cost per patient for each service area.

# Table 9D

## Relationship between Table 4 and Patient Generated Revenue Reporting on 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
- Children's Health Insurance Program (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 (Medicare and Medicaid): Subset of Medicare patients who are dually eligible



Patients who are uninsured on Table 4 may, on Table 9D, be Self-Pay or Other Public. Patients may be Other Public if their care was covered by 1) a local program or 2) another third party payer, if the services were non-medical and covered by the payer.

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



# Primary Medical Insurance Categories

## Table 4 (Cont.)

- 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;
  - **NOT** grant programs reimbursing limited benefits (e.g., Early and Periodic Screening, Diagnosis and Treatment (EPSDT), Breast and Cervical Cancer Control Programs (BCCCP))
    - ✓ Patients receiving these limited services are often **uninsured** on Table 4, but may be **Other Public** on Table 9D.
- Private Insurance: Commercial insurance, insurance purchased for public employees or retirees, insurance purchased on the federal or state exchanges

Line	Principal Third-Party Medical Insurance
7	None/Uninsured
8a	Medicaid (Title XIX)
8b	CHIP Medicaid
8	<b>Total Medicaid</b> (Line 8a + 8b)
9a	Dually Eligible (Medicare and Medicaid)
9	<b>Medicare</b> (Inclusive of dually eligible and other Title XVIII beneficiaries)
10a	Other Public Insurance (Non-CHIP) (specify ____)
10b	Other Public Insurance CHIP
10	<b>Total Public Insurance</b> (Line 10a + 10b)
11	<b>Private Insurance</b>
12	<b>TOTAL</b> (Sum of 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 – Include co-pays and deductibles; state and local indigent care programs ( <i>Do not include revenues from programs with limited benefits–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	4-6: Medicare
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), EPDST, BCCCP, etc.
10b: Other Public CHIP (commercial carrier outside Medicaid)	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

# COVID-19 Uninsured Program Reporting

## Table 9D

Federal Funding	Other Names	Statute	Date Issued	Reported on UDS
Reimbursement for costs of uninsured patients from HRSA	HRSA Uninsured Claims Program (administered by United Health/Optum Pay)	Families First and PPHCE Acts each appropriated funding to reimburse for testing uninsured; also, a portion of the Provider Relief Fund is for this purpose, including to reimburse for COVID-19 treatment costs for uninsured.	Claims have been submitted as early as May 2020.	<p><b>Table 9D, Line 8c: Other Public Including COVID-19 Uninsured Program</b></p> <p>Report full charges in Column A, collections in Column B, etc., as with all other lines.</p>

- Only HRSA’s COVID-19 Claims Reimbursement to health care providers and facilities for testing and treatment of the uninsured patients is reported.
- ***Do not report write offs or costs to treat or test uninsured patients that are not reimbursed through HRSA’s COVID-19 Claims Reimbursement program on this line.***



# Collection Rates by Payer

Collection Rate by Payer (% of Charges Collected)	All Grantees	Community Health Centers	Migrant Health Centers	Homeless Health Centers	Public Housing Health Centers
Medicaid	77%	77%	59%	77%	82%
Medicare	58%	59%	35%	45%	45%
Other Public	59%	61%	36%	26%	24%
Private Insurance	57%	59%	40%	33%	19%
Self Pay Charges	23%	24%	8%	5%	10%
<b>Overall</b>	<b>62%</b>	<b>61%</b>	<b>10%</b>	<b>47%</b>	<b>61%</b>



# Managed Care Utilization

## Table 4

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	<b>Total Member Months</b> (Sum of Lines 13a+13b)					

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 Medicaid member months ÷ 12 = 3,066

Insurance categories on Table 4

Example: 4,174 Medicaid patients

Managed care lines on Table 9D

Example: Medicaid net capitation \$1,044,850 ÷ member months 36,788 = \$28



# Managed Care Crosswalk of Tables 4 + 9D

Managed Care Cell on Table 4	Related Managed Care Line on Table 9D
<b>Medicaid Capitated</b> Member Months, Line 13a, Col a	Medicaid Managed Care (capitated), Line 2a
<b>Medicaid Fee-for-Service</b> Member Months, Line 13b, Col a	Medicaid Managed Care (fee-for-service), Line 2b
<b>Medicare Capitated</b> Member Months, Line 13a, Col b	Medicare Managed Care (capitated), Line 5a
<b>Medicare Fee-for-Service</b> Member Months, Line 13b, Col b	Medicare Managed Care (fee-for-service), Line 5b
<b>Other Public Capitated</b> Member Months, Line 13a, Col c	Other Public, Managed Care (capitated), Line 8a
<b>Other Public Fee-for-Service</b> Member Months, Line 13b, Col c	Other Public, Managed Care (fee-for-service), Line 8b
<b>Private Capitated</b> Member Months, Line 13a, Col d	Private Managed Care (Capitated), Line 11a
<b>Private Fee-For-Service</b> Member Months, Line 13b, Col d	Private Managed Care (fee-for-service), Line 11b

If there is managed care revenue on managed care lines on Table 9D, then the related cell on Table 4 should have member months, and vice versa.



# Managed Care

- **Managed Care Organizations (MCOs)** have different names (MCOs, Health Maintenance Organization, Accountable Care Organization, Coordinated Care Organization, etc.)
- Payers may have **multiple MCOs** under contract (e.g., Medicaid and Private).
- Health center receives a monthly **enrollment list** of patients in the managed care plan.
- MCO contracts must be **risk-based** to be considered managed care.

Plans where the patient can go to another primary care provider (PCP) with whom they are not enrolled and have that PCP be reimbursed are not managed care plans. There must be an enrollment “lock in” with the PCP for some period; minimally, one month.



# 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 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
Combined capitation/FFS plans	Do not report enrollees on Table 4 as fee-for-service managed care; Revenue as fee-for-service managed care on Table 9D “b” line

# Managed Care Charges: 2019

Managed Care Charges by Category <i>(of Total)</i>	All Grantees	Urban	Rural	Small	Large
% Managed Care Charges	36%	42%	21%	26%	37%
% Capitated Managed Care Charges	11%	13%	5%	5%	12%
% Fee-for-Service Managed Care Charges	25%	29%	16%	21%	26%

# Patient-Related Revenue

## Table 9D

Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Retroactive Settlements, Receipts, and Paybacks (c)				Adjustments (d)	Sliding Fee Discounts (e)	Bad Debt Write-Off (f)
				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)			
1	Medicaid Non-Managed Care									
2a	Medicaid Managed Care (capitated)									
2b	Medicaid Managed Care (fee-for-service)									
3	<b>Total Medicaid</b> (Sum of Lines 1+2a +2b)									
4	Medicare Non-Managed Care									
5a	Medicare Managed Care (capitated)									
5b	Medicare Managed Care (fee-for-service)									
6	<b>Total Medicare</b> (Sum of Lines 4+5a+5b)									

### Report (Columns)

- Column a: Charges (2020)
- Column b: Collections (**cash** basis)
- Columns c1–c4: Reconciliations
- Column d: Contractual adjustments
- Column e: Self-pay sliding discounts
- Column f: Self-pay bad debt

### By Payer (Lines)

- 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

				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)

- Report total **billed** charges by payer source
  - **Undiscounted, unadjusted, gross charges for services based on fee schedule**
    - ✓ Include **all service charges** (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

				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)

- Include **all payments** received in 2020 for services to patients
  - Capitation payments
  - Contracted payments
  - Payments from patients
  - Third-party insurance
  - Retroactive settlements, receipts, and payments
    - ✓ Include pay for performance, quality bonuses, value-based payments, and other incentive payments
- Do not include “Meaningful Use” 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)			Penalty/Payback (c4)
	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)	
<ul style="list-style-type: none"> <li>Payments reported in C1–C4 are <b>part of</b> Column B total, but do <b>not equal</b> Column B</li> </ul>	<p><b>FQHC prospective payment system (PPS) reconciliations</b> <i>(based on filing of cost report)</i></p>	<p><b>Wrap-around payments</b> <i>(additional amount per visit to bring payment up to FQHC level)</i></p>	<ul style="list-style-type: none"> <li>Managed care pool distributions</li> <li>Pay for performance (P4P)</li> <li>Other incentive payments</li> <li>Quality bonuses</li> <li>Value based payments</li> </ul>	<ul style="list-style-type: none"> <li>Paybacks or deductions by payers because of over payments or penalty <i>(report as a positive number)</i></li> </ul>



# Pay for Performance

- Many health centers are in **Value Based Payment** contracts or contracts that pay performance bonuses. These are reported in **Column B: Collections** as well as in **Column C3: P4P**, on the line of the payer you received the monies from.



# Column d: Adjustments

## Table 9D

				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)

- Adjustments 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 adjustments – reclassify to second 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)
- Column d = a – b



# Reclassification of Charges

Reclassify Charge

Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Retroactive Settlements, Receipts, and Paybacks (c)						
				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)
10	Private Non-Managed Care	<del>\$200</del> \$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**

				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)

- 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)				Adjustments (d)	Sliding Fee Discounts (e)	Bad Debt Write-Off (f)
				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)			
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 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 this was written off by the health center
- \$180 included as the sliding fee discount



# Column f: Bad Debt Write-Off

## Table 9D

				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)

- Only report **patient bad debt** (not third-party payer bad debt)
  - Report on Line 13
  - Third-party payer bad debt is not reported in the UDS
- Include amounts owed by patients considered to be uncollectable and formally written off during 2020, 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 is not patient bad debt (or a sliding discount)



# Average across Health Centers

Ratios	All Grantees	Urban	Rural	Small	Large
Average Charge per Unduplicated Patient	\$1,184	\$1,251	\$1,031	\$1,099	\$1,193
Average Charge per Billable Visit	\$316	\$340	\$288	\$312	\$326



# Revenue Considerations for Reporting Table 9D Accurately



# Reporting 340B Contract Pharmacy

Table	Related Reporting/Impact
8A (Costs)	<ul style="list-style-type: none"> <li>Report the <b>amount the pharmacy charges for managing dispensing of drugs</b> on Line 8a, Pharmacy.</li> <li>Report the <b>full amount paid for drugs, either directly (by clinic) or indirectly (by contract pharmacy)</b> on Line 8b, Pharmaceuticals.</li> <li>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, Column B.</li> <li>Report payments to pharmacy benefit managers on Line 8a, Pharmacy.</li> <li>Some pharmacies engage in fee splitting and keep a share of profit. Report this as a payment to the pharmacy on Line 8a, Pharmacy.</li> </ul>
9D (Patient Revenue)	<ul style="list-style-type: none"> <li><b>Charge (Column A) is the health center/contract pharmacy's full retail charge for the drugs dispensed, <u>by payer</u>.</b> If retail is unknown, ask the pharmacy for retail prices for the drugs dispensed.</li> <li><b>Collection (Column B) is the amount received from patients or insurance companies.</b> Health centers must collect this information from the contract pharmacy in order to report accurately.</li> <li><b>Adjustments (Column D) is the amount disallowed by a third party for the charge</b> (if on Lines 1–12).</li> <li><b>Sliding Fee Discount (Column E) is the amount written off for eligible patients per health center policies (Line 13).</b> Calculate as retail charge/pharmacy charge, minus amount collected from patients (by pharmacy or health center), minus amount owed by patients.</li> </ul>
9E (Other Revenue)	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.

**Key Takeaway: You need the breakdowns as outlined here to report correctly; ask now!**



# Payer Mix

- Table 9D shows the best example on the UDS of payer mix, Table 4 only shows medical insurance.
  - 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.



# Test Your Understanding!

## A few income, insurance, and payer edits



Short Description	Common Edit Flag
<b>Member Months in Question</b>	Table 4: A large number of Medicaid member months is reported compared with the total Medicaid enrollment served reported on Line 8
<b>Patients Unknown Income Questioned</b>	Table 4: More than 50% of total patients are reported as having Unknown income
<b>Inter-year Change in Uninsured Patients</b>	Table 4: The percentage of Uninsured patients to total patients has significantly increased when compared to prior year—Current Year 33%; Prior Year = 14%
<b>CHIP</b>	Table 4: More than 25% of CHIP patients are adults
<b>Change in Collections in Question</b>	Table 9D: A large change from the prior year in collections per medical+dental+mental health visit is reported
<b>Self-Pay Reporting in Question</b>	Table 9D: More collections and write-offs are reported than charges for self-pay, Line 13
<b>FQHC Medicaid Non-Managed Care Retroactive Payments Questioned</b>	Table 9D: FQHC Medicaid Non-Managed Care retros exceed 50% of collections

# Test Your Understanding! (Cont.)

More income, insurance, and payer edits



Short Description	Common Edit Flag
<b>Possible Material Reclassification Problem</b>	Table 9D: The self pay collection rate 0.76 exceeds the combined collection rate for Medicare and Private Insurance 0.52
<b>Large change in accounts receivable for Total Medicaid is reported</b>	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%
<b>Charge to Cost Ratio Questioned</b>	Tables 8A and 9D: Total charge to cost ratio of 0.7 is reported that suggests that charges are less than costs
<b>Inter-year Capitation PMPM questioned</b>	Tables 4 and 9D: The average Medicaid capitation PMPM reported on Line 2a \$56 is significantly different from the prior year \$24
<b>Patient Revenue Reported in Question</b>	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

# Other Revenue Table 9E



# Other Revenue

## Table 9E

- Report **non-patient-related income** received in 2020
  - **Cash receipts** – amount drawn down (not award)
  - Include income that supported activities described in your scope of services
  - Report funds from the entity from which you received them
  - Complete specify fields

Line	Source	Amount (a)
<b>BPHC Grants (Enter Amount Drawn Down—Consistent with PMS 272)</b>		
1a	Migrant Health Center	
1b	Community Health Center	
1c	Health Care for the Homeless	
1e	Public Housing Primary Care	
1g	<b>Total Health Center (Sum of Lines 1a through 1e)</b>	
1k	Capital Development Grants, including School-Based Health Center 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) (HSE and LAL ECT)	
1o	Health and Economic Recovery Omnibus Emergency Solutions Act (HEROES)/Health, Economic Assistance, Liability Protection and Schools Act (HEALS)	
1p	Other COVID-19-Related Funding from BPHC (specify ____)	
1q	<b>Total COVID-19 Supplemental (Sum of Lines 1l through 1p)</b>	
1	<b>Total BPHC Grants (Sum of Lines 1g + 1k + 1q)</b>	
Line	Source	Amount (a)
<b>Other Federal Grants</b>		
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	<b>Total Other Federal Grants (Sum of Lines 2 through 3b)</b>	
<b>Non-Federal Grants or Contracts</b>		
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	<b>Total Non-Federal Grants and Contracts (Sum of Lines 6 + 6a + 7 + 8)</b>	
10	Other Revenue (non-patient related revenue not reported elsewhere) (specify ____)	
11	<b>Total Revenue (Sum of Lines 1 + 5 + 9 + 10)</b>	



# Income Categories

- **BPHC Grants:** Funds received directly from BPHC, including funds passed through to another agency
- **COVID-19 Supplemental Funding:** new lines added for 2020 reporting (1l-1q)
- **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, Housing and Urban Development (HUD), Substance Abuse and Mental Health Services (SAMHSA), Centers for Disease Control and Prevention (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	Amount (a)
<b>BPHC Grants (Enter Amount Drawn Down—Consistent with PMS 272)</b>		
1a	Migrant Health Center	
1b	Community Health Center	
1c	Health Care for the Homeless	
1e	Public Housing Primary Care	
1g	<b>Total Health Center</b> (Sum of Lines 1a through 1e)	
1k	Capital Development Grants, including School-Based Health Center 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) (HSE and LAL ECT)	
1o	Health and Economic Recovery Omnibus Emergency Solutions Act (HEROES)/Health, Economic Assistance, Liability Protection and Schools Act (HEALS)	
1p	Other COVID-19-Related Funding from BPHC (specify ____)	
1q	<b>Total COVID-19 Supplemental</b> (Sum of Lines 1l through 1p)	
1	<b>Total BPHC Grants</b> (Sum of Lines 1g + 1k + 1q)	
<b>Other Federal Grants</b>		
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	<b>Total Other Federal Grants</b> (Sum of Lines 2 through 3b)	



# Income Categories (Cont.)

- **State and Local Government:** Funds received by 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 340B payments here—These revenue are reported on Table 9D

Line	Source	Amount (a)
<b>Non-Federal Grants or Contracts</b>		
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	<b>Total Non-Federal Grants and Contracts</b> (Sum of Lines 6 + 6a + 7 + 8)	
10	Other Revenue (non-patient related revenue not reported elsewhere) (specify ____)	
11	<b>Total Revenue</b> (Sum of 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 a state or 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"> <li>• Based on a current or prior level of service or lump sum per visit (not fee-for-service)</li> <li>• Private contracts with tribes are to be reported as private, on Table 9D</li> <li>• Do not report these funds on both Tables 9D and 9E</li> </ul>



# Considerations for Reporting Table 9E Accurately



# Considerations

- Remember that Table 9E is reported on a cash basis (cash receipts, not accrued income)
  - Only include revenues that were received/ drawn down in 2020, not full awards
  - Do not include in-kind donations, those are reported on Table 8A
- Be sure that the following are NOT reported on this table:
  - 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 organization from whom **you received the funds**
  - For example, if you receive a grant from your state's CDC, from a US CDC grant they received, then you would report this as a state grant (Line 6).



# Resources, Questions, and Answers



# Resources to Support Financial and Operational Reporting

- [UDS Training Website](#)
  - [Operational Costs and Revenue training module](#)
  - [Reporting Donations guide](#)
  - [Financial Tables Guidance handout](#) (common error checks)
  - [Table 8A Fact Sheet](#)
  - [Table 9D Fact Sheet](#)
  - [Table 9E Fact Sheet](#)
- [Two-part Financial Series Webinar](#)



# Available Assistance

- Technical assistance materials are available online:
  - [HRSA website](#)
  - [UDS training website](#)
- Year-round telephone and [email](#) support line for UDS reporting questions and use of UDS data: 866-837-4357
- [HRSA Customer Support Center](#) for EHBs account access and roles: 877-464-4772, Option 3
- [Health Center Program support](#) for EHBs system issues: 877-464-4772, Option 1
- UDS Report and preliminary reporting environment access (in [EHBs](#))



# Webinars

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- Upcoming Webinars (registration links available at the [UDS training](#) website)
  - COVID-19 Office Hour. Monday, November 2, 1:00–2:00 p.m. ET.
  - UDS for BHWs: Review of Reporting Requirements. Thursday, November 12, 1:00–3:00 p.m. ET.
- Past Webinars (archived on [BPHC UDS Reporting Resources](#) website)
  - 2020 UDS Changes Webinar
  - Quality Improvement Award Technical Assistance
  - Reporting Visits in the UDS
  - UDS Clinical Tables Part 1: Screening and Preventive Care
  - UDS Clinical Tables Part 2: Maternal Care and Children’s Health
  - UDS Clinical Tables Part 3: Disease Management
  - Reporting UDS Financial and Operational Tables



# Thank You!

**Jillian Maccini**

**Training and Technical Assistance Specialist, John Snow, Inc.**

Bureau of Primary Health Care (BPHC)

Health Resources and Services Administration (HRSA)



udshelp330@bphcdata.net



866-UDS-HELP

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# Contact Information

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

**1-866-UDS-HELP**

or

**1-866-837-4357**

**[udshelp330@bphcdata.net](mailto:udshelp330@bphcdata.net)**





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