UDS: UNIFORM DATA SYSTEM

Table 9D: Patient-Related Revenue

PURPOSE:

Table 9D collects information on charges, collections, retroactive settlements, allowances, self-pay sliding discounts, and self-pay bad debt write-offs.

CHANGES:

- There are no changes to the Table 9D reporting requirements for 2018.
- Many of the requirements have been further clarified in this version of the UDS Manual.

HOW DATA ARE USED

These data are used to calculate average charge per visit, payer mix, and charge-to-cost ratio.

KEY TERMS:

FULL CHARGES: The total gross charges to a payer for a billable service according to your fee schedule.

COLLECTIONS: The total gross receipts for the year from a payer regardless of the period for which the service was rendered.

FORMS OF MANAGED CARE PAYMENT:

MANAGED CARE CAPITATED: Capitation fees paid to the health center (usually monthly) regardless of whether services were delivered 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.

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. 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.

OTHER PUBLIC: Includes state or other public insurance; non-Medicaid CHIP; state-based programs which cover a specific service or disease such as BCCCP, Title X, Title V, TB. Does not include indigent care programs.

PRIVATE: Includes private and commercial insurance; Medi-gap programs, Tricare, Trigon, Workers Comp, etc.; contracts with schools, jails, Head Start, etc. Insurance purchased through state or federal exchanges are reported as "private" unless you can identify them as being enrolled through purchased subsidies from a Medicaid Expansion program (in which case, report as Medicaid).

SELF-PAY: Charges for which patients are responsible and all associated collections. Includes payments for services covered by indigent care programs.

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TABLE TIPS:

CHARGES (COLUMN A)

- Undiscounted, unadjusted charges based on fee schedule, for services provided in the measurement year.
- Do not include "charges" where no collection is attempted or expected, such as for enabling services or pharmacy samples.
- Under no circumstances should the actual amount paid be used as full charges (i.e. FQHC rate should never be reported as charges).

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.

ADJUSTMENTS (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.
- Column (c3) or "Other Retroactive Payments" includes risk pools, incentives, P4P, and withholds.
- These amounts are also included in column (b).

ALLOWANCES (COLUMN D)

- Reductions in payment by a third party based on a contract.
- Reduce the allowance in column(d) by the amount of 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.
  - Deductibles or co-payments that are not paid by a third party and not collected from a patient.
  - For 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).

SLIDING DISCOUNTS (COLUMN E)

- Reduction in the amount due or paid for services rendered based solely on the patient's documented income and family 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.
- Self-pay line only.

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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 must 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 (340B)

- Charges are reported by payer in column (a).
- The amount received from the patient (Line 13) or insurance company (Line 10) is reported in column (b).
- The amount written off for a third-party payer 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: 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 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.
- 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 (see sample tables on next page).

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TABLE 9D (Part II of II) — PATIENT-RELATED REVENUE (Scope of Project Only)						
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 FOR 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	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