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 2019.
- Many of the requirements have been further clarified in this version of the UDS Manual.

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

KEY TERMS:
FULL CHARGES: The total unadjusted 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 in which the service was rendered.

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

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

OTHER PUBLIC: Includes state or 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., that are paid by the organization and based on patient visits. Insurance purchased through state or federal exchanges are reported as “private”, even if subsidies are used to support that purchase.

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

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

MANAGED CARE FEE-FOR-SERVICE: Charges and collections for patients assigned to the health center under a managed care arrangement and seen on a fee-for-service basis.
### Table 9D: Patient-Related Revenue

#### TABLE TIPS:

**CHARGES (COLUMN A)**
- Undiscounted, unadjusted charges based on fee schedule, for services provided in the measurement year.
- Do not enter “charges” where no collection is attempted or expected, such as for enabling services or pharmacy samples.
- Under no circumstances should the actual amount paid be used as full charges (e.g., FQHC rate or PPS rate should not be reported as charges).
- For Medicare charges, if your system uses both the G-code charge and actual charge, you can remove G-code charges by running a report to get the total for G-code charges for the year, then subtract this number from total charges and report the difference in Column A.

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

**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. These are often referred to as wrap payments.
- Column (c3) or “Other Retroactive Payments” includes risk pools, incentives, Pay for Performance (P4P), and withholds.
- These amounts are also included in column (b).
- Column (c4) or “Penalty/Payback” enter payments made by the health center to payers because of overpayments collected earlier. This could include ACO downside risk payments.

**ALLOWANCES (COLUMN D)**
- Allowances are payment reductions granted as part of an agreement with a third-party payer.
- Reduce the allowance in column(d) by the amount of FQHC adjustments (c1–c4).
- Allowances do not include:
  - Non-payment for services not covered by the third party
  - Non-payment of bills which were not submitted in a timely fashion or properly signed/submitted.
  - 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). This does not apply for fee-for-service payers.

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 116-125.
Table 9D: Patient-Related Revenue

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.
- Line 13 — self-pay line only.

BAD DEBT (COLUMN F)

- Amounts considered to be uncollectable from the patient and formally written off during the calendar year, regardless of when the service was provided.

  Only self-pay bad debt is reported, third-party bad debt is not reported.

RECLASSIFYING CHARGES:

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

REPORTING CHARGES AND COLLECTIONS FOR PHARMACEUTICALS DISPENSED AT CONTRACT PHARMACIES

- Charges are reported by payer in column (a).
- The amount received from the patient (Line 13) or insurance company is reported in column (b).
- The amount 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: Table 4 reports primary medical insurance and Table 9D includes all charges and collections including those for other services such as dental. Charges and collections by payer type on Table 9D relate to insurance enrollment on Table 4.
- Table 4, lines 13a–b and Table 9D: Capitated managed care revenue on Table 9D divided by capitated member months on Table 4 should approximate 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).
### Table 9D: Patient-Related Revenue

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

<table>
<thead>
<tr>
<th>Line</th>
<th>Payer Category</th>
<th>Full Charges This Period (a)</th>
<th>Amount Collected This Period (b)</th>
<th>RETROACTIVE SETTLEMENTS, RECEIPTS, AND PAYBACKS (C)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Collection of Reconciliation/ Wrap Around Current Year (c1)</td>
</tr>
<tr>
<td>14</td>
<td>TOTAL (Lines 3+6+9+12+13)</td>
<td>52,440,869</td>
<td>41,010,494</td>
<td>4,113,290</td>
</tr>
</tbody>
</table>

#### TABLE 8A — FINANCIAL COSTS

<table>
<thead>
<tr>
<th>Line</th>
<th>Cost Center</th>
<th>Accrued Cost (a)</th>
<th>Allocation of Facility and Non-Clinical Support Services (b)</th>
<th>Total Cost After Allocation of Facility and Non-Clinical Support Services (c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FINANCIAL COSTS FOR MEDICAL CARE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Medical Staff</td>
<td>20,287,757</td>
<td>9,441,909</td>
<td>30,029,666</td>
</tr>
<tr>
<td>2</td>
<td>Lab and X-ray</td>
<td>1,302,135</td>
<td>662,268</td>
<td>1,964,403</td>
</tr>
<tr>
<td>3</td>
<td>Medical/Other Direct</td>
<td>2,839,075</td>
<td>1,329,591</td>
<td>4,168,666</td>
</tr>
<tr>
<td>4</td>
<td>TOTAL MEDICAL CARE SERVICES (Sum Lines 1 through 3)</td>
<td>24,428,967</td>
<td>11,733,768</td>
<td>36,162,735</td>
</tr>
<tr>
<td>FINANCIAL COSTS FOR OTHER CLINICAL SERVICES</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Dental</td>
<td>3,986,773</td>
<td>1,771,103</td>
<td>5,757,876</td>
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<tr>
<td>6</td>
<td>Mental Health</td>
<td>1,356,455</td>
<td>652,157</td>
<td>2,008,612</td>
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<td>7</td>
<td>Substance Use</td>
<td>446,473</td>
<td>217,386</td>
<td>663,859</td>
</tr>
<tr>
<td>8a</td>
<td>Pharmacy not including pharmaceuticals</td>
<td>1,587,276</td>
<td>790,340</td>
<td>2,377,616</td>
</tr>
<tr>
<td>8b</td>
<td>Pharmaceuticals</td>
<td>2,177,064</td>
<td></td>
<td>2,177,064</td>
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<tr>
<td>9</td>
<td>Other Professional (Specify__________)</td>
<td>555,819</td>
<td>280,298</td>
<td>83,618</td>
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<tr>
<td>9a</td>
<td>Vision</td>
<td>1,111,640</td>
<td>560,597</td>
<td>167,236</td>
</tr>
<tr>
<td>10</td>
<td>TOTAL OTHER CLINICAL SERVICES (Sum Lines 5 through 9A)</td>
<td>11,221,500</td>
<td>4,271,881</td>
<td>13,235,881</td>
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</tbody>
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