Table 9D: Patient Related Revenue

Welcome

Hi, welcome and thanks for joining me today to learn about Table 9D: Patient-Related Revenue.

Please click START to begin.

Welcome

I'm Steve, your UDS Report expert, and I am here to help you complete Table 9D.

This table collects data on all the funds that come to you through charges for services to patients, regardless of the form of payment or the type of payer. This is very important data, for you and for HRSA, and we appreciate your taking the time to learn how to ace this part of your report!

Introductions

Let's start with introductions.

- If you'd like, please let me know who you are by typing your name in the box. This information is just used as we interact during this session and is not saved.
- If you don't want to enter your name, just click **Sign In.**

Get Started or View Navigation

If you've been here before and know how to use the navigational features, you can go straight to the training by clicking on the **LET'S GET STARTED button**.

If you'd like to learn more about our training's navigational features - click on the **HOW TO NAVIGATE button** to continue.

Course Navigation

Navigation: Table of Contents

Before I go on - if you are interested in hearing the audio narration, please be sure to adjust your computer speakers so that you can hear me.

Also ON THE LEFT of the screen, you'll see a tab that says “TABLE OF CONTENTS.” You can use this tab to go anywhere you want within this course. You may find it useful if you want to review something specific about Table 9D. In that case, you can just click on any of the topics listed and jump to that particular section of the course. If you would like an overview that covers all the topics, just stick with me.

Navigation: Play, Previous, Next

AT THE BOTTOM of the screen, you'll see a control bar with navigation controls and buttons that will let you adjust your viewing experience:

- If you want to stop the video, just hit the play button once (to pause), then hit it again to resume.

- You can also slide the progress bar to the left if you would like to repeat some of the material, or slide it to the right to jump ahead.
- To go to the slide just before or to proceed to the next slide, use the buttons to the right of the control bar labeled “PREVIOUS” and “NEXT.”

Navigation: Resources, Exit

There are several links AT THE TOP RIGHT of your screen:

- If you click on the RESOURCES link, you will see additional files and links to websites that will help you in completing your Report. You can also download a copy of the Transcript here; and
- When you're done, click on the EXIT link, and you will exit the course entirely.

Navigation: Icons

Throughout the course, you will see icons that you can click on to:

- View or print the UDS tables;
- Refer to the UDS Manual;
- See helpful hints that should help you with your UDS Report; or
- Take you to a Case Study example to see how all of the UDS data works together.

One last thing before we begin - if you need to leave this training early and return to it later, you can do that. When you come back next time, we will remember where you left off and ask you whether you want to continue from there or start again from the beginning.

I think that covers the details about how to move through the course. Let's get started!

Table 9D Training

What is Table 9D?

As we start, if you would like to see a close-up of this table, please click on the VIEW THE TABLE icon IN THE LOWER RIGHT OF THE SCREEN to view (and even print out) Table 9D. You may find it helpful to have it available to you as we go through the training.

So, what is Table 9D?

What is Table 9D?

Table 9D is one of three tables that make up the Financial Profile for the UDS Report.

Every health center, including look-alikes, completes this table each year as part of its Universal report.

What is Table 9D?

Table 9D is used as a means of getting a handle on what revenues you are receiving for the services you provide. You're going to report those payments according to the payer - for example, Medicaid, Medicare, and so on.

Here is a quick overview of the information you'll be reporting:

- First, you'll report the full charges for the services provided to patients according to your fee schedule.
- Next, you'll report what you actually collected during the reporting year. This will include retroactive settlements, receipts, and payments. Of course, we know that you often are not paid the full amount on your fee schedule, so we need to take this in account.
- You'll be reporting contractual allowances made on third-party reduced payments (for example, Medicaid), as well as sliding fee discounts that you give to patients who are paying for their own care.
- You'll also report write-offs on self-pay bad debt.

Don't worry, we're not going to quiz you on this yet! We will cover all this in detail during the course - THEN we'll quiz you. But I promise to make sure you're ready.

Why Are These Data Important?

This table is not just a bunch of figures no one is ever going to look at again. No way - you can do cool things with these numbers.

The Bureau uses this information to determine some helpful data, including the average charge per visit, your payer mix, the charge-to-cost ratio, and managed care activity. This same information can help you in program management. We will show you how to mine the table for this type of gold later in this module.

How Can This Training Help Me?

Here is what you can expect to learn if you stick with me.

By the end of this module, you will understand:

- How to report full charges and amounts collected during the reporting period;
- How to report retroactive settlements, receipts and penalties or paybacks; and
- How to report allowances you give to third-party payers and the sliding discounts you give to patients, based on your fee schedule.

Key Terms

Here are a few terms it might be helpful to define up front.

- First, remember I told you this is about cash? Well, what that means is that your entries represent gross charges and adjustments and actual cash receipts for the

reporting year. This is different from the way you reported data in Table 8A.

- We'll also talk about “full charges.” What we're talking about there are the entire gross charges for a billable service according to your fee schedule. Remember that the statute requires you to have a fee schedule. That's the one we mean here.
- And, we'll also talk about “reclassifying charges” since it is essential for this table. To reclassify, you should move co-payments, deductibles, and charges for non-covered services that are rejected by the primary payer to the next payer responsible for the charge. This may be another insurance type or it may be the patient’s responsibility. When it’s the patient’s responsibility, it would be moved to the self-pay line. Show collections of these amounts on the appropriate line.

Table 9D: Step-By-Step Instructions

With that brief overview and time spent on definitions, let's take a close look at Table 9D step-by-step.

Table 9D: Rows & Columns

Let's start out by taking a look at how Table 9D is laid out. First, look down. (You're not afraid of heights, are you? Not to worry, it's only two pages.)

- Table 9D rows consist of the required reporting payer categories. From top to bottom, they are: Medicaid, Medicare, Other Public sources, Private, and Self Pay. You have some breakdowns within those, but we'll get to those later.
- Revenue, charges, and allowances related to each of these payer categories are recorded in the columns. From left to right, they are: full charges, collections, a large category related to retroactive settlements, receipts, and payback, allowances, sliding discounts, and bad-debt write offs. Again, we'll talk about each of these in more detail as we move through the course.

Okay, that's the big picture. Now let's zoom in on the details.

Column A: Full Charges This Period

Let's start by going through each of the columns first.

In the upper left corner (in Column a) you will record the total gross charges by payer. What that means is your full charges - NO ADJUSTMENTS, NO DISCOUNTS (you only wish you got paid this much, right?). That's the number we want to start with: the full charge according to your fee schedule. This is not the same as your FQHC rate - we are asking you to report your full charges here.

What Should I Include in Column A?

Let's talk a little more about what you'll actually report in Column a. Column a is where you will report all charges for billable, patient-related services. Be sure to include:

- The amount you charged any payer or patient according to your fee schedule;

even if some or all of them are adjusted (for example, to the amount Medicaid will reimburse), discounted based on the patient's ability to pay, or eventually written off as bad debt.

- Keep in mind that pharmaceuticals that are dispensed through a 340(b) contract pharmacy are reported at their usual (UCR) gross charge, even though they are sold at a discounted rate to clinic patients.

For more information about reporting contract pharmacy data, click on the "DID YOU KNOW" icon at the top left of the screen.

Did You Know: Contract Pharmacy

Health centers sometimes have difficulty reporting information about their contracted (or 340 (b)) pharmacies Table 9D.

Here's some information we hope will help:

- Be sure to report the full charge by payer in **Column a**. That is, the full value of the drug - not the discounted rate that the patient pays;
- The amount you receive from the patient or insurance company is what you'll report in **Column b**;
- You'll report any amount that has been written off by the insurance company in **Column d**; and
- In **Column e**, you'll report the amount you've written off as a discount for your patient.

To be sure you're filling out each of the categories correctly, be sure to get **detailed information** from your contracted pharmacy. If you only receive a "final tally" of your net profit - go back to them and ask for additional information so you may report complete and accurate information on Table 9D.

What's Out?

What DOES NOT get reported in Column a is **anything you cannot charge for**. So, you will not include charges for services or items that you gave to your patients that you did not expect to get paid for. For example:

- Enabling services;
- Donated pharmaceuticals, pharmacy samples & free vaccines;
- Transportation that can't be reimbursed; and
- WIC services.

Charges for services or items which are generally not billable or covered by traditional third-party payers should not be included on this table. For example, a charge for parking or for job training would not normally be included. But one exception is if the payer (for example, Medicaid) accepts billing (and **pays**) for these services.

Column B: Amount Collected This Period

Column b - my favorite column! This is where you will report the money that actually came in. Again, you're going to report this amount according to the source of payment on the rows below (Medicaid, Medicare, other public, private, or self-pay).

And, just a reminder, we're doing this according to **when the cash came in**. In other words, it doesn't matter if you provided the service in prior years (or even in pioneer days) - if you received payment for it **during the reporting year**, it goes in Column b.

What Should I Include in Column B?

So, remember, in Column b you'll report nearly everything that came in (in the way of cash) during the reporting year. And, again, this includes all payments received during the reporting year for services provided to patients.

Payments from third-party payers include:

- FQHC reconciliations;
- Managed care capitation payments;
- Quality bonuses;
- Court settlements;
- Payments for pharmaceuticals; and
- All the payments you're going to report in Column c (that's retroactive settlements, receipts, and paybacks).

Just one quick note here, if capitations are not recorded in your receivables system, be sure to recover this number from the General Ledger and include that amount in Column b.

What's Out?

What is NOT INCLUDED in Column b are:

- Cash donations;
- Meaningful Use EHR payments received from Medicare or Medicaid; or
- Payments from state or local indigent care programs.

All of those will be reported on Table 9E (Other Revenues).

What Goes Where?

OK, so now that we've covered some of what you'll report on Table 9D, let's see if you can help Marge, your colleague at North Side (our fictitious health center), figure out this table.

On the next few slides, click on where you think each of these figures would be reported on Table 9D. If you do not think it belongs in either column, just click **NEITHER a NOR b.**

What Goes Where?

Let's get started with this first one. In which of these columns would you report:

- $100 paid by Medicaid for services provided in 2013?

Answer: Amount Collected This Period (b)

Feedback When Correct:

Correct, you're right. $100 paid by Medicaid for services provided in 2013 would go in Column b.

Feedback When Incorrect:

Incorrect. Oh no, sorry. $100 paid by Medicaid for services provided in 2013 would go in Column b.

What Goes Where?

Great, let's try another. In which column would you report:

- $10,000 in capitation payments?

Answer: Amount Collected This Period (b)

Feedback When Correct:

Correct, you're right. $10,000 in capitation payments would also go in Column b.

Feedback When Incorrect:

Incorrect. Oh no, sorry. $10,000 in capitation payments would also go in Column b.

What Goes Where?

Nicely done. Now, where would you report:

- $200 charged to a state indigent care program?

Answer: Full Charges This Period (a)

Feedback When Correct:

Correct. Very good! $200 charged to a state indigent care program would go in Column a.

Feedback When Incorrect:

Incorrect. Sorry, no. $200 charged to a state indigent care program would go in Column a.

What Goes Where?

If you'd like to keep going, we have a few more you can do. If you think you're good to go, feel free to click the SKIP AHEAD LINK in the LOWER LEFT of the screen to skip the extra questions.

If you want to try a few more - here's the next one! Where would you report:

- $300 worth of donated pharmaceuticals?

Answer: Neither (a) Nor (b)

Feedback When Correct:

Correct. Very good! Donations don't go in either of these columns. These amounts should be included in Table 8A, Line 18.

Feedback When Incorrect:

Incorrect. Sorry, no. Donations don't go in either of these columns. These amounts should be included in Table 8A, Line 18.

What Goes Where?

Let's see about this one:

- $25 paid by a client for services billed at $75?

Answer: Amount Collected This Period (b)

Feedback When Correct:

Correct. That's right! $25 paid by a client for services billed at $75 would go down as an amount collected this period, or Column b. Even if the patient or payer doesn't pay the full amount, it's still a collection.

Feedback When Incorrect:

Incorrect. Sorry. $25 paid by a client for services billed at $75 would go down as an amount collected this period, or Column b. Even if the patient or payer doesn't pay the full amount, it's still a collection.

What Goes Where?

You're doing great! We've only got a couple more, but if you think you've had enough, again feel free to click the SKIP AHEAD LINK in the LOWER LEFT of the screen to skip our last couple questions.

If you want to continue, answer this next one for us. Where would you report:

- $150 for substance abuse counseling billed according to the fee schedule?

Answer: Full Charges This Period (a)

Feedback When Correct:

Correct! $150 for substance abuse counseling billed according to the fee schedule belongs in Column a.

Feedback When Incorrect:

Incorrect. Sorry. $150 for substance abuse counseling billed according to the fee schedule belongs in Column a.

What Goes Where?

And, the last one! Where would you report:

- $100 paid by a local business to support the clinic?

Answer: Neither (a) Nor (b)

Feedback When Correct:

Correct! $100 paid by a local business to support the clinic is a donation, and doesn't belong in either column or on this table at all. Donations should be listed in Table 8A, Line 18.

Feedback When Incorrect:

Incorrect. Sorry. $100 paid by a local business to support the clinic is a donation, and doesn't belong in either column or on this table at all. Donations should be listed in Table 8A, Line 18.

"Retroactive Settlements, Receipts, and Paybacks" (Column C, 1-4)

OK great. Now let's take a look at where you'll report Retroactive Settlements, Receipts, and Paybacks in those middle columns (columns c1 through c4).

- First, in Column c1, you will report reconciliations and wraparound payments for services provided during the current reporting period;
- Then, to the right-in Column c2 - those reconciliations and wraparound payments that came in for services provided during previous reporting periods. In Column c2, you'll also report the prior-year component of any multi-year settlements you received;
- In Column c3, you'll report any other retroactive payments that came in during the reporting year; and
- In Column c4, you'll report any payments you had to make because you received too much money for a service and had to pay it back, or because you had to pay a penalty to a managed care plan.

Let's look at each of these more closely to make sure it's clear what we're looking to see, and what we don't want to see, in these numbers.

Columns C1 & C2: Reconciliation/Wraparound

OK, let's start with the first two columns (c1 and c2) - where you'll report the collection of reconciliation and wraparound payments.

- First for services delivered in the current reporting year; and
- Then for services delivered in previous years.

So, what do we mean by reconciliations and wrap-around payments? Piece of cake.

- *Reconciliations* are lump-sum retroactive adjustments based on the filing of a cost report; and
- *Wrap-around payments* are additional amounts paid for each visit that bring the total up to FQHC rates.

Did You Know: Wrap-around Payments

These payments are often seen in managed care programs. Some states use them with all Medicaid payments; however these types of payments might come from Medicaid, Medicare, or other public payers.

What Should I Include in Column C3?

Let's look a little more closely at the next column - Column c3. In Column c3 you'll report about “other” retroactive payments you've received.

What are we talking about? Well, this might be cash payments resulting from:

- A redistribution of a managed care risk pool;
- Pay-for-performance incentives; or
- Withholds from any payer.

Something else that would be reported in Column c3 would be payments you received for enrolling a person in CMS's patient-centered medical home (PCMH) demonstration grant, regardless of whether or not there is a visit involved. And, finally, court-ordered payments.

Did You Know: Withhold

What's a withhold?

Well, it's a percentage of payments (or a set dollar amount) that is held in a risk pool. This amount may, or may not, be returned to you. If it is returned (you receive payment) - then you'll need to report that amount in Column c3.

What's Out?

What you WILL NOT report in Column c3 are:

Any Eligible Provider payments from CMS for implementing electronic health records.

Those payments will be reported on Line 3a of Table 9E.

Column C4: Penalty/Payback

Great. Let's finish up the columns in c1 through c4.

- So, let's say one of your payers overpaid you for services you provided and you have to give that extra money back; you'll report that amount in Column c4. Now, here's the tricky part-even though this is really money that **you're paying out rather than receiving**, you're going to **report that amount in Column c4 as a positive number**. So, if you sent out a check for $10, you'll report it in Column c4 as 10 (not -10). Got it? Great.
- This column is also where you'll report any “penalty” payments you made to managed care plans for over-utilization of the inpatient or specialty pool funds. If you make this payment by having it deducted from your monthly payment checks, you will include it here just as if you had paid it back in cash. This type of penalty payment is pretty rare these days, but just in case you have one, here's where it goes. And, again, even though it's money you're paying back, we want you to report a positive number in Column c4.

Columns C1-4: Retroactive Settlements, Receipts, & Paybacks

So, as you can see, there are lots of things that might end up in columns c1 through c4:

- Payments for Medicaid, Medicare, or S-CHIP FQHC reconciliations;
- Managed care pool distributions;
- Payments from managed care withholds; and
- Paybacks to FQHC or HMOs.

An important point about what you're reporting in columns c1 through c4 - the amounts in each of these columns (including the penalties) should also be reflected in the amount you report as “collected” in Column b. These are all considered to be a subset of your collections, but it's important to note that collections are not limited to these items, so we would not expect to see them balance out.

OK, great. Let's keep going.

Column D: Allowances

Column d, allowances, is where you'll report any reductions in payments by a third party based on a contract; again, reported separately (on each row) by payer.

Did You Know: Allowances

What's an allowance?

Well, an allowance is the portion of the bill that you agree not to collect from a third-party payer based on a contract. The difference between what you charge and what you

AGREE TO ALLOW the payer to pay is the contractual allowance. Virtually all insurance companies have a maximum amount they pay, and the center agrees to write off the difference between what they charge and that contracted amount. This amount - the difference - is what you are reporting in Column d.

What's Out?

Allowances- in Column d- DO NOT include:

- Amounts for which another third party or individual can be billed (for example, from a Medigap payer). Those amounts will only be classified as an adjustment if all the sources of payment for the difference have been exhausted and no further funds can be collected;
- Bills for services that were rejected by the third-party payer, either because the services were not covered or unacceptable for some reason (for example, submitted late, improperly signed, or improperly submitted); and
- Deductibles or co-payments that are actually due from the patient.

Column D: Tricky Bits

Okay, here are a few of the tricky parts to Column d.

- First, you need to reduce the amount of an allowance by the net amount of any retroactive settlements and receipts. The allowance should only be the amount you were not paid by the insurance or by anyone else. So, you'll need to take into account whatever payments, settlements, and receipts you reported in Column c (including current and prior year FQHC reconciliations, managed care pool distributions, and other payments). This may result in a negative number being reported as the allowance in Column d.
- Second, capitated plans are a little special, too. Usually, these plans pay on a per-member, per-month basis, so there aren't any receivables for specific services. For these types of plans, the allowance you'll report in Column d will be: the difference between the full charges (Column a) and the amount you actually collected (Column b), unless you received payment from some other source.
- And, third, you've probably noticed that Line 13 on column d is grayed out. That is because, when you allow a patient to reimburse you less than what they owe (because of their income or family size) - that is not considered an allowance. Instead, you'll report that amount as a **sliding discount** (in Column e).

Example: Column D

Let's look at an example. Let's say that you were paid MORE than you charged. You billed the office visit to the State Title XIX agency for $75, but they paid you the negotiated FQHC rate, which is actually higher by $38; so you were paid $113 for a visit that you billed at $75.

What now?

- You report the full charge - $75 - in Column a, Line 1 (Medicaid).
- After payment was received, you record the $113 payment in Column b of Line 1.
- The $38 payment **over the actual charge** is reported as a **negative allowance** (-$38) in Column d, Line 1. Are you with me? The underpayment on the previous slide is a positive number. The OVERPAYMENT is a negative number.

Column E: Sliding Discounts

The amount of sliding fee discounts is reported in Column e (on Line 13). By sliding discount, we mean a reduction in the amount a patient is charged for services based on the verified family income.

What do you actually put in Column e? We're looking for the sliding fee discount-or the amount of the charge you have calculated that the patient **does not** need to pay due to low family income at the time of service. So if the full charge for services was $75 and the patient was charged $25, what gets reported in Column e is the difference (the amount discounted as a sliding fee) - which, in this case, is $50. Please note that the sliding discounts column is only used for the self-pay line.

Reporting Sliding Discounts

There are a few key points you should know to make sure you're reporting sliding discounts correctly.

- Sliding discounts are based on the patient's documented income and family size at the time of service (as they relate to the Federal Poverty Level). You may not offer sliding discounts automatically to specific categories of patient (for example, students, homeless persons, etc.) however your board may approve policies to allow patients to self-declare their income.

Sometimes health centers confuse sliding discounts with other collection issues, so let me straighten out a couple of those possible errors.

- First, the amount of the discount must be determined up front and not applied retroactively to past due amounts; and
- Second, a very important point - a sliding discount is NOT the same as bad debt or an allowance. It is distinctly different from either and should only be reported in Column e.

Column F: Bad Debt Write Off

Hey, we've almost made it to the end of the columns! Yay, you! Let's cover this last column, then we'll take a moment to review what you've learned.

OK, so, Column f is used to report only bad debt associated with self-pay charges. That is, debt that was charged to a patient (that the patient was responsible for paying), but that they didn't pay or that did not qualify as a sliding discount.

Bad debt is considered money that you should have collected from the patient but were not able to or didn't for some reason. This debt is considered to be uncollectable and is formally written off during the current calendar year, regardless of when the service was provided.

What Should I Include in Column F?

The only thing you should include in Column f is **self-pay bad debt**. However, this could include multiple years' worth of uncollected self-pay charges if you're cleaning up your books and writing off self-pay debt that had lingered for a time. If that is the case for you - where you're writing off a large amount of previous years' self-pay debt - please include a note in the EHB to let your Reviewer know. This will help save time during the review process.

What's Out?

You SHOULD NOT report any **third-party bad debt** in Column f, Line 13. We make that pretty hard to do since all the rows have Column f grayed out except self-pay; but just in case, we want to make sure that what you're reporting in Column f, Line 13, is only related to self-pay bad debt.

Also, some centers might have grants that allow them to write off charges for a certain class of individuals. If you have such a grant, just report the full (undiscounted) charge in Column a and the amount collected in Column b. The remaining “discounted” amount is not reported in the UDS and is not considered a “sliding discount.”

Reporting Tips

A couple of things that you should absolutely NOT do when reporting charges, collections, and allowances on Table 9D are:

- Never reclassify bad debt to a sliding discount; even if a patient becomes eligible for a discount sometime after the service was provided, it's still considered bad debt; and
- Do not report bad debt as a cost on Table 8A.

Let’s Take a Break…

So now let's take a quick break and see if you can put everything we've talked about so far into action.

Reviewing Measures: Help Sandy Get It Right!

You asked your new assistant, Sandy, to review the training on Table 9D so she can help you complete this table. She did as you asked, but she was a little distracted. To make sure she's got it right, you're reviewing a few points with her.

Sandy thinks ALL the statements on the next several slides are correct. Let's see if you think she is right. Just click:

- “Yay, Sandy” if you think she has it right; or

- “Oops” if you think she has something wrong.

Reviewing Measures: Help Sandy Get It Right!

Here’s the first one:

- Charges for things like patient transportation or staff job training should always be reported in Column a (full charges this period).

Answer: Oops!

Feedback When Correct:

Correct. You're right (and Sandy is wrong). Charges that are generally not billable or not covered by traditional third-party payers should usually not be included in Column a. Charges should only be reported in Column a if the payer accepts billing and pays for these services.

Feedback When Incorrect:

Incorrect. No, sorry, Sandy has this one wrong. Charges that are generally not billable or not covered by traditional third-party payers should usually not be included in Column a. Charges should only be reported in Column A if the payer accepts billing and pays for these services.

Reviewing Measures: Help Sandy Get It Right!

OK, let’s see about this statement:

- The amounts reported in Columns c1 through c4 (Retroactive Settlements, Receipts, and Paybacks) are NOT included in the amount reported in Column b (collections).

Answer: Oops!

Feedback When Correct:

Correct. Right! The amounts reported in columns c1 through c4 should be included in the total amount reported in Column b (collections).

Feedback When Incorrect:

Incorrect. Sorry, no. Sandy has this one wrong. The amounts reported in Columns c1 through c4 should be included in the total amount reported in Column b (collections).

Reviewing Measures: Help Sandy Get it Right!

See how Sandy does here:

- Money that we pay back to payers, because of overpayment, is reported in Column c4 (Penalty/payback) and reported as a positive number.

Answer: Yay Sandy!

Feedback When Correct:

Correct. Absolutely, Sandy is right. Column c4 captures payments health centers make to payers due to overpayment collected from them earlier. These figures are always expressed as a positive number.

Feedback When Incorrect:

Incorrect. Sorry, no. Sandy has this one right. Column c4 captures payments health centers make to payers due to overpayment collected from them earlier. These figures are always expressed as a positive number.

Reviewing Measures: Help Sandy Get it Right!

In Column d (allowances), we report the difference between the full charge for services and the amount we were reimbursed (based on a contractually-agreed upon amount) - unless someone else paid the difference.

Answer: Yay Sandy!

Feedback When Correct:

Correct. That's right! If you were ultimately paid the difference between the full charge and the amount you agreed to be paid by someone other than the payer, it is not an allowance and should not be reported in Column d.

Feedback When Incorrect:

Incorrect. Nope, Sandy has this right. If you were ultimately paid the difference between the full charge and the amount you agreed to be paid by someone other than the payer, it is not an allowance and should not be reported in Column d.

Reviewing Measures: Help Sandy Get it Right!

If we didn’t determine a patient to be eligible for a sliding discount at the time they received services, we can’t record a sliding discount in Column e.

Answer: Yay Sandy!

Feedback When Correct:

Correct. Yes, Sandy is absolutely right. Even if you later determine the patient to be eligible for a sliding discount, but you hadn't done so at the time the service was provided, you missed the boat on the sliding discount.

Feedback When Incorrect:

Incorrect. Sorry, no. Even if you later determine the patient to be eligible for a sliding discount, but you hadn't done so at the time the service was provided, you missed the boat on the sliding discount.

Reviewing Measures: Help Sandy Get it Right!

OK, one more:

- Column f (bad debt) captures only self-pay bad debt- money that a patient was responsible for but we were unable to collect.

Answer: Yay Sandy!

Feedback When Correct:

Correct. You're right, Sandy nailed this one. That's exactly what self-pay bad debt is - money a patient was responsible for that you couldn't collect. You will report that amount in Column f if you formally gave up trying to collect it and wrote it off during this calendar year.

Feedback When Incorrect:

Incorrect. Sorry, Sandy had this right. That's exactly what self-pay bad debt is - money a patient was responsible for that you couldn't collect. You will report that amount in Column f if you formally gave up trying to collect it and wrote it off during this calendar year.

Payer Categories

Okay, we've gotten to the easy part, which is the payer categories. This aspect of the table is pretty straightforward.

On each row, you will report your charges, collections, reconciliations, and allowances by five payer categories:

- Medicaid;
- Medicare;
- Other Public;
- Private; and
- Self-Pay.

Realize that there is a relationship between Table 4 where patients are reported by insurance coverage and Table 9D where you report charges and collections by payer type. We'll talk about this in more detail in just a bit.

Payer Subcategories

With the exception of the self-pay line (Line 13), each payer category has three sub-groupings:

- Non-managed Care or fee-for-service;

- Capitated Managed Care; and
- Fee-for-service managed care.

Let's talk about each of these three forms of payment now.

The first, non-managed care or fee-for service, includes charges which are billed to a third-party payer (or directly to a patient) which list each of the services provided using CPT codes and the charge associated with each of these services. The third-party payer pays some or all of the bill generally based on agreed upon maximums or discounts.

The second, managed care (capitated), includes charges that are billed to a managed care payer listing each of the services provided and the associated fee. The HMO pays the health center a monthly capitation fee *regardless of whether or not any services were rendered during the month.* If the services are on a list of covered services in the agreement between the health center and the HMO (although an FQHC wrap-around payment may be made for Medicaid, Medicare, or CHIP services), no further payment is provided by the HMO. If the service is "carved out" of the listed services, an additional amount is reflected as a fee-for-service managed care service. The capitation (monthly payment) is not reported as an additional charge, but it *is* reported as a collection.

The third, managed care (fee-for-service), applies to situations where patients are assigned to the health center and must receive their primary care from the health center - hence the managed care inclusion - but no monthly fee is paid. Instead, the HMO pays some or all of the bill generally based on agreed upon maximums or discounts. A supplemental wrap-around payment can also be paid. *In addition,* some carved out charges and collections for capitated patients are reflected on these lines.

Lines 1-3: Medicaid

Let's start with the first major category - Medicaid - reported on Lines 1 through 3. Medicaid includes:

- Straight Medicaid;
- Early Periodic Screening, Diagnosis, and Treatment (EPSDT), including charges for those children who are only eligible for screening services; and
- The Medicaid part of Medi-Medi or crossovers.
- If your State Children's Health Plan (CHIP) is paid by Medicaid (and not managed care), then you'll report that information on Line 1, 2a or 2b (depending on the type of Medicaid).
- If your state provides Medicaid expansion funds to individuals to purchase their own insurance, you will report ACA Medicaid-expansion programs using Medicaid funds to help patients purchase insurance through exchanges.

Be sure to report all services billed to (and paid for) by Medicaid - under the "Medicaid" category - even if you are paid through a fiscal intermediary or an HMO.

Lines 4-6: Medicare

The next category Medicare - on Lines 4 through 6 includes:

- Medicare;
- Medicare Advantage; and
- The Medicare portion of dual eligible and people covered by Medicare and a private payer.

Lines 7-9: Other Public

On Lines 7 through 9 you'll report other public revenues. This includes:

- State and other public insurance programs;
- CHIP programs operated by a third party (not Medicaid); and
- State-based grant programs that reimburse for services (for example, breast and cervical cancer grants, family planning grants, well child and tuberculosis). While these grant programs are not considered "insurance" and patients receiving these services may have been counted as "uninsured" (on Table 4) - you'll still report charges and collections directly related to patient services on Table 9D.

Please note, however, that "other public" **DOES NOT INCLUDE** indigent care programs. Patients whose only payment source is an indigent care program will be reported as "uninsured" on Table 4 and their charges, and any associated self-pay collections, will be reported on the self-pay line (Line 13).

Lines 10-12: Private

On Lines 10 through 12, the private payer category includes:

- Blue Cross (that are not Medicare Advantage plans);
- Tricare;
- Trigon; and
- Other commercial insurers; as well as
- Workers' Compensation. As you may know, Workers' Compensation is not considered a patient's insurance - instead it is a liability insurance paid for by employers to cover work-related injuries; and
- Insurance purchased through the ACA-supported state exchanges; unless you can identify them as enrolled through subsidies from the ACA Medicaid Expansion program.

Line 13: Self-Pay

All self-pay charges, collections, and adjustments are reported on Line 13. Self-pay includes charges, collections, and adjustments for:

- Full-fee patients;
- Sliding scale patients; and
- “Nominal fee” or “zero-pay” patients.

Also reported on Line 13 are:

- The self-pay portion of third-party charges (for example, co-pays and deductibles) - we'll talk more about this reclassifying charges momentarily; and
- Any services not covered by a person's insurance.

Line 13 is also where you'll report:

- Charges to dental patients who only have medical insurance.

Did You Know: Reclassifying Charges

Here's a tip - you will want to be sure that you recheck your self-pay charges to make sure that you've reassigned the patient portion of third-party charges down on the self-pay line.

Reclassifying Charges

Now let's focus on reclassifying charges. Let's say that only some of a patient's charges for services will be paid by Medicaid or another third party. You will need to reclassify the uncovered portion of the charge that is the patient's responsibility to the self-pay line; and reduce the third-party charge by the amount that is the patient's responsibility.

Northside Example

Let's use an example from North Side to make sure I've gotten this point across - it's something that confuses a lot of health centers.

Let's say that a North Side patient with BCBS insurance (a private, non-managed care plan) has a $150 charge for a medical visit of which only $100 is covered by this plan. This is the patient's only medical insurance. The remaining $50 is the patient's responsibility.

In this example, the $100 charge should be reported on Line 10, Column a (private non-managed care charges) and the remaining $50 portion of the charge should be moved to Line 13, Column a (self-pay charges).

Cross-Table Issues

Table 9D is closely tied to the Zip Code table, and Tables 4, 5, 8A, and 9E.

Cross-Table Issues: Zip Code & Table 4

First, let's look at the Zip Code table and Table 4, and how they relate to Table 9D.

We mentioned just a bit ago that information being reported on Tables 4 (and the Zip Code table) and 9D are related.

- When reviewing Table 9D, be sure to check that charges and collections reported by payer are consistent with insurance enrollment you reported on Table 4. Remember, what is being reported on Table 9D are the revenues generated from patients (reported by insurance category) on Table 4 and the Zip Code table.
- In some cases, such as when an uninsured patient's service is covered by a categorical grant (and the charge is classified as "Other Public" on 9D), or when a patient has a secondary insurance that is charged, the Table 4 and 9D payer categories won't always match exactly.
- Also, check to make sure that managed care charges and collections you're reporting on Table 9D make sense when compared to the number of member months reported on Table 4.

Cross-Table Issues: Table 5

Similarly, visits reported on Table 5 should have some relationship to the charges reported on Table 9D.

So, an important accuracy check you could do is to see if the average charge per visit makes sense. You can do this by comparing the billable visits reported on Table 5 with the charges reported on Table 9D. Billable visits include non-nursing medical visits, dental, mental health, and ophthalmologist visits.

Cross-Table Issues: Table 8A

And, lastly, check to make sure that gross charges reported on Table 9D make sense when compared to reimbursable costs reported on Table 8A.

If the result looks quite different from what you were expecting, you will want to check your numbers again to make sure they're error-free.

Did You Know: Charges to Costs (National)

Did you know that in a recent year, the national average for the ratio of charges to reimbursable costs was 117 percent?

Congratulations

Congratulations! You've completed the training on Table 9D!

Thank you for taking the time today to learn about this table and for testing your knowledge. We appreciate your efforts to give us the data we need to support you in your important work.

Review

You can review any topic that we just covered by clicking on the hyperlinks in the Table of Contents on the left of your screen, but if you would like to do something else, click the **NEXT** button to see your options.

Please remember to access and download additional training resources by clicking on the RESOURCES LINK in the upper right-hand corner of your screen.

Additional Resources

These resources allow you to access National- and State-level UDS data; and, other reporting resources such as Quick Fact Sheets, training webinars, and the in-person regional training schedule. For ongoing questions, you can also email: UDSHelp330@BPHCDATA.NET or call the UDS Helpline toll-free at 866-UDS-HELP.