Table 4: Selected Patient Characteristics

Hi, welcome and thanks for joining me today to learn about Table 4: Selected Patient Characteristics.

Click the START button to begin.

Welcome

I'm Steve, your UDS Report expert, and I am here to help you complete Table 4.

This table is important because it includes key components that are part of the Patient Profile - it describes them by income, insurance, and other access barriers. The numbers reported in this table can also be used with other data in your UDS report to calculate and report several important measures. For example, in combination with Table 9D, we can calculate average Medicaid charges per Medicaid patient, average capitation per member month, and other similar estimates.

Sounds like Table 4 includes a lot of valuable information, right?

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.

Navigation: Table of Contents & Transcript

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.

If you would like to read the transcript, you can see it over here in the "TRANSCRIPT" tab on the LEFT of your screen.

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 4. 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, Main Menu, 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;
- If you click on the MAIN MENU link, you can return to the UDS Learning Center's library; 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!

What is Table 4?

So, what is Table 4?

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 4. You may find it helpful to have it available to you as we go through the training.

What is Table 4?

Table 4 is the last of the four tables that make up the Patient Profile, or that describes key characteristics of your patients, in the UDS Report.

Every health center will complete most of Table 4 as part of their Universal Report. If you receive two or more 330 grants, you will also complete a separate grant table for each of the special population funding streams you have.

Most of Table 4 is the same for all health centers. Look-alikes and Nurse Managed Health Clinics (NMHCs) have a slightly-modified version of this table, with different requirements for the section on special populations. We will talk about these differences in detail toward the end of the training.

You may have noticed the asterisks on this slide. What that means is that you should look for important exceptions to these rules. Let's dig a little deeper…

What is Table 4?

The two important exceptions to these rules involve the sub-section of this table that focuses on managed care utilization and include the following:

- This section is only included in the Universal Report; and
- It is only reported by health centers that have capitated and/or fee-for-service managed care (HMO) contracts.

What is Table 4?

With these differences in mind, Table 4 is similar to the Zip Code table and Tables 3A and 3B in that it reports on the same group of unduplicated patients. Now, it reports patients by their:

- Income as a percentage of Federal Poverty Level (FPL);
- Primary medical insurance;
- Managed care utilization (more specifically, the number of patient member months in managed care plans); and
- Membership in special populations.

If you would like to view more about Table 4, please click the VIEW THE MANUAL icon in the lower right of the screen.

Why are these data important?

UDS data are critically important to the Bureau of Primary Health Care (BPHC) and are used in a number of ways, but this wealth of information can also be useful to you.

For example, you can use the data reported on Table 4 to describe your patients in terms of their income level, insurance status, managed care utilization, and membership in special populations. These are important characteristics that you can include when applying for additional grants and other funding or when presenting to stakeholders.

You can also use it with the other data you report in the UDS to calculate important financial measures like collections or charges per patient in a given insurance category. How you use this information is up to you! It is all available to you so just remember this resource and let it help support your work!

Learning Objectives

We're looking forward to spending this time together to help you report as accurately and as efficiently as possible!

Learning Objectives

After this time focusing on Table 4, we hope that you will be ready to:

- Collect data and report patients accurately by their income, medical insurance, managed care member months, and membership in select special populations.

Learning Objectives

- And, complete Table 4 so that it is consistent with the other Patient Profile tables (especially the Zip Code Table and the medical insurance numbers you report there) and the rest of your UDS report (especially Table 9D).

Key Terms

Before we get into the details of the numbers, let's go over some key terms that will be important for understanding this table. I'll go over them briefly here, but feel free to click on the VIEW THE MANUAL icon on this screen to see these definitions in more detail.

- As we go through the training, we will talk about “total patients.” And by that we mean all of the people who have had one or more UDS-reportable visits at your health center, during the reporting year.
- So, to figure out who is a patient you have to know what a “reportable visit” is, right? If you want to click on the Manual icon on this screen, you can read about how a visit is defined in detail. But briefly, it is a face-to-face contact between a patient and a provider during which the provider exercised independent, professional judgment in the provision of services. To be included as a visit, the services must have been documented in your health center's charts.
- We'll also talk about “Grant Program Patients” or those patients who have had one or more UDS-reportable visits in the year that were supported by one of the special population grant programs (e.g., Health Care for the Homeless (HCH)).

Key Terms

There are also terms that are more specific to the subsections in Table 4. Click on the VIEW THE MANUAL icon on this screen to see these definitions in more detail.

For Insurance and Managed Care, we'll highlight two that are particularly important:

- “Third party insurance” refers to the patient's primary source of medical insurance (if any) at the time of their last visit. It is a patient's principal third party medical insurance source and includes Medicaid, Medicare, Other Public, and Private insurance, such as Blue Cross. Just one quick note-some patients will have more than one type of insurance, and you may bill each of them. Here, we're asking you to categorize patients based on the insurance type that you would bill first if they had a medical visit.
- Counting managed care member months is critical for Table 4. A “managed care member month” is defined as one member being enrolled for one month in a managed care plan. The total number of member months equals the sum of the monthly enrollment for the reporting year.

Let's focus on a few more definitions before we get into the details of how to complete Table 4.

Key Terms: Special Populations

For the last section of Table 4, there are several key terms related to reporting special populations. To make sure we have a common understanding of these, were going to walk through them now. This may seem like a lot, but remember, you can always refer to the UDS Manual to review the definitions.

First, when reporting special populations, we'll talk about “Migratory and Seasonal Agricultural Workers.” Here, the UDS is asking you to include patients whose principal employment is agriculture on a seasonal basis. By principal employment, we mean that their work has to have been their primary source of income within 24 months of their last visit. This usually refers to hired laborers who are paid by piecework, hourly, or daily wages.

- ***Migratory*** describes workers who establish a temporary home for such employment.
- Whereas ***Seasonal*** describes workers who do not establish a temporary home for this work.

Key Terms: Special Populations

- A second special population that we'll discuss are “Homeless Patients.” For the purposes of the UDS, these are patients who lack housing (including patients whose primary residence is a supervised public or private facility that provides temporary living arrangements) and patients living in transitional housing. Both would be considered “homeless” for the UDS Report.
- Another special population group are “School-Based Health Center Patients.” These would be patients who received health care services at an in-scope school-based health center, located on or near school grounds.

Did you know: Special Populations

All health centers need to report the total number of patients who are:

- Migrant workers (Line 16);
- Homeless (Line 23);
- Receiving school-based services (Line 24);
- Veteran (Line 25); or
- Public housing residents (Line 26).

This is true, EVEN IF, you do not receive special population funding.

Key Terms: Special Populations

Just a few more definitions to cover, then we'll move on.

- We'll also ask you to report on “Veteran patients” - referring to a person who has been discharged from the United States uniformed services.

And lastly, in this section of Table 4, we'll ask you to report on your number of “Public Housing Patients.” Even if you do not receive Public Housing Primary Care (PHPC) funding, we would like you to report your patients as "**residents of public housing**" if they are served at health center sites located in or immediately accessible to public housing. By "public housing" we mean agency-developed, owned, or assisted low-income housing, including mixed finance projects. For UDS purposes, do not count residents of housing units without public housing agency support other than Section 8 housing vouchers. The reason for this exclusion is because the Bureau is interested in identifying residents living in concentrated areas that could, potentially, be served by a public housing primary care clinic. Identifying those living in scattered-site housing, though technically publicly-funded, wouldn't help toward that goal.

Table 4: Instructions

With that overview and an idea of how you're feeling about Table 4, let's go ahead and jump into the step-by-step instructions on how to complete it accurately.

Who Should I Include?

One of the first things to note is that, like the Zip Code Table and Tables 3A and 3B, Table 4 asks for an **unduplicated count** of patients. This means that each patient is counted only once on this table, regardless of how many times they received services or how many types of services they've received.

Also, you will need to report ALL of your health center's patients here; this is not limited to just medical patients. On Table 4, we want you to include everyone who had at least one reportable visit, in any of the service categories, during the reporting year.

What do I report?

Now that we have all of your unduplicated patients in mind, you will use this table and its sections to report four things about them:

1) Household income as a percent of the Federal poverty level;
2) Primary Medical Insurance by major age groups;
3) Managed care member months; and,
4) Membership in special populations.

It may seem like a lot, but you can do it!

Did you know: Self Report

Income should be self-reported by patients as a part of your routine registration/intake process or confirmed as you determine eligibility for a sliding fee discount.

Factors such as homelessness or agricultural employment are not adequate for determining a patient's income. Likewise, do not use insurance (e.g., Medicaid or other public insurance) as a proxy for income. This information should be collected directly from the patient during the intake process and reported as it is received.

Section 1: Income

Let's walk through each one together, starting with the first thing I mentioned - household income as a percent of the Federal poverty level. Here, you will report patients by income ranges on Lines 1-4.

- As you can see, the income ranges are categorized relative to the Federal poverty guidelines. For example, "from "100% and below" to "over 200%."
- The Federal poverty guidelines are updated each year - you can access them by clicking the link on the screen.

Did you know: Income Data

Collect accurate income data by following these important tips!

- Collect and report household income.
- Don't forget to collect or update it at least once a year. It has to have been updated within a year of their last visit.
- If you update it during the year, report the most current information.

The Federal poverty guidelines are also updated each year - you can access them by clicking the link on the screen.

Unknown Income

The last income category listed (on Line 5) is labeled "Unknown." Use this category to report patients whose income is unknown - either because it wasn't collected or has not been collected or updated within a year of their last visit.

Income should be self-reported by patients as a part of your routine registration/intake process or confirmed as you determine eligibility for a sliding fee discount. If you do not have this information for a particular patient, please do not attempt to "assign" an income level based on other information you may have about the patient. For example, knowing that someone is homeless, is an agricultural worker, or is insured by Medicaid is not adequate to determine their income.

Did you know: Unknown

While we offer the "Unknown" income category, you should use it sparingly. Let me explain what I mean.

BPHC would like to have income data for all patients, whenever possible. Having this information allows the Bureau to identify the proportion of patients who are low income and learn more about this population that is a target of the Health Center program.

Given the importance of this information, if you report a large portion of patients with "unknown" income, your Reviewer is likely to ask you for more information to help us understand your data, or ask you to correct the data if you made a mistake. There may be a clear programmatic reason for a high number of patients with unknown income, but just know that your Reviewer may want to hear more about that to better interpret your data. They are also likely to encourage you to improve your efforts and training for collecting income data for future UDS Reports.

Section 1: Cross-Table Issues

Now that you know how to complete the Income section of Table 4, it's important for you to know how this section relates to other tables in your UDS report.

- Remember that the Zip Code table, and Tables 3A, 3B, and each section in Table 4 (including this income section) are all capturing the SAME unduplicated patients.
- What I mean by this is that the total number of patients you report on Line 6 **must equal** the number of patients you report on all of the other Patient Profile Tables.

Section 2: Insurance by Age Group

Now that you know how to report patients by their income level, let's concentrate on the second section in Table 4 where you'll report the same patients, but this time, by their principal source of third-party medical insurance. For each of the types of medical insurance, you'll report patients by two major age groups:

- Those aged 0-17 (in column a); and
- Those 18 and over (in column b).

And, just like you did on Table 3A, you will calculate patients' ages using a cut-off date of June 30th.

Did you know: December Age

We just want to point out here that you might think that your patients' ages will remain the same, no matter where you are reporting their age on the UDS tables. However, that is not the case.

How age is calculated will differ across UDS tables. Let me clarify:

- As we just mentioned, for Table 4, you will calculate patients' ages using a cut-off date of June 30th;
- But for Tables 6B and 7-you'll calculate patients' age as of December 31st.

Why is this important? Well, because this means that the number of patients in each age category will vary slightly across tables. So, while the number of patients of a certain age on Tables 6B and 7 may be close to those on Table 4, they will not be the same, because of the different dates used to calculate their ages.

Lines 7-12: Insurance

First, you can see that, primary medical insurance is reported in 7 separate categories:

- None/uninsured (on Line 7);
- Regular Medicaid (on Line 8a)
- CHIP (or Children's Health Insurance Program) Medicaid (on Line 8b);
- Dually Eligible (Medicare & Medicaid) on Line 9a;
- Medicare (on Line 9);
- Other Public Insurance non-CHIP (on Line 10a);
- Other Public Insurance CHIP (on Line 10b); and
- Private Insurance (on Line 11)

Click on the VIEW THE MANUAL icon on the screen to read more about the insurance categories reported on Table 4.

Lines 7-12: Insurance

The numbers of patients are subtotaled on two lines along the way:

- On Line 8: where you'll subtotal Regular Medicaid and CHIP Medicaid; and
- On Line 10: where you'll subtotal Other Public Insurance-Non-CHIP and CHIP.

Then, you'll total all of the patients across medical insurance lines and report the total on Line 12. You'll add Lines 7, 8, 9, 10, and 11 for each of the two age group columns.

Lines 7-12: Insurance

Let me point out that the insurance categories here in Table 4 (Selected Patient Characteristics) are slightly different from the ones used on the Zip Code table.

- On Table 4 we separate out Medicaid, CHIP, and Other Public insurances;
- While we keep them together on the Zip Code table.

Insurance Guidelines

These insurance categories may seem straightforward but sometimes they cause confusion. Here are some guidelines that might help:

- If you have Medicaid-only patients, they will always be reported on Line 8, regardless of whether or not the Medicaid coverage is administered through a private insurance company.
- Similarly, you will always report Medicare patients on Line 9, regardless of the fiscal intermediary - e.g., Medicare Advantage.

• Patients who are eligible for both Medicaid and Medicare will be reported on Line 9a (dually-eligible). Patients reported on this line will be a subset of those reported on Line 9 (Medicare). In other words, dually-eligible patients will be reported on Line 9a (as dually-eligible) and on Line 9 (Medicare). Please note that, dually eligible patients should **not** be reported on Line 8 (Medicaid); and MediGap enrollees should not be included on Line 9a (as dually eligible), but they will be included on Line 9 (Medicare).

You can click on the VIEW THE MANUAL ICON for more information about specific rules related to reporting insurance categories.

Did you know: Workers Comp

Did you know that you should not report:

- Workers' Compensation as medical insurance? An individuals' medical insurance is something that ensures overall health and wellness and belongs to the individual patient. Workers' Compensation provides coverage for an employee who has suffered an injury or illness resulting from job-related duties **only.** If a patient at your health center is receiving services covered by Workers' Compensation, you will still report the patient's primary source medical insurance. That might be private insurance, public insurance, or the patient may not be insured at all, and would be reported as uninsured.
- Publicly-funded programs, such as the Breast and Cervical Cancer Screening Program, are also not insurance and should not be counted here. These types of grant programs may reimburse the health center for services provided to eligible patients, but they do not count as medical insurance that belongs to the patient.

Insurance Guidelines

You will report CHIP (or the Children's Health Insurance Program) patients differently, depending on how it is handled in your state. For example:

- If the program is operated by the Medicaid program in your state - then you will report CHIP patients on Line 8b.
- If the program is operated by a commercial carrier in your state - then you will report CHIP patients under the "Other Public" category on Line 10b.

Lines 7-12: Insurance

If you viewed the Zip Code training, you may remember these three tips for reporting the different insurance categories:

1. Only report the patients' third party MEDICAL insurance.
2. Include each patient under the type of insurance that you would bill first if the patient had a medical visit (and was covered by more than one type of insurance).
3. Report the type of insurance the patient had **as of their last visit** in the reporting year, even if it did not pay for the visit in whole or in part.

Collecting Insurance Information from Patients

As with the Zip Code table, it's important for you to know that there is no option for "Unknown" insurance on Table 4. The reason for this is that you must obtain medical insurance information for every one of your patients, not just your medical patients. Even if you have a patient who is only receiving dental services-for the purposes of the UDS Report-you are required to collect and submit their primary medical insurance here. Now, you may never need that medical insurance for billing purposes, but you will need that information so that you can submit Table 4.

Also remember that you need to ask your patients for this information. Just as we talked about earlier regarding collecting income information, please collect insurance information directly from your patients and report it on Table 4.

Lines 7-12: Insurance

There are a few circumstances under which you would report patients as "Uninsured" (on Line 7):

- If a patient is eligible and you are serving them through a grant program such as Breast and Cervical Cancer, Family Planning, or Immunization-and the patient does not have medical insurance-you will report them on Table 4 as "uninsured." Though these types of programs cover some health services, they are not considered "medical insurance" and should not be reported as such.
- If you provide services to patients in correctional facilities-you may report those individuals as "uninsured."
- Patients receiving services through state/local government subsidized "indigent care programs"-are considered "uninsured."

Lines 7-12: Insurance Assumptions

Keep in mind that patients living in residential drug programs, college dorms, and military barracks, may not be presumed uninsured and you must still collect insurance information on them. Let's move on and discuss some cross-table issues you can run into.

Cross-Table Issues

Now that you know how to complete the Insurance section of Table 4, it's important for you to also know how this information relates to what you will report in other tables in your UDS report.

- First, remember that Tables 3A, 3B, 4, and the Zip Code table are all capturing the SAME patients. What I mean by this is that the total number of patients you report on Table 4 (Line 12) **must equal** the number of patients you report on other sections of Table 4 and all of the other Patient Profile Tables.
- A second critical place for consistency is between this insurance section on Table 4 (Lines 7-12) and the charges and collections by payor reported on Table 9D. These two sets of information should fit with each other-for example, if you are reporting Medicare patients on line 9 on Table 4, you should also be reporting Medicare charges and collections on Table 9D.

Cross-Table Issues

- Third, as we briefly mentioned earlier, Table 4 is also closely related to the Zip Code table in that both tables report patients by medical insurance, **but** in slightly different ways. What this means for you is that:
  - The total number of patients by insurance that you report on the Zip Code table must equal the number of patients by insurance on Table 4. More specifically, the grand totals at the bottom of each insurance column on the Zip Code table must match the corresponding insurance numbers on Table 4.

Cross-Table Issues

Let me give you an example: If the North Side Health Center reports a total of 7,285 privately insured patients on the Zip Code table (in column e). The total number of privately-insured patients reported on Table 4 (Line 11) should be the same. And, look, it is - on Table 4 (Line 11), North Side reported 1,959 privately-insured patients (0-17 years old) and 5,326 patients (18 and older). If you add the two age groups together, you see that they are reporting 7,285 privately-insured patients on Table 4, the same number reported on the Zip Code table.

Seems easy enough, but this is an area that many health centers struggle with. In a recent reporting year, more than half of all health centers received EHB edits because the information they were reporting on these two tables did not agree. So, take the time to double check those figures.

Cross-Table Issues

Another place where the Insurance section on Table 4 needs to match up is on Table 3A, where the patients' ages should coincide. So, the number of patients, 0-17 years old, on Table 4 (Line 12, column a) must match the number reported on Table 3A (Lines 1 through 18, columns a & b). The same is true for the number of patients age 18 and older on Table 4 (Line 12, column b). This must match the number reported on Table 3A in lines 19 through 38, columns a and b.

This is another place on the UDS Report that seems to cause problems for health centers. Recently, about half received edits because the “age” numbers on Tables 3A and 4 did not align.

Find & Flip

Let's break for you to play "Find and Flip" where you try to find the problems in this health center's Insurance Section on Table 4.

When you click on a number that is a problem, that area will flip over and provide more information. If you happen to click on something that isn't a problem, you can try again and keep trying until you find them all (just 4 areas in this report).

- Click the PLAY FIND & FLIP button to try your hand at the game; or
- Click the SHOW ME button to reveal the answers.

Find & Flip: Show me

These areas look like possible problems:

Places where age and insurance don't seem to work together:

- CHIP Medicaid, line 8b, reports 7,295 patients 18 and older and only 7 who are younger than 17. Since children are the ones mostly eligible for CHIP, this is an unlikely split.
- Line 9 shows only 51 Medicare patients who are 18 and older while 2,031 are aged 0-17. This is an unlikely split since older adults, aged 65 and older, are the most likely to have Medicare.

Nothing specific:

- Patients are listed on line 10a (Other Public Insurance Non-CHIP) but nothing is included on the specify line.

Numbers that don't add up:

- Line 10 should be the total of line 10a and 10b - 2,799 instead of 2,800.

Find & Flip: Play Me

Let's get this detective work started by giving you some hints that will help you zero in on possible problems. Try to find:

- Places where age and insurance don't seem to work together;
- Nothing specific; and,
- Numbers that don't add up.

If you'd like to go ahead and see the answers, click the "SHOW ME" button.

Section 3: Managed Care Utilization

Now let's move on to the third section in Table 4. Here is where we ask only those health centers with capitated and/or fee-for-service managed care contracts to report the number of managed care member months for capitated and fee-for-service managed care contracts.

This portion of Table 4 is only included as part of the Universal Report.

• If you do not have capitated and/or fee-for-service managed care (HMO) contracts, you may want to skip this part of our training by clicking the SKIP AHEAD button.

Did you know: PCCM

Primary Care Case Management (PCCM) patients are not included in the Managed Care Utilization section. CMS PCMH Demonstration grants that pay a small monthly fee (usually less than $10 per member per month) to “manage” patient care are also not included here.

One way to quickly check is to divide the related collections (from Table 9D) by the number of member months on Table 4. If this total is less than $10 per member per month then it is likely to be PCMH or other incentive money, and not managed care (and not reported here).

Section 3: Managed Care Utilization

If your health center has capitated and/or fee-for-service managed care contracts, then you will report the number of managed care member months for each payor in the Managed Care Utilization section of Table 4.

Section 3: Managed Care Utilization

This section of Table 4 has the two types of managed care contracts:

- Capitated (on Line 13a); and
- Fee-for-service (on Line 13b).

These are then totaled and reported on Line 13c (Total Member Months).

Section 3: Managed Care Utilization

The managed care insurance types are listed in columns a through d (Medicaid, Medicare, Other Public, Private) and totaled in column e.

Did you know: Big Change

Sometimes health centers experience a big fluctuation in managed care utilization from one year to the next particularly when changes are made to state or local health insurance programs.

If this is the case for your health center, just write a brief note in the EHB before submitting your report to explain the situation. This will help your Reviewer interpret your data upon initial review. If the explanation you provide is clear and explains the reason for the differences from year-to-year, your Reviewer may not have to follow up with you about this issue-ultimately saving you time and effort.

Member Months

With these payor categories and types of insurance in mind, you will use this section of Table 4 to report the number of member months in each. To report accurately, it is critical to understand two key points:

- First, a member month is defined as one member enrolled in a managed care plan for one month.

Member Months

So, if you have one person who is a member of a managed care plan for a full year, that person would count as “12” member months (one person, for 12 months).

Member Months

But, if every member in a family of five were enrolled in a managed care plan for 6 months each, then they would account for a total of 30 member months between them.

Why is that? Well, each member (and there are 5 of them) were enrolled for 6 months each - so, 5 family members x 6 months = 30 member months.

Member Months

- Another important thing to understand about calculating member months is that you need to do so using the monthly enrollment reports provided to you by your managed care organizations. Realize that, in some instances, “members or enrollees” might not always be “patients.”

  What do I mean by that? Well, a managed care enrollee may be “assigned” to your health center by the managed care organization and, in the case of capitated plans, you may have “member months” reported for them but that enrollee may not have made use of any of the services during the reporting year. Regardless, you will report all of that enrollee's member months on Line 13a (Capitated Member months).

Did you know: Check Numbers

Check your numbers before you hit the “Submit” button on your UDS Report!

- To see if your data make sense, take the number of member months you are reporting within an insurance category and divide that number by 12 (months) to get the approximate number of enrollees. Then ask yourself, “does this number make sense?”
- You can also divide the collections in the corresponding line on Table 9D by the member months on Table 4 to see if the per member per month (PMPM) rate makes sense. If not, it could be that you are missing some member months or have reported incorrect revenue amounts.

Section 3: Cross-Table Issues

We talk a lot about how the tables in the UDS Report are related. Here is another place where that is the case. Information reported in the Managed Care Section on Table 4 and information reported on Table 9D should closely relate. Let me explain how.

- The number of member months you'll report on Table 4 (on Lines 13a & b) should be tied to what you report for managed care collections on Table 9D. Remember, if you do not report managed care on Table 4, you will most likely not report managed care collections on Table 9D.
- Your Reviewer will use the numbers on these two tables to calculate the average collection per Medicaid enrollee or the average capitation Medicaid per member per month (PMPM). If these numbers turn out to be very different than what you reported last year or seem unreasonable in some way - your Reviewer will have to check back with you to better understand what you are reporting.
- You can check this yourself before submitting your report by dividing the collections in the corresponding line on Table 9D by the member months on Table 4 to see if the PMPM rate makes sense. If not, it could be that you are missing some member months or have reported incorrect collection amounts.

Section 4: Characteristics-Special Populations

The last section of Table 4 looks at a few specific populations served by health centers. Here we're asking you to report the number of patients who are:

- Migratory and seasonal agricultural workers;
- Homeless;
- Served by school-based health centers;
- Veterans; and
- Served at a public housing site.

To report this information accurately, it's important that you understand who reports what. Let's review those specific details now.

Agricultural Workers or Dependents

First, **all health centers** will report their number of patients considered Agricultural Workers and their Dependents. Again, these are patients whose principal employment is agriculture on a *seasonal* basis and that this work has been their principal source of income within 24 months of their last visit.

- On Line 16 - You will report the total number of agricultural workers and their dependent family members who have also used your center.

Agricultural Workers or Dependents

Only Section 330(g) Migrant Health Center grantees will also provide **separate totals** for migratory and for seasonal agricultural workers and their dependents.

- On Line 14 (migratory) - you will include patients who establish a temporary home for such employment; and
- On Line 15 (seasonal) - you will include patients who do not establish a temporary home for this work.

Homeless Patients

Next, **all health centers** will report their total number of homeless patients on Line 23. This count should include any person known to have been homeless at the time of any service provided during the reporting period.

Homeless Patients

Only Section 330(h) Homeless Program grantees will also provide **separate totals** for the type of shelter arrangement the patient had when they were first encountered during the reporting year. The living arrangements specifically include:

- Living in a shelter (on Line 17);
- In transitional housing (on Line 18);
- Doubled up; this must be a temporary and unstable housing situation (on Line 19);
- On the street; including living outdoors, in a car, in an encampment, in makeshift housing/shelter or in other places generally not deemed " fit for human occupancy" (on Line 20); or
- In other situations, such as living in an SRO or single room occupancy hotel (on Line 21).

For more information about each of these shelter arrangements, click on the VIEW THE MANUAL ICON in the lower right of the screen.

School-Based Health Center Patients

All health centers will also need to report on the number of their "School-Based Health Center" patients (on Line 24). Here, you will count patients who received services at the approved school service delivery sites listed in your grant or designation application.

- You should include preventive and primary health care services; but
- **Not** screenings or en-mass treatments such as vaccinations or fluoride treatments.

Veterans

All health centers will report their total number of patients who have been discharged from the uniformed services of the United States (on Line 25).

- This information will likely be taken from your patient intake forms.
- You will only report a patient as a "veteran" if they have been **discharged** from the military. Therefore, patients who are still serving are not considered veterans.
- And, for the purposes of the UDS, those who have served in the military in another country are not reported here.

Public Housing Residents

On the last line in this section (Line 26), all health centers will report the *total number* of patients served at a site located in or immediately accessible to public housing. You will report on these patients here *regardless* of whether or not the patients actually reside in public housing, or if the health center receives Section 330(i) - Public Housing Primary Care.

- For the purposes of the UDS, the definition of public housing is restricted to geographically-defined programs - either high rise projects or 221(d)(3) low rise programs, but not scattered site or Section 8 rent subsidy programs.
- You can use patients' addresses to identify and count public housing residents.
- Although the site would largely serve public housing residents, others who live close by may also use the center. In such instances, these individuals would be counted on this line even though they are not personally public housing residents.

Find & Flip

Let's stop to play “Find and Flip” again. This time you'll try to find the problems in this health center's Special Populations Section on Table 4. It's important to know that this health center is a 330g grantee only.

Here's a quick recap of how this works - When you click on a number that is a problem, that area will flip over and provide more information. If you happen to click on something that isn't a problem, you can try again and keep trying until you find them all (just 3 areas in this report).

- Click the PLAY FIND & FLIP button to try your hand at the game; or
- Click the SHOW ME button to reveal the answers.

Find & Flip: Play Me

Here are some hints to get this detective work started and to help you zero in on possible problems.

- This center is located in a large, urban city-it's unusual to see high numbers of these types of patients.
- And unusual to see low numbers of these types of patients.
- On the Zip Code and other Patient Profile tables, this center reports a total of 59,954 patients. Given its size, it's unlikely to have so few of this population.

If you'd like to go ahead and see the answers, click the "SHOW ME" button.

Find & Flip: Show me

These areas look like possible problems and are worth checking:

This center is located in a large, urban city - therefore, it's unusual to see:

- **high** numbers of agricultural workers and their dependents; and
- **low** numbers of homeless patients.

On the Zip Code and other Patient Profile tables, this center reports a total of 59,954 patients. Given its size, it's unlikely to have only 3 veterans.

CHIP split

That's right! CHIP Medicaid, line 8b, reports 7,295 patients 18 and older and only 7 who are younger than 17. Since children are the ones mostly eligible for CHIP, this is an unlikely split.

Medicare

Good eye! Line 9 shows only 51 Medicare patients who are 18 and older while 2,031 are aged 0-17. This is an unlikely split since older adults, aged 65 and older, are the most likely to have Medicare.

Total

Right! Line 10 should be the total of Lines 10a and 10b (2,799), not 2,800.

Not an answer

Sorry, that's not one of the problem areas. Click the red "x" to close the window and return to the table.

Specify

Right! Patients are listed on line 10a (Other Public Insurance Non-CHIP) but nothing is included on the specify line.

High agricultural

Good eye! This center is located in a large, urban city-it's unusual to see high numbers of agricultural workers and their dependents.

Homeless

Right! This center is located in a large, urban city-it's unusual to see low numbers of homeless patients.

Veterans

Good eye! On the Zip Code and other Patient Profile tables, this center reports a total of 59,954 patients. Given its size, it's unlikely to have so few veterans reported.

Not an answer

Sorry, that's not one of the problem areas. Click the red "x" to close the window and return to the table.

Look out for these common problems!

We have covered a lot today by focusing on Table 4! As we wrap up, let me see if I can help you and your team ace this table by telling you how to avoid some of the errors we typically see. When completing Table 4, be sure to:

- Count all of your patients only once in each section (income, insurance, and special populations). Remember that these sections of Table 4 represent an unduplicated count of your patients and should match the total patients you're reporting on the Zip Code Table and Tables 3A and 3B.
- Check that your dual eligible patients are being included in both lines 9a and 9, but **are not** included in line 8.
- Check that the insurance enrollment numbers you've reported on Table 4 (on Lines 7-12) and the Zip Code table match.
- Check that the age groups on Table 4 and the ages you've reported on Table 3A match.
- Check that the insurance enrollment numbers you've reported on Table 4 (on Lines 7-12) and the charges and collections by payor on Table 9D relate and make sense.

Look out for these common problems!

- Take a look at your public housing number on line 26. Is it a small number like 10 or 20? Remember, all patients served at this location should be counted, so unless your location opened at the end of December, this number is probably higher.
- Compare the number of member months you've reported on Table 4 (in lines 13a and b) against the collections you've reported on Table 9D. For the capitated lines, check if these per member per month (PMPM) numbers seem reasonable.
- Report special populations even if you don't receive special population funding.
- And remember that the total number of patients you report on a Grant Report table needs to be equal to (or less than) the number of patients you report on your Universal Report tables.
- Add a comment in the EHB if your health center experienced big changes since last year.

Congratulations

Congratulations! You've completed the training on Table 4!

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.

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.