HRSA
Health Resources & Services Administration

Reporting Uniform Data System (UDS) Financial and Operational Tables: The Basics

October 22, 1:00-2:30 p.m. (ET)

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Vision: Healthy Communities, Healthy People

Opening Remarks

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Agenda

- Overview of purpose and scope of the UDS
- Introduction of UDS financial tables and related operational tables.
  For each table:
  - Review of UDS table terminology
  - Review of potential coronavirus disease (COVID-19) related impact on table
  - Relationship to other tables

Overview of Data Collected in UDS Tables

- **Patient Profile:** Capture the demographic information of health center patients who received in-scope services.
- *The patient profile tables, also called the demographic tables are the ZIP Code Table, Table 3A, Table 3B, and Table 4.*

- **Clinic Services and Outcomes:** Capture staff, visits, services, and outcomes related to all in-scope services provided to health center patients.
- *The clinical services and outcomes tables are Table 5, Table 6A, Table 6B, and Table 7.*

- **Financial Tables:** Capture the costs and revenues (both patient-generated and other revenues) related to in-scope services.
- *The financial tables are Table 8A, Table 9D, and Table 9E.*
- *These will be our focus today!*

All data is reported for the full calendar year, Jan. 1, 2020 through Dec. 31, 2020.

HRSA Health Center Program

All interrelated, so important to understand all tables!

Health Center patient is a patient with a UDS countable visit in the reporting year

A **UDS countable visit** (captured on Table 5) is a visit that is documented, individual, real-time contact between patient and licensed/ credentialed provider who exercises independent, professional judgment in the provision of that service.

Demographic information reported for all unduplicated Health Center patients (Tables ZIP, 3A, 3B, 4).

Clinic service and outcomes tables (Tables 5, 6A, 6B, and 7) reflect ONLY services provided to health center patients, and reflect ALL health center patients who meet criteria.

Financial tables (Tables 8A, 9D, 9E) reflect ALL and ONLY patients and services that are reflected in all other tables.

Step 1: Determine what sites/ locations and services are in-scope. (Sites: Form 5B, Services: Form 5A)

Step 2: Determine which patients had visits for in-scope services that were real-time, documented in the patient record, with a provider exercising independent professional judgement at those in-scope sites/ locations in the year.

Step 3: Report all in-scope patients, services, full-time equivalents (FTEs), **costs, and revenues** on the UDS

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Overview of Financial Tables

Table 8A: Financial Costs

- Costs related to FTEs, by cost center
- Costs related to services/ contracts, by cost center
- Pharmaceutical costs
- Costs for facilities and non-clinical support services
- Value of donated facilities, services, and supplies

Table 9D: Patient-related Revenue

- Charges, by payer, related to services provided to patients
- Collections, by payer, related to services provided to patients
- Adjustments, by payer, related to services provided to patients
- Revenue classified as managed care or non-managed care for each payer
- Sliding fee discount for patients
- Bad debt for patients

Table 9E: Other Revenue

- Federal grant revenue including health center funding and COVID-19 supplemental funding from HRSA
- State/ local grant revenue
- Private/ foundation revenue
- Other revenue including cash donations

Costs on Table 8A

Operating Costs

Cost Centers

Cost center refers to a single service area to which financial costs can be attributed. These align with **service areas** on Table 5. Here are some examples:

Cost Center on Table 8A	Service Area on Table 5 (which include FTEs and visits)
Line 1: **Medical** staff costs	Lines 1–12: Medical Providers and Clinical Support Staff
Line 2: Medical **Lab and X-ray** costs	Line 13-14: Medical Lab and X-Ray
Line 5: **Dental** costs	Lines 16-18 Dentists, dental hygienists, etc.
Line 6: **Mental Health** costs	Lines 20a-20c: Psychiatrists, licensed clinical psychologists, LCSWs
Line 7: **Substance Use Disorder** costs	Line 21: Substance Use Disorder
Line 8a: **Pharmacy** costs	Line 23: Pharmacy
Line 9: **Other Professional** costs	Line 22: Other professional
Line 9a **Vision** costs	Lines 22a-22c: Vision (ophthalmologists, optometrists, etc.)
Line 11a-11h: **Enabling** (case management, transportation, outreach)	Lines 24-28: Enabling (case management, patient and community education)

Accrued Costs

- **Accrued costs are those costs incurred by a given cost center in the year.**
- For example, accrued costs are all of the costs incurred in the reporting period for the provision of services, including staff costs (salary, fringe benefits, continuing medical education (CME), etc.), supplies, depreciation of equipment, software or systems, interest payments on any loans, costs for contracted care, etc.
- Accrued costs **do not include**:
  - Costs for anything incurred outside the reporting period
  - Bad debt expense of any kind
  - Loan principal payments
  - Costs for services the health center did not pay for directly (e.g., services that the health center referred, but were billed by the third party provider)
  - Gross costs for capitalized expenses

Examples: Accrued Costs by Function

- **Costs attributable to a given cost center (such as medical, dental, or mental health)**
- Includes:
  - Costs for **staff who work specifically in/ for that cost center or service area** (e.g., optometrists in the vision department)
  - Costs for **contracted services**, such as contract pharmacy.
  - Costs for **systems or software used specifically by that cost center/ service area** (e.g., case management platform used by enabling department)
  - **Depreciation on capital expenditures**, such as equipment, used specifically by that cost center/ service area (e.g., x-ray machines used by dental department)
  - **Interest payments on capital expenditures or loans specific to that cost center/ service area** (e.g., interest on loan to purchase mobile van for the medical department)

Financial Costs

Table 8A Columns

Reporting of Table 8A is done in three columns, which are as follows:

Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
Accrued direct costs Include costs of: ▪ Staff ▪ Fringe benefits ▪ Supplies ▪ Equipment ▪ Depreciation ▪ Related travel	Allocation of facility and non-clinical support services ▪ Allocate to all other cost centers (lines) Must equal Line 16 from Column a	Sum of Columns a + b (done automatically in electronic handbooks (EHBs)) Represents total cost to operate service Used to calculate cost per visit and cost per patient

Medical Cost Center

Table 8A, Lines 1-3, Column a

- Line 1: **Medical staff** salary and benefits
  - **Includes** costs for all staff directly attributable to medical department including medical providers, medical assistants
  - **Includes** contracted medical care
  - Does **not** include: Value of volunteer staff
- Line 2: Medical **lab and x-ray** direct costs
  - **Includes** all direct costs for lab and x-ray, including lab and x-ray that is on-site, and those the health center pay for (or bill for) directly
  - Does **not** include any costs that lab/ radiology bills directly to the patient
- Line 3: **Non-personnel direct medical** costs
  - **Includes** costs for anything else directly attributable to the medical department
  - Does **not** include value of donated goods
  - Does **not** include any pharmacy or pharmaceutical costs

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
	Financial Costs of Medical Care			
1	Medical Staff			
2	Lab and X-ray			
3	Medical/Other Direct			
4	**Total Medical Care Services** (Sum of Lines 1 through 3)			

Other Cost Centers

Table 8A, Lines 5-8b, Column a

- Line 5: **Dental**
  - **Includes** dental staff costs, contracted dental care, electronic dental record costs
  - Does **not** include volunteer or donated dental staff or donated supplies
- Line 6: **Mental Health**
  - **Includes** mental health staff, supplies, and software used specifically by mental health department
- Line 7: **Substance Use Disorder**
  - **Includes** costs of staff reported on Line 21 on Table 5
- Line 8a: **Pharmacy** costs
  - **Includes** dispensing fees for 340B contract pharmacy and pharmacy staff
  - Does **not** include costs of drugs
- Line 8b: **Pharmaceuticals**
  - **Includes** costs of drugs dispensed via 340B contract pharmacy or in-house pharmacy
  - Does **not** include value of donated drugs; does **not** include contract pharmacy dispensing fee

Line	Cost Center	Accrued Cost (a)
	Financial Costs of Other Clinical Services	
5	Dental	
6	Mental Health	
7	Substance Use Disorder	
8a	Pharmacy (not including pharmaceuticals)	
8b	Pharmaceuticals	

Other Cost Centers

Table 8A, Lines 9-11, Column a

- Line 9: **Other Professional**
  - **Includes** staff costs related to any FTEs reported on Line 22 of Table 5
  - Does **not** include any enabling costs, costs for ancillary programs like Women, Infants, and Children (WIC), Healthy Start, job training, etc.
- Line 9a: **Vision**
  - **Includes** vision staff and supplies
  - Does **not** include donated time of optometrist
- Lines 11a-11h, Line 11: **Enabling services**
  - **Includes** costs such as those for education materials, taxi vouchers, Language Line or other interpretation service, in addition to staff costs.

Line	Cost Center	Accrued Cost (a)
	Financial Costs of Other Clinical Services	
9	Other Professional (specify ____)	
9a	Vision	<blank>
Line	**Cost Center**	**Accrued Cost (a)**
	Financial Costs of Enabling and Other Services	
11a	Case Management	
11b	Transportation	
11c	Outreach	
11d	Patient and Community Education	
11e	Eligibility Assistance	
11f	Interpretation Services	
11g	Other Enabling Services (specify ____)	
11h	Community Health Workers	
11	**Total Enabling Services** (Sum of Lines 11a through 11h)	

Overhead

- **Overhead** expenses are facility and non-clinical support service expenses.
- On the UDS, Table 8A, Column a, Lines 14 and 15, Facility Costs and Non-Clinical Support costs, comprise total overhead costs.
  - Line 14: **Facility-related expenses** including facility staff costs, rent or depreciation, mortgage interest payments, utilities, security, grounds keeping, janitorial services, maintenance, etc.
  - Line 15: Costs for all **Non-clinical Support Services** including staff reported on Table 5, lines 30a–30c and 32 (corporate administration, billing, revenue cycle, medical records and intake staff), as well as facility and liability insurance, legal fees; managing practice management system, and direct non-clinical support costs (travel, supplies, etc.)
- On Table 8A, these overhead costs are first recorded in Column a, as accrued costs, and are then allocated to each cost center in the Overhead column, Column b.
- Some overhead costs can be directly allocated to a particular cost center, such as the facility costs for a building that only houses the dental clinic. When this is the case, these allocations should be made first.
- Other overhead costs will be allocated using a proportional method, such as the proportion of square footage that each cost center uses (for facility costs) and percent of total accrued costs of each cost center (for non-clinical support costs).

Overhead Expenses

Table 8A, Column b

- Line 16, Column a is the Total of Lines 14, Facility, and 15, Non-clinical support costs, and **represents the total overhead costs to be allocated in Column b**.
- All overhead costs need to be allocated to cost centers in Column b (Medical, dental, mental health, etc.).
- No overhead allocation for pharmaceuticals (Line 8b) or enabling detail lines (Lines 11a-11h).

Line	Cost Center	Accrued Cost (a)
	Facility and Non-Clinical Support Services and Totals	
14	Facility	
15	Non-Clinical Support Services	
16	**Total Facility and Non-Clinical Support Services** (Sum of Lines 14 and 15)	

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
	Financial Costs of Medical Care			
1	Medical Staff			
2	Lab and X-ray			
3	Medical/Other Direct			
4	**Total Medical Care Services** (Sum of Lines 1 through 3)			

Allocating Overhead to Cost Centers

If no better method exists, use at least a **two-step overhead allocation method**. We will walk through an example.

Line 14: Facility

- For each facility, identify square footage utilized by each cost center and cost per square foot
- Distribute facility costs to each cost center
- Common spaces not dedicated to a specific cost center and administrative space is added to non-clinical support costs and distributed

Line 15: Non-Clinical Support Services

- Distribute non-clinical support costs to the applicable service (optional)
- Decentralized front desk staff, billing and collection systems and staff, etc.
- Consider lower allocation of overhead to contracted services and enabling services
- Allocate remaining costs using straight-line method (proportion of costs to each service category)

Overhead Example: Facilities Costs of $3.7M

Site A, built in 1972
Valued at $400K for 10,000 square feet ($40/square foot)
50% medical, 50% dental

Site B, built in 2017
Valued at $2M for 20,000 square feet ($100/square foot)
30% medical, 40% mental health, 30% admin offices

Site C, built in 1999
Valued at $1.3M for 20,000 square feet ($65/square foot)
50% medical, 25% dental, 25% enabling

Cost Center	Site A	Site B	Site C	Total to be allocated to cost center in Column b
Medical (Lines 1-3)	$40*5,000 =$200K	$100*6,000= $600K	$65*10,000= $650K	$1,450,000
Dental (Line 5)	$40*5,000= $200K		$65*5,000 = $325K	$525,000
Mental Health (Line 6)		$100*8,000= $800K		$800,000
Enabling (Line 11)			$65*5,000 = $325K	$325,000
Administration		$100*6,000= $600K		$600,000*

*Administration facility costs are allocated to non-clinical support and then allocated with non-clinical support services in second step.

HRSA Health Center Program

Overhead Example: Non-Clinical Support of $5M

Line 15: Non-Clinical Support Services are $5M

- Add $600,000 of allocated facilities costs (as shown in last slides)
- Total of $5.6M of non-clinical support costs to be allocated

Distribute non-clinical support costs to the applicable service where possible:

Cost Center	Total to be allocated to cost center in Column b
Medical (Lines 1-3)	$2,500,000
Dental (Line 5)	$500,000
Mental Health (Line 6)	$600,000
Enabling (Line 11)	$500,000
Total Allocated in this Step	$4,100,000
Remaining Non-Clinical Support Costs to be allocated	$1,500,000

Distribute remaining non-clinical support costs using straight line method

Cost Center	Percent of Costs in Column a	Allocation
Medical (Lines 1-3)	60%	60% of $1.5M= $900K
Dental (Line 5)	15%	15% of $1.5M= $225K
Mental Health (Line 6)	15%	15% of $1.5M= $225K
Enabling (Line 11)	10%	10% of $1.5M= $150K
Total		

Overhead Example: Total Overhead of $8.7M

Cost Center	Allocated Facility Costs	Allocated Non-Clinical Support Services	Allocation of Remaining Costs using Straight Line Method	Total Overhead Costs to be Reported in Column b for Cost Center
Medical (Lines 1-3)	$1,450,000	$2,500,000	$900,000	$4,850,000
Dental (Line 5)	$525,000	$500,000	$225,000	$1,250,000
Mental Health (Line 6)	$800,000	$600,000	$225,000	$1,625,000
Enabling (Line 11)	$325,000	$500,000	$150,000	$975,000

Potential Impacts of COVID-19 on Table 8A

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

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

Health center received donations of testing supplies, personal protective equipment (PPE), space for testing, or volunteer time.

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

Health center may have purchased telehealth platforms or additional communication tools (e.g., iPads, web cams) to reach patients and staff at home.

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

For a deeper dive on Table 8A reporting, join next week's training!

We will take this to the next level.

Table 9D

Patient-Related Revenue

Table 9D: Patient-Related Revenue

Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Collection of Reconciliation/ Wraparound Current Year (c1)	Collection of Reconciliation/ Wraparound Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty/ Payback (c4)	Adjustments (d)	Sliding Fee Discounts (e)	Bad Debt Write-Off (f)
1	Medicaid Non-Managed Care									
2a	Medicaid Managed Care (capitated)									
2b	Medicaid Managed Care (fee-for-service)									
3	**Total Medicaid** (Sum of Lines 1+2a +2b)									
4	Medicare Non-Managed Care									
5a	Medicare Managed Care (capitated)									
5b	Medicare Managed Care (fee-for-service)									
6	**Total Medicare** (Sum of Lines 4+5a+5b)									
7	Other Public, including Non-Medicaid CHIP, Non-Managed Care									
8a	Other Public, including Non-Medicaid CHIP, Non-Managed Care (capitated)									
8b	Other Public, including Non-Medicaid CHIP, Non-Managed Care (fee-for-Service)									
8c	Other Public, including COVID-19 Uninsured Program									
9	**Total Other Public** (Sum of Lines 7+8a+8b+8c)									
10	Private Non-Managed Care									
11a	Private Managed Care (capitated)									
11b	Private Managed Care (fee-for-service)									
12	**Total Private** (Sum of Lines 10+11a+11b)									
13	**Self-Pay**									
14	**TOTAL** (Sum of Lines 3+6+9+12+13)									

Charges

- Charges are the amount each service rendered to patients is valued at, according to the health center's **fee schedule**.
  - Per Chapter 16 of the HRSA BPHC health center compliance manual, "The health center must prepare a schedule of fees for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation."
  - Charges on the UDS are reported based on the fee schedule prepared in accordance with this requirement.
- Another way to think about it is that charges *are payer agnostic*. Charges for any given procedure are recognized and reported at the same amount across all payers (while collections and adjustments are likely to be different based on payer agreements).
- Charges are captured in Column a of Table 9D by third-party payer, for all patient services rendered to health center patient in the *reporting year* (January 1 through December 31).
- Charges are *reclassified* (or split across lines) in accordance with co-pay or co-insurance responsibility; for example, if a patient is responsible for 20% of the charge, then 80% of the charge is on the third-party payer line and 20% of the charge is moved to self-pay line.

Collections

- Collections, in Column b on Table 9D, are **total of cash received in the reporting year (January 1 through December 31) for services provided to patients**, regardless of when those services were rendered. If the money was received in the reporting year, then it is reported in Collections.
- Many things are included in Collections:
  - Reimbursement for services provided to patients from third-party payers
  - Managed care or capitation payments
  - Payment for grant covered services from public entities
  - Health center reconciliation or wrap payments
  - Quality bonuses or pay for performance bonuses
  - Monies received from patients or payers for contract pharmacy

Adjustments (formerly called Allowances)

- Adjustments are contractual discounts granted as part of an agreement with a third-party payer. Virtually all insurance companies have a maximum amount they pay for a given service and the center agrees to write off the difference between what they charge and that contracted amount. These are considered contractual adjustments.
- On Table 9D, Adjustments, which have the effect of reducing the amount of charges to be collected, and are reported in Column D as a positive number.
  - Adjustments are reported ONLY for third-party payers.
  - Adjustments **do not include** third-party payer bad debt.
- Reduce the initial adjustment by the amount of retroactive settlements and receipts (reported in Columns c1, c2, and c3), including current- and prior-year Federally Qualified Health Center (FQHC) reconciliations, managed care pool distributions, quality or Pay for Performance (P4P) awards, and other payments. This may *result in a negative number* as the adjustment in Column D.

Third-Party Payers

- A **third-party payer** is any entity, other than the patient, reimbursing the health center for patient services. The patient and the health center are parties directly involved with the service. An outside payer is a 'third-party payer'. Here are the categories on the UDS:
- **Medicaid**
  - Any state Medicaid program, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT), Adult Day Health Care (ADHC), Program of All-inclusive Care for the Elderly (PACE), if administered by Medicaid
  - Medicaid Managed Care Organizations (MCOs)or Medicaid programs administered by third-party or private payers
  - Children's Health Insurance Program (CHIP), when administered by Medicaid
- **Medicare**
  - Any Medicare program or program administered by Medicare
  - Medicare managed care programs, including Medicare Advantage run by commercial insurers.
  - ADHC or PACE if administered by Medicare
- **Other Public**
  - CHIP, when NOT administered by Medicaid
  - State or County-run insurance plans
  - Service contracts with municipal or county jails, state prisons, public schools, or other public entities
  - New for 2020: HRSA COVID-19 Uninsured Program
- **Private**
  - Insurance provided by employers
  - Tricare, Trigon, Federal Employees Insurance Program, workers' compensation
  - Insurance purchased through state exchanges or by individuals
  - *NOT* Medicaid or Medicare programs administered by commercial insurers

Forms of Payment

- Revenue for each third-party payer is generally divided into **three forms of payment**: Non-Managed Care, Managed Care Capitation, and Managed Care Fee for Service.
  - **Non-Managed Care** refers to the payment model in which procedures and services are separately charged and paid for by a third-party payed, based on fee-for-service. The third-party payers pay some or all of the bill based on agreed upon maximums or discounts.
    - ✓ Payments for services to patients who are not assigned to the health center as part of a managed care plan are reported as non-managed care.
  - **Managed Care Capitation** refers to a payment model in which a health center contracts with a managed care organization for a specified set of services, for which the managed care plan pays the health center a set amount for each patient assigned to the health center. This is called a capitation fee, and is typically paid per member per month.
  - **Managed Care Fee for Service** refers to a payment model in which a health center contracts with a managed care organization and is assigned a set of patients for whom the health center is responsible for their care, and is reimbursed on a fee-for-service (or encounter-rate) basis for covered services.
- Note that **Charges** for each of these forms of payment are still reported based on the health center's fee schedule. So, although Managed Care Capitation is paid regardless of services rendered, Charges still need to be reported based on services rendered.

Managed Care

- Managed care (either capitated or fee for service) refers to those payers with which the health center has a *contractual managed care agreement to provide a range of services to patients assigned to the health center*.
  - Typically these agreements include:
    - ✓ Some type of upside or upside and downside risk
    - ✓ Responsibility for managing the care of a set of assigned patients
- Managed care does **NOT** refer to all managed care plans from whom you received payment. In other words, it is likely that you will occasionally provide services and receive payments for patients who are covered by a managed care plan, but who are not assigned to you or with which you do not have a managed care contract.
- This generally requires regular review and reclassification of insurers in your system to be sure that only those with whom you have contractual managed care agreements are categorized as managed care for UDS reporting.

Example: Managed Care

- In reviewing your health center's payer contracts, you identify **six current managed care contracts**.
- In reviewing payments received from managed care plans, you identify **reimbursement received from eleven managed care plans**.
- **Should payments from…**
  - **… all eleven managed care plans be reported as managed care on Table 9D?**
  - **… only the six contracted managed care plans be reported as managed care?**

- Only payments from the six contracted managed care should be reported as managed care (either capitated or fee for service managed care, depending on payment) on Table 9D.
- Payments received from managed care organizations with which the health center does not have a contract (and is therefore not managing the care of a group of assigned patients) should be reported as Non-Managed Care.
- This should align with Managed Care enrollment on Table 4, where managed care patients assigned to the health center (also known as managed care enrollees are reported.

Self-Pay

- Self-Pay refers to charges or portion of charges that are **the responsibility of the patient** (rather than a third-party payer) and includes related collections and write-offs.
  - **Includes** charges incurred by uninsured patients, including those covered by indigent care programs, written off as sliding fee discounts, and/or written off as patient bad debt.
  - **Includes** co-payments, deductibles, and charges to insured individuals for uncovered services that become the patient's personal responsibility.
- Self-pay is reported on Line 13 of Table 9D.
- **Self-pay Charges** may then be paid by the patient and recorded as **Collections**, written off as **Sliding Fee Discounts** based on patient income and family size, or written off as **Bad Debt** when uncollectable (including inability to locate persons, patient's refusal or inability to pay regardless of income).
  - Self-pay does **NOT** include third-party payer bad debt.

At-a-Glance: Reporting Patient-Related Revenue

Report (columns)

- Column a: Charges (2020)
- Column b: Collections (**cash** basis)
- Columns c1-c4: Supplemental payments/ paybacks
- Column d: Contractual adjustments
- Column e: Self-pay sliding discounts
- Column f: Self-pay bad debt write-off

By Payer (rows)

- Lines 1-3 Medicaid
- Lines 4-6 Medicare
- Lines 7-9 Other Public
- Lines 10-12 Private
- Line 13 Self-pay

By Form of Payment

- Non-managed care
- a) Capitated managed care
- b) Fee-for-service managed care

HRSA Health Center Program

Potential COVID-19 Impact on Table 9D

Health centers may have limited in-person contact for some of 2020, thereby limiting patients' ability to come in and pay their bill.

- Health Center Program requirements specify that health centers must provide sliding fee and make every effort to be reimbursed for services to cover their costs.
- Self-pay charges are recorded in Line 13, Column a, regardless of whether patient has the ability to pay (logistical or financial).
- If the patient qualifies for Sliding fee, then it is applied based on board approved policy, and reported on Line 13, Column e.
- Uncollected portion of the charge could remain outstanding (and not reported anywhere) and **be paid after the public health emergency *or* written off as Bad Debt later**, per health center policy.

Health center patients may have lost their insurance coverage if they were laid off or lost their job, thereby shifting charges from what would have been Private (employer health insurance) to Self-Pay (uninsured).

- Self-pay charges are recorded in Line 13, Column a, based on the health center's fee schedule.
- Sliding fee is applied as appropriate based on income and family size, in accordance with board approved policy, and reported on Line 13, Column e.
- Any uncollectable portion of the charge would be written off as Bad Debt (Line 13, Column f), per health center policy.

For a deeper dive on Table 9D reporting, join next week's training!

We will take this to the next level.

Table 9E

Other Revenue

Table 9E: Other Revenue

- Other revenue includes all non-patient receipts that cover in-scope activities, received or drawn down in 2020.
- **Other revenue is reported on a cash basis** meaning the amount actually drawn down or received in 2020, not the full award amount.
  - ✓ For example, the health center may receive a grant award for $100,000 across four years. Only the cash received in 2020 would be included here (e.g., $25,000).
- Other revenue is reported on the line that aligns with the entity from which the funds were received.

Line	Source	Amount (a)
	BPHC Grants (Enter Amount Drawn Down—Consistent with PMS 272)	
1a	Migrant Health Center	
1b	Community Health Center	
1c	Health Care for the Homeless	
1e	Public Housing Primary Care	
1g	**Total Health Center** (Sum of Lines 1a through 1e)	
1k	Capital Development Grants, including School-Based Health Center Capital Grants	
1l	Coronavirus Preparedness and Response Supplemental Appropriations Act (H8C)	
1m	Coronavirus Aid, Relief, and Economic Security Act (CARES) (H8D)	
1n	Expanding Capacity for Coronavirus Testing (ECT) (H8E and LAL ECT)	
1o	Health and Economic Recovery Omnibus Emergency Solutions Act (HEROES)/Health, Economic Assistance, Liability Protection and Schools Act (HEALS)	
1p	Other COVID-19-Related Funding from BPHC (specify ____)	
1q	**Total COVID-19 Supplemental** (Sum of Lines 1l through 1p)	
1	**Total BPHC Grants** (Sum of Lines 1g + 1k + 1q)	
	Other Federal Grants	
2	Ryan White Part C HIV Early Intervention	
3	Other Federal Grants (specify ____)	
3a	Medicare and Medicaid EHR Incentive Payments for Eligible Providers	
3b	Provider Relief Fund (specify ____)	
5	**Total Other Federal Grants** (Sum of Lines 2 through 3b)	
	Non-Federal Grants or Contracts	
6	State Government Grants and Contracts (specify ____)	
6a	State/Local Indigent Care Programs (specify ____)	
7	Local Government Grants and Contracts (specify ____)	
8	Foundation/Private Grants and Contracts (specify ____)	
9	**Total Non-Federal Grants and Contracts** (Sum of Lines 6 + 6a + 7 + 8)	
10	Other Revenue (non-patient related revenue not reported elsewhere) (specify ____)	
11	**Total Revenue** (Sum of Lines 1 + 5 + 9 + 10)	

Revenue Sections on Table 9E

- BPHC Grants
  - Health Center Grants
  - COVID-19 Supplemental
- Other Federal Grants
  - Ryan White
  - Other federal grants such as those from the U.S. Department of Agriculture (USDA), U.S. Department of Housing and Urban Development (HUD), Substance Abuse and Mental Health Services Administration (SAMHSA), and Centers for Disease Control and Prevention (CDC)
  - Meaningful Use/Promoting Interoperability incentives
  - Provider Relief Fund
- Non-federal Grants or Contracts
  - State government
  - Indigent care
  - Local government
  - Foundation/Private
- Other revenue, including cash donations, cash proceeds from fundraising, interest income, etc.

Table 9E: COVID-19 Federal Funding Reporting

Federal Funding	Statute	Eligible Recipients	Date funding issued	Reported on Table 9E on the UDS
H8C Grants	COVID Supplemental Appropriations, March 4	330 awardees	March 27	Line 1l, in BPHC Grants section
H8D Grants	CARES Act, March 27	330 awardees	April 7 & 8	Line 1m, in BPHC Grants section
H8E Grants	Paycheck Protection Program and Health Care Enhancement Act (PPHCEA)	330 awardees *and LALs*	May 7	Line 1n, in BPHC Grants section.
Provider Relief Fund	Round 1: Established in CARES Act. Round 2: Expanded in PPHCEA	Round 2: Rural hospitals, clinics, FQHC	Round 2: After April 24	Table 9E, Line 3b, in Other Federal Grants section. Fill in Specify Line!

Potential COVID-19 Considerations for Table 9E

- Do not report the proceeds of any loan received for operations, a mortgage, or other purposes as revenue on the UDS.
  - This includes Paycheck Protection Program (PPP) loans which are forgivable and therefore may be converted to 'grants'. That is not reported on the UDS. There may be other similar programs at the state level, the rules are the same for that.
- Be sure that individual cash donations or fundraising receipts are reported on Line 10 of this table.
  - Any donations of supplies, materials, or time are reported on Table 8A, Line 18, Value of Donated Facilities, Services, and Supplies.
  - Donations or grants from foundations or private organizations are reported on Line 8, not Line 10.

Financial Reporting Resources

UDS Financial Tables Reporting Guidance

- This resource provides health centers with information about common reporting considerations and issues to consider when reporting UDS Tables 8A, 9D, and.
- Includes tips and acronyms.

Comparison Performance Metrics from UDS Financial Tables

- This webinar is October 28 from 1-2:30pm ET.
- This will include a deeper dive into financial table reporting and related metrics.
- It will expand on much of what we talked about in today's webinar.

Table-specific Fact Sheets

- Table 8A Fact Sheet
- Table 9D Fact Sheet
- Table 9E Fact Sheet
- Each provides information such as key terms relating to UDS financial tables, highlights changes from the prior year, informing the use of UDS data, providing helpful hints for completing UDS tables, and emphasize the importance of cross-table relationships and considerations.

These and other financial reporting resources are available at BPHCdata.net/resources/financial/.

HRSA Health Center Program

Thank You!

Jillian Maccini

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