UDS: UNIFORM DATA SYSTEM

Table 4: Selected Patient Characteristics

PURPOSE:

Table 4 is used to report on selected patient characteristics, including income, insurance status, managed care, and membership in special populations. In combination with the other patient profile tables, it provides an understanding of the demographics of those receiving services.

CHANGES:

- There are no changes to the Table 4 reporting requirements for 2018.
- Many of the requirements have been further clarified in this version of the UDS Manual.

KEY TERMS:

INSURANCE AND MANAGED CARE:

- ***Third party insurance:*** Main source of insurance for primary medical care services. Report this as of the last visit of the reporting year.
- ***Managed care member month:*** Defined as 1 member being enrolled for 1 month in a managed care plan. Total number of member months equals the sum of the monthly enrollment for the reporting year.

SPECIAL POPULATIONS

- ***Migratory or Seasonal Agricultural Worker:*** A patient whose principal employment is agriculture on a seasonal basis. Migratory describes those who establish a temporary home for such employment. Seasonal describes those who do not establish a temporary home for such employment.
- ***Homeless Patient:*** A patient who is homeless at the time of any service provided during the reporting year.
- ***School-Based Health Center Patient:*** A patient receiving health care services at a school-based service delivery site in their scope of project. This includes in-scope school-based health centers located on or near school grounds that provide on-site comprehensive preventive and primary health services.
- ***Veteran:*** A patient who has been discharged from the uniformed services of the United States.
- ***Public Housing Patient:*** A patient who is served at health center sites located in or immediately accessible to public housing, regardless of whether the health center site receives PHPC funding, or the individual physically resides in public housing.

HOW DATA ARE USED:

- **Patient Characteristics:** Describes the patients by income and insurance.
- **Managed Care Utilization:** Describes managed care enrollment in terms of member months per payer.
- **Special Populations:** Provides information about special populations receiving services.

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TABLE TIPS:

- Table 4 is completed for both the Universal Report and grant-specific report.

INCOME

- Total patients by income must equal total patients by insurance and total patients in each section of Tables 3A and 3B.
- Income is to be updated annually. The report should include the most current information available.
- Income must be reported by the patient. Do not assume income (e.g., report a Medicaid-insured patient as low-income). The patient can self-declare income as long as it is consistent with health center policies and procedures.
- Official poverty guidelines are available online at: **https://aspe.hhs.gov/poverty-guidelines**.
- Use Line 5 (unknown) to report patients whose income information was not collected during the calendar year.

INSURANCE:

- Breast and Cervical Cancer Control Program, Workers Comp, indigent care programs, and other programs that cover only a specific service are ***not*** considered insurance.

MANAGED CARE

- Enrollees in Primary Care Case Management (PCCM) programs, which pay a small monthly fee (usually less than $10 per member per month) that do not cover patient care, are not reported as managed care.
- Do not include managed care enrollees whose capitation or enrollment is limited to behavioral health or dental services only, though an enrollee who has medical and dental coverage (for example) is counted.

SPECIAL POPULATIONS

- All 330 programs report the total number of agricultural worker patients (Line 16), homeless patients (Line 23), school-based patients (Line 24), veterans (Line 25), and public housing patients (Line 26) served.
- Report the patient's shelter arrangements as of the first visit during the reporting period.
- ***Homeless*** (Lines 17–22) are only reported by 330h grantees. These are patients who lack housing (regardless of family membership), including individuals whose primary residence during the night is a supervised public or private facility providing temporary living accommodations and individuals who reside in transitional housing. This information is recorded based on where they spent the previous/recent nights:
  - Homeless Shelter (Line 17)
  - Transitional (Line 18)
  - Doubling up (Line 19)
  - Street (Line 20)
  - Other (Line 21)
  - Unknown (Line 22)

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- ***Migratory Agricultural Workers*** (Line 14) are usually hired laborers who are paid piecework, hourly or daily wages and who establish a temporary home for the purposes of employment. Also include on Line 14, migratory workers who have had this work as their principle source of income within 24 months of their last visit and their dependent family members who have used the center.

- ***Seasonal Agricultural Workers*** (Line 15) are individuals whose principal employment is in agriculture on a seasonal basis (as opposed to year-round employment) and who do not establish a temporary home for purposes of employment. Seasonal agricultural workers who have had this work as their principle source of income within 24 months of their last visit are reported on Line 15 as are their dependent family members who have used the center.

- ***School-Based Health Center Patients*** (Line 24) are reported by all health centers that identified a school-based health center as a service delivery site in their grant or designation application and scope-of-project description. The total number of patients who received primary health care services at a school service delivery site is reported. Services may have been targeted to the students at the school or their children, siblings or parents, as well as persons residing in the immediate vicinity of the school.

- ***Veterans*** (Line 25) are patients who have been discharged from the uniformed services of the United States. They are reported by all health centers. Patients who are still in the uniformed services (including the National Guard) are not considered veterans.

- ***Public Housing Patients*** (Line 26) should be reported on Line 26 if they are served at health center sites that are located in or immediately accessible to public housing, regardless of whether the health center site receives Public Housing Primary Care (PHPC) funding or the patient resides in public housing. Patients who reside in scattered site Section 8 housing should be excluded.

CROSS TABLE CONSIDERATIONS:

- The total patients reported by insurance type must match on Table 4 (Lines 7–12) and the Zip Code Table. For example, total Medicare patients on Table 4 (Line 9) must match the total of the Medicare Column (d) on the Zip Code Table.

- Reporting of charges and collections by payor on Table 9D relates to insurance enrollment on Table 4. For example, dividing Medicaid revenues on Table 9D, Line 3, Column (a) or Column (b) by Total Medicaid Patients on Table 4 (Line 8) equals the average charge/average collection per Medicaid Patient (see below).

- Reporting of managed care revenues on Table 9D relates to member months on Table 4. Dividing managed care capitation income by member months equals average capitation per member per month (PMPM). For example, dividing Medicaid capitated income (Table 9D, Line 2a, Column b) by Table 4, Line 13a, Column (a) equals Medicaid PMPM (see below).

SELECTED CALCULATIONS:

See next page for the two examples described below:

- **Calculation of Average Charge per Medicaid Patient:** $26,744,788/(20,061+15,396) = $754/Medicaid Patient

- **Calculation of Average Collection per Medicaid Enrollee:** $29,325,761/(20,061+15,396) = $827/Medicaid Patient

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TABLE 4 — SELECTED PATIENT CHARACTERISTICS
Reporting Period: January 1, 2018 through December 31, 2018

CHARACTERISTIC		NUMBER OF PATIENTS
Line	**Income as Percent of Poverty Guideline**	**Number of Patients (a)**
1	100% and below	
2	101-150%	
3	151-200%	
4	Over 200%	
5	Unknown	
6	**Total** (Sum Lines 1-5)	

Line	Principal Third Party Medical Insurance	0-17 years old (a)	18 and older (b)
7	**None/Uninsured**	**4,958**	**19,257**
8a	Regular Medicaid (Title XIX)	20,061	15,396
8b	CHIP Medicaid		
8	**Total Medicaid (Line 8a+8b)**	**20,061**	**15,396**
9a	Dually Eligible (Medicare and Medicaid)		163
9	**Medicare** (Inclusive of dually eligible and other Title XVII beneficiaries)	2	**6,860**
10a	Other Public Insurance Non-CHIP (specify:_____)	3	738
10b	Other Public Insurance CHIP		
10	**Total Public Insurance (Line 10a+10b)**	**3**	**738**
11	**Private Insurance**	**2,460**	**4,713**
12	**TOTAL** (Sum Lines 7+8+9+10+11)	**27,484**	**46,964**

Line	Managed Care Utilization Payer Category	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	TOTAL (e)
13a	Capitated Member months	369,658				369,658
13b	Fee-for-service Member months					
13c	**Total Member months (Sum Lines 13a+13b)**	369,658				**369,658**

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TABLE 9D — PATIENT RELATED REVENUE								
				Retroactive, Settlements, Receipts, and Paybacks (c)				
Line	Payer category	Full Charges This Period (a)	Amount Collected This Period (b)	Collection of Reconciliation/ Wrap Around Current Year (c1)	Collection of Reconciliation/ Wrap Around Previous Years (c2)	Collection of Other Retro Payments: P4P, Risk Pools, Withholds, etc. (c3)	Penalty/ Payback (c4)	Allowances (d)
1	Medicaid Non-Managed Care	5,028,253	3,890,883		1,135,473			1,166,506
2a	Medicaid Managed Care (capitated)	7,411,041	10,080,620	4,113,290		2,944,160		-2,669,579
2b	Medicaid Managed Care (fee-for-service)	14,305,494	15,354,258					-494,501
3	**Total Medicaid** (Lines 1+2a+2b)	**26,744,788**	**29,325,761**	**4,113,290**	**1,135,473**	**2,944,160**		**-1,997,574**
4	Medicare Non-Managed Care							
5a	Medicare Managed Care (capitated)							
5b	Medicare Managed Care (fee-for-service)							
6	**Total Medicare** (Lines 4+5a+5b)							
7	Other Public including Non-Medicaid CHIP (Non-Managed Care)							
8a	Other Public including Non-Medicaid CHIP (Managed Care Capitated)							
8b	Other Public including Non-Medicaid CHIP (Managed Care fee-for-service)							
9	**Total Other Public** (Lines 7+ 8a +8b)							