Table 9D: Patient Related Revenue

**PURPOSE:**
Table 9D collects information on charges, collections, retroactive settlements, allowances, self-pay sliding discounts, and self-pay bad debt write-off.

**CHANGES:**
- There are no changes to the Table 9D reporting requirements for 2017.
- Many of the requirements have been further clarified in this version of the UDS Manual.

**HOW DATA ARE USED**
These data are used to calculate average charge per visit, payer mix, and charge-to-cost ratio.

**KEY TERMS:**

**FULL CHARGES:** The entire gross charges to a payer for a billable service according to your fee schedule.

**COLLECTIONS:** The entire gross receipts for the year from a payer regardless of the period for which the service was rendered.

**FORM OF PAYMENT:**

**MANAGED CARE CAPITATED:** Capitation fees paid to the health center (usually monthly) regardless of whether services were delivered or not.

**MANAGED CARE FEE-FOR-SERVICE:** Charges and collections for patients assigned to the health center under managed care arrangement and seen on a fee-for-service basis.

**Payers:**

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

**MEDICARE:** Includes all routine Medicare; Medicare Advantage; Medicare portion of Medi-Medi or crossovers. If your system uses both the G-code charge and actual charge, you can remove G-code charges by running a report to get the total for G-code charges for the year, then subtract this number from total charges and report the difference in Column A.

**OTHER PUBLIC:** Includes state or other public insurance; Non-Medicaid CHIP; state-based programs which cover a specific service or disease such as BCCCP, Title X, Title V, TB. Does not include indigent care programs.

**PRIVATE:** Includes private and commercial insurance; Medi-gap programs, Tricare, Trigon, Workers Comp, etc.; contracts with schools, jails, Head Start, etc. Insurance purchased through state or federal exchanges are reported as “private” unless you can identify them as being enrolled through purchased subsidies from a Medicaid Expansion program (in which case, report as Medicaid).

**SELF-PAY:** Charges for which patients are responsible and all associated collections. Includes payments for indigent care program services.
Table 9D: Patient Related Revenue

**TABLE TIPS:**

**CHARGES (COLUMN A)**

- Undiscounted, unadjusted charges based on fee schedule, for services provided in the measurement year.
- Do not include “charges” where no collection is attempted or expected, such as for enabling services or pharmacy samples.
- Under no circumstances should the actual amount paid be used as full-charged (i.e. FQHC should never be reported as charges).

**COLLECTIONS (COLUMN B)**

- Amount collected as payment for, or related to, the provision of services on a cash basis, including payments from third party payers, capitation payments, payments from patients, and collections for services provided in a prior year.

**ADJUSTMENTS (COLUMNS C1 – C4)**

- Columns (c1) and (c2) include payments for FQHC or S-CHIP settlements (difference between established per-visit rate and initial payments) and reconciliations (submission of a cost report) for current or prior year.
- Column (c3) or “Other Retroactive Payments” includes risk pools, incentives, PFP, and withholds.
- These amounts are also included in column (b).

**ALLOWANCES (COLUMN D)**

- Reductions in payment by a third party based on a contract.
- Reduce the allowance in column(d) by the amount of FQHC adjustments (c1-c4).
- Allowances do not include:
  - non-payment for services not covered by the third party
  - non-payment of bills which were not submitted in a timely fashion or properly signed/submitted.
  - deductibles or co-payments that are not paid by a third party and not collected from patient.
  - For capitated insurance only, the allowance is calculated as the difference between total charges and collections unless there are early or late capitation payments (column d = column a – column b).

**SLIDING DISCOUNTS (COLUMN E)**

- Reduction in the amount due or paid for services rendered based solely on the patient’s documented income and family size as it relates to federal poverty level.
- May be applied to co-payments, deductibles, and non-covered services for insured patients when the related charge has been moved to the self-pay line.
- Self-pay line only.
Table 9D: Patient Related Revenue

BAD DEBT (COLUMN F)

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

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

RECLASSIFYING CHARGES:

■ Co-payments and deductibles as well as charges for non-covered services rejected by third parties should be moved to the payer responsible for the charge.

■ It is essential to reclassify these charges and portions of charges appropriately.

■ Show collections of these reclassifications on the appropriate line.

REPORTING CHARGES AND COLLECTIONS FOR PHARMACEUTICALS DISPENSED AT CONTRACT PHARMACIES

■ Charges are reported by payer in column (a)

■ The amount received from the patient (Line 13) or insurance company (Line 10) is reported in column (b).

■ The amount written off for an insurance company is reported in column (d).

■ The amount written off for a patient as a sliding discount is reported in column (e).

CROSS TABLE CONSIDERATIONS:

■ Table 4, lines 7-12 and Table 9D: Reporting of charges and collections by payer on Table 9D relates to insurance enrollment on Table 4. (Shown on Table 4)

■ Table 4, lines 13a-b and Table 9D: Reporting of capitated managed care revenues on Table 9D divided by capitated member months on Table 4 should approximate PMPM. (Shown below.)

■ Table 5 and Table 9D: Billable visits on Table 5 should relate to charges on 9D (charge per visit).

■ Table 8A and Table 9D: Reimbursable costs should relate to gross charges if fee schedule is designed to cover costs.

■ Table 9D, line 13, column (e) and Table 9E, line 6a, column a: If indigent care funds on Table 9E reimburse for services delivered to uninsured patients in the current year, they should not exceed sliding fee discount on Table 9D.
### Table 9D: Patient Related Revenue

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

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

**TABLE 8A — FINANCIAL COSTS**

<table>
<thead>
<tr>
<th>Line</th>
<th>Cost Center</th>
<th>Accrued Cost (a)</th>
<th>Allocation of Facility and Non-Clinical Support Services (b)</th>
<th>Total Cost After Allocation of Facility and Non-Clinical Support Services (c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FINANCIAL COSTS FOR MEDICAL CARE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Medical Staff</td>
<td>20,287,757</td>
<td>9,641,909</td>
<td>30,029,666</td>
</tr>
<tr>
<td>2</td>
<td>Lab and X-ray</td>
<td>1,302,135</td>
<td>662,268</td>
<td>1,964,403</td>
</tr>
<tr>
<td>3</td>
<td>Medical/Other Direct</td>
<td>2,839,075</td>
<td>1,329,591</td>
<td>4,168,666</td>
</tr>
<tr>
<td>4</td>
<td>TOTAL MEDICAL CARE SERVICES (Sum Lines 1 through 3)</td>
<td>24,428,967</td>
<td>11,733,768</td>
<td>36,162,735</td>
</tr>
<tr>
<td>FINANCIAL COSTS FOR OTHER CLINICAL SERVICES</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Dental</td>
<td>3,986,773</td>
<td>1,771,103</td>
<td>5,757,876</td>
</tr>
<tr>
<td>6</td>
<td>Mental Health</td>
<td>1,356,455</td>
<td>652,157</td>
<td>2,008,612</td>
</tr>
<tr>
<td>7</td>
<td>Substance Use</td>
<td>446,473</td>
<td>217,386</td>
<td>663,859</td>
</tr>
<tr>
<td>8a</td>
<td>Pharmacy not including pharmaceuticals</td>
<td>1,587,276</td>
<td>790,340</td>
<td>2,377,616</td>
</tr>
<tr>
<td>8b</td>
<td>Pharmaceuticals</td>
<td>2,177,064</td>
<td></td>
<td>2,177,064</td>
</tr>
<tr>
<td>9</td>
<td>Other Professional (Specify___________)</td>
<td>555,819</td>
<td>280,298</td>
<td>83,618</td>
</tr>
<tr>
<td>9a</td>
<td>Vision</td>
<td>1,111,640</td>
<td>560,597</td>
<td>167,236</td>
</tr>
<tr>
<td>10</td>
<td>TOTAL OTHER CLINICAL SERVICES (Sum Lines 5 through 9A)</td>
<td>11,221,500</td>
<td>4,271,881</td>
<td>13,235,881</td>
</tr>
</tbody>
</table>