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:
None for 2016

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.

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 patient assigned to the health center under managed care arrangement and seen on a fee-for-service basis.

PAYERS:
MEDICAID: Includes all routine Medicaid under any name, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) under any name, Medicaid part of Medi-Medi or crossovers, Children’s Health Insurance Program (CHIP) if paid through Medicaid as it is in some states, may include fees for other state programs that are paid by the Medicaid intermediary in some states.

MEDICARE: Includes all routine Medicare, Medicare Advantage, Medicare portion of Medi-Medi, or crossovers.

OTHER PUBLIC: Includes state or other public insurance programs; Non-Medicaid CHIP programs; state-based programs that cover a specific service or disease such as Breast and Cervical Cancer Control Program (BCCCP), Title X, Title V. 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.

SELF-PAY: Charges for which patients are responsible and all associated collections.

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 expected or will be attempted such as for enabling services or pharmacy samples.
- Under no circumstances should the actual amount paid be used as full-charged (i.e., Federally Qualified Health Center (FQHC) should never be reported as charges).
### Table 9D: Patient Related Revenue

#### 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 related to 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.
- **Remember:** Reduce the allowance in Column (d) by the amount of FQHC adjustments (c1-c4).
- Allowances do not include:
  - non-payment for services that are not covered by the third party;
  - non-payment of bills that 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. Thus: *(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

#### 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 that is written off for an insurance company is reported in Column (d).

- The amount written off for a patient as a sliding discount is written off 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.
**SELECTED CALCULATION: MANAGED CARE ACTIVITY**

- **Average capitation per member per month (PMPM) =** Divide capitated managed care revenues/capitated member months by payer.

- **For example, private capitated managed care revenues/private capitated member months = PMPM**

**SELECTED CALCULATION: RATIO OF CHARGES TO REIMBURSABLE COST**

- **Total charges =** Table 9D, Line 14, Column (a) = 52,440,869

- **Total loaded cost for billable services =** Table 8A, Column (c), L4 + L10: Loaded cost for billable services = $49,398,616

**TABLE 9D — PATIENT RELATED REVENUE**

<table>
<thead>
<tr>
<th>Line</th>
<th>Payer Category</th>
<th>Full Charges This Period (a)</th>
<th>Amount Collected This Period (b)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Private Non-Managed Care</td>
<td>4,398,124</td>
<td>2,047,567</td>
</tr>
<tr>
<td>11a</td>
<td>Private Managed Care (Capitated)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>11b</td>
<td>Private Managed Care (Fee-for-service)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>12</td>
<td>Total Private (Sum Lines 10+11a+11b)</td>
<td>4,398,124</td>
<td>2,047,567</td>
</tr>
</tbody>
</table>
## 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>
<th>Collection of Reconciliation/ Wrap Around Current Year (c1)</th>
<th>Collection of Reconciliation/ Wrap Around Previous Years (c2)</th>
<th>Collection of Other Retroactive Payments Including Risk Pool/ Incentive/Withhold (c3)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></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></td>
<td>4,113,290</td>
<td>1,306,596</td>
<td>2,944,160</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>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>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>