Uniform Data System (UDS) Financial Tables Guidance

Table	Brief Description	Checks
Costs: Table 8A		
5 & 8A	Sync FTEs to costs	• Explain costs with no FTEs. This may be due to having paid referred care contracts for lab, x-ray, and other services. • Significant differences in the CY-PY are compared. Check for differences and correct or provide clear explanations. Unreasonably low or high costs per FTE may be an indication of a possible mismatch of cost and FTEs. This may be explained by donated staff where there are FTEs on the service line but the cost is reported on the donated line.
5 & 8A	Other programs and services FTEs and cost	• The Other Programs and Services category includes in-scope items and programs not classifiable elsewhere and those not exclusively tied to health center patients. This line includes: WIC, pass-through cost, space leased to others, health center staff contracted to other organizations, retail pharmacy, adult day health care, research, etc. • "Specify" text box in this category across both Tables 5 & 8A should contain the same program and description (e.g., if WIC is described on Table 5, Line 29 for the program FTE, the costs on Table 8A, Line 12, should also note they relate to WIC). • Receipts related to these costs are reported on Table 9E on the appropriate line. For example, pass-through receipts are reported on Table 9E, Lines 1a-1e (on line for funding received), and are offset by an equal amount of cost on Table 8A, Line 12.
8A & 9E	Donation descriptions	• Donated drugs (Table 8A) are to be valued at 340B prices, reported on Line 18, and described in the specify box. Drugs donated by the pharmaceutical company directly to the patient are not reported. • In-kind (non-monetary) donations made to the health center are reported on Table 8A, Line 18, not on Table 9E. • Report only cash donations on Table 9E, Line 10, Other Revenue, not as a donation on Table 8A. • All donations (non-cash donations on Table 8A and cash donations on Table 9E) must be described in the specify boxes.
8A	Pharmacy costs	• Reporting no pharmacy or pharmaceutical cost on Table 8A is unusual and should be explained as a table comment. • The cost for medications administered by clinicians in-house are to be reported on the pharmaceutical line and not in medical. • Report dispensing cost from 340B contract pharmacies on the Table 8A, Line 8a, Pharmacy. Contract pharmacies take their fees from sales receipts before reimbursing the health center. The dispensing cost should not be omitted, as this may result in understated drug replenishment cost. • Review pharmacy cost (Table 8A, Line 8a) if it is greater than drug cost (Table 8A, Line 8b). Nationally, pharmaceutical costs are 62% of the total pharmacy costs. • Work with contract pharmacies to ensure the health center receives detailed reports that show the pharmacy, drug, and dispensing fees costs separately

		Refer to the UDS Manual Appendix B, which provides further detail on reporting 340B contract pharmacy costs. • Pharmacy revenue data may be questioned, particularly in centers where the pharmacy cost is significant (when the costs exceed $1M or more or the cost is proportionately much greater than the national average of 14% of total cost).

8A	Overhead allocation methods	• There are multiple ways which overhead (facility and non-clinical support [administration]) may be allocated. Health centers should use the simplest method which produces a reasonably accurate and comparable result to a more complex method.
		  ○ Allocating known direct costs first is preferable. For example, all the facility cost of a dental-only site would be charged directly to dental.
		  ○ Doing an allocation of facility cost second and administration cost third is also preferable.
		• A lesser overhead charge should be considered for large purchased-service items (e.g., lab, X-ray).
		• If the proportion of overhead cost to direct cost is the same for each line, it indicates that a one-step method was used. Given that managing personnel consumes most of the overhead, using square feet of space or equal proportions of overhead to cost centers as the sole allocation basis will generally not produce an accurate allocation of overhead. Using total direct cost, FTEs, or personnel cost applicable to a cost center is a preferable one step basis.

8A	Overhead outliers	• Overhead cost to total cost rates of 7% for facility and 25% for non-clinical support (administration) are stable national averages over time. There is little deviation from the mean. Outliers (unusually high or low) will be questioned to check for misclassifications of cost. Explain significant change in rates from the prior year in comments. • Large pharmacy programs will drive overhead rates down.
All	Subrecipients and contractors	• Health centers should identify the existence of subrecipient and large contractor arrangements and those arrangements should be clearly documented and included on the UDS. • Subrecipients are to report a complete set of UDS tables, which are consolidated with the health center's data. • Contractors report the services delivered and the cost reported is the amount paid by the health center.

Table	Brief Description	Checks
Patient	**Service Revenue: Table 9D**	
9D	Adjusting charges and collections (retros, receipts, paybacks, adjustments, sliding fee, and bad debt)	• Report retros on Table 9D, in Columns C1, C2, and C3 **and** add to Column B as collections. Also, subtract retros out of Column D as adjustments. Do the opposite mathematical steps for Column C4, for paybacks made with check. • No Medicaid adjustments is more likely in states where Medicaid or its MCOs pay the centers their FQHC rate rather than a market rate. It could also be that the health center is improperly recognizing charges at the FQHC rate rather than the fee schedule charge rate. The absence of wraps or settlements for managed care plans should be explained. • Sliding fee adjustments are reviewed for reasonableness. Usually, the direction of change from the PY is consistent with the change in self-pay charges. • Bad debt reported on the UDS currently only includes self-pay patient debt. The reported debt can be either the amount directly written off from patient accounts or, ideally, the change in the allowance account for self-pay at the end of the year.
4 & 9D	Insurance vs. Payer	• Table 4 classifies patients by medical insurance and Table 9D classifies revenue data by the payer from which the revenue is expected or received. • The patient mix and charge payer mix are usually comparable with some difference expected. Nationally the charge mix for Medicaid plus Medicare (64%) is higher than the patient mix for Medicaid plus Medicare (61%). • There are limited Other Public insurances, but commonly Other Public payers. Categorical grants such as Title X and BCCEDP are not insurance and the patients are usually classified as uninsured on Table 4.

4 & 9D	Managed care enrollment data consistency	• The determination of managed care reporting in the UDS is that the health center has a contractual agreement with a managed care organization or managed care plan through which the health center is assigned patients and is responsible for managing the comprehensive care of those patients.
		• MCOs who don't provide enrollment data are not considered managed care for UDS reporting on both Tables 4 and 9D.
		• Outlier (unusually high or low) PMPM capitation and charges PMPY amounts will be questioned as will any significant change from the PY.
		  ○ Unusually low capitation amounts (for example between $5-$10 per member per month) may be due to case management being mistakenly reported as managed care.
		  ○ High amounts could be due to missing enrollment data or unusually high-risk coverage (e.g., HIV or prenatal).
		  ○ Outlier PMPM amounts should be explained.
		• There will be no wraps if MCOs are paying PPS rather than market rates. Wraps and settlements are to be allocated on the three lines within each payer and in Columns C1 and C2. The absence of wraps or retroactive settlements should be explained.

5 & 9D	Charge ratios	• Charges per patient, charges per visit, and charge to cost ratio outliers may be questioned (when unusually high or low). ○ Large pharmacy operations may explain high ratios and low productivity may explain a low charge to cost ratio.
9D	In-house and contract pharmacy revenue	• Contract and in-house pharmacy revenue are reported on Table 9D. • Pharmacy revenue data are to be reported on Table 9D in the same manner as other services are reported. Pharmaceutical charges are to be recorded in a uniform amount - generally the retail or UCR price - for each drug, by payer, and by date of service; collections are to be reported by payer upon receipt along with any corresponding adjustments. • Pharmacy revenue data can be problematic because of limitations of the data provided by the contract pharmacies, generally using 340B purchased drugs. Work with contract pharmacies to ensure the health center receives detailed reports that show the drug and dispensing fees charges by payer, date of service, and amounts collections and adjusted during the year by payer. Refer to the UDS Manual Appendix B, which provides further detail on reporting contract pharmacy revenue. • In rare instances, when pharmacy revenue details are not properly tracked by contractors, receipts by payer are not always known. Report the receipts on Table 9D, Line 13 Self Pay, Column B, and offset those receipts with an equal amount of charges in Column A. Steps are to be implemented to properly document and correct for this situation in future UDS reporting.
9D	Medicare G-codes or other capitated or negotiated rates	• Charges across all payers are to be reported from the health center's schedule of fees. Charges are not to be reported at negotiated or discounted rates. • Medicare requires the G-codes and CPT codes to be included on Medicare claims. Remove the G-codes from the charges reported on the UDS. Most practice management systems have corrected for this, and if not, a manual adjustment is needed. • The failure to exclude Medicare G-codes from charges will overstate the Medicare payer mix.
9D & 9E	Performance incentives	• Many managed care plans and many other insurers pay a performance bonus or incentives. These are to be reported in Columns B and C3 of Table 9D, and not on Table 9E. • Incentive and performance payments are to be reported on Table 9D except for CMS EHR incentive receipts, which are reported on Line 3a of Table 9E.
9D	Accounts receivables and charge reclassification	• Charges less collections less adjustments = change in accounts receivable (A/R). Nationally, A/R increased in an amount equal to 0.3 months of charges. The change in A/R is usually consistent with the change in charges - when charges increase A/R increases. Large changes in A/R are questioned. • Check that a large increase is not the result of adjustment entries being reversed. Large A/R decreases may be an error if retroactive payments are included as collections in Column B, but were not taken out of Column D, as adjustments. • Charges are to be reclassified to secondary and subsequent payers when appropriate. Failure to do this may cause the change in Medicare and Private payer A/R to increase and self-pay to decrease.

Table	Brief Description	Checks
Other Revenue: Table 9E		
9E	Other revenues	• Table 9E only includes cash receipts related to other, non-patient service revenue. • Loan proceeds are not reported because they are not revenue. Insurance proceeds are not reported if the loss was taken as an asset reduction. • Loans are not reported as revenue anywhere in the UDS.
9D & 9E	Categorical grant receipts	• Categorical grant receipts which are tied to patient services are reported on Table 9D. • Categorical grants which are not tied directly to specific patient services and which reimburse for expenses are reported on Table 9E.
9D & 9E	Indigent care	• Indigent care should be reported consistently in states and localities. • Report the portion of the charge not covered by the indigent care program or the patient's responsibility as a sliding fee discount on Table 9D in Column E. • Indigent program receipts are reported on Table 9E.
9E	COVID-19 receipts	• COVID-19 supplemental funds through the BPHC are to be checked against the COVID-19 grant sources and activity code. • Report on Table 9E, Lines 1l-1p2, only the amount drawn down during the calendar year, not the award total. The amount should never exceed the total award amount. • Receipts directly from the Provider Relief Fund through HHS are to be reported on Table 9E, Line 3b. • Report other COVID-19 receipts received on the Table 9E line representing the entity for which the health center received funds from, regardless of original source.
9E	Receipts by source	• Receipts are reported by the source from whom they were received and not where they originated. For example, RW A = local government or non-profit, RW B = state, and RW C = federal. • Use the specify boxes to identify dollars by source.
8A, 9D, & 9E	Surplus or loss	• Surplus or Loss = Tables 9D+9E receipts less Table 8A cost before donations. • Large surplus or loss for CY and PY are questioned. Check if the amount is consistent with audited net revenue. • Check if some receipts or costs are missing, particularly pharmacy revenue or cost. • A possible reason for changes from year to year may be timing of grant or wrap receipts showing deficit one year and surplus the next.

9E	Large change in revenue sources from prior year	• Review prior year grant and contract Table 9E reporting for comparability to check that items are not omitted. • Check for accuracy when reporting significant reduction or no dollars in the current year from programs and vice versa.
9E	Other receipts	• Do not report any patient service revenue on the Other Revenue line. • Other Revenue, Line 10, are to be described. Nationally, other receipts = 4% of total 9D+9E receipts. • Retail pharmacy receipts are reported as other revenue on Table 9E, Line 10.

Note: Follow the UDS Manual instructions when reporting on the financial tables, though they may differ from accounting principles. Reporting questions not clearly addressed by the UDS Manual are to be discussed with the UDS support line or the reviewer who will counsel with the health center's UDS team to determine the best approach.

Acronyms Used:

- A/R - Accounts receivable
- BCCEDP - Breast and Cervical Cancer Early Detection Program
- CMS - Centers for Medicare & Medicaid Services
- COVID-19 - Coronavirus disease
- CY - Current or calendar year
- EHR - Electronic health record
- FQHC – Federally-qualified health center
- FTE - Full-time equivalent
- HHS - U.S. Department of Health and Human Services
- HIV - Human immunodeficiency virus
- MCO - Managed care organization
- PMPM - Per member per month
- PMPY - Per member per year
- PPS - Prospective payment system
- PY - Prior year
- RW - Ryan White
- UCR - Usual, customary, and reasonable
- WIC - Women, infants, and children