INSTRUCTIONS FOR COMPLETING

ANNUAL UTILIZATION REPORT OF PRIMARY CARE CLINICS
(COMMUNITY AND FREE)

REPORT PERIOD
JANUARY 1, 2018 THROUGH DECEMBER 31, 2018

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
ACCOUNTING AND REPORTING SYSTEMS SECTION
LICENSED SERVICES DATA AND COMPLIANCE UNIT
2020 WEST EL CAMINO AVENUE, SUITE 1100
SACRAMENTO, CA 95833

(916) 326-3854
www.oshpd.ca.gov

Office of Statewide Health Planning and Development

Accounting and Reporting Systems Section
Licensed Services Data and Compliance Unit

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Annual Utilization Report of Primary Care Clinics
for
Report Periods Ended in 2018

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ANNUAL UTILIZATION REPORT
of PRIMARY CARE CLINICS - 2018
Community and Free

These are the instructions for completing the 2018 Annual Utilization Report of Primary Care Clinics. Additionally, it contains a table of primary care providers, a table of federal poverty level guidelines, and a glossary of terms used within the industry.

Please contact the Office of Statewide Health Planning and Development (OSHPD) Technical Support at (916) 326-3854, or utilization@oshpd.ca.gov for any questions or for further clarification.

GENERAL INSTRUCTIONS

1. Section 127285 and Section 1216 of the Health and Safety Code requires every licensed clinic to file with the Office of Statewide Health Planning and Development (OSHPD) an annual report that contains financial, utilization, and patient demographic information. Failure to file a timely report may result in a suspended license by the California Department of Public Health (CDPH) until the report is completed and filed with OSHPD.

2. The standard report period for Annual Utilization Reports covers the period from January 1 to December 31, unless there has been a change in licensure (ownership) during the calendar year. In this case, the former licensee is responsible for submitting a final report that covers January 1 to the last date of licensure, while the new licensee is responsible for submitting an initial report that covers the effective date of licensure to December 31.

   Note: Clinics are encouraged to request permission to submit a combined 12-month report if there has been a change in licensure during the calendar year. The former and current licensees need to agree which licensee will be responsible for submitting the report. Please send your request to file a combined report by e-mail to utilization@oshpd.ca.gov, or contact OSHPD Technical Support for instructions.

   If a clinic opens or resumes operations during the year, the first utilization report must cover from the effective date of licensure to December 31. If a clinic closes or suspends operations during the year, the final utilization report must cover from January 1 to the date of closure or suspension.

3. All primary care clinics are required to submit their Annual Utilization Reports using OSHPD's System for Integrated Electronic Reporting and Auditing (SIERA) for calendar year 2018 and thereafter. SIERA can be used with Google Chrome, Microsoft Edge and Internet Explorer, Apple Safari, and Mozilla Firefox. Other browsers can be used, but they may not provide complete functionality in SIERA. Please visit SIERA at https://siera.oshpd.ca.gov/.

4. **Do not submit the hardcopy report to OSHPD**. Only facilities with prior formal written approval for modification of submission may use a different submission format.

5. Annual Utilization Reports are due on or before February 15 if the report is for a full 12-month report period. If the clinic closes, the report is due 14 days from the date of notification from OSHPD. To start a report, click on "Submit" for the report year under the facility name and information.

   Note: If February 15th falls on a weekend or holiday, the due date will be the first working day after the weekend or holiday.

6. Enter all amounts as whole numbers. Enter financial data to the nearest dollar. Do not use decimals, commas, dollar signs, spaces or special characters.

   Note: The only tables in the report that allow the use of the decimals are the "FTE's and Encounters by Primary Care Provider" and the "FTE's and Contacts by Clinic Support Staff". Both are located in Report Page 2 of the Annual Utilization Report.

7. SIERA Utilization will calculate totals for a report page or the entire report by clicking on the "Calculate" button on the bottom of the page.

8. When you have validated the report and eliminated all of the fatal errors and explained all of the warning errors in the Edits on the bottom of the report, you are ready to submit the report to OSHPD. Click on the "Submit" button at the bottom of the report. A Certify Report page will appear that will ask you to certify the accuracy of the report. If you agree with the terms, click on checkbox and "Certify" button. Be aware that if you accept certification that you are certifying **under penalty of perjury** that the information supplied is, to the best of your knowledge, accurate, truthful, and complete. If the report is accepted, the status will show as "Submitted". You can print this screen for your records. If it is not valid, the SIERA Utilization application will send you back to the report and show any remaining errors. Repeat until the report has been submitted.

9. When the report has been submitted, you can view your report in the SIERA Utilization system. Log into SIERA Utilization, on the SIERA Utilization Home page will display your facility's reports. If you have multiple facilities, you may filter for the OSHPD ID number or name of your facility, then select "Filter". The report will be listed with a status of "Submitted" and any reports that have not been submitted will display a status of "Pending" or "Delinquent" if passed the due date.

10. To view the original report, click on the "View" link under the Original Submission column. If you need to make changes to the report, select "Revise/View" and you will access the originally submitted report. Make necessary changes and save and re-validate before submitting the report again. (While the report is being revised it will have an "In Process" icon ( ) next to the report year. Hovering over the icon ( ) will display the user of last saved report. To continue with the revision, click on "Revise/View" for the report year and the last saved report will be displayed and ready for submission. When re-submitted, the status will change to "Revised". You can revise the report as many times as needed by following the same steps.

REPORT PAGE 1 – GENERAL INFORMATION

This report page contains basic information about the clinic and its parent corporation, if any, and the person completing the report.

1. **Lines 1 - 5: Clinic Name and Address**
   The information for lines 1 through 5 is automatically entered from OSHPD's Licensed Facility Information System (LFIS) based on data from the California Department of Public Health, Licensing & Certification Division (CDPH). If you find any errors in this information, please notify us by e-mail at utilization@oshpd.ca.gov or call (916) 326-3854.

2. **Lines 6 - 8: Facility Telephone Number, Administrator Name, and E-mail Address**
   Enter the facility's main phone number on line 6 and the administrator's name on line 7. Enter the administrator's e-mail address on line 8 if one is available. The administrator's e-mail address will not be made available to the public.

3. **Line 9: Operation Status**
   On line 9, select "Yes" or "No" from the drop down menu to indicate whether or not the clinic was in operation at any time from January 1 through December 31. If you selected "No" indicating that the facility was not in operation during the year, complete Report Page 1 only and click "save". Then go to the end of the report, skip "validate and save" and select the "submit" button to file the report with OSHPD.

4. **Lines 10 - 11: Dates of Operation:**
   If you selected "Yes" on line 9 because the clinic was in operation during the year, enter the beginning and ending dates of operation on lines 10 and 11, respectively.

   > **Example** – A clinic began operation on April 15th and continued operation for the rest of the year. Line 10 would be 04/15/2018 and line 11 would be 12/31/2018.

5. **Lines 12 – 16: Parent Corporation Information**
   If the clinic is owned by another entity, list the name, address and phone number of the other entity on lines 12 through 16. If the clinic is not owned by another entity, leave these lines blank.

6. **Lines 17 – 20: Person Completing the Report (Report Contact Person)**
   The information on lines 17 through 20 will be filled in automatically based on the report preparer's registration information. The e-mail address on line 20 will not be made available to the public.

7. **Line 30: Submitted By and Submitted Date and Time**
   When the report is submitted, the SIERA Utilization application will supply the name of the person who submits the report, the date, and the time of submission on line 30 of the final, submitted version of the report. Before the report is submitted line 30 will read, "Not submitted yet".

REPORT PAGE 2 – CLINIC SERVICES

This report page includes information on the community services and patient care services provided by the clinic, as well as information about languages spoken by patients and staff, and the composition of the clinic's primary care providers. It also provides an accurate picture of the staffing level and volume of services delivered for each type of primary care practitioner at the clinic, regardless of the means by which they are reimbursed (or even whether they are reimbursed).

1. **Line 1: License Category (Type)**
   The clinic's license category for line 1 is automatically completed by OSHPD based on data from CDPH, Licensing and Certification Division. License categories are Community and Free. If you find any discrepancies in this information, please notify us by e-mail at utilization@oshpd.ca.gov or call (916) 326-3854.

2. **Line 2: Federally Qualified Health Center (FQHC)**
   On line 2, select from the drop down box whether your clinic is an FQHC or an FQHC "look-alike" or neither.

3. **Line 3: Rural Health Clinic (RHC)**
   On line 3, select "Yes" or "No" from the drop down box whether your facility is a 95-210 Rural Health Clinic or not.

4. **Lines 10 – 23: Community Services**
   On lines 10 through 23, check ("✓") which Community Services are offered by the clinic. For example, if the clinic offered Adult Day Care and Transportation services, check ("✓") lines 10 and 21. Leave the boxes blank for the services that do not apply.

5. **Lines 30 – 40: Health Services**
   On lines 30 through 40, check ("✓") which Health Services are offered by the clinic. For example, if the clinic offered Medical and Mental Health, check ("✓") lines 30 and 33. Leave the boxes blank for the services that do not apply.

   > **SIERA Utilization Note:** On lines 10 through 65, check ("✓") the box to indicate service provided (lines 10 – 40) or language spoken (lines 50 – 65). To remove the check ("✓"), click the box again.

6. **Lines 50 - 65: Column 1: Languages Spoken by Staff**
   In column 1, lines 50 through 65, check ("✓") if one or more of your staff speaks a language listed. Leave the boxes blank for the languages that do not apply.

   > **Example** – if your clinic has one staff person who speaks Chinese and another who speaks Spanish, you would check ("✓") in column 1, lines 53 and 63.

   Note: Do not indicate the number of staff persons who speak a language listed. The only acceptable entries are either a check ("✓") or a blank. If you have four staff persons who speak Spanish, you would still check ("✓") column 1, line 63.

7. **Lines 50 – 65, Column 2: Languages Spoken by Patients**
In column 2, lines 50 through 65, check ("✓") each language in which 1% (or more) of your patient population is best served. Also check ("✓") if 100 or more patients are best served in that language, even if that number is less than 1%. If you don't have the exact numbers, an estimate is acceptable.

> **Example –** A clinic has a sizable population that speaks Spanish and approximately 150 patients who speak Hmong. You would check ("✓") line 63 in column 2 to indicate the Spanish speaking population. Also you would check ("✓") line 55, column 2 because the population of Hmong speaking patients was estimated to be in excess of 100, even if 150 is less than 1% of the patient population**.**

8. **Line 70: Patients Best Served in a Language Other Than English**
Enter on line 70, the **percent** of patients that are best served in a language other than English. Please report the percentage to the nearest WHOLE percent. This figure may be an estimate based on the experience of the clinic staff because clinics normally do not keep data on who is "best served in another language".

> **Example** – the staff of a clinic estimate that 50% of the clinic's patients are best served in Spanish and 10% best served in Hmong. You would enter "60" on line 70. The only acceptable entry for line 70 is a whole number between 1 and 100. If the clinic does not have the threshold level of patients (1% or 100 individuals) for any language group, leave line 70 blank.

9. **Line 71: Designation of Language**
If there is an entry on line 70 (percentage of patients best served in another language), select from the drop down menu on line 71 the primary non-English language spoken by the clinic's patients.

> **Example** – the staff of a clinic estimate that 50% of the clinic's patients are best served in Spanish and 10% best served in Hmong. You would enter "60" on line 70 and "Spanish" on line 71. This would indicate that the majority of the non-English speaking patients spoke Spanish. The language selected on line 71 must be one of the languages checked on lines 50 through 65.

10. **Lines 75 – 86: FTEs and Encounters by Primary Care Provider**
Most of the professions in the table are self-explanatory. However, for line 85 (Other Providers billable to Medi-Cal) the individuals must be both "licensed" for that profession and be approved for reimbursement by the Medi-Cal program. A listing of these Medi-Cal Billable Providers is contained in the Glossary.

Note: For more information on counting and reporting FTEs, see "Full-Time Equivalent (FTE)" in the Glossary.

Example 1:
Scenario – A patient sees another health care provider such as a podiatrist or an optometrist whom the doctor at the clinic referred the patient to, does that visit count as an encounter?

A patient visit to an out of clinic health care provider can be recorded as an encounter IF:

1) The patient visit meets the usual criteria for an encounter (i.e. face to face visit with a health care professional, the professional is licensed, the professional exhibits independent judgment and the encounter is recorded in a patient chart)

AND

2) The encounter meets one of the following criteria:
   i. The clinic assumes full risk under an HMO - the clinic must pay the full amount of the bill
   OR
   ii. The clinic is a new start up that does not have a dental facility but required to provide dental services as part of their start up requirements. In such cases the clinic must purchase dental services on the market to meet the start-up requirements.

Example 2:
Scenario – A patient sees a specialist such as a radiologist, does that visit count as encounter?

A visit to receive specialty services (such as x-ray, MRI or laboratory procedures) is not considered an encounter. However, if the cost of the service is paid by the clinic, it should be recorded as an expense on Report Page 7, Line 35 “Outside Patient Care Services”.

Example 3:
Scenario – The primary care providers such as counselors from a clinic make home visits to see patients. Should those home visits be included as encounters?

If the procedures delivered at the home visit are billed at the usual and customary charges, and the visit meets the four criteria for an “encounter” then the visit should be recorded as an encounter.

Example 4:
Scenario – Are patient visits to the clinic’s on-site pharmacy considered encounters? Where should the encounters and gross revenue be reported?

A patient’s visit to a clinic’s on-site pharmacy is not considered an encounter. This service is “attendant to” a medical (or dental) counter.

The gross revenue should be listed by the expected payment source that covers the purchase in Report Page 6. The costs associated with operating the pharmacy should be listed along with the clinic's other operating costs in Report Page 7. The costs associated with the purchase of the pharmaceuticals should be listed under "Supplies-Medical and Dental" in Report Page 7.

Column 1: Salaried Provider - Enter on lines 75 through 86 the number of FTEs (to two decimal places) for each primary care provider who is salaried. The understanding in the employment agreement between primary care provider and the clinic will determine the equivalent staffing. For example, if the employment understanding was that the practitioner would work "half-time", the clinic would report 0.50 FTE for that person.

Column 2: Contracted Provider - Enter on lines 75 through 86, the number of FTEs (to two decimal places) for each primary care provider who is hired under an hourly, daily, weekly, or other time based contractual relationship and is not considered to be a salaried employee. Include staff persons who are supplied by a third-party, such as university staff sent to the clinic as the result of a contractual agreement with the university. In these cases, the hours worked must be translated to a full-time equivalent (FTE) using 2080 hours as the denominator.

Health professionals who are hired to backfill a salaried position while the salaried employee is on vacation, out sick, getting professional training or gone from the clinic for any other reason will be reported in this column. The calculation for converting the hourly service to an FTE is the same as for any other contract position (see below).

Example: A physician works 16 hours per week for 52 weeks and is reported as 0.40 FTE as follows: Multiply 16 hours per week times 52 weeks per year to equal 832 hours per year. Divide 832 hours per year by 2080 hours per FTE to equal 0.40 FTE (report to two decimal places).

Column 3: Volunteer Provider - Enter on lines 75 through 86 the number of FTEs (to two decimal places) for each primary care provider who is a volunteer. The fact that the clinic does not pay a practitioner does not mean that it should not report the equivalent staffing which the volunteer represents. Calculate the number of FTEs based on the time worked during the year divided by 2080 hours (see example above).

Column 4: Total FTEs – The SIERA Utilization application will complete column 4, lines 75 through 86, with the sum of columns 1, 2, and 3 for each primary care provider.

Column 5: No. of Encounters – Enter on lines 75 through 86 the total number of encounters in each primary care provider category. As a general rule, only one practitioner can be credited with an encounter per patient per day, but there are some exceptions to this general rule. Please see the definition of "encounter" in the Glossary.

11. **Line 87: Total FTEs and Encounters**
The SIERA Utilization application will complete line 87 with the sum of lines 75 through 86 for columns 1 through 5.

12. **Lines 90 – 101: FTEs and Contacts by Clinical Support Staff**
Complete lines 90 through 101 for columns 1 through 4 using the same instructions described for lines 60 through 74. In column 5, enter the number of patient contacts for each clinical support staff category. By definition, the clinic services administered by these staff are not considered “encounters”.

13. **Line 102: Total FTEs and Contacts**
The SIERA Utilization application will complete line 102 with the sum of lines 90 through 101 for columns 1 through 5.

REPORT PAGE 3 – PATIENT DEMOGRAPHICS

This report page reports an **unduplicated** count of all persons seen in the clinic during the report period. An individual must have at least one encounter during the year in order to be counted as a "patient". The total number of patients reported by Race, Ethnicity, Federal Poverty Level, Age Category, and Patient Coverage must agree. The SIERA Utilization application will not allow you to submit your report if the total patients on any one of the tables do not match the other tables.

1. **Lines 1 – 6: Race**
   Enter on lines 1 through 6 the number of patients in each race category seen by the clinic during the report period. The racial categories are the official State categories.

2. **Line 7: Total Patients (Race)**
   The SIERA Utilization application will complete line 7 with the sum of lines 1 through 6.

3. **Lines 10 - 12: Ethnicity**
   The purpose of this table is to identify the portion of the clinic's patients who are of Hispanic background. If the clinic does not collect data on the ethnicity of its patients, an estimate is acceptable. On line 10 enter the number of patients who are of Hispanic background. Enter on lines 11 and 12 the number of patients who are non-Hispanic or of unknown ethnicity, respectively.

4. **Line 13: Total Patients (Ethnicity)**
   The SIERA Utilization application will complete line 13 with the sum of lines 10, 11 and 12.

5. **Lines 20 – 26: Federal Poverty Level**

   Note: The Federal Poverty Level table for the 2018 report has been modified to reflect eligibility levels of the federal Patient Protection and Affordable Care Act and the California Medi-Cal program. Appendix B shows the the income amount associated with each of the Federal Poverty Level Guidelines.

   Enter on lines 20 through 25 the number of patients by poverty level category. All patients whose income level cannot be determined are to be reported as Unknown on line 25.

   The purpose of this table is to classify the income level of the clinic's patients based on the Federal Poverty Level. All patients must be accounted for on this table. The poverty level for a family of a given size is determined using the current Income Poverty Guidelines by the Federal Department of Health and Human Services (see Appendix B). In cases where the clinic does not collect income-level data, an estimate is acceptable.

6. **Line 26: Total Patients (Federal Poverty Level)**
   The SIERA Utilization application will complete line 26 with the sum of lines 20 through 25.

7. **Lines 30 – 38: Age Category and Gender**
Enter the male and female patients in columns 1 and 2, respectively, for each age category on lines 30 through 38. For the purpose of this report, use the age of the patients as of June 30 of the report year.

> **Example**: An individual was a patient in January, but his/her 65th birthday was in December of this year. This patient would be counted in the group of 45 – 64 (line 37).

Note: In most cases the data for this table will be an output of the clinic's practice management software. If that software is programmed to report the ages of patients at a point in time different than June 30th (for example Dec 31st) then use the data the software produces.

8. **Line 39: Total Patients (Age Category and Gender)**
The SIERA Utilization application will complete line 39 of columns 1 and 2 with the sum of lines 30 through 38.

PATIENT COVERAGE
The purpose of this table is to classify the clinic's patients according to the type of full spectrum health insurance coverage and to identify those persons that are uninsured.

Full spectrum health insurance is coverage for all healthcare problems, not just a range of services (such as family planning only) or a specific disease (breast cancer). Thus such programs as Medi-Cal are coverage while programs such as Family Pact are not. While Family Pact is "insurance" it is not full spectrum coverage for all health problems, it only covers a specific set of medical procedures (i.e. those related to family planning), which is the reason it is classified as episodic coverage.

If a patient has coverage under two or more programs classify the patient by the payment source that is responsible for the first dollar of coverage. The most common example of this is the patient covered by both Medicare and Medi-Cal, commonly referred to as the "Medi-Medi" patients. These patients are classified as Medicare because that program has to be billed first. After Medicare pays, the claim is then "crossed over" to Medi-Cal, which will pay any residual amount that Medicare did not pay up to Medi-Cal's 'Schedule of Maximum Allowable'.

Enter the number of patients on lines 45 through 57 by each of the programs offering patient coverage. The three basic coverage categories are: third-party coverage, self-pay/sliding fee, and free.

9. **Lines 45 - 52: Third-Party Coverage** – These programs listed on these lines offer "full spectrum health insurance" coverage (i.e. the coverage does not exclude payment for any type of medical procedure). With the exception of "Private Insurance" on Line 50 these programs are government sponsored, typically have income eligibility standards and patients are enrolled.

Note: Private Insurance (Line 50)

Private insurance does not have income eligibility rules but may require co-insurance or deductibles. Even though there are co-insurance and deductible payments it is still "full spectrum coverage".

Note: Covered California (Line 51)
Patients enrolled in Covered California healthcare plans are recored on the Patient Coverage table under Line 51. Private Insurance, Line 50, are for those patients with traditional commercial health plans.

Note: High deductible insurance policies.
Patients sometimes have medical coverage through their employer but there is a very high deductible (in the thousands of dollars per year). The insurance company will not pay any claim until the patient has paid for services totaling the deductible requirement. Classify such patients as "Self Pay/ Sliding Fee Scale" on line 55.

10. **Line 53: My Health LA**
This is a Los Angeles County program used by community clinics to reimburse them for services given to low income patients not eligible for Medi-Cal.

11. **Line 54: PACE Program (Program of All-Inclusive Care for the Elderly)**
If a Medicare beneficiary or Medi-Cal recipient chooses to enroll in a PACE program, the following conditions apply:

    (a) Medicare and Medi-Cal benefit limitations and conditions relating to amount, duration, scope of services, deductibles, copayments, coinsurance, or other cost-sharing do not apply.

    (b) The participant, while enrolled in a PACE program, must receive Medicare and Medi-Cal benefits solely through the PACE organization.

12. **Line 55: Self-Pay/Sliding Fee** - this category includes patients who are uninsured but are expected to pay for only a portion of the Gross charges. Clinics typically discount the fee based on a formula that uses family income and number of family members such as the Federal Poverty Level Guidelines. This also includes patients under Healthy San Francisco program.

13. **Line 56: Free**– this category includes patients who typically do not have any type of insurance coverage, are low income and have met the clinic's eligibility guidelines for charity care based on their inability to pay. Clinic services will be rendered without charge. The primary difference between free patients and self pay patients is that free are not expected to pay any part of the service fees because they meet the clinic's charity care guidelines and are not billed. There should be a charity care policy that was approved by the clinic's board of directors that describes the charity care policy.

    Example – classification of Medi-Medi patients:
    A patient who is eligible for both Medicare and Medi-Cal is sometimes referred to as a "cross-over" patient or a "Medi/Medi" patient. Medicare pays the first dollar and any residual unpaid charges are 'crossed-over' to Medi-Cal, which pays these residual charges up to the Medi-Cal maximum allowable

reimbursement. **In this example, the patient would be classified as a Medicare patient because the Medicare program was responsible for the "1st dollar" of the total reimbursement.**

In cases where the coverage changes during the year (i.e. the patient changes from Medi-Cal to private insurance due to finding a job) the clinic should use the coverage on December 31st for classification purposes.

This table shows as a "snapshot" of the patient population's health insurance coverage at the end of the year (again insurance coverage refers to insurance that covers the full spectrum of health procedures, not programs that are focused on one disease or a specific issue such as family planning). All such snapshots have the drawback that they are an arbitrary count based on a single day's view that purports to represent the entire year (in this case December 31st). However, because many patients experience changes in coverage during the course of the year it is too difficult to use a set of rules that attempts to define the "dominant" coverage.

CHDP Gateway:
Some children come to the clinic and receive a Medical Evaluation by the physician or nurse practitioner. The children's parents do not have healthcare insurance and the clinic submits the paperwork to CDPH which in turn decides whether or not the child qualifies for Medi-Cal. The State has 60 days to make this determination, during which time the child is presumed to qualify for Medi-Cal. Patients for whom no determination has been made are to be considered Medi-Cal.

14. **Line 58: Total Patients (Patient Coverage)**
The SIERA Utilization application will complete Line 58 with the sum of lines 45 through 57. Every person that had at least one encounter during the year must be accounted for in this table even if his/her only encounter was reported under Episodic Programs (lines 60 – 66).

EPISODIC PROGRAMS
This table is a patient count for each of the programs that reimburse the clinic for treating patients with specific diseases (i.e. breast cancer) or a specific range of services (i.e. FamilyPact) but do not enroll persons in a full spectrum health insurance-type relationship. All patients listed in Episodic Programs table must also be separately accounted for in the Patient Coverage table. Each program listed in this table should record a patient count if the listed program paid for one (or more) encounters during the year.

Each patient listed in the Episodic Program table must also be accounted for in the Patient Coverage table.

Example 1:
Scenario - Mrs. Jones, who is not enrolled in any type of insurance program, is treated by the clinic. Because she is a low-income resident and she is receiving cancer treatment, the clinic bills the BCCTP program and is paid. Mrs. Jones started her treatment towards the end of the year and only had one encounter with the clinic during the year.

> She would be counted as a Self-Pay/Sliding Fee patient on line 55 of the Patient Coverage table (3.55.1) and a BCCTP patient on line 60 of the Episodic Program table (3.60.1).

Example 2:
Scenario - Ms. Smith is seen in the clinic for family planning services. The clinic bills the Family Pact program and is reimbursed for the encounter. This is Ms. Smith's only encounter with the clinic during the year.

> She would be counted as a Self-Pay/Sliding Fee patient on line 55 of the Patient Coverage table (3.55.1) and a Family Pact patient on line 62 of the Episodic Program table (3.62.1).

Note: Do not report Family Pact patients as Medi-Cal patients ***unless*** they are separately enrolled in the Medi-Cal program. Typically, women who receive family planning services under Family Pact do not have any type of full spectrum health coverage and are thus classified as "self-pay patients".

Example 3:
Scenario - A Medicare patient has one encounter with the clinic during the year in which a breast exam was paid for by the Breast Cancer program.

> In that case the BC program would receive a patient count of "1" on line 60 of the Episodic Coverage table (3.60.1). That same patient would also be counted in the Medicare program on line 45 of the Patient Coverage table (3.45.1) – even though Medicare did not pay for that encounter. The logic is that the patient is enrolled in Medicare and did receive services in the clinic during the year.

Note: In all the examples the patient had only one encounter during the year and yet was counted in both the Patient Coverage and the Episodic Coverage tables. This is because all patients must be accounted for in the Patient Coverage table while the Episodic Coverage is a listing of programs that are of interest but do not offer full spectrum healthcare insurance.

Also note: The reversal is not true. Not all patients counted on the Patient Coverage table must be accounted for on the Episodic Program table.

Example 4:
Scenario - A Medi-Cal patient is seen by the clinic and the clinic is reimbursed for the encounter. The patient did not have an encounter that was paid for by any of the programs listed in the Episodic Coverage table.

In this case the Medi-Cal program would be given credit for the patient (Patient Coverage table – 3.47.1), but nothing would be reported in the Episodic Program table.

It is possible that a clinic could report zero patients in the Episodic Programs table or more patients than were listed in the Patient Coverage table (if every patient were seen by more than one episodic program).

15. **Lines 60 – 65: Episodic Programs**
Enter the number of patients in which the listed programs paid for one or more encounters during the year. Patients can be listed in more than one program. For example, a person could have one encounter paid for by the BCCTP program and a second encounter paid for by the Family Pact program. In this case, the patient would be counted under both programs.

CHDP Gateway: See note in paragraph 14 above

16. **Line 66: Total (Episodic) Patients**
The SIERA Utilization application will complete line 66 with the sum of lines 60 through 65. It is a duplicate count and does not tie to any other table.

17. **Line 70: Child Health and Disability Prevention (CHDP) Assessments**
Enter the number of CHDP assessments performed during the report period by the clinic on line 70. A patient could have more than one CHDP assessment during the year, thus the number of assessments does not have to equal the number of CHDP patients on 3.61.1.

18. **Lines 70 and 75: Seasonal Agricultural & Migratory Workers**
Enter the total number of patients and encounters on lines 70 and 75, respectively, for patients who can be classified as migratory or seasonal agricultural workers, as defined below:

Seasonal Agricultural Worker - an individual, whose principal employment is in agriculture, who typically works for a limited period of time on crops located in the area of their permanent address. These workers may establish a permanent residence in the area and commute to work. Such employment must have been within the last 24 months.

Migratory Worker – an individual whose principal employment is in agriculture, whose employment in the area is typically connected to planting or harvesting a crop after which they move to another area. These workers typically do not establish a permanent residence in the area. Such employment must have been within the last twenty-four months.

REPORT PAGE 4 - ENCOUNTERS BY PRINCIPAL DIAGNOSIS

This report page contains the total number of encounters by principal diagnosis and must be equal to the total number of encounters in Encounters by Primary Services (report page 5, line 35, column 1), FTE's and Encounters by Primary Care Provider (report page 2, line 87, column 5), and Revenue and Utilization by Payer (report page 6, line 1, column 18). If the total number of encounters does not match in these report pages, the SIERA Utilization application will not allow you to submit your report.

1. **Lines 1 – 21: Encounters by Principal Diagnosis**

   Note: For calendar year beginning January 1, 2018 reporting will be based solely on the ICD-10-CM Codes.

   Enter the total number of encounters on lines 1 through 21 by the principal diagnosis according to the ICD-10-CM diagnoses groups. Use lines 1 through 18 to report medical diagnoses and line 19 for all dental diagnoses. Line 20 is for Family Planning "Z" codes. For clinics that use the ICD-10-CM codes to record their dental diagnoses, report the ICD-10-CM dental diagnoses on line 19. Line 21 "Other" is to record all diagnoses that cannot be classified elsewhere in the table.

   Do not report the secondary or any subsequent diagnoses for any encounter. (There is only one primary diagnosis for each encounter).

2. **Line 22: Total Encounters (Diagnosis)**
   The SIERA Utilization application will complete the total encounters on line 22 with the sum of lines 1 through 21.

REPORT PAGE 5 - ENCOUNTERS BY PRINCIPAL SERVICE

This table classifies each medical encounter by its CPT (Common Procedural Terminology) procedure codes, all dental encounters are to be counted on line 32. Use the "primary procedure code" to classify encounters. Do not report secondary or subsequent procedure codes, each encounter is to be counted only once.

The total encounters on line 35 must agree with the total number of encounters reported on Encounters by Principal Diagnosis (report page 4, line 22, column 1), FTEs and Encounters by Primary Care Provider (report page 2, line 87, column 5), and Revenue and Utilization by Payer (report page 6, line 1, column 18).

1. **Lines 1 – 30: Classification of Diseases and/or Illnesses**
   Enter the total number of medical encounters using the CPT code groups on lines 1 through 30.

2. **Line 31: Family Planning "Z" Codes**
   Enter on line 31 the total number of encounters in which the primary service reported was identified by a family planning "Z" code.

3. **Line 32: Dental Encounters**
   Enter on line 32 the total number of encounters in which the primary service provided was identified by a dental code.

   Note: Report all dental procedures on line 32. While dental procedures are often recorded using CDT codes, all dental encounters are to be recorded on this line, regardless of the coding scheme used by the clinic.

4. **Line 33:** Enter on line 33 the total number of encounters in which the primary service provided was identified by a Category III code from 0042T through 0463T. These T codes began in 2003 and must be used instead of the unlisted CPT codes.

5. **Line 34: All Other Encounters**
   Enter all encounters on line 34 that cannot be classified on lines 1 through 33.

6. **Line 35: Total Encounters (Procedures)**
   The SIERA Utilization application will complete line 35 by auto-summing lines 1 through 34.

SELECTED PROCEDURE CODES

This table includes data for selected CPT codes that are of particular interest. Unlike the previous table, the procedure codes listed in this table do not have to be the primary service code for that encounter. Enter the number of procedures for each of the defined CPT codes (or range of codes).

> **Example**: A child comes to the clinic for the first time and receives an initial evaluation by the physician. At the same encounter, the patient is given a Hib vaccine. The evaluation was CPT-coded as "99201" and would be reported on

line 1 of the Encounters by Principal Service (and that would be the only thing counted for that table). However, the secondary CPT code of “90647” (Hib vaccine) would be recorded on line 53 of this table. This procedure by itself is not a separate encounter but it is such an important service that collection of the data is warranted.

For some of these procedures, the clinic acts as the critical “gateway” to the service although it may not actually perform all of the procedure or pay for it. None the less, the purpose of the report is to accurately portray the clinic’s public health contribution to the community. Thus, if the clinic plays a critical role in the provision of one or more of these selected services, then the procedure should be reported in this table.

Example: The clinic collects the pap smear specimen and sends it to a lab for processing. The clinic should count each of these specimens in “Pap Smear” (5.50.1) even though the lab conducted the test and another entity paid for the test. The clinic is the gateway point that played the important role of taking the specimen.

7. **Lines 40 – 67: Selected Procedures**

Enter the number of procedures on lines 40 through 67 in which the given CPT code was either the primary or subsequent procedure code.

REPORT PAGE 6 - REVENUE AND UTILIZATION BY PAYER

This report page includes the encounters, gross revenues (charges), write-offs, and net patient revenue for each of the clinic's payment sources. These data are totaled in column 19.

NOTE: For Free Clinics: In order to report Free/Complimentary write-offs (charity care) on line 4, free clinics must record and report gross revenue (charges) at the full-established rates on line 2. If a Free Clinic has not established a charge structure they may enter the same amount entered for Total Operating Expense on 7.43.1 as the Gross Revenue.

ENCOUNTERS

1. **Line 1, Columns 1 – 12, 14 - 17: Encounters; Column 13: Patients**
   Enter the number of encounters for each payer source on line 1 except for column 13. Each encounter is classified according to the program that is the "primary" payer for the encounter. This is typically the program that pays the "first dollar of coverage". It may or may not be the predominant payer, i.e., responsible for 51% or more of the bill depending on the situation.

   > **Example – Medi-Medi encounters**: A patient is enrolled in both Medicare and Medi-Cal. The patient receives an examination at the clinic. Medicare is billed and pays 60% of the charges. The clinic then bills Medi-Cal for the residual and Medi-Cal pays up to the Medi-Cal "maximum allowable" for the procedure. This would be counted and reported as a Medicare encounter because that program paid the first dollar of the patient's medical bill.

   Column 1: Medicare – report all encounters that were reimbursed by Medicare under the traditional fee-for-service method.

   Column 2: Medicare Managed Care – report all encounters that were reimbursed under the terms of a managed care contract funded in whole or in part by Medicare.

   Column 3: Medi-Cal - report all encounters that were reimbursed by Medi-Cal under the traditional fee-for-service method.

   Column 4: Medi-Cal Managed Care - report all encounters that were reimbursed under the terms of a managed care contract funded in whole or in part by Medi-Cal.

   Column 5: County Indigent/CMSP/MISP - report all encounters that were reimbursed by a County program regardless of whether it is a traditional fee-for-service payment or a managed care contract. These patients are considered indigent and are the responsibility of the county.

   Column 6: Private Insurance - report all encounters that were reimbursed by a private insurance program. Do not include encounters from Covered California health plans. (See note on patients with "high deductible insurance" policies below).

   Column 7: Covered California – report all encounters that were reimbursed by Covered California healthcare plans.

Note: On patients with ***high deductible insurance policies***. In some cases the patient may be enrolled in medical insurance through his / her employer. However, the insurance has a high yearly deductible (for example $5,000) before the insurance will pay claims. For all intent and purposes, these patients do not have insurance for primary care and can be classified as "self pay / sliding fee scale" because it is highly unlikely they will pass the threshold where the insurance will become effective.

Column 8: Self-Pay/Sliding Fee - report all encounters for patients who were uninsured and responsible for paying the full amount of charges or a discounted amount. These patients do not meet the clinic's charity care eligibility guidelines and therefore, do not qualify for free care. In some cases these patients may qualify for a discount of the fees based on their ability to pay. These discounts are known as sliding fee scale discounts. A patient who has insurance but elects to pay by cash would also be included here.

Healthy San Francisco patient encounters are to be recorded as Self Pay/ Sliding Fee Scale encounters.

Column 9: Free – report all encounters for those patients who met the clinic's charity care guidelines and are not being billed for any services. These patients are identified at the time of service as being eligible for 100% free care. Do not include patients who were able and responsible, but unwilling, for paying, or patients whose third-party coverage was denied after billing.

Column 10: Breast Cancer Programs – report all encounters in which one of the breast cancer programs were billed. Examples of these programs are the Breast Cancer Early Detection Program (BCEDP) and the Breast and Cervical Cancer Treatment Program (BCCTP).

Column 11: CHDP– report all encounters in which the Child Health and Disability Prevention program was billed.

Column 12: Family PACT – report all encounters in which the Family PACT program was billed.

Column 13: PACE (Program of All-Inclusive Care for the Elderly) – Since this is an all inclusive care program, report the number of patients being served instead of the number of encounters.

Column 14: My Health LA – report all encounters in which patients are covered under Los Angeles County's My Health LA program. This column should be completed only by clinics located in Los Angeles County.

Column 15: Alameda Alliance for Health – report all encounters in which the Alameda Alliance for Health program was billed. This column should be completed only by clinics located in Alameda County.

Column 16: Other County Programs – report all encounters in which a county program not listed above has reimbursed the clinic.

Column 17: All Other Payers – report all encounters in which a program not listed above has reimbursed the clinic.

2. **Line 1, Column 18: Total Encounters**
The SIERA Utilization application will complete column 18 with the sum of columns 1 through 17.

The total number of encounters in line 1, column 18 must be equal to the total number of encounters in Encounters by Principal Diagnosis (report page 4, line 22, column 1), Encounters by Primary Services (report page 5, line 35, column 1), and FTE's and Encounters by Primary Care Provider (report page 2, line 87, column 5). If the total number of encounters does not match in these report pages, the SIERA Utilization application will not allow you to submit your report.

GROSS REVENUE

3. **Line 2, Columns 1 – 17: Gross Revenue**
For each payment source, enter on line 2 the amount of Gross Revenue, which is defined as total charges at the clinic's full-established rates (usual customary charges) for primary care services before deductions from revenue are applied.

Gross Revenue - is also referred to as "charges". These charges must be valued and reported according to an overall charge structure established by the clinic, and must be applied uniformly to all patients and payers. Gross Revenue is **not** the amount reimbursed by the third-party payer. This amount is considered Net Patient Revenue and will be calculated on line 11 (line 2 minus line 10). Any differences between Gross Revenue and Net Patient Revenue must be reported on lines 3 through 9.

> **Example**: A clinic had 5,000 Medi-Cal encounters. The total value of all procedures was $500,000, or the sum of all the charges for the 5,000 procedures billed at their "usual and customary" rate. Medi-Cal reimbursed the clinic $425,000. The clinic must report the full value of the charges ($500,000) as Gross Revenue even though the amount actually paid was less due to Medi-Cal maximum allowable reimbursement.**$75,000 would be recorded on "Contractual Adjustments"** (Sec. 6, line 5, col 3). The SIERA Utilization application would then calculate the "Total write offs and adjustments (6.10.3) and the "Net Patient Revenue Collected" (6.11.3). Note that the report preparer will know the Net Patient Revenue from the sum of the Medi-Cal Remittance Advices, they will have to calculate the Contractual Adjustment, enter that figure and allow SIERA Utilization to generate the Net Patient Revenue.

Managed Care Payers - The amount entered for these payers should be the total charges for all procedures valued at their usual and customary rate without discounts or adjustments, even though the managed care health plan may not have been "billed" for each procedure.

4. **Line 2, Column 18: Total Gross Revenue**
The SIERA Utilization application will complete column 18, line 2 with the sum of columns 1 through 17.

WRITE-OFFS AND ADJUSTMENTS

Write-offs and Adjustments are also called “deductions from revenue” and are the difference between usual and customary charges (Gross Revenue) and the amount received from patients and payers (Net Patient Revenue). These revenue deductions consist of contractual adjustments with third-party payers, bad debts, sliding fee write-offs, and free care. Also included in this category are grants that are received to directly offset the cost of providing patient care services. Such grants have a credit balance and will appear as a negative deduction from revenue.

5. **Line 3, Columns 1 – 17: Sliding Fee Scale Write-Offs**
For each payment source, enter on line 3 the amount that was “written-off” as a sliding fee because of discounts given to patients. Sliding fee scale write-offs typically relate to uninsured patients, and is the amount of usual and customary charges which are reduced based on payment policies established by the clinic. Sliding fee scale write-offs are generally based on family income, where patients with the lowest income level receive the largest reduction. Typically the patient still has an obligation to pay for a portion of the bill and the discounted portion is written-off as a sliding fee.

Note: Not all payment programs will have Sliding Fee Scale Write-Offs.

My Health LA – The Gross Revenue (i.e. charges) for patients that are treated under this program should be recorded at the usual and customary rate for the procedures rendered.

Healthy San Francisco – The Gross Revenue (i.e. charges) for patients that are treated under this program should be recorded at the usual and customary rate for the procedures rendered.

6. **Line 3, Column 18: Total Sliding Fee Scale Write-Offs**
The SIERA Utilization application will complete column 18, line 3 with the sum of columns 1 through 17.

My Health LA – Typically the clinics “write off” most or all of the patient charges for patients in these programs. The net patient revenue (line 11) for this program should be a small percent of the Gross Revenue.

Healthy San Francisco – Patients of all income levels are eligible for this program and the write off percentage varies based on income level. Patients at or below 100% of the Federal Poverty Level should have all of their charges written off on this line. For those above 100% of the Federal Poverty Level the clinic’s customary sliding fee scale should be used to determine the amount of charges written off on this line.

7. **Line 4, Columns 1 - 17: Free / Complimentary Write-Offs**

For each payment source, enter on line 4 the amount that was "written-off" as free or complimentary care. Patients classified as "Free" in column 9 should account for the majority of "free" care, although it's possible for other payment categories to report "free" care. This can occur when a patient is responsible for a portion of a bill, such as co-insurance and deductibles, and is later determined to be unable to pay. Another instance is when a patient originally classified as Self-Pay (column 8) is later determined to be unable to pay for all or part of the bill.

In order to qualify as "free" care, the services must be provided to patients who qualified under the clinic's charity care policy as being unable to pay. The determination of which patients are "free" should be based on charity care policies approved by the clinic's board of directors.

Free Clinics: There are some clinics that are organized and being licensed as "Free" clinics. These clinics should use column 9 to report their financial data and can report financial data even though a "bill" is not sent to the patient. The reporting of "Gross Revenue" allows the Free clinic to report the full amount of charity care services provided. This means that a "usual and customary" charge must first be developed.

> **Example** – A Free clinic had 500 encounters. The Gross Revenue (charges) for clinic services were $42,500, but none were billed to the patients or collected. Column 9 would be completed as follows:
>
> | | | |
> |---|---|---|
> | Line 1, column 9 | Encounters | 500 |
> | Line 2, column 9 | Gross Revenue | $42,500 |
> | Line 4, column 9 | Free/Complimentary | $42,500 |
> | Line 10, column 9 | Total Write-Offs & Adjustments | $42,500 |
> | Line 11, column 9 | Net Patient Revenue | $ 0 |
>
> All the other lines would be 0 (or blank)

FREE CLINICS ONLY

In some cases a "Free" clinic does not have a revenue (i.e. "charge") structure because it does not bill either the patient or a third party for the services of the clinic. These clinics (and only these) have some options in reporting:

1) – Report Gross Revenue as the value the services rendered at "market price" even though no one is being charged. The total value of these services will be written off on line 4 and the net patient revenue will still be $0. This is the preferable way to report because the Annual Utilization Report will accurately record the value of the uncompensated care delivered.

2) – If the clinic does not know the value of their services they could report Gross Revenue (Sec. 6, line 2, col. 9) equal to the total of the costs incurred in operating the clinic as reflected on the Income Statement (Sec. 7, line 43, col. 1). Again it would be written off on line 4 and the net patient revenue will be $0. This method is somewhat easier than the first method, however, it tends to undervalue the uncompensated care given.

8. **Line 4, Column 18: Total Free / Complimentary Write-Offs**
The SIERA Utilization application will complete column 18, line 4 with the sum of columns 1 through 17.

9. **Line 5, Columns 1 – 17: Contractual Adjustments**
For each third-party payer, enter on line 5 the amount of contractual adjustments. Contractual Adjustments are the differences between usual and customary charges (Gross Revenue) and the amounts received from third-party payers (Net Patient Revenue). Contractual adjustments do not apply to individual patients; thus, no contractual adjustments should be reported under Self-Pay/Sliding Fee (column 8) and Free (column 9).

The two basic reimbursement arrangements with third-party payers are:

- **Fee-for-Service -** the clinic enters into contractual agreements with third-party payers whereby the clinic agrees to a schedule of reimbursement rates for each procedure or encounter. The total amount of reimbursement expected under the contractual agreement is usually less than the Gross Revenues (charges). In such cases, the difference between the Gross Revenues (charges) and the revenue received is reported as a contractual adjustment.

- **Capitation (Managed Care) -** the clinic enters into a contract with a managed care health plan, where capitated payments (per member per month) are received in exchange for providing clinic services to health plan members. The Contractual Adjustment is the difference between Gross Revenue (charges) listed on line 2 and the total amount of capitated payments received, which are included in Net Patient Revenue on line 11.

NOTE: In capitated contracts, Gross Revenue (charges) must still be recorded and reported at the usual and customary rates for each service provided, even though a bill will not be rendered to the patient of the managed care health plan. Gross revenue is the sum of the fees that would have been billed for each procedure code had the clinic been using a fee-for-service reimbursement arrangement.

10. **Line 5, Column 18: Total Contractual Adjustments**
The SIERA Utilization application will complete column 18, line 5 with the sum of columns 1 through 17.

11. **Line 6, Columns 1 - 17: Bad Debt**
For each payment source, enter on line 6 the amount of patient accounts receivable which were determined to be uncollectible because of a patient's unwillingness to pay. While the majority of bad debts will relate to patients classified as Self-Pay (column 8), bad debts could also arise from unpaid co-insurance and deductibles related to insured patients. By definition, patients classified as Free (column 9) should not have any bad debts. Because bad debts are classified as deductions from revenue, they are not to be reported in operating expenses.

12. **Line 6, Column 18: Total Bad Debt**
The SIERA Utilization application will complete column 18, line 6 with the sum of columns 1 through 17.

13. **Line 7, Columns 5 - 17: Grants (credit balance)**
This line is no longer used. Any grant funds from either the Federal Government, State Government, local governments or private sources will be recorded on the Income Statement (Sec. 7) as "Other Operating Revenue", lines 5 through 20 (the line on which it is recorded will depend on the source of the grant).

My Health LA – (Column 14)
My Health LA is a program that offset some of the costs incurred in delivering care to the indigent.

The Encounters, Gross Revenue and Sliding Fee Scale write offs are reported on Sec. 6 (lines 1, 2, and 3 respectively, col. 14). Typically most (if not all) of the Gross Revenue is written off as a sliding fee scale write off because the clinic does not expect to collect more than an minimal amount from these patients.

Example:
A clinic had 5,000 My Health LA encounters. The total value of all procedures was $500,000, or the sum of all the charges for the 5,000 procedures billed at their "usual and customary" rate. My Health LA reimbursed the clinic $425,000. The clinic must report the full value of the charges ($500,000) as Gross Revenue. **$75,000 would be recorded on "Contractual Adjustments"** (Sec. 6, line 5, col 14). The SIERA Utilization application would then calculate the "Total write offs and adjustments (6.10.14) and the "Net Patient Revenue Collected" (6.11.14).

Line No.		(13) Family PACT	(14) PACE Program**	(15) My Healthy LA (MHLA)	(16) Alameda Alliance	(17) Other County	(18) All Other Payers
1.	Encounters			5000			
2.	Gross Revenue (Charges at 100% Rate)			500000			
3.	Sliding Fee Scale Write-offs						
4.	Free/Complimentary Write-offs						
5.	Contractual Adjustments			75000			
6.	Bad Debts						
7.	Grants (see Section 7)						
8.	Other Adjustments						
9.	Reconciliation						
10.	**Total Write-offs & Adjustments (sum lines 3 through 9)**	0	0	75,000	0	0	0
15.	**Net Patient Revenue (collected) (line 2 – line 10) (Click to Total)**	0	0	425,000	0	0	0

14. **Line 7, Column 18: Total Grants (credit balances)**
This line is no longer being used.

15. **Line 8, Columns 1 – 17: Other Adjustments**
Enter on line 8 any other adjustments that reduce Gross Revenue and do not fit into one of the categories on lines 3 through 7. Included here are such revenue deductions as Policy Discounts (discounts provided to employees) and Administrative Adjustments (write-offs of small account balances).

16. **Line 8, Column 18: Total Other Adjustments**
The SIERA Utilization application will complete column 18, line 8 with the sum of columns 1 through 17.

17. **Line 9, Columns 1 – 17: Reconciliation**
In some programs, the initial payment received by the clinic for services is an interim payment. At some point there is an audit of a cost report and the clinic is paid additional monies (or has to repay monies) based on the results of the audit. This subsequent payment is referred to as the "reconciliation payment".

For each appropriate payer, enter on line 9 reconciliation payments that were or will be received or paid. If reconciliation payments were received or projected to be received, enter the amount as a negative (bracketed) figure. If reconciliation payments were paid or projected to be paid, enter the amount as a positive figure.

If a program includes reconciliation payments, there are two acceptable methods to record the reconciliation amount.

Accrual Method
The clinic is able to accurately determine the amount of the reconciliation payment before it is received or paid. This determination could be a percentage of accounts receivable based on previous years' experience or based on a completed cost report. Recognizing the reconciliation payment in the report period in which it is earned provides a more accurate comparison of gross revenue, net patient revenue, and expenses. If the clinic uses the accrual method, enter the calculated amount of the reconciliation payment on line 9 for the appropriate payer source.

"Cash-basis" Method
If the clinic does not have the ability to accurately determine the reconciliation payment, it should record the reconciliation payment in the report period when the actual payment was received or paid. This means that a reconciliation payment related to a prior fiscal year may be recorded and reported in the current fiscal year, and that a reconciliation payment related to the current fiscal year may be accounted and reported in the next fiscal year.

To achieve consistency and accuracy in reporting, the clinic may not use both methods, i.e., record the actual reconciliation payments received during the report period ("cash method") and make a projection of the amount likely to be received from the payer

("accrual method"). Reconciliation payments do not pertain to patients classified as Self-Pay/Sliding Fee Scale (column 8) or Free/Complimentary (column 9).

MEDI-CAL SCOPE OF SERVICE CHANGES – recording lump sum payments

Any scope change reconciliation payment will be recorded as a **negative** Reconciliation payment in the Medi-Cal program (i.e. record the lump sum payment as a negative amount in sec. 6, line 9, column 3) in the year in which the monies were received. Do not go back to any prior period and try to revise that report.

Also make note of the increased Scope of Service payment in the General Comments section at the end of the report.

Example:
A clinic has a July 1**, 2009** - June 30**, 2010** fiscal year. On Nov 1, 2010 the clinic applies to CDPH for a Scope of Service **Change** using the service information and cost data from 7/1/2009 - 6/30/2010.
On January 15, 2011 CDPH approves **an** increase in the "**per visit PPS rate"** and determines the cost per encounter should increase by $10.00. They also **pay the clinic** a **total of** $5,000 **as a Change in** Scope of Service **reconciliation** payment for 500 Medi-Cal encounters seen between July 1, 2010 and January 14, 2011.
This **reconciliation payment** would be recorded on the 2011 Annual Utilization Report (not the 2010). The amount would be recorded as a negative **$**5000 (i.e - **$**5000) on Sec. 6, line 9, col. 3 "Medi-Cal Reconciliation". The "normal" Medi-Cal Gross Revenues would be recorded on line 2 and the "normal" Contractual Adjustment would be entered on line 5 (for FQHC's this will often be a negative number as well). Also note in the General Comments "**09/10** Scope of Service **Change approved and** payment of $5,000 received in Jan 2011").

18. **Line 9, Column 18: Total Reconciliation**
The SIERA Utilization application will complete column 18, line 9 with the sum of columns 1 through 17.

19. **Line 10, Columns 1 – 18: Total Write-Offs and Adjustments**
The SIERA Utilization application will complete line 10 with the sum of lines 3 through 9. Any grants on line 7 will be subtracted. These amounts represent the total revenue deductions from the Gross Revenue for payer and in total.

20. **Line 11, Columns 1 – 18: Net Patient Revenue**
The SIERA Utilization application will automatically subtract line 10 from line 2 and enter the result on line 11. These amounts represent the actual revenue received by the clinic for patient services from each payment source and in total.

REPORT PAGE 7 - INCOME STATEMENT

Lines have been added for reporting the Federal Stimulus Grants from the American Recovery and Reinvestment Act (ARRA) starting 2009.

All other County grants are recorded on Sec. 7, Line 20, Col. 1 (Other County Grant Programs).

The Income Statement displays the sources of operating revenue for the clinic, the types of expenses required to operate the facility, and the net from operations. One specific operating expense, Information Technology (including ERH), is being added. The definitions of both revenue and expenses are provided below and are consistent with those found throughout this report and in the healthcare industry.

1. **Line 1: Gross Patient Revenue**
   Gross patient revenue on line 1, column 1 will be completed by the SIERA Utilization application using the gross revenue amount reported in report page 6, line 2, column 18. This figure represents the total Gross Revenue (charges) reported by the clinic at its full-established rates for all patient care services.

2. **Line 2: Total Write-Offs & Adjustments**
   Line 2, column 1 will be completed by the SIERA Utilization application using Total Write-offs and Adjustments from report page 6, line 10, column 18. This figure represents the difference between gross revenue (charges) and net patient revenue (amounts received) reported by the clinic from all payment sources.

3. **Line 3: Net Patient Revenue**
   Line 3, column 1 will be completed by the SIERA Utilization application using Net Patient Revenue from report page 6, line 11, and column18. This figure represents the actual revenue received by the clinic from all payment sources for patient care operations.

OTHER OPERATING REVENUE

This revenue category represents amounts received that were not reimbursements from third-party payers and patients for patient care services. While Other Operating Revenue is typically used for the purpose of underwriting clinic operations, this category also includes income from non-medical sources, such as investments and interest income. Examples include Federal grants, State contracts, and donations from private parties.

4. **Line 5: Federal Funds: Grants – all others (e.g. 330 funds)**
   Enter on line 5, column 1 the amount of Federal grants or Federal contracts that do not relate directly to patient care services, and are provided to the clinic to underwrite its overall mission.
   Do not report third-party reimbursements for patients covered by a federal program, e.g., Medicare reimbursements. (Medicare is a “payment source” and Medicare revenue is reported in report page 6.)

Example: A clinic receives a $10,000 grant from the federal government to provide community services. The grant may define the population to focus the service (e.g., patients over 65) and even define the targeted programs (e.g., patient transportation). The clinic receives the monies under the terms of the grant ($2,500 per quarter) and must provide documentation to prove that expenses were incurred and results achieved that meet the terms of the grant.

5. **Federal Stimulus Grants – American Recovery and Reinvestment Act (ARRA)**

The Annual Utilization Report (AUR) contains only an Income Statement (Report Page 7 of the report), yet many of the accounting transactions associated with the ARRA grants are Balance Sheet accounts that do not show up in any report page of the AUR. Accordingly, only those transactions that involve Income Statement accounts are reported. There are two basic ARRA grant scenarios: 1) grants used to offset operating expenses, and 2) grants used to acquire capital assets and/or make capital improvements.

Grant funds that are used to cover direct expenses (such as salaries, supplies and non-capital goods) will have offsetting entries on the Income Statement. The amount of the grant that is "drawn down" will be reported as "Other Operating Revenue" under the appropriate federal grant. The corresponding expenditure will be included in the appropriate "Operating Expenses" line. However, the grant expenses will not be separately identifiable (for example an Increased Demand for Services grant that was used to hire physicians: the amount "drawn down" for salary expenses during the year would be recorded as a revenue on Report Page 7, line 11, while the expense would be recorded as "Salaries, Wages & Employee Benefits" on Report Page 7, line 31; but the expense amount would be co-mingled with all other salary expenses). Thus both the revenue and expense amounts would be included in Report Page 7.

ARRA grants used for capital purchases are accounted and reported differently, because the ARRA grants are used to reimburse the facility after the cost of acquiring or improving capital assets has been incurred, and because the capital asset will have a useful life of several years. Reporting is similar to that of donated capital assets, where the Balance Sheet (capital asset and Fund Balance accounts) reflects acquisition of the new capital asset. In this case, the ARRA grant is not reported as Other Operating Revenue. Only the depreciation expense attributed to the report year will be reported on the Income Statement. The offsetting account, "Accumulated Depreciation" appears only on the Balance Sheet.

New Access Point (NAP) and Increased Demand for Services (IDS)-
The NAP and IDS grant funds that are drawn down (i.e. actually spent) on **non capital goods** and services during the year will be reported as Other Operating Revenue (Report Page 7, lines 10 and 11 respectively) and a corresponding expense amounts will be reported under Operating Expenses in Report Page 7. Report only the actual fund "spent" (i.e. matched with incurred expenses) during the current year.

Example: a clinic corporation received a $250,000 IDS grant award in the summer and hired two new physicians at $10,000 per month, both of whom

worked at the same clinic. The doctors began work on November 1st. These entries on the Annual Utilization Report would be as follows:

Report Page 7, Line 11
Other Operating Revenue – Increase Demand for Services (IDS)
$40,000 of grant funds associated with current expenses (2 physicians X $10,000 per month X two months) would be recorded in line 11.
Note – even though the grant award was $250,000 record only the funds that were *expended* during the last two months of the year.

Report Page 7, Line 31
Operating Expenses – Salaries, Wages, Employee Benefits
The $40,000 of physician salary expenses (2 physicians X $10,000 per month X two months) would be reported on line 31, along with all other salary expenses. Note the grant-related expenses would be co-mingled with all other salary expenditures and would not be separately identifiable as a "grant expense item" on the Income Statement.

Report Page 2, Line 75, Column 1
An increase of .33 FTE physicians would be recorded
[i.e. 2.00 FTE's / year X .166 years (2 / 12) = .33 FTE's]
– As with expenses, the salaried FTE's would show an increase, but the grant supported positions would not be separately identifiable.

Report Page 2, Line 75, Column 5
The encounters for the two new physicians would be recorded here, along with the encounters for the non-grant supported physicians. As with the expenses, the grant supported encounters would be co-mingled with the non grant encounters.

The same rules would apply if the clinic contracted for physician services from a local medical group or medical school. In this case the entries would be:

1. The entry for Other Operating Revenue would remain the same (i.e. $40,000 on Report Page 7, Line 11;
2. The operating expense would be recorded as Contract Services Professional (Report Page 7, Line 32 instead of salaries on Line 31);
3. The increase of .33 FTE physicians would be recorded on Report Page 2, Line 75, Column 2 instead of Column 1; and
4. The associated physician encounters would still be reported on Report Page 2, Line 75, Column 5.

6. **Line 10: New Access Point (NAP) Grants**

The New Access Point (NAP) grant is funding which supports clinic's new service delivery site/sites to increase the number of medically underserved and uninsured people with access to comprehensive primary and preventive health care services.

7. **Line 11: Increased Demand for Services (IDS) Grants**
The Increased Demand for Services (IDS) grant is funding which supports clinic's response to increases in demand for services, including addressing increases in uninsured population and increasing services at the existing site.

8. **Line 12: Capital Improvement Project (CIP), including Facility Improvement Project (FIP) Grants**
The Capital Improvement Program (CIP) grant is funding which supports the construction, repair and renovation of the clinic site. This funding (CIP/FIP) can also be used to purchase new equipment or health information technology (HIT) systems and the adoption and expansion of the use of electronic health records.

CIP grants, including the FIP grants, are generally used to acquire Property, Plant and Equipment (PPE). Most of the accounts affected [as the grant monies move through the accounting system] are on the Balance Sheet. Basically, the PPE account and Fund Balance will be increased by the cost of the capital asset, after the cash transactions between the hospital, vendor, and federal government have been completed. Only the depreciation expense attributed to the report year will be recorded on the Income Statement. These grants are not to be reported as Other Operating Revenue. Therefore, no CIP or FIP grant amount would be listed in the "Other Operating Revenue" portion of Report Page 7. However, the yearly depreciation expenses associated with the capital items are to be recorded on the Income Statement as Depreciation Expense (Report Page 7, Line 36 – Rent / Depreciation / Mortgage Interest Expense).

> **Example:** a clinic was awarded a $300,000 CIP grant in June of 2009 to build three new exam rooms. The building project has begun and the work is scheduled to be completed in July 2011. Nothing is to be reported on the 2009 Annual Utilization Report because the project is not completed. During this time, the Balance Sheet will reflect increases in Construction-in-Progress and the Fund Balance, as CIP grants monies are "spent" on construction-related costs.
>
> Once the project is completed and the buildings are recorded as PPE on the Balance Sheet, then depreciation expense can be recorded. If we assume the project is completed on schedule and the auditors establish a 30-year useful life for the capital improvement, the depreciation expense for this project will be $5,000 on the 2011 AUR.
>
> (i.e $300,000 project cost / 30 years = $10,000 depreciation expense per year
>
> $10,000 depreciation expense per year X .5 years = $5,000)
>
> In this case the depreciation expense associated with the new exam rooms would be recorded on Report Page 7, line 36 "Rent/ Depreciation/ Mortgage Interest" but it would be co-mingled with all of the other depreciation expense for the clinic and would not be separately identifiable.

Allocating Capital Improvement Project grants
If CIP grant funds are used to purchase a capital asset (plant, property or equipment) that is used by multiple clinics under common ownership or control, the depreciation expense must be allocated among those clinics. There are a number of acceptable ways to do this:

1. If the grantee's auditors have developed a reasonable method to allocate the expenses associated with a capital improvement between the corporation's clinics, the resulting expense amounts can be reported on each clinic's Annual Utilization Report.
2. If the grantee's auditors have not developed an allocation method and if the plant, property or equipment are used evenly by the grantee's clinics, then the depreciation expense can be allocated equally among them.
3. Finally, if the grantee's auditors have not developed an allocation method and if the plant, property or equipment's use can be tracked based on the delivery of patient services (such as an Electronic Medical Record), then allocate the expense based on percentage of encounters.

Estimated Useful Life of capital goods
Use the depreciation period developed by the grantee's auditors.

9. **Line 15: State Funds: Other**
All other State grants (or funding) that are not the result of direct billing for services would be listed on Line 15, column 1.

Do not report third-party reimbursements for patients covered by a State program, e.g., Medi-Cal reimbursements. (Medi-Cal is a "payment source" and Medi-Cal revenue is reported in report page 6.)

COUNTY FUNDS – lines 7 through 10
This portion of the Income Statement has been changed in 2013. There is a specific line for "Other County Grant Programs" to report any other grants received from a County.

10. **Line 7: My Health LA**
As of 2017, all My Health LA figures (previously Healthy Way LA) are reported in Report Page 6, Column 14 (see page 26).

Do not report third-party reimbursements for patients covered by a local program. These amounts are reported in report page 6.

11. **Line 8: This line is no longer being used.**

12. **Line 9: This line is no longer being used.**

13. **Line 20: Other County Grant Programs**
Enter on line 20, col. 1 the amount of any other county grant funds received by the clinic during the year.
Healthy San Francisco - record the amount of the Healthy San Francisco grant on this line.

14. **Line 21: Local (City or District) Funds**
Enter on line 21, col. 1 the amount of any other grant funds that were given to the clinic by either the city government or a local “district” entity.

15. **Line 22: Private**
Enter on line 22, column 1 private grants or contracts that do not relate directly to patient care services and are provided to the clinic by a private non-governmental entity to underwrite its overall mission. Typically these funds were awarded to the clinic based on a competition in which the clinic had to submit a grant proposal.

16. **Line 23: Donations / Contributions**
Enter on line 23, column 1 funds donated to the clinic to underwrite its overall mission. Typically these are given in small amounts and are not based on any type of grant competition.

17. **Line 24: Other**
Enter on line 24, column 1 funds generated or received by the clinic that are not reported elsewhere. Revenue that was generated from non-patient care operations would be reported here. Examples include rent from properties owned by the clinic and leased out to other entities; interest income from investments; and any other type of income that was earned for non-medical services.

18. **Line 25: Total Other Operating Revenue**
The SIERA Utilization application will complete line 25, column 1 with the sum of lines 5 through 24.

19. **Line 30: Total Operating Revenue**
The SIERA Utilization application will complete line 30, column 1 with the sum of line 3 (Net Patient Revenue) and line 25 (Total Other Operating Revenue). This amount represents the total revenue received from all sources.

OPERATING EXPENSES

This portion of the Income Statement represents all expenses incurred by the clinic for the purpose of delivering patient care.

20. **Line 31: Salaries, Wages and Employee Benefits**
Enter on line 31, column 1, the total compensation for all staff employed by the clinic. This includes salaries, wages and employee benefits. In addition to payroll benefits, also included here are paid time-off, health insurance, life insurance, pension and retirement, and workers' compensation insurance.

21. **Line 32: Contract Services - Professional**
Enter on line 32, column 1 the expenses associated with medical or dental professional services purchased under contract from another entity, e.g., a physician medical group or university. This situation may arise due to the inability to hire salaried staff or because it is the most economical means to provide the service.

> **Example**: The clinic contracts with a university that provides a physician three days per week at the clinic site. The physician is an employee of the university. The total amount of the contract is reported here.

22. **Line 33: Supplies – Medical and Dental**
Enter on line 33, column 1 the cost of consumable medical supplies that were used to provide patient care. This includes such supply items as bandages, gauze, paper gowns, disposable gloves, plastic cups, etc.

23. **Line 34: Supplies – Office**
Enter on line 34, column 1 the cost of consumable non-medical supplies that were used to operate the business functions of the clinic, but not used directly in providing patient care. Included here would be patient charts, pens, pencils, billing forms, copy paper, fax cartridges, etc.

24. **Line 35: Outside Patient Care Services**
Enter on line 35, column 1 the expenses associated with patient care services purchased under contract from another entity, such as a hospital, laboratory, or physicians group. These services are typically specialized diagnostic or therapeutic services, such as radiology or laboratory services, in which it would be uneconomical for the clinic to hire the staff and purchase the equipment in order to provide the service.

> **Example:** The clinic contracts with a laboratory down the street to perform complex lab tests that cannot be performed on-site by clinic staff. The parties agree on a fee schedule and the lab bills the clinic for services rendered. The total amount paid to the lab would be reported as an expense here.

25. **Line 36: Rent / Depreciation / Mortgage Interest**
Enter on line 36, column 1 the total rent paid by the facility. If the clinic owns its building, then depreciation expense and interest expenses on any long-term borrowings are to be included here. Also included here are similar costs associated with equipment

that is either rented or capitalized (major movable and fixed). Minor equipment that is purchased and expensed should be reported in Supplies (lines 33 and 34).

26. **Line 37: Utilities**
Enter on line 37, column 1 the total amount paid for electricity, gas, water, sewer, telephone, Internet services, and any other utility service.

27. **Line 38: Professional Liability Insurance**
Enter on line 38, column 1 the total premium paid for professional liability insurance to cover the clinic's health care professionals.

28. **Line 39: Other Insurance**
Enter on line 39, column 1 the total premiums paid for all types of insurance other than professional liability. This would include fire, flood, and general liability insurance premiums for the clinic.

29. **Line 40: Continuing Education**
Enter on line 40, column 1 the total cost of providing continuing education classes for healthcare professionals. To maintain professional licenses or certification, many healthcare professionals are required to complete minimum education requirements each year.

30. **Line 41: Information Technology (including EHR)**
Enter on line 41, column 1 all expenses that are related to the acquisition of hardware or software for the purpose to adopt and expand the use of electronic health records.

31. **Line 42: All Other Expenses**
Enter on line 42, column 1 all expenses that are not reported elsewhere. Included here are such expenses as travel, repair and maintenance contracts, legal and audit fees, and consulting fees, as well as allocated expenses from a home office.

32. **Line 43: Total Operating Expenses**
The SIERA Utilization application will complete line 43, column 1 with the sum of lines 31 through 42. This figure represents the total operating expenses of the clinic.

33. **Line 44: Net From Operations**
This is the net profit/loss incurred by the clinic for the delivery of patient care services. Line 44, column 1 will be completed by the SIERA Utilization application by subtracting line 43 (Total Operating Expenses) from line 30 (Total Operating Revenue).

REPORT PAGE 8 - Major Capital Expenditures

Section 127285 of the Health and Safety Code requires all clinics to report: 1) "acquisitions of diagnostic or therapeutic equipment during the reporting period with a value in excess of five hundred thousand dollars ($500,000)", and 2) "commencement of projects during the reporting period that require a capital expenditure for the facility or clinic in excess of one million dollars ($1,000,000)."

EQUIPMENT ACQUIRED OVER $500,000

1. **Line 1: Equipment Acquired Over $500,000**
   On line 1, select "Yes" or "No" from the drop down box to indicate whether or not your clinic has purchased any diagnostic or therapeutic equipment with a value greater than $500,000 during the report period.

   If your answer is "yes", you must complete the equipment detail on lines 2 through 11, as needed. Use one line for each equipment acquisition. If you answered "no", skip to line 15.

EQUIPMENT DETAIL

If your answer is "yes" on line 1, column 1, lines 2 through 11 will need to be completed, as necessary. Use a separate line for each individual acquisition of diagnostic and therapeutic equipment, not the total sum of all equipment purchased during the report period.

2. **Lines 2 - 11, Column 1: Description of Equipment**
   Enter in column 1 a description of any individual piece of equipment purchased during the year, whose value was more than $500,000.

3. **Lines 2 - 11, Column 2: Value**
   Enter in column 2 the value (purchase price or fair market value) of the equipment acquisition.

4. **Lines 2 - 11, Column 3: Date of Acquisition**
   Enter in column 3 the date the equipment was acquired.

5. **Lines 2 - 11, Column 4: Means of Acquisition**
   To indicate the means used for acquiring equipment, select from the drop down box whether the equipment was purchased, leased, donated, or if other means were used.

CAPITAL EXPENDITURES OVER $1,000,000

6. **Line 15: Capital Expenditures over $1,000,000**
   On line 15, select "Yes" or "No" from the drop down box to indicate whether or not your clinic had capital expenditures that were more than $1,000,000 during the report period.

   If your answer is yes, you must complete the capital expenditure detail on lines 20 through 24, as needed. If you answered "no", skip to line 30.

7. **Lines 20 through 24, Column 1: Description of Project**
Enter on lines 20 through 24, column 1 a description of the capital project. Remember, the total project must have a projected total value of more than $1,000,000 to be reported.

8. **Lines 20 through 24, Column 2: Projected Total Capital Expenditure**
Enter on lines 20 through 24, column 2 the total projected cost of the capital project, even if some of the monies will be spent in a future year. Remember, the total project must require an aggregate capital expenditure of more than $1,000,000 to be reported.

9. **Lines 20 through 24, Column 3: OSHPD Project Number**
Enter on lines 20 through 24, column 3, the OSHPD Project Number if one was assigned. If no OSHPD Project Number was assigned, enter "N/A" in column 3.

CAPITAL FUND

A Capital Fund is a method of separately accounting for funds that have been reserved specifically for capital projects, either equipment purchases or building projects. Because these funds are restricted as to their use, they are reported in the financial statements, but in a balance sheet separate from the unrestricted balance sheet. If you do not account separately for funds that are reserved for capital expenditures, leave lines 30 through 34 blank.

10. **Line 30: Beginning Balance**
Enter on line 30 the balance of the Capital Fund at the beginning of the report period. If the clinic does not have a Capital Fund, leave the table blank.

11. **Line 31: Current Year Contributions**
Enter on line 31 the total of all contributions to the Capital Fund during the report period.

12. **Line 32: Current Year Interest Earnings**
Enter on line 32 the total of all interest that was earned by the Capital Fund during the report period.

13. **Line 33: Current Year Expenditures**
Enter on line 33 the total of all expenditures paid for by the Capital Fund during the report period. Enter as a positive amount.

14. **Line 34: Ending Fund Balance**
The SIERA Utilization application will complete line 34 by adding lines 30, 31 and 32, and subtracting line 33.

APPENDIX A

PRIMARY CARE PROVIDERS

A. MEDICAL SERVICES PROVIDERS:

PHYSICIAN

- General Practitioner
- Internist
- Obstetrician/Gynecologist
- Allergist
- Dermatologist
- Surgeon
- Ophthalmologist
- Family Practitioner
- Pediatrician
- Psychiatrist
- Cardiologist
- Orthopedist
- Urologist
- Other specialists and sub-specialists

NURSES: *

- Clinical Nurse Specialist
- Public Health Nurse
- Home Health Nurse
- Visiting Nurse
- Registered Nurse
- Licensed Practical Nurse
- Licensed Vocational Nurse
- Psychiatric Nurse

MID-LEVEL PRACTITIONERS: *

- Certified Nurse-Midwife
- Nurse Practitioner
- Physician Assistant

B. DENTAL PROVIDERS:

DENTIST

- General Practitioner
- Oral Surgeons
- Periodontist
- Pedodontist
- Dental Hygienist
- Oral Therapist

C. OTHER PROVIDERS:

- Psychologist
- Psychiatric Social Worker
- Licensed Clinical Social Worker
- Audiologist
- Occupational Therapist
- Podiatrist
- Physical Therapist
- Nutritionist/Dietician
- Optometrist
- Speech Therapist
- Chiropractor

* Mid-level Practitioners and Nurses are considered providers ONLY when they act independently in the provision of health care.

APPENDIX B

FEDERAL POVERTY LEVEL GUIDELINES – 2018

Number in Family	Below 100%	100 - 138%	139 - 200%	201 - 400%	Above 400%
1	< $12,140	$12,140 - $16,753	$16,754 - $24,280	$24,281 - $48,560	> $48,560
2	< $16,460	$16,460 - $22,715	$22,716 - $32,920	$32,921 - $65,840	> $65,840
3	< $20,780	$20,780 - $28,676	$28,677 - $41,560	$41,561 - $83,120	> $83,120
4	< $25,100	$25,100 - $34,638	$34,639 - $50,200	$50,201 - $100,400	> $100,400
5	< $29,420	$29,420 - $40,600	$40,601 - $58,840	$58,841 - $117,680	> $117,680
6	< $33,740	$33,740 - $46,561	$46,562 - $67,480	$67,481 - $134,960	> $134,960
7	< $38,060	$38,060 - $52,523	$52,524 - $76,120	$76,121 - $152,240	> $152,240
8	< $42,380	$42,380 - $58,484	$58,485 - $84,760	$84,761 - $169,520	> $169,520

For family units with more than 8 members, add $4,320 for each additional member at or below 100% level.

(These Poverty Level Guidelines were published in the Federal Register on January 18, 2018)

GLOSSARY

AGRICULTURE:

Farming in all of its aspects, including:

- cultivation and tillage of the soil:
- the production, cultivation, growing and harvesting of any commodity grown on, in, or as an adjunct to or part of a commodity grown in, or on, the land;
- the production of dairy products, the raising of livestock, bees, furbearing animals, or poultry; and /or
- any practice performed by a farmer or on a farm as an incident to or in conjunction with such farming operations, including preparation for market, delivery to storage or to carriers for transportation to market.

AMERICAN RECOVERY AND REINVESTMENT ACT (ARRA) GRANTS:

Federal Stimulus Funds established for FY 2009 and FY 2010.

BIRTHING SERVICES:

These include labor and delivery services for pregnant women.

COMMUNITY EDUCATION:

Services of an educational or counseling nature carried out by licensed or non-licensed staff; i.e., family planning education, nutrition, parenting, or hypertension.

COMMUNITY HEALTH CENTERS (CHCs):

Community health centers (CHCs) provide comprehensive primary health care services using a culturally sensitive, family-oriented approach. Services are available to anyone, regardless of their ability to pay. CHCs tailor their services to meet the specific needs of their community and its residents, including special populations such as the homeless, migrant and seasonal farm workers, HIV/ AIDS patients, the elderly, residents of public housing, and chronic alcohol and substance abusers. The focus of CHCs is to provide services in the most underserved areas.

COUNTY MEDICAL SERVICES PROGRAM (CMSP):

This is a county indigent program where the county population is 300,000 persons or less.

COVERED CALIFORNIA:

A marketplace for people and small businesses to find out if they are eligible for financial help and buy health insurance.

CO-PAYMENT:

This is the portion of the bill for which the individual patient is responsible.

DEPENDENTS (FAMILY MEMBERS):

A dependent is any person living in your household, as a relative or non-relative, whose gross income is less than $2,500 annually. The head of household must provide over one-half the dependent's total support.

DIAGNOSTIC EQUIPMENT:

Equipment that helps the physician identify and determine the cause of an illness, e.g., x-ray equipment, CAT scanners, PET scanners, etc.

ENCOUNTER(s):

An encounter is recorded when a licensed practitioner (medical, mid-level medical, dental, mental health) using independent judgment, examines or treats a patient, and records the findings in the patient's chart.

The types of encounters permitted would be

- Medical (see note below),
- Nutritional
- Health Education
- Mental health,
- Dental,

Multiple encounters on the same day are possible, but they require multiple providers, a separate diagnosis or treatment plan by each provider. The plan must be prepared by a practitioner using independent judgment, and the visit must be fully charted. One provider cannot provide a medical, health educational and nutritional encounter even if the doctor saw a diabetic, adjusted his medications, warned him about eating patterns and provided him with a new diet plan to keep him more stable. Similarly when the doctor asks the nurse to do the health education portion of the encounter, the clinic does not report a medical and a health education encounter. However, if the doctor orders services from a health educator, who then sits down and does a full (separately charted) health education visit that would be considered a second encounter. If the health educator subsequently refers the patient to a nutritionist who does yet another separately charted face-to-face nutrition assessment, this would be counted as a third encounter (medical with the doctor, health education with the health educator, and nutritional with the nutritionist).

NOTE: Only one **type** of encounter would be allowed per patient visit to the clinic, i.e., one medical encounter per patient visit. If the patient sees both a mid-level medical practitioner and the physician on the same visit, the encounter would be recorded under the practitioner that did the majority of work on that day. Even if the patient came back a second time in the same day, only one encounter would be reported unless the second visit was for a problem unrelated to the initial encounter.

ETHNICITY - HISPANIC:

A person having Hispanic ethnicity is one who identifies with or is of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin.

FARM WORKER AND DEPENDENT (s):

See Seasonal Agricultural and Migratory Workers.

FEDERAL 95-210 Clinic:

This is a federally funded, fixed-rate program applicable only to rural clinics.

FEDERALLY QUALIFIED HEALTH CENTER (FQHC):

Federally Qualified Health Centers (FQHCs) were created in the early 1990s and are public or nonprofit, consumer-directed health care corporations. FQHCs provide high quality, cost-effective and care to medically underserved areas and populations. FQHCs are required to provide a wide range of services to receive funding, including primary and preventive services, cancer and other disease screening, well child services, eye, ear, and dental screening, family planning services, emergency medical and dental services, and some pharmaceutical services. If a particular health center does not have the capacity to provide one or more of these services directly, they must provide them through contracts or cooperative arrangements. These safety-net providers are primarily health centers that are supported by federal grants under the US Public Health Service Act (PHSA): Community Health Centers, Migrant Health Centers, Health Care for the Homeless Programs, Public Housing Primary Care Programs and Urban Indian and Tribal Health Centers. FQHCs must meet rigorous federal standards related to quality of care and services, cost, and governance. They are qualified to receive cost-based reimbursement under Medicaid and Medicare law.

FEDERALLY QUALIFIED HEALTH CENTER "LOOK-ALIKE":

Some clinics meet basic qualifications that regular FQHCs do: they are public or nonprofit, provide services to anyone regardless of their ability to pay, serve a medically underserved area or population, and have a board in which patients make up the majority. These clinics are not FQHCs because they lack the funding necessary to receive Public Health Service (PHC) grants. Instead, they are called **FQHC "look-alikes"** and receive the same cost-based reimbursement as FQHCs. Some states use look-alikes to provide health services in areas of need, even if PHS funds are not available.

FQHC:

See Federally Qualified Health Center

FULL-TIME EQUIVALENT (FTE):

For salaried positions: The understanding contained in the employment agreement shall be the determining factor when reporting FTE practitioner in the annual utilization report. If the understanding is that the practitioner is being hired as "full-time" then the clinic should report that practitioner as 1.00 FTE (use two decimal places on the form). This same logic would also apply if the understanding contained in the employment agreement **specified** part time employment (i.e. if the understanding was the practitioner was a "half time employee", he/she would be reported as 0.50 FTE).

Note that this definition does not make any distinction between duties the physician actually performs. Time spent on tasks associated with patient care is included in the FTE definition as well as the time spent actually seeing patients. Such functions as making rounds, charting, arranging hospital admission, supervising mid-level practitioners or nurses or residents, participating in quality assurance, peer review or utilization, etc. would all be considered as part of the FTE. The reported FTE is based on the understanding of the physician's total work effort contained in the employment agreement. **No time is "carved out" or excluded.**

For contracted positions: A contractual employee who is reimbursed on the basis of time (hourly, daily, weekly or monthly) by which a specific rate per time is defined and the payment is based on the amount of time worked in the clinic. The time basis could be the hour, day, week or some other time frame. The employee could have a direct relationship with the clinic (such as a physician who is hired under an hourly contract) or the clinic could contract with a third party to supply staff to the clinic (i.e. the clinic would have a contract with a university which would supply staff). In these cases the hours worked (and paid for) must be translated to full-time equivalent using 2080 hours as the denominator. Thus, if a physician works 16 hours per week for 52 weeks he/she would be 0.40 FTE.

16 hours per week X 52 weeks per year = 832 hours per year.
832 hours per year / 2080 hours per FTE = 0.40 FTE's (report to the second decimal place)

For volunteer positions: At some clinics unpaid staff makes up a significant portion of the service delivery capability. These volunteers must be converted to full-time equivalents similar to contractually paid staff. The FTE would be calculated by dividing the hours worked per year by 2080 as you would for a position paid on a time basis (see above).

MY HEALTH LA

Los Angeles County no-cost healthcare coverage to eligible adults in Los Angeles county.

LOW INCOME HEALTH PROGRAM (LIHP)

In 2014 transitioned into the Medical Program.

MEDI-CAL "BILLABLE" PROVIDERS

The following clinical support staff are both licensed and are approved for reimbursement by the Medi-Cal program.

- Clinical laboratory (services billed by laboratory)
- Orthotist
- Prosthetist
- Occupational therapist
- Physical therapist
- Podiatrist (when services are rendered in a Skilled Nursing Facility [SNF] Level A or B)
- Radiologist
- Speech pathologist
- Audiologist

MEDICALLY INDIGENT ADULT SERVICES PROGRAM (MISP):

This is a county indigent program where the county population is greater than 300,000 persons.

OFF-SITE ENCOUNTERS:

These are encounters that take place in a location other than the clinic site, including the patient home (home visits), hospitals, migrant camps, etc.

ON-SITE ENCOUNTERS:

These are encounters that take place at the clinic's service site, including satellite clinics and mobile vans.

OUTREACH:

The time when clinic staff goes into the community informing prospective patients of the availability of the clinic services and assisting patients in obtaining these services.

PACE:

This is an Acronym for Program of All-Inclusive Care for the Elderly. At a minimum, services furnished at the PACE center include primary care (physician and nursing services), social services, restorative therapies, personal care and supportive services, nutritional counseling, recreational therapy and meals. For more details visit the website (www.cms.hhs.gov/PACE).

PATIENT(S):

This is the number of <u>unduplicated</u> patients who received health care services from a licensed or certified provider during the reporting period. If a patient was covered by more than one third-party during the reporting period, e.g., Medicare and Private Insurance, use the payer category that was responsible for the first dollar of coverage, even if there is a secondary payer. In cases where the coverage changes during the year use the coverage in effect on December 31.

PROVIDER:

A LICENSED or CERTIFIED individual who assumes primary responsibility for assessing the patient and exercises independent judgment as to services rendered during the encounter. See attachment "A" for a listing of Medical Providers, Dental Providers, and Other Providers.

RACE – ASIAN / PACIFIC ISLANDER:

A person who has origins in or who identifies with any of the original oriental peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands, including Hawaii, Laos, Vietnam, Cambodia, Hong Kong, Taiwan, China, India, Japan, Korea, the Philippine Islands, and Samoa.

RACE - BLACK:

A person having origins in or who identifies with any of the black racial groups of Africa.

RACE - NATIVE AMERICAN / ALASKAN NATIVE:

A person having origins in or who identifies with any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.

RACE – OTHER / UNKNOWN:

Any possible options not covered in the other race categories.

RACE – WHITE:

A person having origins in or who identifies with any of the original Caucasian peoples of Europe, North Africa, or the Middle East. This includes Ireland, Germany, Italy, Near East, Arabia or Poland.

RURAL HEALTH CLINIC (RHC):

Rural health clinics (RHCs) were created under the Rural Health Clinic Services Act of 1977 to improve access to care for underserved populations in rural areas of the country. The passage of this act provided a reimbursement mechanism under Medicare and Medicaid that reimburses for services of midlevel practitioners in RCHs. Prior to passage of this Act, mid-level practitioners were not eligible for reimbursement from Medicare, or in some states, Medicaid. In order to be certified, RHCs must be located in an area that is not an urbanized area as defined by the Bureau of the Census and in a Medically Underserved Area (MUA) or Health Profession Shortage Area (HPSA).

SEASONAL AGRICULTURAL AND MIGRATORY WORKERS:

MIGRANT WORKER (includes dependents):

An individual, whose principal employment is in agriculture on a seasonal basis as opposed to year-round employment and who, for purposes of employment, DOES establish a temporary place of residence. Migrant workers live in a work area temporarily. Such employment must have been within the last 24 months.

SEASONAL AGRICULTURAL WORKERS (FARMWORKERS) (includes dependents):
An individual whose principal employment is in agriculture, on a seasonal basis, as opposed to year-round employment; and who, for purposes of employment, DOES NOT establish a temporary place of residence. Seasonal workers commute to work in the area of their permanent address. Such employment must have been within the last 24 months

SOCIAL SERVICES:
These include assessment, referral and follow-up services to assist patients with their health and social needs. They are usually provided on an on-going basis. These may include childcare, translation, legal assistance, housing, etc.

STATE LEGALIZATION IMPACT ASSISTANCE PROGRAM (SLIAG):
This is a program that provides funding for public assistance, public health, and educational services for newly legalized residents.

THERAPEUTIC EQUIPMENT:
This is equipment that a provider uses to treat a patient, e.g. lithotriptors, linear accelerators, or cardiac catheterization equipment. This term may refer to equipment that must be anchored due to safety issues.

VOLUNTEERS:
Staff that deliver services for the clinic without compensation. Typically volunteer staff work less than full-time, but may account for a significant portion of the service delivery capability. Count only volunteers who work on a scheduled basis. These volunteers must be converted to full-time equivalents similar to contractually paid staff. The FTE will be calculated by dividing the hours worked per year by 2080, similar to calculating a position paid on a time basis (see FTE).