Income Analysis Form

(Required for NHHCS)

OMB No.: 0915-0285. Expiration Date: 3/31/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration INCOME ANALYSIS FORM August 1, 2022 – July 31, 2023	FOR HRSA USE ONLY		
	Applicant Name	Grant Number	Application Tracking Number

Line #	Payer Category	Patients by Primary Medical Insurance	Billable Visits	Income per Visit	Projected Income	Prior FY Income:______
Part 1: Patient Service Revenue – Program Income						
		(a)	(b)	(c)	(d)	(e)
1	Medicaid					
2	Medicare					
3	Other Public					
4	Private					
5	Self-Pay					
6	Total (Lines 1–5)					
Part 2: Other Income – Other Federal, State, Local and Other Income						
7	Other Federal					
8	State Government					
9	Local Government					
10	Private Grants/ Contracts					
11	Contributions					
12	Other					
13	Applicant (Retained Earnings)					
14	Total Other: (Lines 7–13)					
Total Non-Federal (Non-section 330) Income (Program Income Plus Other)						
15	Total Non-Federal (lines 6+14)					
Comments/Explanatory Notes (if applicable)						

Public Burden Statement: Health centers (section 330 grant funded and Federally Qualified Health Center look-alikes) deliver comprehensive, high quality, cost-effective primary health care to patients regardless of their ability to pay. The Health Center Program application forms provide essential information to HRSA staff and objective review committee panels for application evaluation; funding recommendation and approval; designation; and monitoring. The OMB control number for

this information collection is 0915-0285 and it is valid until 3/31/2023. This information collection is mandatory under the Health Center Program authorized by section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b). Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland, 20857 or paperwork@hrsa.gov.

Instructions for Attachment 6: Income Analysis Form

Use the Income Analysis Form to show the expected income sources, projected patient services income, and other income from all sources (other than the NHHCIA grant) for the upcoming budget period of August 1, 2022 through July 31, 2023. The Income Analysis form includes:

- Program income (known as patient service revenue), and;
- All other income (known as other federal, state, local, and other income).

Part 1: Patient Service Revenue—Program Income

Patient service revenue is income directly tied to the provision of services to patients. This includes services that are reimbursed by health insurance plans, managed care organizations, categorical grant programs (e.g., breast and cervical cancer screening), employers, and health provider organizations. Reimbursements may be based upon visits, procedures, member months, enrollees, the achievement of performance goals, or other service related measures.

The program income section groups billable visits and income into the five payer groupings used in the Uniform Data System (UDS) (see the UDS Manual for details). All patient service revenue is reported in this section of the form.

Exclude patient service revenue for sites or services not in the approved scope of project or pending HRSA approval.

Column (a) Patients by Primary Medical Insurance: The projected number of unduplicated patients classified by payer based upon the patient's ***primary medical insurance*** (payer billed first). The patients are classified in the same way as in the UDS Manual, Table 4, lines 7–12. Examples for determining where to count patients include:

- A crossover patient with Medicare and Medicaid coverage is to be classified as a Medicare patient on line 2.
- A Medicaid patient with no dental coverage who is only seen for dental services is to be classified as a Medicaid patient on line 1 with a self-pay visit on line 5.

Column (b): Billable Visits: Includes all billable/reimbursable visits. The value is typically based on assumptions about the amount of available clinician time, clinical productivity (visits per unit of time), and mix of billable by payer. Exclude billable services related to laboratory, pharmacy, imaging, and other ancillary services from this column. Note other significant exclusions or additions in the Comment/Explanatory Notes box at the bottom of the form.

Note: The patient service income budget is primarily based upon income per visit estimates. However, some forms of patient service income do not generate reportable visits, such as income from laboratory or pharmacy services, capitated-managed care, performance incentives, wrap payments, and cost report settlements. Based on historical experience, you may choose to include some or all of this income in the income per visit assumption. You may also choose to separately budget for some or all of these sources of patient service income.

Column (c): Income per Visit: Calculated by dividing projected income in Column (d) by billable visits in Column (b).

Column (d): Projected Income: Project accrued net revenue, including an allowance for bad debt, from all patient services for each pay grouping. Pharmacy income, if applicable, may be estimated using historical data to determine the number of prescriptions per medical visit and the average income per prescription. All separate projections of income are consolidated and reported here.

Column (e): Prior FY Income: The income data from the most recent completed fiscal year, which will be either interim statement data or audit data, when available.

(Lines 1–5) Payer Categories: The five payer categories (Medicaid, Medicare, Other Public, Private, and Self-Pay) reflect the five payer groupings used in Table 9d of the UDS. The UDS instructions are to be used to define each payer category (see the UDS Manual).

Visits are reported on the line of the primary payer (payer billed first). When a single visit involves more than one payer, attribute each portion of the visit income to the payer group from which it is earned. In cases where there are deductibles

and co-payments to be paid by the patient, report that income on the self-pay line. If the co-payment is to be paid by another payer, report that income on the other payer's line. It is acceptable to include that income on the primary payer line, if you cannot accurately associate the income to secondary and subsequent sources.

Classify all service income by payer, including pharmacy and other ancillary service revenue. If you do not normally classify the projected ancillary or other service revenue by payer category, allocate the projected income by payer group using a reasonable method, such as the proportion of medical visits or charges. In the form Comments/Explanatory Notes section, note the method used.

(Line 1) Medicaid: Income for services billed to and paid for by Medicaid (Title XIX), regardless of whether they are paid directly or through a fiscal intermediary or a Health Maintenance Organization. Medicaid income may include fee-for-service reimbursement, capitated managed care, fee-for-service managed care, Early Periodic Screening, Diagnosis, and Treatment (EPSDT), Children's Health Insurance Program (CHIP), and other reimbursement arrangements administered either directly by the state agency or by a fiscal intermediary. It includes all projected Medicaid income from managed care capitation, incentives, and primary care case management income.

(Line 2) Medicare: Includes income from fee-for-service reimbursement, capitated managed care, fee-for-service managed care, Medicare Advantage plans, and other reimbursement arrangements administered either directly by Medicare or by a fiscal intermediary. It includes all projected income from managed care capitation, risk pool distributions, performance incentives, pharmaceutical reimbursements, and case management fee income.

(Line 3) Other Public: Income from federal, state, or local government programs earned for providing services or pharmaceuticals that are not reported elsewhere. A CHIP operated independently from the Medicaid program is an example of other public insurance. Other Public income also includes income from categorical grant programs when the grant income is earned by providing services. Examples of these include CDC's National Breast and Cervical Cancer Early Detection Program.

(Line 4) Private: This line includes income from private insurance plans, managed care plans, insurance plans, and other private contracts for services or pharmaceuticals. This includes plans such commercial insurance (e.g., Blue Cross and Blue Shield), managed care plans, self-insured employer plans, group contracts with unions and employers, service contracts with employers and Veteran's Administration Community Based Outpatient Clinic (CBOC) contracts. Revenue from health benefit plans earned by government employees, veterans, retirees, and dependents, such as TRICARE, the federal employee health benefits program, state employee health insurance benefit programs, teacher health insurance, and similar plans are to be classified as private insurance.

(Line 5) Self-Pay: Income from patients, including full-pay, self-pay, and sliding fee patients, as well as the portion of the visit income for which an insured patient is personally responsible.

(Line 6) Total: This is the sum of lines 1-5.

Part 2: Other Income – Other Federal, State, Local and Other Income
Classify other income by revenue source. This section includes all income other than the patient service revenue shown in Part 1 (exclusive of the NHHCIA grant request). It includes other federal, state, local, and other income. It is other revenue that is earned but not directly tied to visits, procedures, or other specific services. It includes income from services provided to non-health care system patients (patients of an entity with which the health care system is contracting) either in-house or under contract with another entity such as a hospital, nursing home or other health care system). (See Lines 9 and 10 for examples of services provided to non-health care system patients.) It also includes income from in-house retail pharmacy sales to individuals who are not patients of the health care system. Income is to be classified based on the source from which it was received and not the source from which it originated.

(Line 7) Other Federal: Income from direct federal funds where your organization is the recipient of a Notice of Award from a federal agency. Exclude the NHHCIA grant request in this NCC or federal funds awarded through intermediaries (see Line 9 below). It includes funds from federal sources such as the Centers for Disease Control and Prevention (CDC); Housing and Urban Development (HUD); Centers for Medicaid and Medicare Services (CMS); Department of Health and Human Services (DHHS) funding under the Ryan White Part C program; and others. For consistency with the UDS Manual, report CMS electronic health record (EHR) incentive program income here.

(Line 8) State Government: Income from state government funding, contracts, and programs, including uncompensated care funding; state indigent care income; emergency preparedness funding; mortgage assistance; capital improvement

funding; school health funding; Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); immunization funding; and similar awards.

(Line 9) Local Government: Income from local government grants, contracts, and programs, including local indigent care income; community development block grants; capital improvement project funding; federal funding awarded through intermediaries; and similar awards. For example, a health care system that contracts with the local Department of Health to provide services to the Department's patients is to report all the income earned under this contract on this line; and Ryan White Part A funds are federal funds awarded to municipalities who in turn make awards to provider organizations, so Ryan White Part A funding received directly from the municipality would be shown on this line.

(Line 10) Private Grants/Contracts: Income from private sources such as foundations, non-profit entities, hospitals, nursing homes, drug companies, employers, other health care systems, and similar entities. For example, a health care system operating a pharmacy in part for its own patients and in part as a contractor to another health care system is to report the pharmacy income for its own patients in Part 1 and the income from the contracted health care system on this line.

(Line 11) Contributions: Income from private entities and individual donors that may be the result of fundraising.

(Line 12) Other: Incidental and other income not reported elsewhere and includes items such as Payroll Protection Program revenue, interest income, patient record fees, vending machine income, dues, and rental income. Applicants typically have at least some "Other" income to report on Line 12.

(Line 13) Applicant (Retained Earnings): The amount of funds needed from your organization's retained earnings or reserves in order to achieve a breakeven budget. Explain in the Comments/Explanatory notes section why applicant funds (retained earnings) are needed to achieve a breakeven budget. Amounts from non-federal sources, combined with the NHHCIA funds, should typically be adequate to support normal operations.

(Line 14) Total Other: This is the sum of lines 7–13.

(Line 15) Total Non-Federal (Non-NHHCIA) Income (Program Income Plus Other): The sum of Lines 6 and 14 (the total income aside from this NHHCIA grant).

Note that in-kind donations are not included as income on the Income Analysis form. Applicants should discuss in-kind donations in the Performance Narrative of the NHHCIA NCC.