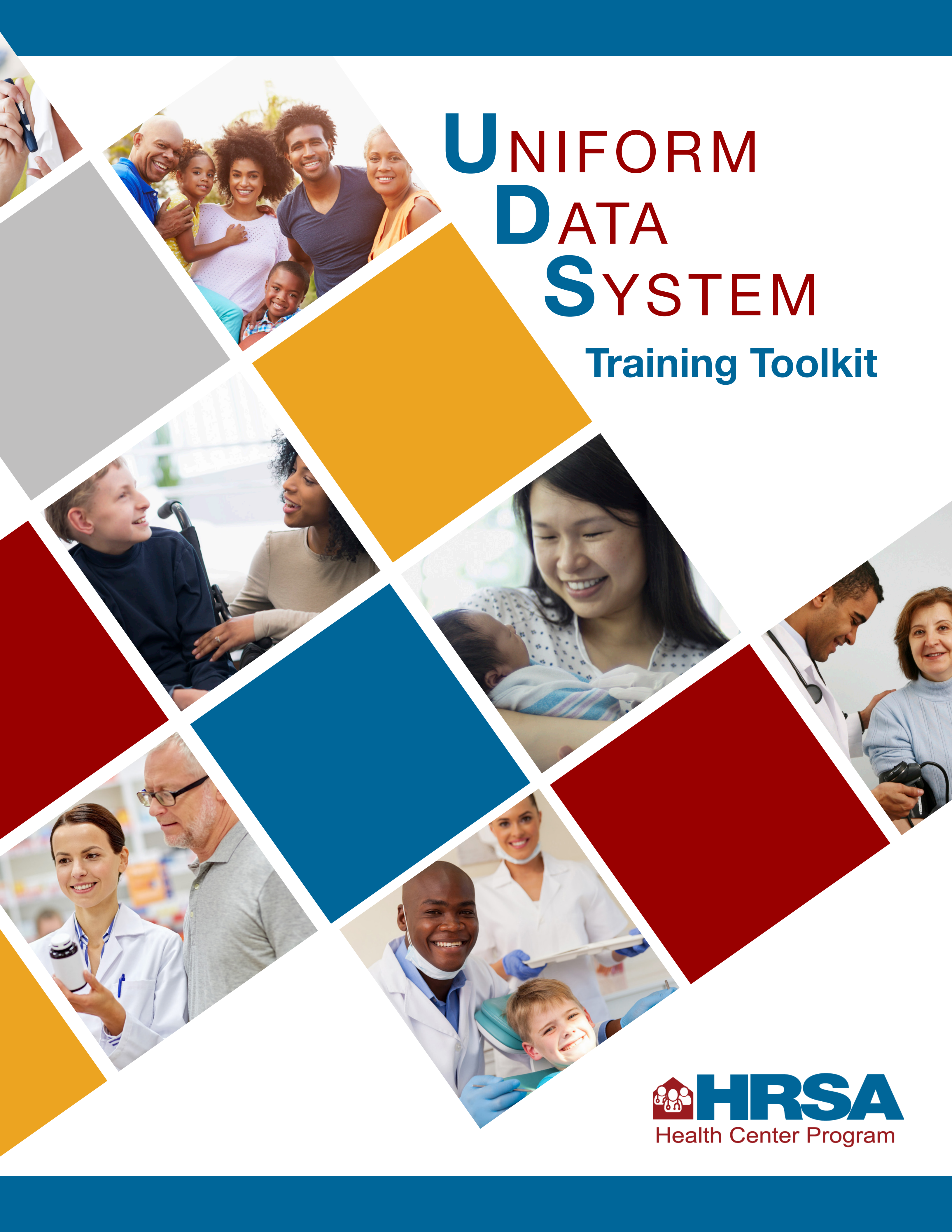

Uniform Data System
Training Toolkit
HRSA
Health Center Program

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UDS Training Toolkit

Resources Included in the Annual State-Based UDS Training

ID	Table of Contents	Resource	Brief Description
1	Logistics	List of Materials in Toolkit and Other Linked Resources	List of materials provided to participants attending annual state-based trainings
2	Logistics	Acronyms Used	Acronyms used in the in-person training presentation
3	Logistics	Agenda	In-person training agenda
4	Logistics	PCA UDS Training Evaluation	Instructions on how to access the evaluation form to be completed at the end of the final session
5	Training - Chapters by Section	UDS Training Presentation Slide Deck	Annual state-based training PowerPoint
5a	Overview	Who, What, Where, When, and Why of the UDS	Slides 1-14
5b	Patient Profile	ZIP Code Table, Tables 3A, 3B, and 4	Slides 15-29
5c	Services and Utilization	Tables 5 and 6A	Slides 30-59
5d	Clinical Quality Measures	Tables 6B and 7	Slides 60-85
5e	Financials	Tables 8A, 9D, and 9E	Slides 86-119
5f	Other Forms	Health Information Technology, Other Data Elements, and Workforce	Slides 120-125
5g	Tips	Resources and Tips for Success	Slides 126-137
6	Reporting Resources	UDS Manual	2020 UDS Reporting Manual Instructions
7	Reporting Resources	UDS Tables (PDF)	Blank set of 2020 UDS Tables (PDF)
8	Reporting Resources	Nurse Visit Guidance	Considerations to properly report and account for nurse visits
9	Reporting Resources	Virtual Visits Guide	Considerations to properly report virtual visits
10	Reporting Resources	Mental Health and Substance Use Disorder Addendum	Considerations to properly report the mental health and substance use disorder addendum of table 5
11	Reporting Resources	Table 6A Code Changes	Table 6A codes updated since the prior year
12	Reporting Resources	2020 Clinical Measures Descriptions Handout	Criteria to be used to report clinical measures in the 2020 UDS
13	Reporting Resources	Telehealth Impact on Clinical Measure Reporting	Guide to determine how services to patients provided via telehealth should be considered when reporting the UDS clinical measures
14	Reporting Resources	COVID-19-Related FAQs for UDS Reporting	Addresses common questions about UDS reporting in COVID-19-related situations
15	Reporting Resources	Helpful Codes for HIV and PrEP Measures	ICD and RxNORM codes to consider when identifying patients newly diagnosed with HIV and those for PrEP management
16	Reporting Resources	Financial Tables Reporting Considerations	Considerations to properly report the UDS financial tables (8A, 9D, & 9E)
17	Reporting Resources	Beginner Training Resources	UDS training resources for those new to UDS
18	Reporting Resources	Advanced Training Resources	UDS training resources for those experienced to UDS
19	System Resources	User Guide for Accessing the UDS in EHB	Detailed guide to accessing and using EHBs for UDS reporting
20	System Resources	Checklist for Submission	Checklist for UDS preparers and submitters to use prior to submission
21	Data Resources	2019 State Performance Indicators Statistics	State comparison statistics of patient profile, quality of care, and service delivery indicators using 2019 data
22	Data Resources	330 UDS 2019 Roll-Ups National Universal	330 program national rollup report using 2019 data
23	Data Resources	Look-Alike 2019 Roll-Ups National Universal	LAL program national rollup report using 2019 data
24	Data Resources	BHW 2019 Roll-Ups National Universal	BHW program national rollup report using 2019 data

2020 UDS Training Presentation Acronym List

ADHC – Adult Day Health Care
BCCCP – Breast & Cervical Cancer Control Program
BHW – Bureau of Health Workforce
BMI – Body Mass Index
BPHC – Bureau of Primary Health Care
CARES – Coronavirus Preparedness and Response Supplemental Appropriations Act
CDC – Centers for Disease Control and Prevention
CHC – Community Health Center
CHIP – Children's Health Insurance Program
CME – Continuing Medical Education
CMS – Centers for Medicare & Medicaid Services
eCQI – Electronic Clinical Quality Improvement
eCQMs – e-Specified Clinical Quality Measures
DATA – Drug Addiction Treatment Act of 2000
EHBs – Electronic Handbooks
EHR – Electronic Health Record
EPSDT – Early and Periodic Screening, Diagnostic, and Treatment
FMLA – Family and Medical Leave Act
FPL – Federal Poverty Level
FTE – Full-time Equivalent
FQHC – Federally Qualified Health Center
HEALS – Health, Economic Assistance, Liability Protection and Schools Act
HEROES – Health and Economic Recovery Omnibus Emergency Solutions Act
HC – Health Center
HCH – Health Care for the Homeless
HHS – Health and Human Services
HIT – Health Information Technology
HITEQ – Health Information Technology, Evaluation, and Quality Center
HRSA – Health Resources and Services Administration
HSO – Health Services Offices
HUD – United States Department of Housing and Urban Development
ICD – International Classification of Diseases
IVD – Ischemic Vascular Disease
LAL – Look-alike
LBW – Low Birth Weight
LGBTQIA+ - Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual
MAT – Medication-assisted Treatment
MU – Meaningful Use
MCO – Managed Care Organization
MH – Mental Health
MHC – Migrant Health Center
OQI – Office of Quality Improvement
PACE – Program of All-Inclusive Care for the Elderly
PAL – Program Assistance Letter
PHPC – Public Housing Primary Care
PMS – Payment Management System

PPE – Personal Protective Equipment
PPHCEA – Paycheck Protection Program and Health Care Enhancement Act
PRE – Performance Reporting Environment
PREP – Pre-Exposure Prophylaxis
P4P – Pay for Performance
QI – Quality Improvement
SAMHSA – Substance Abuse and Mental Health Services Administration
SOGI – Sexual Orientation/Gender Identity
SUD – Substance Use Disorder
TA/T – Technical Assistance/Training
UDS – Uniform Data System
USHIK – United States Health Information Knowledgebase
VHA – Veterans Health Administration
WIC – Women, Infants, and Children

Annual State-Based UDS Training Agenda

The 2020 Annual State-Based UDS Trainings are being provided virtually in real-time over one to four sessions, as arranged with the state or territory Primary Care Association. These sessions include full UDS reporting instruction to provide opportunities to discuss the handling of specific reporting topics with the trainer and peers.

- Welcome
- Learning objectives
- Introduction to materials/resource
- Overview of the UDS (who, what, where, when, how)
- High level review of 2020 changes
- Impact of novel coronavirus (COVID-19)
- Top concerns
- Introducing and identifying patients and visits (as a central feature of the UDS)
- Patient demographic tables (ZIP Code Table; Tables 3A, 3B, and 4)
- Table 5: Staffing, Visits, and Integrated services on the selected service addendum
- Table 6A: Selected diagnoses and services
- Tables 6B and 7: Clinical quality measure reporting
    - Focus on new measures, telehealth, and top concerns
- Table 8A: Costs
- Table 9D: Patient-related revenue
- Table 9E: Other revenue
- Forms: Health Information Technology, Other Data Elements, Workforce Training
- Tips for success
- Address outstanding questions of participants

2020 Annual State-Based UDS Training Program Evaluation

Thank you for attending the **2020 Annual State-Based Uniform Data System (UDS) Training**.

We are very interested in your feedback on this year's webinar UDS training series and would like to ask you to complete the evaluation survey **within 48 hours** of the final session. Instructions are provided below to aid you with the process. The evaluation link will be provided to participants by the Primary Care Association (PCA) on the day of the final session through the webinar platform and by email following the final session.

We ask that each attendee only submit one evaluation pertaining to your overall experience with this training series.

1. Navigate to the evaluation survey link: https://redcap.link/UDSWebinarEvaluation

2. Please select the date you are completing the evaluation.

   Please enter today's date
   * must provide value
   Today M-D-Y

3. Please select the PCA whose 2020 Annual State-Based Training you attended using the drop-down list.

   Please select the PCA whose 2020 Annual State-Based Training you attended.
   * must provide value

4. Complete the evaluation.

5. Please remember to click on '**SUBMIT**' when you are finished.

   Submit

   Thank you!

Uniform Data System (UDS) Reporting Requirements Training

Calendar Year 2020

Bureau of Primary Health Care (BPHC)

Health Resources and Services Administration (HRSA)

Vision: Healthy Communities, Healthy People

Agenda

- Welcome and Logistics
- Overview of the UDS and Impact of the Novel Coronavirus Disease (COVID-19)
- Reporting the Patient Profile
- Reporting Clinical Services and Quality of Care Indicators
- Reporting Operational and Financial Tables
- Other Required UDS Reporting Forms
- Tips for Success

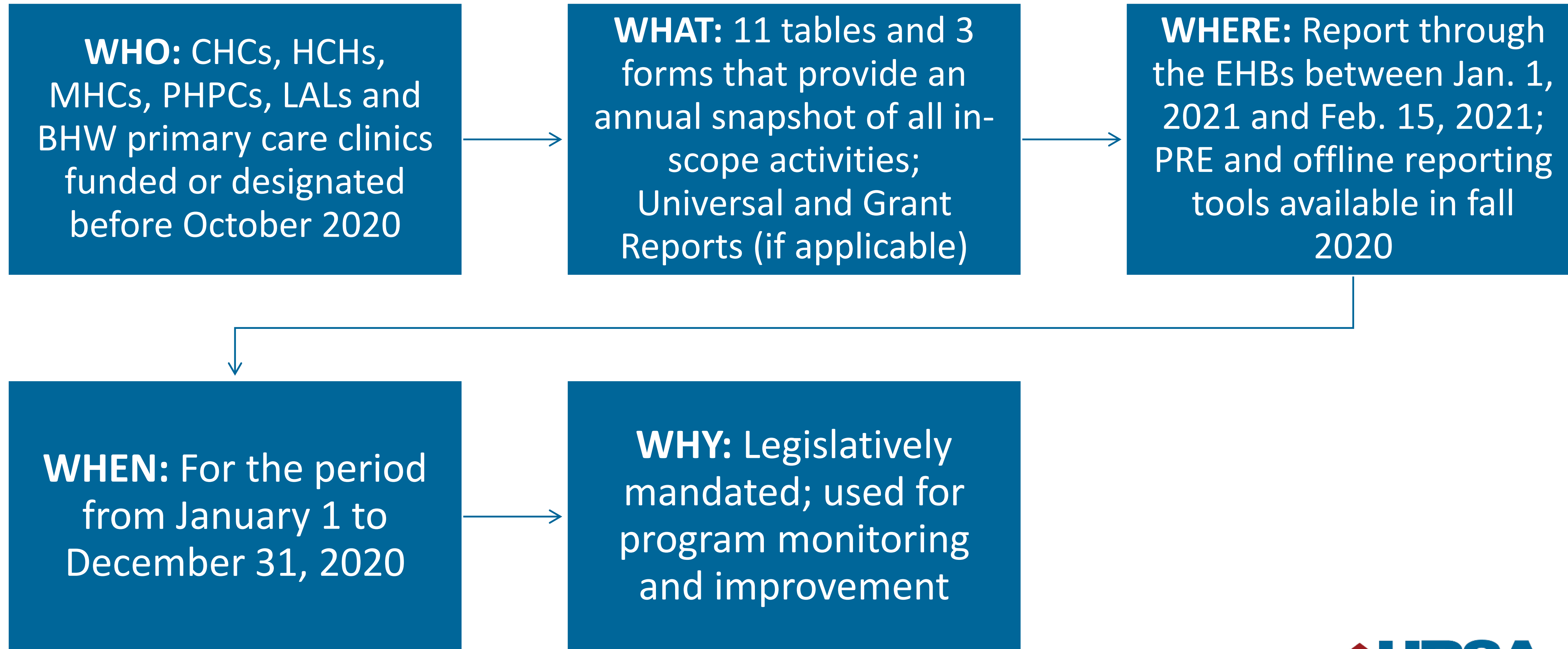
Key Materials Provided with This Training

- UDS Reporting Instructions (2020 UDS Manual)
- 2020 UDS Tables
- Beginner and Advanced Training Resource Fact Sheets
- Clinical Measures Handout
- Telehealth Impact on Clinical Measures
- List of Acronyms and Abbreviations
- Selected Statistics
- Proposed UDS Changes for Calendar Year 2021

Overview of the UDS and the Impact of COVID-19

The Who, What, Where, When, and Why of the UDS

Who, What, Where, When, and Why of the UDS



HRSA Health Center Program

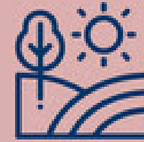
Value of the UDS

HRSA-Funded Health Centers Improve Lives

Nearly 30M people — that's **1 in 11** in the U.S.— rely on a HRSA-funded health center for care, including:

1 in 8 children

1 in 5 rural residents



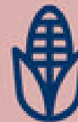
398K+ veterans

885K+ served at school-based health centers

1 in 3 living in poverty

1 in 5 Medicaid recipients

1M+ agricultural workers



1.4M+ homeless

Overview of UDS Report

Four Primary Sections

Patient Demographic Profile

- **ZIP** Code, medical insurance
- **Table 3A:** Age, sex at birth
- **Table 3B:** Race, ethnicity, language, sexual orientation, gender identity
- **Table 4:** Income, medical insurance, special population

Clinical Services and Outcomes

- **Table 5:** Staff, visits, and patients
- **Table 6A:** Selected services and diagnoses
- **Table 6B:** Clinical quality measures
- **Table 7:** Clinical outcome measures by race/ethnicity

Financial Tables

- **Table 8A:** Financial costs
- **Table 9D:** Patient-related charges and collections
- **Table 9E:** Other revenue

Other Forms

- **Appendix D:** Health Information Technology (HIT) Capabilities
- **Appendix E:** Other Data Elements
- **Appendix F:** Workforce

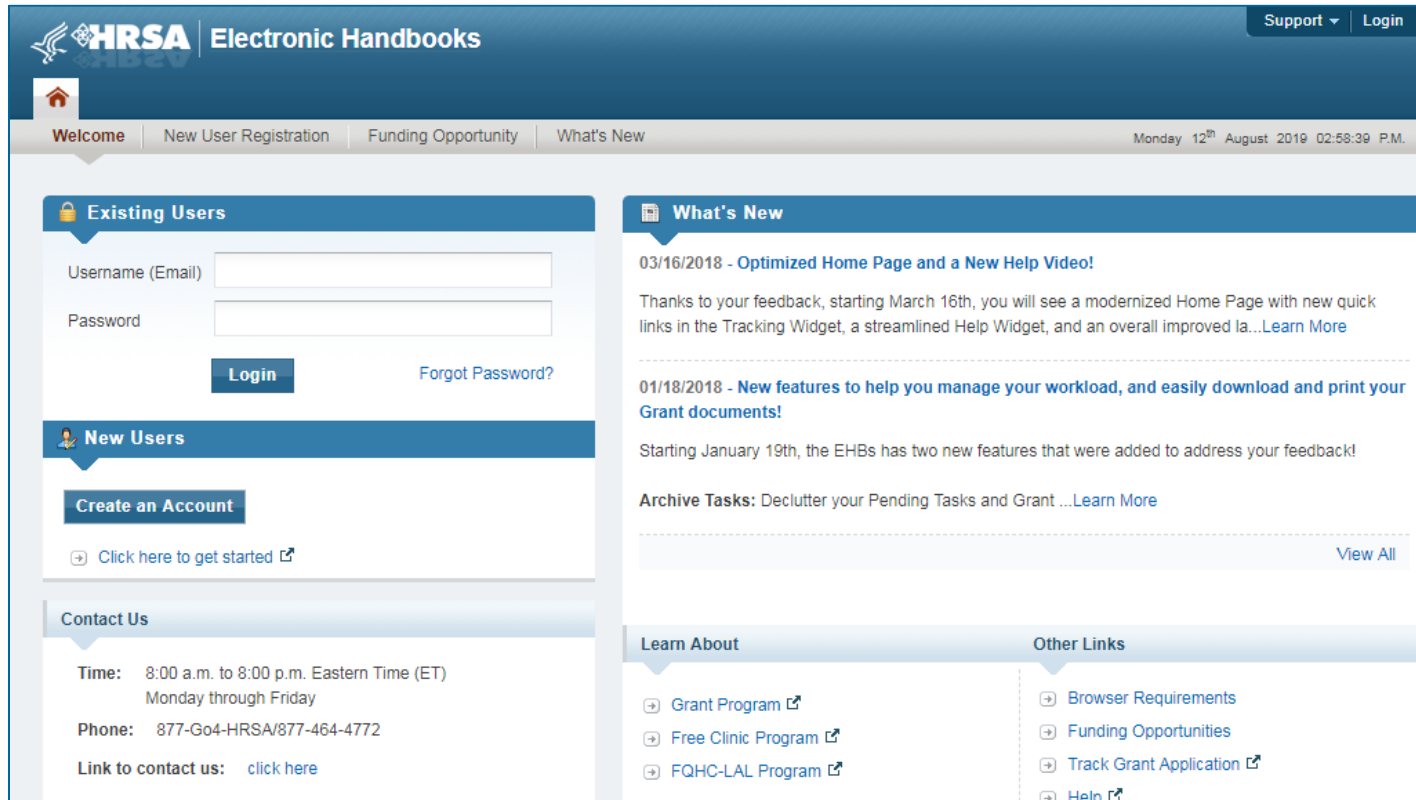
Overview of UDS Report

Eleven Tables and Three Forms

- All tables and forms are completed in a Universal Report
  - Universal Report—completed by all reporting health centers
  - Grant Report(s)—completed only by awardees that receive 330 grants under multiple funding streams

Table	Report GRANT REPORT(S) if you receive 330 grants under multiple program authorities: CHC (330 (e)) ◆ HCH (330 (h)) MHC (330 (g)) ◆ PHPC (330 (i))
ZIP Code	No
3A, 3B, 4	Yes
5	Yes, but patients and visits only
6A	Yes
6B, 7, 8A, 9D, 9E	No
Health Information Technology, Other Data Elements, & Workforce Forms	No

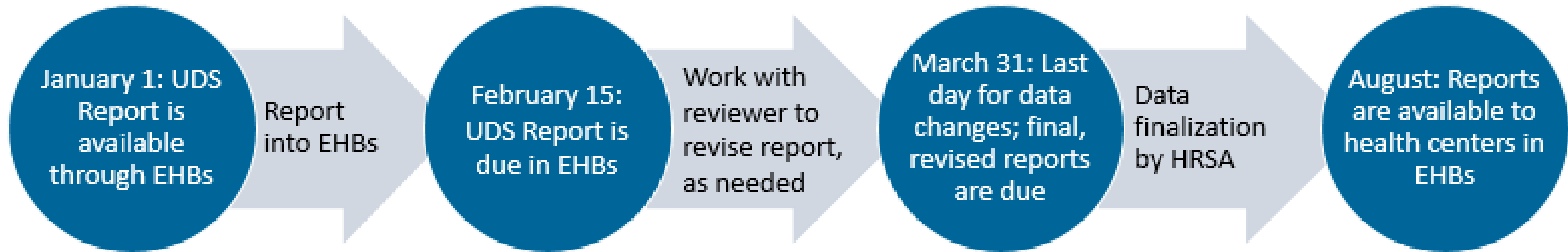
Where to Report: The Electronic Handbooks (EHBs)



Access EHBs at: https://grants.hrsa.gov/2010/WebEPSExternal/Interface/Common/AccessControl/Login.aspx

- All people who will be tasked with data entry or review need a login
- Tools (link to video)
  - Excel Template
  - Excel Upload
  - Comparison Tool
  - PRE
  - Edits (link to video)
- **EHBs Helplines**
  - **For account or login issues:** HRSA Call Center (877-464-4772, Option 3)
  - **For functionality issues:** Health Center Program Support (877-464-4772, Option 1)

Reporting Timeline



How Much UDS Experience Do You Have?

This is my first time!

I have a **few years of UDS experience** (3 or fewer).

I have a **good amount of UDS experience** (4 to 8 years)!

I am an **experienced UDS pro** (8 years or more)!

HRSA Health Center Program

UDS in the Time of COVID-19

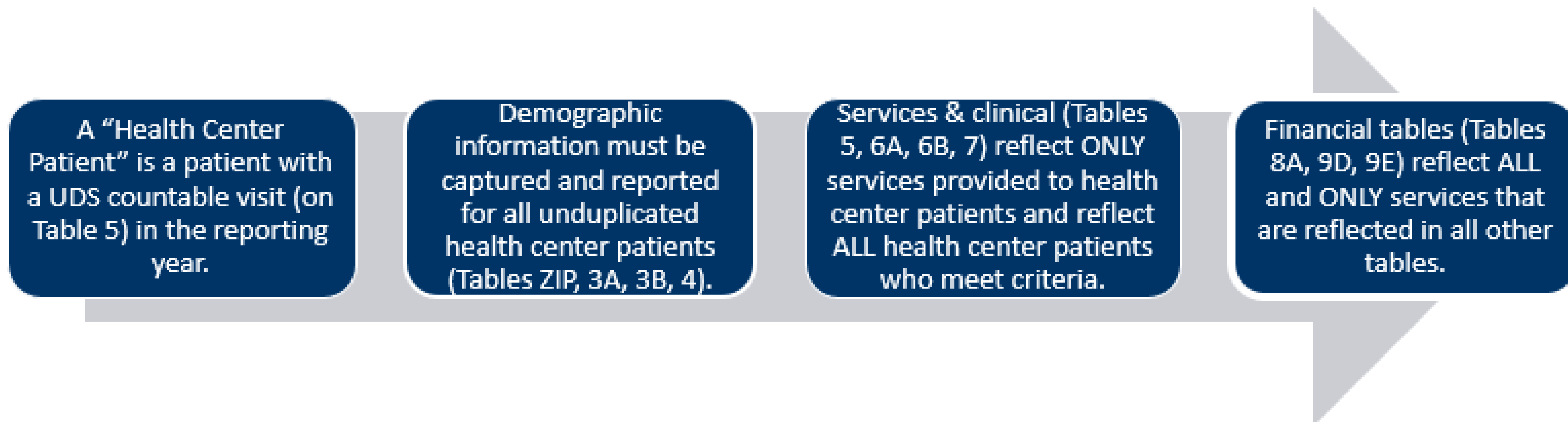
Impact of Service Changes in 2020

HRSA
Health Center Program

Health Centers May Have Many Changes in 2020

Potential Changes in Services	Health center made a rapid move to telehealth and expansion of telehealth services, including audio-only and distant site.	Health center started offering COVID-19 testing or treatment in the health center, in the community, or at temporary sites.	Staff were furloughed or laid off, or volunteer staff provided services.	Sites or services were closed (temporarily or permanently).	Health center received new funding such as H8C grants, H8D grants, H8E grants, Provider Relief Fund, Paycheck Protection Program, etc.
Tables to Be Considered	• Patient profile on **Tables ZIP, 3A, 3B, 4** • Visits on **Table 5** • Clinical services/ outcomes on **Tables 6A, 6B, 7**	• Patient profile tables (ZIP, 3A, 3B, 4) • Visits on **Table 5** • Services on **Table 6A** • Charges/revenue on **Table 9D**	• Staffing on **Table 5** • Costs on **Table 8A**	• Staffing on **Table 5** • Selected diagnoses and services on **Table 6A** • Costs on **Table 8A**	• Patient-related revenue on **Table 9D** • Non-patient-related revenue on **Table 9E**

As Always, This Is All Interrelated!



Step 1: Determine what sites/locations and services are in-scope (sites: Form 5B, services: Form 5A).

Step 2: Determine which patients had visits for in-scope services that were real-time, documented in the patient record, with a provider exercising independent professional judgement at those in-scope sites/locations.

Step 3: Report all in-scope patients, services, FTEs, costs, and revenues on the UDS.

HRSA Health Center Program

ZIP Code Table, Tables 3A, 3B, and 4: The Patient Profile, Understanding Who You Are Serving

2020 Changes: Addition of an "Unknown" category in the sexual orientation and gender identity section of Table 3B

Patients

- **Patient:** A person who has at least one *countable* visit in one or more service category during the reporting year.
- In the patient profile tables (ZIP Code Table and Tables 3A, 3B, and 4), each person counts once regardless of the number of visits or services received.

ZIP Code Table

- Report total patients by ZIP Code of residence and primary medical insurance.
- List ZIP Codes with 11 or more patients in Column A.
  - Aggregate ZIP Codes with 10 or fewer patients as “other.”
- Total patients’ ZIP Code by insurance must equal counts on Table 4.
- Use local address for migratory agricultural workers and people from other countries residing in the U.S.; use clinic address for persons experiencing homelessness if no other address.

ZIP Code (a)	None/ Uninsured (b)	Medicaid/ CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
03824	5	4	2	1	12
<system allows insertion of rows for more ZIP codes>					
Other ZIP Codes					
Unknown Residence					
Total	5	4	2	1	12

HRSA Health Center Program

Patients by Age and Sex at Birth

Table 3A

- Report total patients by age and sex at birth or as reported on birth certificate.
  - Use age as of June 30.
  - Patients by age must equal Table 4 insurance by age groups (0–17 years old and 18 and older).

Line	Age Groups	Male Patients (a)	Female Patients (b)
1	Under age 1		
…	…	…	…
7	Age 6		1
8	Age 7		
9	Age 8		1
10	Age 9		
11	Age 10	5	
12	Age 11		
13	Age 12		1
16	Age 15	1	1
17	Age 16		1
18	Age 17		
…	…	…	…
23	Age 22	1	
39	Total Patients (Sum lines 1-38)	7	5

HRSA Health Center Program

Ethnicity, Race, and Language

Table 3B

Line	Patients by Race	Hispanic or Latino/a (a)	Non-Hispanic or Latino/a (b)	Unreported/Refused to Report Ethnicity (c)	Total (d) (Sum Columns a+b+c)
1	Asian		1		1
2a	Native Hawaiian				
2b	Other Pacific Islander				
2	Total Native Hawaiian/Other Pacific Islander (Sum Lines 2a+2b)				
3	Black/African American	3	1		4
4	American Indian/Alaska Native				
5	White	2	4		6
6	More than one race				
7	Unreported/refused to report race	1			1
8	**Total Patients** (Sum of Lines 1 + 2 + 3 to 7)	6	6		12

Line	Patients Best Served in a Language Other than English	Number (a)
12	Patients Best Served in a Language Other than English	4

- Report total patients by ethnicity and race.
  - This is self-reported by patients or caregivers.
  - If race is known, but ethnicity is not, report in Column B.
  - If patients select multiple races, report as “more than one race.”
  - Only report patients with unknown race and unknown ethnicity on line 7, Column C.
- Report patients best served in a language other than English on Line 12.

Sexual Orientation and Gender Identity (SOGI)

Table 3B

Line	Patients by Sexual Orientation	Number (a)
13	Lesbian or Gay	2
14	Heterosexual (or straight)	8
15	Bisexual	
16	Something else	
17	Don't know	1
18	Chose not to disclose	1
18a	Unknown	3
19	**Total Patients** (Sum of Lines 13 to 18a)	15
Line	**Patients by Gender Identity**	**Number (a)**
20	Male	3
21	Female	7
22	Transgender Man/Transgender Male	
23	Transgender Woman/Transgender Female	
24	Other	1
25	Chose not to disclose	1
25a	Unknown	3
26	**Total Patients (**Sum of Lines 20 to 25a)	15

Report total patients by Sexual Orientation and Gender Identity (self-reported by patients or caregivers).

- **Something else (Line 16)/Other (Line 24):** Patients who do not identify with other available categories, such as:
  - ✓ Genderqueer or non-binary for gender identity,
  - ✓ Asexual or pansexual for sexual orientation.
- **Chose not to disclose (Lines 18 and 25):** Patients who choose not to disclose their sexual orientation or gender identity.
- **Unknown (Lines 18a and 25a):** Sexual orientation or gender identity is unknown *to the health center*; it is not collected or unable to be captured in systems.

HRSA Health Center Program

Income and Insurance

Table 4

Line	Income as a Percent of Poverty Guideline	Number of Patients
1	100% and below	**7**
2	101–150%	**1**
3	151–200%	**1**
4	Over 200%	**1**
5	Unknown	**2**
6	**TOTAL** (Sum of Lines 1–5)	**12**

Line	Principal Third-Party Medical Insurance	0-17 years old (a)	18 and older (b)
7	**None/Uninsured**	**1**	**1**
8a	Medicaid (Title XIX)	blank	**1**
8b	CHIP Medicaid	**1**	
8	**Total Medicaid** (Line 8a + 8b)	**1**	**1**
9a	**Medicare** (Inclusive of dually eligible and other Title XVIII beneficiaries)		
9	Other Public Insurance (Non-CHIP) (specify ____)	blank	**2**
10a	Other Public Insurance CHIP	**1**	
10b	**Total Public Insurance** (Line 10a + 10b)	blank	blank
11	**Private Insurance**	**1**	
12	**TOTAL** (Sum of Lines 7 + 8 + 9 + 10 + 11)	**4**	**1**

- Lines 1–4: Patients by income
  - Use income based on federal poverty guidelines.
    - ✓ Use most recent income data within 12 months prior to the most recent calendar year visit.
    - ✓ This can be based on documents submitted or self-reported per Board policy (consistent with the Health Center Program Compliance Manual).
    - ✓ Do not use insurance or special population status as proxy for income.
- Line 5: Unknown income
- Lines 7–11: Patients by primary medical insurance
  - Use medical insurance at last visit.
  - Patients by insurance and age must equal detail on ZIP Code Table and Table 3A.

Insurance Categories

Table 4

- **None/Uninsured:** Patient had no medical insurance at last visit (includes uninsured patients for whom the health center may be reimbursed through grant, contract, or uncompensated care fund)
- **Medicaid (Title XIX):** Medicaid and Medicaid-managed care programs, including those administered by commercial insurers
- **CHIP Medicaid OR Other Public Insurance CHIP**:
  - If CHIP paid by Medicaid, report on 8b.
  - If CHIP reimbursed by commercial carrier outside of Medicaid, report on 10b.
- **Dually Eligible (Medicare and Medicaid):** Subset of Medicare patients who also have Medicaid coverage
- **Medicare:** Include Medicare, Medicare Advantage, and Dually Eligible
- **Other Public Insurance (Non-CHIP) (specify):** State and/or local government insurance that covers a broad set of services; NOT grant programs reimbursing limited benefits (e.g., EPSDT, BCCCP)
- **Private Insurance:** Commercial insurance such as that purchased in whole or in part by employer, insurance purchased for public employees or retirees, or insurance purchased on the federal or state exchanges

Line	Principal Third-Party Medical Insurance
7	**None/Uninsured**
8a	Medicaid (Title XIX)
8b	CHIP Medicaid
8	**Total Medicaid** (Line 8a + 8b)
9a	**Medicare** (Inclusive of dually eligible and other Title XVIII beneficiaries)
9	Other Public Insurance (Non-CHIP) (specify ____)
10a	Other Public Insurance CHIP
10b	**Total Public Insurance** (Line 10a + 10b)
11	**Private Insurance**
12	**TOTAL** (Sum of Lines 7 + 8 + 9 + 10 + 11)

HRSA Health Center Program

Managed Care
Table 4

- Managed Care Organizations (MCOs) have different names (e.g., MCOs, Health Maintenance Organization, Accountable Care Organization, Coordinated Care Organization).
- MCOs may have multiple plans with different payers (e.g., Medicaid, private).
- Health center receives or can go online to request/download a monthly enrollment list of patients in the managed care plan.
- Patients are in managed care if they must receive all their primary care from the health center itself.
- MCOs may include financial risk.

Line	Managed Care Utilization	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	TOTAL (e)
13a	Capitated Member Months					
13b	Fee-for-service Member Months					
13c	**Total Member Months** (Sum of Lines 13a + 13b)					

Does your state have managed care?

Yes. | No. | Not sure.

Managed Care Utilization
Table 4 (and Table 9D)

Report the sum of monthly enrollment for 12 months by type of insurance

A member month = **one member enrolled for 1 month**

Complete only for managed care contracts where the patient must go to health center for their primary care. Include:

Capitated plans: For a flat payment per month, services from a negotiated list are provided to patients

Fee-for-Service plans: Paid according to the fees established for primary care and other services rendered

There is generally a relationship between:

Member months on Table 4

Example: 36,788 Medicaid member months ÷ 12 = 3,066

Insurance categories on Table 4

Example: 4,174 Medicaid patients

Managed care lines on Table 9D

Example: Medicaid net capitation $1,044,850 ÷ member months 36,788 = $28

HRSA Health Center Program

IMPORTANT KEY:

Income, insurance, and managed care reporting on Table 4 ties closely to patient revenue on Table 9D

We will discuss Table 9D later!

Considerations When Reporting Income- and Insurance-Related Data

Table	Description
Table 4 Table 9D	Review the reporting if the percentage of patients with unknown income on Table 4 is high when compared to sliding fee discounts reported on Table 9D.
Table 4	Follow up with managed care contracts for enrollment data if missing for managed care contracts. Collect monthly enrollment for the full year.
Table 4	Understand the level of coverage for adults under CHIP when a large percentage of adults are reported on the CHIP line.

Special Populations

Table 4

- **All health centers report Lines 16, 23, 24, 25, and 26.**
- **MHC Awardees**
  - Report migratory (**Line 14**–temporary home) and seasonal (**Line 15**).
- **HCH Awardees**
  - Report (**Lines 17–22**) where individuals who experience homelessness are housed as of first visit during reporting year.

Line	Special Populations	Number of Patients (a)
14	Migratory (330g awardees only)	
15	Seasonal (330g awardees only)	
16	**Total Agricultural Workers or Dependents** (All health centers report on this line)	
17	Homeless Shelter (330h awardees only)	
18	Transitional (330h awardees only)	
19	Doubling Up (330h awardees only)	
20	Street (330h awardees only)	
21a	Permanent Supportive Housing (330h awardees only)	
21	Other (330h awardees only)	
22	Unknown (330h awardees only)	
23	**Total Homeless** (All health centers report on this line)	1
24	**Total School-Based Health Center Patients** (All health centers report on this line)	
25	**Total Veterans** (All health centers report on this line)	1
26	**Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site** (All health centers report on this line)	

Special Populations Resources: HRSA-funded National TTA Partners

Tips for Patient Profile (ZIP, 3A, 3B, and 4)

DO…

- ✓ Roll up data into the UDS categories if you collect race and ethnicity or SOGI data in more granular detail than the UDS.
- ✓ Report all patients by income on Table 4.
  - ✓ Patient income can be self-reported if consistent with the health center's board-approved policies and procedures.
  - ✓ If patient reports 0 income, then they are reported at below 100% (Line 1). If unknown, report as unknown (Line 5).
- ✓ Ensure demographic information is updated regularly in accordance with UDS manual.
- ✓ Collect special population information, even if you do not have a special population grant.

DON'T…

- ⃠ Include patients on the demographic tables (ZIP, 3A, 3B, and 4) who have not had a reported visit on Table 5.
- ⃠ Submit without double checking all tables align—for example, age across Table 3A and insurance on Table 4, and primary medical insurance across ZIP Table and Table 4.
- ⃠ Report patients with unknown medical insurance as uninsured on ZIP Table and Table 4; Be sure to collect medical insurance information!

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Considerations When Reporting Patient-Related Data

Table	Description
ZIP Code	Don’t type the word “Other” as a ZIP Code. Report the count in the already available “Other” field.
ZIP Code Table 4	Report Medicaid, CHIP, and Other Public together on the ZIP Code Table, but on separate lines on Table 4.
Table 3B	Be sure patients whose sexual orientation or gender identity is unknown, meaning not collected, are reported on the new “Unknown” lines.
Table 4	“Public Housing” reporting is location based.

Reporting Services and Quality of Care Indicators

Tables 5, 6A, 6B, and 7

Table 5: Staffing and Utilization

2020 Changes: No major changes to reporting

Full Time Equivalent (FTE) by Provider Type

Table 5

- Report all staff who support in-scope operations.
  - Include employees, interns, volunteers, residents, and contracted staff.
  - Do not include paid referral provider FTEs when paid by service (not by hours).
- Report staff by function and credentials.
  - Staff time can be allocated across multiple lines.
  - Clinicians should be reported on their line of credentialing.
  - Appendix A in the UDS Reporting Instructions is a helpful tool that can be used to classify personnel.
- Report FTE: 1 FTE = 1 person full-time for entire year.
  - "Full-time" is defined by the health center.
  - Employment contract for clinicians
  - Staff FTE can exceed 1.0 FTE *if paid overtime*.

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b)	Patients (c)
1	Family Physicians	.25	10	2	
…	…	…	…		
5	Pediatricians	1.0	12	1	
7	Other Specialty Physicians				
8	**Total Physicians (Sum lines 1-7)**	1.25	22	3	
9a	Nurse Practitioners	.6	3		
9b	Physician Assistants				
10	Certified Nurse Midwives				
10a	**Total NP, PA, and CNMs (Sum lines 9a - 10)**	.6	3		
11	Nurses	3.0			
12	Other Medical Personnel				
13	Laboratory Personnel	1.0			
14	X-Ray Personnel				
15	**Total Medical (Sum lines 8+10a through 14)**	5.85	25	3	10
16	Dentists		5		
17	Dental Hygienists		4		
17a	Dental Therapists				
18	Other Dental Personnel				
19	**Total Dental Services (Sum lines 16-18)**		9		5
…	…	…	…		…
24	Case Managers	2.4	6		
25	Patient/Community Education Specialists				
26	Outreach Workers				
27	Transportation Staff				
27a	Eligibility Assistance Workers	0.3			
27b	Interpretation Staff	0.3			
27c	Community Health Workers				
28	Other Enabling Services (specify__)				
29	**Total Enabling Services (Sum lines 24-28)**	3.0	6		1
29a	**Other Programs/Services (specify__)**				
29b	**Quality Improvement Staff**				
30a	Management and Support Staff	2.5			
30b	Fiscal and Billing Staff	1.5			
30c	IT Staff	0.5			
31	Facility Staff				
32	Patient Support Staff	3.0			
33	**Total Facility and Non-Clinical Support Staff (Sum lines 30a - 32)**	7.5			
34	**Grand Total (Sum lines 15+19+20+21+22+22d+23+29+29a+29b+33)**	16.35	40	3	

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Example: Calculate FTE

Employees with full benefits*

One full-time staff person worked for 6 months of the year:

1. Calculate base hours for full-time:

   Total hours per year:

   40 hours/week x 52 weeks = 2,080 hours

2. Calculate this staff person's paid hours:

   Total hours for 6 months:

   40 hours/week x 26 weeks = 1,040 hours

3. Calculate FTE for this person:

   1,040 hours/2,080 hours = **0.50 FTE**

Employees with no or reduced benefits*

Four individuals worked 1,040 hours scattered throughout the year:

1. Calculate base hours for full-time:

   Total hours per year:

   40 hours/week x 52 weeks = 2,080 hours

2. Deduct benefits: (10 holidays, 12 sick days, 5 continuing medical education [CME] days, and 3 weeks vacation)

   10 + 12 + 5 + 15 = 42 days x 8 hours = 336

   2,080 – 336 = 1,744

3. Calculate combined person hours:

   Total hours: 1,040 hours

4. Calculate FTE:

   1,040 hours/1,744 hours = **0.60 FTE**

*Benefits defined as vacation/holidays/sick benefits

Reporting FTEs During COVID-19

- **Defining key terms related to reporting FTE on Table 5 during COVID-19.**
  - Furlough
  - Family and Medical Leave Act (FMLA)
  - Disability
  - Volunteer

Source: Pexels

IMPORTANT KEY:

FTE reporting on Table 5 ties closely to costs on Table 8A.

We will discuss Table 8A later!

Defining a Visit

- Documented
- One-on-one *(either in-person or virtual)*
- Licensed/credentialed provider
- With a provider who exercises independent and professional judgement
  - Group visits are only countable for behavioral health.
  - Clinic and virtual visits are allowable for each of the service categories.

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Reporting Visits During COVID-19

- **UDS definitions of reportable patient visits remain in effect for the 2020 UDS Report.**
  - If an individual is screened or tested for COVID-19, but the health center *does not* provide additional services that meet the criteria of a reportable visit, this person and visit are not reported in the UDS Report.
  - If an individual is screened or tested for COVID-19 *and* the health center provides additional services that meet the criteria of a reportable visit, this patient and visit are reported in the UDS Report.

Source: Pexels

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Counting Multiple Visits

- On any given day, a patient may have only one visit per service category per provider counted on the UDS.
  - Service categories include medical, dental, mental health, substance use disorder, other professional, vision, and enabling.
- If multiple providers in a single service category deliver multiple services at the *same location* on a single day, count only one visit.
- If services are provided by *two different providers* located at *two different sites* on the same day, count two visits.
  - A virtual visit and a clinic visit are considered to be two different sites and may both be counted as visits even when they occur on same day.

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Contacts That Do Not, ALONE, Count as Visits

Screenings or Outreach	Group Visits	Tests/Ancillary Services	Dispensing/ Administering Medications	Health Status Checks
Information sessions for prospective patients	Patient education classes	Drawing blood	Dispensing medications from a pharmacy	Follow-up tests or checks (e.g. patients returning for HbA1c tests)
Health presentations to community groups	Health education classes	Laboratory or diagnostic tests	Giving injections	Wound care
Immunization drives	*Exception: behavioral health group visits*	COVID-19 tests	Providing narcotic agonists or antagonists or a mix	Taking health histories

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Locations of Visits

Table 5

- Visits must be provided at the health center site or at another approved location.
  - Count visits provided by both paid and volunteer staff.
  - Count virtual visits.
  - Include paid referral visits.
  - Count when following current patients in a nursing home, hospital, or at home.
    - ✓ Do not count if patient is first encountered at these locations unless the site is listed on Form 5B as being in your approved scope.

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1	Family Physicians				
2	General Practitioners				
3	Internists				
4	Obstetrician/Gynecologists				
5	Pediatricians				
7	Other Specialty Physicians				
8	**Total Physicians** (Lines 1–7)				
9a	Nurse Practitioners				
9b	Physician Assistants				
10	Certified Nurse Midwives				
10a	**Total NPs, PAs, and CNMs** (Lines 9a–10)				

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Location of Visits: Clinic

Table 5

- Clinic Visits (Column B): Report documented *in-person contact* between a patient and a licensed or credentialed provider who exercises their independent, professional judgment in the provision of services to the patient.

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1	Family Physicians				
2	General Practitioners				
3	Internists				
4	Obstetrician/Gynecologists				
5	Pediatricians				
7	Other Specialty Physicians				
8	**Total Physicians** (Lines 1–7)				
9a	Nurse Practitioners				
9b	Physician Assistants				
10	Certified Nurse Midwives				
10a	**Total NPs, PAs, and CNMs** (Lines 9a–10)				

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Location of Visits: Virtual

Table 5

- Virtual visits (Column B2): Report documented *virtual (telemedicine) contact* between a patient and a licensed or credentialed provider who exercises their independent, professional judgment in the provision of services to the patient.
- Must be provided using interactive, synchronous audio and/or video telecommunication systems that permit real-time communication between the provider and a patient.
  - "Store and forward" methods or other asynchronous contacts are not countable.

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1	Family Physicians				
2	General Practitioners				
3	Internists				
4	Obstetrician/Gynecologists				
5	Pediatricians				
7	Other Specialty Physicians				
8	**Total Physicians** (Lines 1–7)				
9a	Nurse Practitioners				
9b	Physician Assistants				
10	Certified Nurse Midwives				
10a	**Total NPs, PAs, and CNMs** (Lines 9a–10)				

View the Virtual Visits guidance file here.

Two Telehealth Situations That May Be New

Virtual Visits: Health center is not the originating site

Example: For the telehealth visit, patient is at home while the provider is in the clinic or at their own home. The visit is for in-scope services.

Virtual Visits: Audio-only visits

Example: Patient has flu symptoms and has an initial telehealth assessment scheduled, but does not have broadband at home, so needs a telephone visit. The provider has an audio-only phone visit with the patient.

- To be counted as a visit, the interaction must **be real-time video and/or audio**.
- It is important to note that reporting also **requires proper coding** of telehealth (e.g., use of 95 modifier or POS 02).
- Providers need to have **access to patient records** (EHR) and document in the patient record.
- The patient must be registered and **all relevant demographic, insurance, clinical, and other data about the patient must be collected**.
- The patient must be included on clinical tables, if measure population criteria is met.

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Discussion: What Counts as a Virtual Visit?

Examples of Type of Service	Counts	Does Not Count
Health center provider provides in-scope services via telemedicine/telehealth to a patient not physically present at the same location as the provider.		
Health center provider provides out-of-scope services via telemedicine/telehealth to a patient not physically present at the same location as the provider.		
A non-health center provider not physically present at the health center provides services to a patient at the health center through telemedicine/telehealth, and the health center covers the cost of the services by the provider.		
A non-health center provider not physically present at the health center provides services to a patient at the health center through telemedicine/telehealth, and the health center does not pay for the services.		
A provider at the health center confers with a provider at a different health center via video chat regarding a patient's care.		
A patient and a provider discuss a patient's health concerns via a secure email through the EHR.		
A staff member at the health center takes a photograph of a patient's skin condition and sends it through the portal to a provider not physically present at the health center for diagnosis.		
Interaction is not coded or charged as telemedicine/telehealth services.		

*Table assumes that interactions meet the other criteria of a visit (e.g., documented, conducted by a provider who exercises independent and professional judgement).

What Counts as a Virtual Visit?

Examples of Type of Service	Counts	Does Not Count
Health center provider provides in-scope services via telemedicine/telehealth to a patient not physically present at the same location as the provider.	X	
Health center provider provides out-of-scope services via telemedicine/telehealth to a patient not physically present at the same location as the provider.		X
A non-health center provider not physically present at the health center provides services to a patient at the health center through telemedicine/telehealth, and the health center covers the cost of the services by the provider.	X	
A non-health center provider not physically present at the health center provides services to a patient at the health center through telemedicine/telehealth, and the health center does not pay for the services.		X
A provider at the health center confers with a provider at a different health center via video chat regarding a patient's care.		X
A patient and a provider discuss a patient's health concerns via a secure email through the EHR.		X
A staff member at the health center takes a photograph of a patient's skin condition and sends it through the portal to a provider not physically present at the health center for diagnosis.		X
An interaction is not coded or charged as telemedicine/telehealth services.		X

*Table assumes that interactions meet the other criteria of a visit (e.g., documented, conducted by a provider who exercises independent and professional judgement).

Patients and Visits by Service and Provider Type

Table 5

Visits (b and b2)	Patients (c)
Count clinic and virtual visits that meet definition ▪ Not all staff generate visits ▪ Not all contacts = visits ▪ A single visit may consist of multiple services, but counts as only one Report in column (b) or (b2) by service provider	Unduplicated count of patients by service category ▪ Same person can receive multiple services ▪ Sum of patients by service ≠ total patients Report in column (c) by service category

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1	Family Physicians				
2	General Practitioners				
3	Internists				
4	Obstetrician/Gynecologists				
5	Pediatricians				
7	Other Specialty Physicians				
8	Total Physicians (Lines 1–7)				
9a	Nurse Practitioners				
9b	Physician Assistants				
10	Certified Nurse Midwives				
10a	Total NPs, PAs, and CNMs (Lines 9a–10)				
11	Nurses				
12	Other Medical Personnel				
13	Laboratory Personnel				
14	X-ray Personnel				
15	Total Medical (Lines 8 + 10a through 14)				
16	Dentists				
17	Dental Hygienists				
17a	Dental Therapists				
18	Other Dental Personnel				
19	Total Dental Services (Lines 16–18)				
20a	Psychiatrists				
20a1	Licensed Clinical Psychologists				
20a2	Licensed Clinical Social Workers				
20b	Other Licensed Mental Health Providers				
20c	Other Mental Health Staff				
20	Total Mental Health (Lines 20a-20c)				
*	***Excerpt from Table 5***				

Table 5: Completing the Selected Service Detail Addendum

2020 Changes: No major changes to reporting

Addendum Captures Integrated Behavioral Health

The addendum reflects integrated behavioral health provided by the health center by:

- Capturing data on **mental health (MH) services** provided by medical providers
- Capturing data on **substance use disorder (SUD) services** provided by medical providers *and* MH providers
- Together with services/visits reported in the main part of Table 5, providing an ***unduplicated count*** of MH and SUD services across all provider types

Line	Personnel by Major Service Category: Mental Health Service Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
20a01	Physicians (other than Psychiatrists)				
20a02	Nurse Practitioners				
20a03	Physician Assistants				
20a04	Certified Nurse Midwives				
Line	**Personnel by Major Service Category: Substance Use Disorder Detail**	**Personnel (a1)**	**Clinic Visits (b)**	**Virtual Visits (b2)**	**Patients (c)**
21a	Physicians (other than Psychiatrists)				
21b	Nurse Practitioners (Medical)				
21c	Physician Assistants				
21d	Certified Nurse Midwives				
21e	Psychiatrists				
21f	Licensed Clinical Psychologists				
21g	Licensed Clinical Social Workers				
21h	Other Licensed Mental Health Providers				

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Reporting Personnel in Addendum

- In Column A1, report the ***number*** of providers by type of MH and/or SUD services.
  - Medical providers can be counted once in each section if they provide both MH and SUD services.

The addendum documents *number* of personnel. Do not report FTEs in the addendum.

Providers contracted on a fee-for-service basis should be counted in addendum (but FTE will not be in the main part of Table 5).

Line	Personnel by Major Service Category: Mental Health Service Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
20a01	Physicians (other than Psychiatrists)				
20a02	Nurse Practitioners				
20a03	Physician Assistants				
20a04	Certified Nurse Midwives				

Line	Personnel by Major Service Category: Substance Use Disorder Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
21a	Physicians (other than Psychiatrists)				
21b	Nurse Practitioners (Medical)				
21c	Physician Assistants				
21d	Certified Nurse Midwives				
21e	Psychiatrists				
21f	Licensed Clinical Psychologists				
21g	Licensed Clinical Social Workers				
21h	Other Licensed Mental Health Providers				

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Determining Visits to Include in Addendum

Include, *at minimum*, all countable visits with providers included in **Table 5, Column A1**, with International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes:

- SUD: Table 6A, Lines 18–19a
- MH: Table 6A, Lines 20a–20d

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
Selected Mental Health Conditions, Subs tance Use Disorders, and Exploitations				
18	Alcohol-related disorders	F10-, G62.1, O99.31-		
19	Other substance-related disorders (excluding tobacco use disorders)	F11- through F19- (exclude F17-), G62.0, O99.32-		
19a	Tobacco use disorder	F17-, O99.33-		
20a	Depression and other mood disorders	F30- through F39-		
20b	Anxiety disorders, including post-traumatic stress disorder (PTSD)	F06.4, F40- through F42-, F43.0, F43.1-, F93.0		
20c	Attention deficit and disruptive behavior disorders	F90- through F91-		
20d	Other mental disorders, excluding drug or alcohol dependence	F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0- and F43.1-), F50- through F99- (exclude F55-, F84.2, F90-, F91-, F93.0, F98-), O99.34-, R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0		

Determining Visits to Include in Addendum *(Cont.)*

Table 6A

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
	Selected Mental Health Conditions, Substance Use Disorders, and Exploitations			
18	Alcohol-related disorders	F10-, G62.1, O99.31-		
19	Other substance-related disorders (excluding tobacco use disorders)	F11- through F19- (exclude F17-), G62.0, O99.32-		
19a	Tobacco use disorder	F17-, O99.33-		
20a	Depression and other mood disorders	F30- through F39-		
20b	Anxiety disorders, including post-traumatic stress disorder (PTSD)	F06.4, F40- through F42-, F43.0, F43.1-, F93.0		
20c	Attention deficit and disruptive behavior disorders	F90- through F91-		
20d	Other mental disorders, excluding drug or alcohol dependence	F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0- and F43.1-), F50- through F99- (exclude F55-, F84.2, F90-, F91-, F93.0, F98-), O99.34-, R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0		

Addendum

Line	Personnel by Major Service Category: Mental Health Service Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
20a01	Physicians (other than Psychiatrists)				
20a02	Nurse Practitioners				
20a03	Physician Assistants				
20a04	Certified Nurse Midwives				

Line	Personnel by Major Service Category: Substance Use Disorder Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
21a	Physicians (other than Psychiatrists)				
21b	Nurse Practitioners (Medical)				
21c	Physician Assistants				
21d	Certified Nurse Midwives				
21e	Psychiatrists				
21f	Licensed Clinical Psychologists				
21g	Licensed Clinical Social Workers				
21h	Other Licensed Mental Health Providers				

Reporting MH/SUD Treatment Provided as Part of Medical Visits in the Addendum

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1	Family Physicians				
2	General Practitioners				
3	Internists				
4	Obstetrician/Gynecologists				
5	Pediatricians				
7	Other Specialty Physicians				
8	**Total Physicians** (Lines 1–7)				
9a	Nurse Practitioners				
9b	Physician Assistants				
10	Certified Nurse Midwives				
10a	**Total NPs, Pas, and CNMs** (Lines 9a–10)				
11	Nurses				
12	Other Medical Professional				
13	Laboratory Personnel				
14	X-ray Personnel				
15	**Total Medical Care Services** (Lines 8 + 10a through 14)				

Line	Personnel by Major Service Category: Substance Use Disorder Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
21a	Physicians (other than Psychiatrists)				
21b	Nurse Practitioners (Medical)				
21c	Physician Assistants				
21d	Certified Nurse Midwives				

Medical FTEs, Visits, and Patients are reported in Lines 1–15 of the main part of Table 5.

Corresponding providers, visits, and patients may ***also*** be reported on the MH/SUD addendum ***if/when*** MH or SUD services were provided.

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Reporting SUD Treatment Provided as Part of MH Visits in the Addendum

Mental health FTEs, Visits, and Patients are reported on Lines 20a–20 of the main part of Table 5. These mental health staff, visits, and patients may **also** be reported on the addendum, ***if/when*** SUD treatment were provided.

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
20a	Psychiatrists				
20a1	Licensed Clinical Psychologists				
20a2	Licensed Clinical Social Workers				
20b	Other Licensed Mental Health Providers				
20c	Other Mental Health Staff				
20	**Total Mental Health Services** (Lines 20a–c)				
21	**Substance Use Disorder Services**				

Line	Personnel by Major Service Category: Substance Use Disorder Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
21a	Physicians (other than Psychiatrists)				
21b	Nurse Practitioners (Medical)				
21c	Physician Assistants				
21d	Certified Nurse Midwives				
21e	Psychiatrists				
21f	Licensed Clinical Psychologists				
21g	Licensed Clinical Social Workers				
21h	Other Licensed Mental Health Providers				

Line 21 in main part of Table 5 fully captures **SUD FTEs, Visits, and Patients** (do not report in addendum).

Considerations When Reporting Virtual Visits and MH/SUD Addendum Data

Table	Description
Table 5	Be sure virtual visits reported are coded as such and used interactive, synchronous audio and/or video telecommunication systems that permit real-time communication between the provider and a patient, and the interaction otherwise meets the definition of a visit. (Not all interactions are visits.)
Table 5	Check for accuracy if reporting more visits in the addendum than the main part of table 5 for a given provider type. For example, more visits reported in *SUD addendum for psychiatrists* (Line 21e) than there are total *mental health visits on the main part of Table 5* (Line 20).
Table 5	Be sure the addendum only reflects activity already reported as part of a visit on the main portion of Table 5. The addendum only includes MH/SUD treatment provided by medical or MH providers not already reported as part of an existing MH or SUD visit on the main part of Table 5.

Resources to Support Table 5 Reporting

- UDS Training Website
  - Virtual Visit Reporting Handout
  - Mental Health/Substance Use Disorder Services Detail Handout
  - Nurse Visit Guidance Handout
  - UDS Reporting Instructions Appendix A: Listing of Personnel (pages 130–134)
- Telehealth Resource Centers: 12 HRSA-supported regional and 2 national centers (including the Center for Connected Health Policy) provide expert and customizable technical assistance, advice on telehealth technology and state-specific regulations and policies such as Medicaid or private payers as well as Medicare
- HRSA BPHC COVID-19 Frequently Asked Questions (FAQs): UDS Reporting and Telehealth
- Centers for Medicare & Medicaid Services: Telehealth: Provides Medicare telehealth services definitions

HRSA Health Center Program

Table 6A: Selected Diagnoses and Services Rendered

2020 Changes:

- Seven new rows added: four COVID-19 related, one PrEP, and two exploitation-related
- Clarification of what services should be captured on Table 6A

Selected Diagnoses and Services

Table 6A

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
	Selected Infectious and Parasitic Diseases			
1-2	Symptomatic/Asymptomatic human immunodeficiency virus (HIV)	B20, B97.35, O98.7-, Z21		
3	Tuberculosis	A15- through A19-, O98.0-		
4	Sexually transmitted infections	A50- through A64-		
4a	Hepatitis B	B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.1-, O98.4-		
4b	Hepatitis C	B17.1-, B18.2, B19.2-		
4c	Novel coronavirus (SARS-CoV-2) disease	U07.1		

Excerpted from Table 6A

- Only report services/diagnoses if part of (or ordered at) a countable visit.
- Column A: Report the number of **visits** with the selected service or diagnosis.
  - If a patient has more than one reportable service or diagnosis during a visit, count each.
  - Do not count multiple services of the same type at one visit (e.g., two immunizations, two fillings).
  - Resource: Code Changes Handout.
- Column B: Report the number of unduplicated patients receiving the service.

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New Reporting on Table 6A

Seven NEW rows

- **Line 4c:** Novel coronavirus (SARS-CoV-2) disease
- **Line 6a:** Acute respiratory illness due to novel coronavirus (SARS-CoV-2) disease
- **Line 20e:** Human trafficking
- **Line 20f:** Intimate partner violence
- **Line 21c:** Novel coronavirus (SARS-CoV-2) diagnostic test
- **Line 21d:** Novel coronavirus (SARS-CoV-2) antibody test
- **Line 21e:** Pre-Exposure Prophylaxis (PrEP) associated management of all PrEP patients

Table 6A Changes Handout: https://bphcdata.net/wp-content/uploads/2020/06/Table6AChanges.pdf

Key Notes for Table 6A

- Column A describes the total number of visits, at which the service/test/diagnosis was present and coded, to the patients in Column B.
- **Only report tests or procedures that are**
  - **performed by the health center**, or
  - not performed by the health center, but **paid for by the health center**, or
  - not performed by the health center or paid for by the health center, **but whose results are returned to the health center provider to evaluate and provide results to the patient**.

Note that all reporting on Table 6A is only for health center patients.

- This does not include mass testing/screening, tests done for the community, etc.
- Patient must have a *countable* visit on Table 5 and be included in unduplicated patients on demographic tables in order to be counted on Table 6A.

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Tables 6B and 7: Clinical Quality Measures (CQMs)

2020 Changes:

- One measure removed
- Two measures with major changes
- Three new measures
- Measures revised to align with CMS eCQMs

ZIP Table
Table 3A
Table 3B
Table 4
Table 5
Table 6A
Table 6B
Table 7
Table 8A
Table 9D
Table 9E
Forms

To learn more about how these measures align with other national reporting, please visit *UDS CQMs and National Programs Crosswalk* on pages 188–189 in the CY2020 UDS Manual.

Clinical Process and Outcome Measures

Tables 6B and 7

Screening and Preventive Care
Cervical Cancer Screening
Breast Cancer Screening
Body Mass Index (BMI) Screening and Follow-up Plan
Tobacco Use: Screening and Cessation Intervention
Colorectal Cancer Screening
HIV Screening
Screening for Depression and Follow-Up Plan

Maternal Care and Children's Health
Early Entry into Prenatal Care
Low Birth Weight
Childhood Immunization Status
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
Dental Sealants for Children between 6-9 Years

Chronic Disease Management
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet
HIV Linkage to Care
Depression Remission at Twelve Months
Controlling High Blood Pressure
Diabetes: Hemoglobin A1c (HbA1c) Poor Control

General Reminders for Clinical Quality Measures

- *For all measures except the one dental measure*, **all patients who had one or more medical visits (including virtual medical visits)** are eligible for inclusion in the measure according to definitions in the CQM and the 2020 UDS Reporting Instructions.
- Be sure to use the **birthdates specified in the 2020 UDS Reporting Instructions**, which align with the patient's age before the start of the reporting year.
- In order to **ensure data are accurate**, it is important to:
  - Ensure that systems are configured to capture and report new data elements, including updating EHR, installing patches, updating modules, etc.
  - Work with vendors to ensure systems have been updated with required specifications.
  - Validate your data to ensure that workflows are successfully capturing data.
  - Educate affected staff regarding any changes, as appropriate.

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Telehealth and Clinical Quality Measures

- **General Rule (which is notably relevant during COVID-19):**
  - ***If*** the telehealth visit meets a specific CQM's denominator and/or numerator definition, specifications, and UDS virtual visit definition as written in the eCQM and UDS Manual, ***then*** it may be counted toward the measure.
    - ✓ Telehealth Impact on 2020 UDS Clinical Measures Resource
  - Each eCQM is ***defined by the specified measure steward,*** and the UDS Report aligns with their instruction for inclusion (or removal) of telehealth in the evaluation of each component (denominator, exclusion, and numerator).
    - ✓ 2020 UDS Clinical Quality Measures Criteria
    - ✓ Measure steward for each measure can be found in Appendix G of the UDS Manual, pages 188-189

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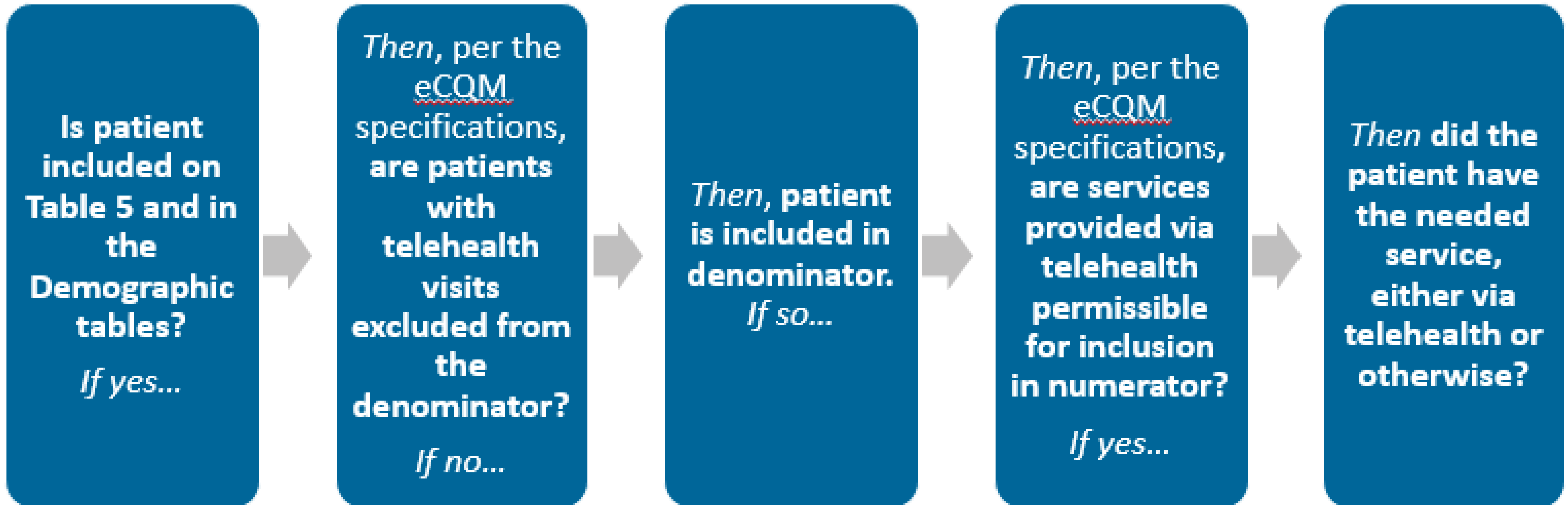
Assessing Telehealth in Clinical Quality Measures



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Clinical Process and Outcome Measures

Table 6B Format

Format: Measure Name				
Line	Measure Name	Denominator (Universe) (a)	Number Charts Sampled or EHR total (b)	Numerator (c)
#	Measure Description	All eligible patients (N)	N, 70, or (80^{+}%)N	# in (b) that meet standard

Example: Section C - Childhood Immunization Status				
Line	Childhood Immunization Status	Total Patients with 2nd Birthday (a)	Number Charts Sampled or EHR total (b)	Number of Patients Immunized (c)
10	MEASURE: Percentage of children 2 years of age who received age-appropriate vaccines by their 2nd birthday	100	93	75

Measure Description	Describes the quantifiable indicator to be evaluated
Denominator (Universe)	Patients who fit the detailed criteria described for inclusion in the measure
Numerator	Patients included in the denominator whose records meet the measurement standard for the measure
Exclusions/ Exceptions	Patients not to be considered for the measure and removed from the denominator
Specification Guidance	CMS measure guidance that assists with understanding and implementation of eCQMs
UDS Reporting Considerations	BPHC requirements and guidance to be applied to the measure

Clinical Process cont'd.

Table 7 Format

- Report by race and ethnicity
- High blood pressure and diabetes:
  - **Column A**: Universe
  - **Column B**: Universe, at least 80% of universe, or exactly 70 patient records
  - **Column C or F**: Number of patients in Column B who meet the standard (numerator)
- Deliveries and birth weight will be discussed later

Line	Race and Ethnicity	Total Patients 18 through 84 Years of Age with Hypertension (2a)	Number Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)
	Hispanic or Latino/a			
1a	Asian			
1b1	Native Hawaiian			
1b2	Other Pacific Islander			
1c	Black/African American			
1d	American Indian/Alaska Native			
1e	White			
1f	More than One Race			
1g	Unreported/Refused to Report Race			
	Subtotal Hispanic or Latino/a			
	Non-Hispanic or Latino/a			
2a	Asian			
2b1	Native Hawaiian			
2b2	Other Pacific Islander			
2c	Black/African American			
2d	American Indian/Alaska Native			
2e	White			
2f	More than One Race			
2g	Unreported/Refused to Report Race			
	Subtotal Hispanic or Latino/a			
	Unreported/Refused to Report Race and Ethnicity			
h	Unreported/Refused to Report Race and Ethnicity			
i	**Total**			

See page 172 of the manual for Table 3B/7 crosswalk.

Summary of Clinical Quality Measure Changes

- Use of Appropriate Medications for Asthma on Table 6B has been **retired**.
- HIV Linkage to Care on Table 6B has been **modified** to within 30 days of diagnosis rather than 90 days, and diagnosis timeframe has changed.
- Controlled Hypertension on Table 7 has been **clarified**.
- Several measures have been updated to align with CMS eCQMs.
- **Three new measures on Table 6B:**
  - Breast Cancer Screening
  - Depression Remission at Twelve Months
  - HIV Screening

Alignment with eCQMs

- An eCQM is a clinical quality measure that is specified in a standard electronic format and is designed to use structured, encoded data present in the EHR.
- Most UDS measures align with eCQMs.
  - All 3 new CQMs added in 2020 UDS are aligned with eCQMS.
- To accurately report, you need to:
  - Understand how to access and read specifications
  - Know where your EHR is looking for required data elements to calculate eCQMs
  - Make sure your providers are recording required data in correct fields

Note: Some health centers with certain EHR vendor packages may see change in clinical performance as data is corrected in the vendor packages.

Resources to Support Clinical Process and Outcomes Reporting

Table	Line	UDS Measure Name	eCQM #	Major Differences from UDS to eCQM
6B	7–9	Early Entry into Prenatal Care	no eCQM	None
6B	10	Childhood Immunization Status	CMS117v8	None
6B	11	Cervical Cancer Screening	CMS124v8	None
6B	11a	Breast Cancer Screening*	CMS125v8	None
6B	12	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	CMS155v8	• eCQM denominator is limited to outpatient visits with a primary care physician or OB/GYN. UDS includes visits with nurse practitioners and physician assistants. • BMI, nutrition counseling, and activity counseling are reported separately in the eCQM but are evaluated together in the UDS.
6B	13	Body Mass Index (BMI) Screening and Follow-Up Plan	CMS69v8	None
6B	14a	Tobacco Use: Screening and Cessation Intervention	CMS138v8	Denominator patient population and numerator are reported separately in the eCQM but evaluated as one group in the UDS.

*** New for 2020**

Resources to Support Clinical Process and Outcomes Reporting

Table	Line	UDS Measure Name	eCQM #	Major Differences from UDS to eCQM
6B	17a	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS347v3	None
6B	18	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	CMS164v7 (no updated eCQM)	None
6B	19	Colorectal Cancer Screening	CMS130v8	None
6B	20	HIV Linkage to Care	no eCQM	None
6B	20a	HIV Screening*	CMS349v2	
6B	21	Screening for Depression and Follow-Up Plan	CMS2v9	None
6B	21a	Depression Remission at Twelve Months*	CMS159v8	None
6B	22	Dental Sealants for Children between 6-9 Years	CMS277v0	Note: Although measure title is age 6 through 9 years, draft eCQM reflects ages 5 through 9 years—continue to use ages 6 through 9 years, as measure steward intended (reference birthdates in manual).

*** New for 2020**

Resources to Support Clinical Process and Outcomes Reporting

Table	Columns	UDS Measure Name	eCQM #	Major Differences from UDS to eCQM
7	1a–1d	Low Birth Weight	no eCQM	None
7	2a–2c	Controlling High Blood Pressure	CMS165v8	Although measure CQL was not updated in 2020 to remove the limit of 6 months, health centers should adjust denominator to account for patients' diagnosis overlapping the measurement year, as measure steward intended.
7	3a–3f	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	CMS122v8	None

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Overview of New Measures

Breast Cancer Screening

- Women aged 51–73 on January 1 with a medical visit
- Women with one or more mammograms during the 27 months prior to the end of the measurement period

Depression Remission at Twelve Months

- Patients aged 12 and older who received a diagnosis of major depression or dysthymia with a PHQ-9 or PHQ-9 modified for teens (PHQ-9M) score greater than 9 during the index event
- Patients who at 12 months (+/- 60 days) had a PHQ-9 or PHQ-9M of 4 or less
- For UDS, this applies to diagnoses made between November 1, 2018, and October 31, 2019, and patients who had at least one medical visit during the measurement year

HIV Screening

- Patients aged 15–65 with a medical visit
- Patients who have had a recorded HIV test in patient record on or after their 15th birthday and before their 66th birthday

Breast Cancer Screening *(New for 2020 UDS)*

Table 6B, Line	Breast Cancer Screening	Total Female Patients Aged 51 through 73 (a)	Charts Sampled or EHR Total (b)	Number of Patients with Mammogram (c)
11a	MEASURE: Percentage of women 51–73 years of age who had a mammogram to screen for breast cancer			

Component	Description
Denominator (a) and (b)	Women 51* through 73 years of age with a medical visit during the measurement period *Use 51 as the initial age to include in assessment. See UDS Reporting Considerations for further detail.
Numerator (c)	Women with one or more mammograms during the 27 months prior to the end of the measurement period
Exclusions	• Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy • Patients who were in hospice care during the measurement period • Patients aged 66 or older who were living long-term in an institution for more than 90 days during the measurement period • Patients aged 66 and older with advanced illness and frailty

Depression Remission at Twelve Months *(New for 2020)*

Table 6B, Line	Depression Remission at Twelve Months	Total Patients Aged 12 and Older with Major Depression or Dysthymia (a)	Charts Sampled or EHR Total (b)	Number of Patients who Reached Remission (c)
21a	MEASURE: Percentage of patients aged 12 years and older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event			

Component	Description
Denominator (a) and (b)	Patients aged 12 years and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 or PHQ-9 modified for teens (PHQ-9M) score greater than 9 during the index event between Nov. 1, 2018, and Oct. 31, 2019, and at least one medical visit during the measurement period
Numerator (c)	Patients who achieved remission at 12 months as demonstrated by the most recent 12 month (+/- 60 days) PHQ-9 or PHQ-9M score of less than 5
Exclusions	• Patients with a diagnosis of bipolar disorder, personality disorder, schizophrenia, psychotic disorder, or pervasive developmental disorder • Patients who died, who received hospice or palliative care services, or who were permanent nursing home residents

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HIV Screening *(New for 2020 UDS)*

Table 6B, Line	HIV Screening	Total Patients Aged 15 through 65 (a)	Charts Sampled or EHR Total (b)	Number of Patients Tested for HIV (c)
20a	MEASURE: Percentage of patients aged 15–65 at the start of the measurement period who were 15–65 years old when tested for HIV			

Component	Description
Denominator **(a) and (b)**	Patients aged 15 through 65 years of age at the start of the measurement period and with at least one outpatient medical visit during the measurement period
Numerator **(c)**	Patients with documentation of an HIV test performed on or after their 15th birthday and before their 66th birthday
Exclusions	Patients diagnosed with HIV prior to the start of the measurement period

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HIV Linkage to Care *(Updated for 2020)*

Table 6B, Line	HIV Linkage to Care	Total Patients First Diagnosed with HIV (a)	Charts Sampled or EHR Total (b)	Number of Patients Seen Within 30 Days of First Diagnosis of HIV (c)
20	MEASURE: Percentage of patients whose first-ever HIV diagnosis was made by health center staff between Dec. 1 of the prior year and Nov. 30 of the measurement year and who were seen for follow-up treatment within 30 days of that first-ever diagnosis			

Component	Description
Denominator (a) and (b)	Patients first diagnosed with HIV *by the health center* between Dec. 1 of the prior year through Nov. 30 of the current measurement year and who had at least one medical visit during the measurement period or prior year
Numerator (c)	Newly diagnosed HIV patients who received treatment within 30 days of diagnosis. Include patients who had a medical visit with a health center provider where treatment for HIV was initiated, or patients who had a visit with a referral provider who initiated treatment for HIV
Exclusions	None

View the Helpful Codes for HIV document, which may be helpful for reporting.

Hypertension *(Clarified for 2020)*

Line	Race and Ethnicity	Total Patients 18–84 Years of Age with Hypertension (2a)	Number of Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)
1a	Asian			
…	…			
i	**Total**			

- The denominator (2a) and (2b) includes health center patients with an active diagnosis of hypertension within the reporting year, not only those diagnosed before June 30.
- Only blood pressure readings *performed by a clinician* or *remote monitoring device* are acceptable for numerator compliance. The device must capture and store the reading which is seen by the clinician or care team member, and be recorded in the patient's chart at the health center.

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Tables 6A, 6B, and 7 Resources

- UDS Training Website
  - Clinical Quality Measures Handout
  - Helpful Codes for HIV and PrEP
  - Table 6A Code Changes Handout
  - Telehealth Impact on Clinical Measures
- Three-part clinical measures webinar series
  - Screening and Preventive Care
  - Maternal Care and Children's Health
  - Disease Management
- Health Information Technology, Evaluation, and Quality Center (HITEQ): A HRSA-funded National Cooperative Agreement

Tips for Clinical Tables (Tables 6A, 6B, and 7)

DO…

- ✓ Know that all involved recognize the many challenges that this year has presented on the provision of care.
- ✓ Report clinical measures (at least the Universe, Column A) if you have medical patients in the age range who meet requirements, even if compliance is 0.
- ✓ Remember that Table 6A diagnoses and services relate to health center patients.
- ✓ Remember that the Diabetes measure is a “negative” measure (lower is better).
  - Column 3F is patients who are *uncontrolled* (no test in the year or HbA1c was >9%).

DON’T…

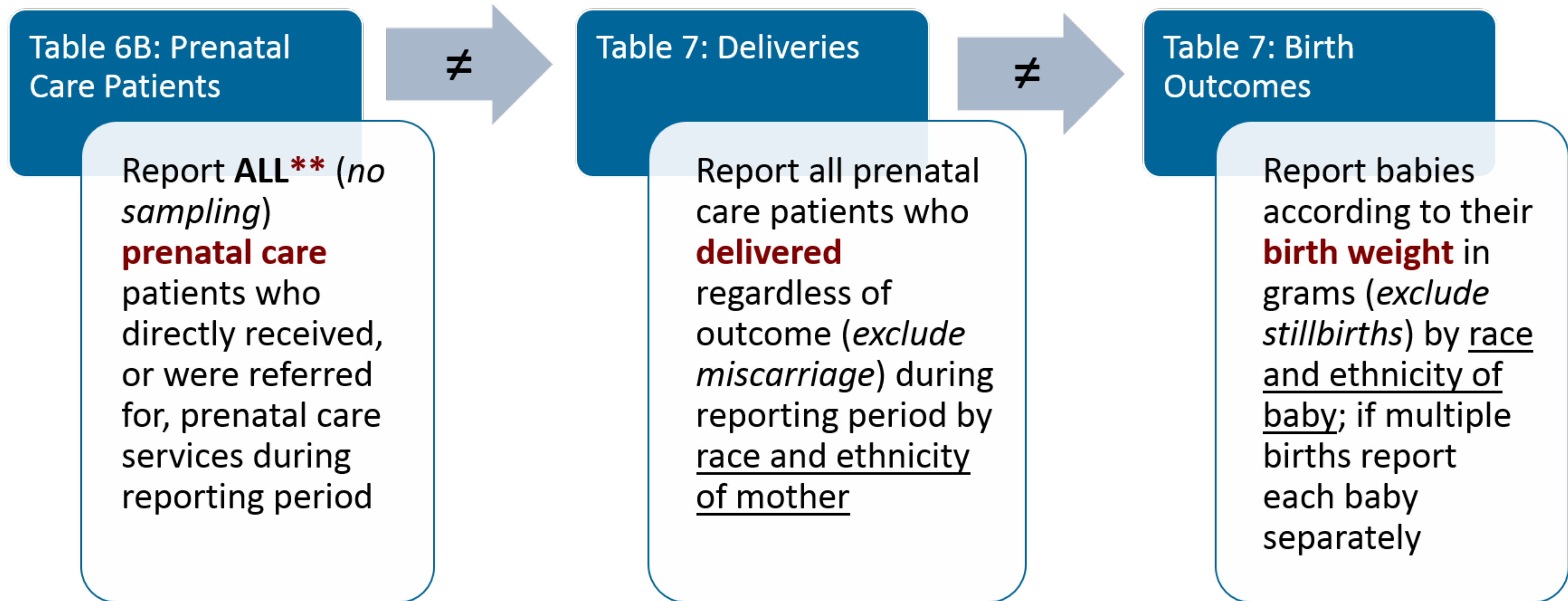
- ⃠ Forget that the hypertension measure now includes patients diagnosed at any point in the reporting year, not just before June 30.
- ⃠ Exclude patients who meet the universe criteria, unless they meet specified exclusion criteria.
  - Patients who have medical visits, including virtual visits, are generally eligible for inclusion in measures.
- ⃠ Try to interpret age or other aspects from the measure title—apply CQI logic!

HRSA Health Center Program

Tables 6B and 7: Prenatal and Birth Outcome Measures

2020 Changes: No major changes to reporting

Maternal Care: Prenatal and Birth Outcome Measures



**Include patients who a) began prenatal care in previous year (2019) and delivered in the reporting year (2020), b) began and delivered in reporting period (2020), and c) began in reporting year (2020) and will not deliver until next year (2021).

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Prenatal Patients by Age and Entry into Prenatal Care

Table 6B

- Line 0: Mark the check box if your health center provides prenatal care through direct *referral only*.
- Lines 1–6: Report all prenatal care patients by age *as of June 30*.
- Lines 7–9: Report all prenatal care patients by trimester they began prenatal care:
  - Prenatal care begins with a comprehensive prenatal care physical exam.
  - Report in Column A if care *began at your health center* (including any patient you may have referred out for care).
  - Report in Column B if care *began with another provider* and was then transferred to you.

0	Prenatal Care Provided by Referral Only (Check if Yes)	

Section A—Age Categories for Prenatal Care Patients: Demographic Characteristics of Prenatal Care Patients

Line	Age	Number of Patients (a)
1	Less than 15 years	
2	Ages 15-19	
3	Ages 20-24	
4	Ages 25-44	1
5	Ages 45 and over	
6	**Total Patients** (Sum of Lines 1-5)	1

Line	Early Entry into Prenatal Care	Patients Having First Visit with Health Center (a)	Patients Having First Visit with Another Provider (b)
7	First Trimester	1	
8	Second Trimester		
9	Third Trimester		

Deliveries and Birth Outcomes

Table 7

- Column 1A: Report prenatal care *patients who delivered* during the measurement year (*exclude miscarriages*) *by race/ethnicity*:
  - Report only one patient as having delivered for multiple births.
  - Report on patients who were successfully referred out for care.
- Columns 1B–1D: Report each live birth by *birthweight* (exclude stillbirths) and race/ethnicity of baby:
  - Count twins as two births, triplets as three, etc.
  - Very low (VLBW) (Column 1B) is < 1,500 grams.
  - Low (LBW) (Column 1C) is 1,500–2,499 grams.
  - Normal (Column 1D) is ≥ 2,500 grams.

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: <1500 grams (1b)	Live Births: 1500–2499 grams (1c)	Live Births: ≥2500 grams (1d)
	Hispanic or Latino/a				
1a	Asian				
1b1	Native Hawaiian				
1b2	Other Pacific Islander				
1c	Black/African American	1	1	1	
1d	American Indian/Alaska Native				
1e	White				
1f	More than One Race				
1g	Unreported/Refused to Report Race				
	Subtotal Hispanic or Latino/a				
	Non-Hispanic or Latino/a				
2a	Asian				
2b1	Native Hawaiian				
2b2	Other Pacific Islander				
2c	Black/African American				
2d	American Indian/Alaska Native				
2e	White				
2f	More than One Race				
2g	Unreported/Refused to Report Race				
	Subtotal Hispanic or Latino/a				
	Unreported/Refused to Report Race & Ethnicity				
h	Unreported/Refused to Report Race & Ethnicity				
i	**Total**				

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Deliveries and Birth Outcomes

Table 7

Section A

- Line 0: Number of health center patients who are pregnant and HIV positive regardless of whether or not they received prenatal care from the health center
- Line 2: Number of deliveries performed by health center clinicians, including deliveries to non–health center patients

Section A: Deliveries and Birth Weight		
Line	Description	Patients (a)
0	HIV-Positive Pregnant Women	0
2	Deliveries Performed by Health Center's Providers	1

View the Prenatal and Birth Outcomes Fact Sheet for more information.

Tips for Prenatal/Birth Measures (Tables 6B and 7)

DO…

- ✓ Include patients still pregnant at the end of the prior year in the current year prenatal and delivery (considering evidence of delivery) sections.
- ✓ Report all prenatal patients whether you provide prenatal services within your health center or refer out for these services.
- ✓ Report each baby in the live births by birthweight columns on Table 7—this means with twins, report two babies for one delivery.

DON'T…

- ⃠ Report health center patients who are referred out for prenatal care in Column B for trimester of entry into prenatal care; report in Column A instead.
- ⃠ Report patients as having delivered during the reporting period when there is no evidence of delivery.
- ⃠ Forget to track delivery outcomes for prenatal care patients, even if they transferred out of the health center.

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Tables 8A, 9D, & 9E: Financial Tables

2020 Changes:

- Table 9D COVID-19 uninsured program
- COVID-Related and Provider Relief Grants on Table 9E

Costs and Patient-Related Revenues

Table 8A: Financial Costs

- **Accrued costs**, including staff and personnel, fringe benefits, supplies, equipment, depreciation, and travel, for all cost centers/service areas
- Overhead for non-clinical support services/admin and facilities
- Value of donated facilities, services, and supplies

Table 9D: Patient-Related Revenue

- Charges, collections, supplemental payments, adjustments, sliding discounts, and self-pay bad debt write offs for **patient-related services** in the reporting year
- Reported by payer and payment contract type
- Collections reported on a cash basis

Table 9E: Other Revenue

- Report **non-patient** receipts received or drawn down in the year
- Grants, contracts, and other funds
- Reported on a cash basis

HRSA Health Center Program

Table 8A: Financial Costs

2020 Changes: No major changes

Financial Costs

Table 8A

Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)

• Medical
• Dental
• Mental Health
• Substance Use Disorder
• Pharmacy & Pharmaceuticals
• Other Professional
• Vision
• Enabling
• Other Program-Related Services
• Administration (non-clinical support)
• Facility
	• Report **accrued** direct costs
	• Include costs of:
	  • Staff
	  • Fringe benefits
	  • Supplies
	  • Equipment
	  • Depreciation
	  • Related travel
	• Exclude bad debt
		• Allocate to all other cost centers (Lines)
		• Must equal Line 16, Column A
			• Sum of Columns A + B (done automatically in EHBs)
			• Represents cost to operate service by category
			• Used to calculate cost per visit and cost per patient

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Tables 5 and 8A Crosswalk

Table 5

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1	Family Physicians	.25	12		
2	General Practitioners				
3	Internists				
4	Obstetrician/Gynecologists				
5	Pediatricians	1.0	13		
7	Other Specialty Physicians				
8	**Total Physicians** (Lines 1–7)	1.25	25		
9a	Nurse Practitioners	.6	3		
9b	Physician Assistants				
10	Certified Nurse Midwives				
10a	**Total NPs, Pas, and CNMs** (Lines 9a–10)	.6	3		
11	**Nurses**	3.0			
12	Other Medical Professional				
13	Laboratory Personnel	1.0			
14	X-ray Personnel				
15	**Total Medical Care Services** (Lines 8 + 10a through 14)	5.85	28		10
16	Dentists		5		
17	Dental Hygienists		4		
17a	Dental Therapists				
18	Other Dental Personnel				
19	**Total Dental Services** (Lines 16–18)		9		5

Table 8A

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
	Financial Costs of Medical Care			
1	Medical Staff			
2	Lab and X-ray			
3	Medical/Other Direct			
4	**Total Medical Care Services** (Sum of Lines 1 through 3)			
5	**Dental**			
6	Mental Health			
7	Substance User Disorder			
8a	Pharmacy (not including pharmaceuticals)			
8b	Pharmaceuticals			
9	Other Professional (specify ____)			
9a	Vision			
10	**Total Other Clinical Services** (Sum of Lines 5 through 9a)			

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Financial Costs

Table 8A

Report costs by cost center

- Line 1: Medical staff salary and benefits, including:
  - Paid medical interns or residents
  - Vouchered or contracted medical services
- Line 2: Medical lab and X-ray direct expense
- Line 3: Non-personnel expenses including HIT/EHR, supplies, CMEs, and travel
- Lines 8a–8b: Separate drug (8b) from other pharmacy costs (8a)
- Lines 5–13 (excluding 8a–8b): Direct expenses including personnel (employed and contracted), benefits, contracted services, supplies, and equipment
  - Line 12: Other Program-Related Services includes space within health center rented out, WIC, retail pharmacy to non-patients, etc.
  - Line 12a: Staff dedicated to HIT/EHR design and QI

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
	Financial Costs of Medical Care			
1	Medical Staff			
2	Lab and X-ray			
3	Medical/Other Direct			
4	**Total Medical Care Services** (Sum of Lines 1 through 3)			
	Financial Costs of Other Clinical Services			
5	Dental			
6	Mental Health			
7	Substance User Disorder			
8a	Pharmacy (not including pharmaceuticals)			
8b	Pharmaceuticals			
9	Other Professional (specify ____)			
9a	Vision			
10	**Total Other Clinical Services** (Sum of Lines 5 through 9a)			
	Financial Costs of Enabling and Other Services			
11a	Case Management			
11b	Transportation			
11c	Outreach			
11d	Patient and Community Education			
11e	Eligibility Assistance			
11f	Interpretation Services			
11g	Other Enabling Services (specify ____)			
11h	Community Health Workers			
11	**Total Enabling Services** (Sum of Lines 11a through 11h)			

Pharmacy Reporting on Table 8A

Health centers with pharmacy programs have many considerations for reporting on the UDS. Some tips for reporting Table 8A accurately:

- Dispensing fees for contract pharmacy (e.g., 340B are reported on Line 8a, Pharmacy, separate from the cost of drugs).
- Costs of pharmaceuticals (either for in-house pharmacy or contract pharmacy) are reported on Line 8b.
- Administrative or overhead costs for the contract pharmacy program, such as clinic's in-house 340B manager or contract manager, should be allocated to Line 8a, Pharmacy, in Column B.
- Report pharmacy assistance program on Line 11e, in the enabling section, not in pharmacy!
- Donated drugs are reported on Line 18, Donated Facilities, Services, and Supplies; value at 340B prices.

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Column A, Lines 14–16

Table 8A

- **Line 14**: Facility-related expenses including direct staff costs, rent or depreciation, mortgage interest payments, utilities, security, groundskeeping, janitorial services, maintenance, etc. Includes staff reported on Table 5, Line 31.
- **Line 15**: Costs for all staff reported on Table 5, Lines 30a–30c and 32, including corporate administration, billing collections, medical records and intake staff, facility and liability insurance, legal fees, practice management system, and direct non-clinical support costs (travel, supplies, etc.).
  - Include malpractice insurance in the service categories, not here.

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
	Facility and Non-Clinical Support Services and Totals			
14	Facility			
15	Non-Clinical Support Services			
16	**Total Facility and Non-Clinical Support Services** (Sum of Lines 14 and 15)			

- **Line 16:** Total indirect costs to be allocated in Column B.

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Allocating Overhead Expenses to Column B

Table 8A

Facility (Line 14)

- Identify square footage utilized by each cost center and cost per square foot.
- Distribute square footage costs to each cost center.

Non-Clinical Support (Line 15)

- Distribute non-clinical support costs to the applicable service.
  - Includes decentralized front desk staff, billing and collection systems and staff, etc.
  - Consider lower allocation of overhead to contracted services.
- Allocate remaining costs using straight-line method (proportion of net costs to each service category).

There are multiple ways that facility and non-clinical support services (Lines 14 and 15, Column A) may be allocated to the cost centers in Column B (Lines 1–13). Use the simplest method that produces reasonably accurate results that are comparable to those obtained by a more complex method.

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Reporting Donations

Donations of Goods and Services

Table 8A, Line 18: Value of Donated Facilities, Services, and Supplies

Cash Donations/Fundraising Revenue

Table 9E, Line 10: Other Revenue (non-patient-related revenue not reported elsewhere)

This may include donations of PPE, tests, space, etc. Health centers may have also received cash donations or revenue from fundraising.

Resource: Reporting Donations in the UDS

HRSA Health Center Program

Table 9D: Patient-Related Revenue

2020 Change: Addition of Line 8c, Other Public, including COVID-19 Uninsured Program

Payer Categories for Patient-Related Revenue

Table 9D

Medicaid

- Any state Medicaid program, including EPSDT, ADHC, PACE, if administered by Medicaid
- Medicaid MCOs or Medicaid programs administered by third-party or private payers
- CHIP, when administered by Medicaid

Medicare

- Medicare managed care programs, including Medicare Advantage run by commercial insurers
- ADHC or PACE if administered by Medicare

Other Public

- CHIP, when NOT administered by Medicaid
- Public programs that pay for limited services, such as BCCCP and Title X
- State- or county-run insurance plans, such as the Massachusetts CommonHealth plan
- Service contracts with municipal or county jails, state prisons, public schools, or other public entities
- Testing and treatment associated with caring for uninsured patients with suspected or actual COVID-19 *administered by HRSA under the COVID-19 Uninsured Program on Line 8c (more on the next slide)*

Private

- Tricare, Trigon, Federal Employees Insurance Program, workers' compensation
- Insurance purchased through state exchanges or provided by employers

Self-Pay

- Portion that the patient is responsible for or that is not covered by a third-party payer—includes co-pay, deductibles, or full charge for the uninsured patients when insurance does not cover (e.g., dental charges to a Medicaid patient)
- Indigent care charge portion reflected here

COVID-19 Uninsured Program Reporting

Table 9D

Federal Funding	Other Names	Statute	Date Issued	Reported on UDS
Reimbursement for costs of uninsured patients from HRSA	HRSA Uninsured Claims Program (administered by United Health/ Optum Pay)	Families First and PPHCE Acts each appropriated funding to reimburse for testing uninsured; also, a portion of the Provider Relief Fund is for this purpose, including to reimburse for COVID-19 treatment costs for uninsured.	Claims have been submitted as early as May 2020.	**Table 9D, Line 8c: Other Public Including COVID-19 Uninsured Program** Report full charges in Column A, collections in Column B, etc., as with all other lines.

- Only HRSA's COVID-19 Claims Reimbursement to health care providers and facilities for testing and treatment of the uninsured patients is reported.
- ***Do not report write offs or costs to treat or test uninsured patients that are not reimbursed through HRSA's COVID-19 Claims Reimbursement program on this line.***

Patient-Related Revenue

Table 9D

				Retroactive Settlements, Receipts, and Paybacks (c)						
Line	**Payer Category**	**Full Charges This Period (a)**	**Amount Collected This Period (b)**	**Collection of Reconciliation/ Wraparound Current Year (c1)**	**Collection of Reconciliation/ Wraparound Previous Years (c2)**	**Collection of Other Payments: P4P, Risk Pools, etc. (c3)**	**Penalty/ Payback (c4)**	**Adjustments (d)**	**Sliding Fee Discounts (e)**	**Bad Debt Write-Off (f)**
1	Medicaid Non-Managed Care									
2a	Medicaid Managed Care (capitated)									
2b	Medicaid Managed Care (fee-for-service)									
3	**Total Medicaid** (Sum of Lines 1+2a +2b)									
4	Medicare Non-Managed Care									
5a	Medicare Managed Care (capitated)									
5b	Medicare Managed Care (fee-for-service)									
6	**Total Medicare** (Sum of Lines 4+5a+5b)									

Report (Columns)

- Column a: Charges (2020)
- Column b: Collections (cash basis)
- Columns c1–c4: Reconciliations
- Column d: Contractual adjustments
- Column e: Self-pay sliding discounts
- Column f: Self-pay bad debt

By Payer (Lines)

- Lines 1–3 Medicaid
- Lines 4–6 Medicare
- Lines 7–9 Other Public
- Lines 10–12 Private
- Line 13 Self-pay

By Form of Payment

- Non-managed care
- a) Capitated managed care
- b) Fee-for-service managed care

Column A: Full Charges

Table 9D

				Retroactive Settlements, Receipts, and Paybacks (c)						
Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Collection of Reconciliation/ Wraparound Current Year (c1)	Collection of Reconciliation/ Wraparound Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty/ Payback (c4)	Adjustments (d)	Sliding Fee Discounts (e)	Bad Debt Write-Off (f)

- Full Charges: Total billed charges across all services, reported by payer source:
  - Undiscounted, unadjusted, gross charges for services owed by payer
  - Based on fee schedule
  - Charges for services provided during the calendar year, including pharmacy charges
- Do not include:
  - “Charges” where no collection is attempted or expected (e.g., enabling services, donated pharmaceuticals, free vaccines)
  - Capitation or negotiated rate as charges
  - Charges for Medicare G-codes
    - ✓ To learn more about CMS payment codes, visit the CMS website.

Column B: Collections

Table 9D

				Retroactive Settlements, Receipts, and Pa ybacks (c)						
Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Collection of Reconciliation/ Wraparound Current Year (c1)	Collection of Reconciliation/ Wraparound Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty/ Payback (c4)	Adjustments (d)	Sliding Fee Discounts (e)	Bad Debt Write-Off (f)

- Include **all payments** received in 2020 for services to patients:
  - Capitation payments
  - Contracted payments
  - Payments from patients
  - Third-party insurance
  - Retroactive settlements, receipts, and payments
    - ✓ Include pay for performance, quality bonuses, and other incentive payments.
- Do not include “Promoting Interoperability” payments from Medicaid and Medicare here (report on Table 9E).

HRSA Health Center Program

Columns C1–C4: Retroactive Settlements, Receipts, and Paybacks

Table 9D

Amount Collected This Period (b)	Retroactive Settlements Receipts, and Paybacks (c)			
	Collection of Reconciliation/Wrap-Around Current Year (c1)	Collection of Reconciliation/ Wrap-Around Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty/Payback (c4)
• Payments reported in C1–C4 are part of Column B total, but do not equal Column B	FQHC prospective payment system (PPS) reconciliations *(based on filing of cost report)*	Wrap-around payments *(additional amount per visit to bring payment up to FQHC level)*	• Managed care pool distributions • Pay for performance (P4P) • Other incentive payments • Quality bonuses • Value based payments	• Paybacks or deductions by payers because of over payments or penalty *(report as a positive number)*

Column D: Adjustments

Table 9D

				Retroactive Settlements, Receipts, and Pa ybacks (c)						
Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Collection of Reconciliation/ Wraparound Current Year (c1)	Collection of Reconciliation/ Wraparound Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty/ Payback (c4)	Adjustments (d)	Sliding Fee Discounts (e)	Bad Debt Write-Off (f)

- Allowances: Agreed-upon reductions/write-offs in payment by a third-party payer:
  - Reduce by amount of retroactive payments in C1, C2, and C3.
  + Add paybacks reported in C4.
- May result in a negative number.
- For managed care capitated Lines (2a, 5a, 8a, and 11a) *only*, allowances equal the difference between charges and collections (Column D = A –B).

HRSA Health Center Program

Column E: Sliding Fee Discounts

Table 9D

				Retroactive Settlements, Receipts, and Pa ybacks (c)						
Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Collection of Reconciliation/ Wraparound Current Year (c1)	Collection of Reconciliation/ Wraparound Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty/ Payback (c4)	Adjustments (d)	Sliding Fee Discounts (e)	Bad Debt Write-Off (f)

- Sliding Fee Discounts: Reductions in patient charges based on their ability to pay
  - Based on the patient's documented income and family size (per federal poverty guidelines), including uninsured patients who are below 2X Federal Poverty Level (FPL)
- May be applied:
  - To insured patients' co-payments, deductibles, and non-covered services
  - Only when charge has been reclassified from original charge line to self-pay
- May not be applied to past-due amounts

Column F: Bad Debt Write Off

Table 9D

				Retroactive Settlements, Receipts, and Pa ybacks (c)						
Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Collection of Reconciliation/ Wraparound Current Year (c1)	Collection of Reconciliation/ Wraparound Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty/ Payback (c4)	Adjustments (d)	Sliding Fee Discounts (e)	Bad Debt Write-Off (f)

- Bad debt: owed by patients considered to be uncollectable and formally written off. during 2020, regardless of when service was provided
- Only report **patient bad debt** (not third-party payer bad debt):
  - Report on Line 13.
  - Third-party payer bad debt is not reported in the UDS.
- Do not change bad debt to a sliding discount.
- Discounts (e.g., to specific groups of patients, cash discounts) or forgiveness is not patient bad debt (or a sliding discount).

Table 9D Example #1

				Retroactive Settlements, Receipts, and Paybacks (c)						
Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Collection of Reconciliation/ Wraparound Current Year (c1)	Collection of Reconciliation/ Wraparound Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty/ Payback (c4)	Adjustments (d)	Sliding Fee Discounts (e)	Bad Debt Write-Off (f)
13	Self-Pay	$200	$10						$180	$10

An uninsured patient was seen at the health center. On the day of the service, the patient qualified for a sliding discount that required her to pay 10% of the service charge:

- The service’s full charge is $200.
- A fee of $20 was charged to the patient (10% of full charge).
- The patient paid $10.
- The patient still owed $10, and this was written off by the health center.

Table 9D Example #2

Reclassify Charge

				Retroactive Settlements, Receipts, and Paybacks (c)						
Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Collection of Reconciliation/ Wraparound Current Year (c1)	Collection of Reconciliation/ Wraparound Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty/ Payback (c4)	Adjustments (d)	Sliding Fee Discounts (e)	Bad Debt Write-Off (f)
10	Private Non-Managed Care	$200	$120					$50		
13	Self-Pay									

An insured patient was seen at the health center. On the day of the service, the service charge for the visit was $200. The insurer paid $120 with an allowance of $50.

- Post service charge for private payer = $200 at time of service.
- Post payment of $120 with a $50 allowance on the private line when payment is received.
- Reduce the initial charge of $200 to private insurance by $30—this is the co-pay owed by the patient.

How do you reclassify the charge?

Table 9D Example #2

Reclassify Charge

				Retroactive Settlements, Receipts, and Pa ybacks (c)						
Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Collection of Reconciliation/ Wraparound Current Year (c1)	Collection of Reconciliation/ Wraparound Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty/ Payback (c4)	Adjustments (d)	Sliding Fee Discounts (e)	Bad Debt Write-Off (f)
10	Private Non-Managed Care	~~$200~~ $170	$120							
13	Self-Pay	$30	$10						$10	$10

An insured patient was seen at the health center. On the day of the service, the service charge for the visit was $200. The insurer paid $120 with an allowance of $50.

- Reclassify the $30 co-pay to self-pay charges.
- The patient was eligible for a $10 sliding discount.
- Of the amount patient was responsible for ($20), patient paid $10.
- At end of year, $10 remained uncollected, was considered bad debt, and was formally written off.

Table 9D Example #3

A patient comes in, states that they still have the same private health plan as the last time that they were seen, and has a visit with a health center provider. When the health center bills the insurance, the claim is denied because the patient was no longer covered by that insurer on the date the patient was seen.

Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)
10	Private Non-Managed Care	Initial Charge	0
11a	Private Managed Care (capitated)		
11b	Private Managed Care (fee-for-service)		
12	**Total Private** (Sum of Lines 10+11a+ 11b)		
13	**Self-Pay**	**Reclassified Charge**	
14	**TOTAL** (Sum of Lines 3+6+9+12+ 13)		

After reclassifying to self-pay, then charge may be paid, may be written off as sliding fee if the patient has qualified, or may be written off as bad debt. (Line 13)

Table 9D Example #4

A health center limited in-person visits for much of 2020, and some patients were not able to come into the office to pay their bill.

- Health Center Program requirements specify that HCs must provide sliding fee and make every effort to be reimbursed for services to cover their costs.[1]
- Self-pay charges would be recorded in Line 13, Column A, regardless of whether the patient could pay.
- Sliding fee would be applied as appropriate based on board-approved policy and procedures, and reported on Line 13, Column E.
- Uncollected portion of the charge could remain outstanding (and not reported anywhere) and be paid after the public health emergency *or* written off as bad debt later, per health center policy.

1. BPHC Coronavirus Funding FAQs

HRSA Health Center Program

Reporting 340B Contract Pharmacy

Table	Related Reporting/Impact
8A (Costs)	• Report the **amount the pharmacy charges for managing dispensing of drugs** on Line 8a, Pharmacy. • Report the **full amount paid for drugs, either directly (by clinic) or indirectly (by contract pharmacy)** on Line 8b, Pharmaceuticals. • If the pharmacy buys prepackaged drugs and there is no reasonable way to separate the pharmaceutical costs from the dispensing/administrative costs, report all costs on Line 8b. Associated non-clinical support services (overhead) costs go on Line 8a, Column B. • Report payments to pharmacy benefit managers on Line 8a, Pharmacy. • Some pharmacies engage in fee splitting and keep a share of profit. Report this as a payment to the pharmacy on Line 8a, Pharmacy.
9D (Patient Revenue)	• **Charge (Column A) is the health center/contract pharmacy's full retail charge for the drugs dispensed, by payer.** If retail is unknown, ask the pharmacy for retail prices for the drugs dispensed. • **Collection (Column B) is the amount received from patients or insurance companies.** Health centers must collect this information from the contract pharmacy in order to report accurately. • **Adjustments (Column D) is the amount disallowed by a third party for the charge** (if on Lines 1–12). • **Sliding Fee Discount (Column E) is the amount written off for eligible patients per health center policies (Line 13).** Calculate as retail charge/pharmacy charge, minus amount collected from patients (by pharmacy or health center), minus amount owed by patients.
9E (Other Revenue)	Do not report pharmacy income on Table 9E, and do not use Table 9E to report net income from the pharmacy. Report actual gross income on Table 9D.

Key Takeaway: You need the breakdowns as outlined here to report correctly.

Considerations When Reporting Patient Revenue–Related Data

Table	Description
Table 9D	Investigate amounts reported if there are more in collections and adjustments or write-offs than charges.
Table 9D	Verify that retroactive payments (C Columns) are included in collections (Column B) and subtracted from allowances (Column D).
Table 9D	Verify large year-end balances owed by payer.
Table 9D	Adjustments are expected to be the contractual amount discounted between what is charged and what payer agrees to pay for services.

Review the relationship between insurance on Table 4 and revenue on Table 9D in the crosswalk on page 171 of the Reporting Instructions.

HRSA Health Center Program

Table 9E: Non-Patient-Related Revenue

2020 Changes:

- Addition of five lines for HRSA BPHC COVID-19 Supplemental Funding
- Addition of a line for Provider Relief Fund

Other Revenue

Table 9E

- Report **non-patient receipts** received or drawn down in 2020.
  - **Cash basis**—amount drawn down (not award).
  - Include income that supported activities described in your scope of services.
  - Report funds by the entity from which you received them.
  - Complete “specify” fields.
- Revenue reported on Tables 9E and 9D represents total income supporting scope of services.

Revenue Categories

- **BPHC Grants:** Funds you received directly from BPHC, including funds passed through to another agency
  - Include the amounts directly received under the various COVID funding sources
- **Other Federal Grants:** Grants you received directly from the federal government other than BPHC
  - Ryan White Part C
  - Other federal grants (e.g., HUD, SAMHSA, CDC)
  - EHR Incentive Payments: Include Promoting Interoperability funds, including funds paid directly to providers and turned over to the health center (exception to last party rule)
  - Provider Relief Fund

Line	Source	Amount (a)
	BPHC Grants (Enter Amount Drawn Down—Consistent with PMS 272)	
1a	Migrant Health Center	
1b	Community Health Center	
1c	Health Care for the Homeless	
1e	Public Housing Primary Care	
1g	**Total Health Center** (Sum of Lines 1a through 1e)	
1k	Capital Development Grants, including School-Based Health Center Capital Grants	
1l	Coronavirus Preparedness and Response Supplemental Appropriations Act (H8C)	
1m	Coronavirus Aid, Relief, and Economic Security Act (CARES) (H8D)	
1n	Expanding Capacity for Coronavirus Testing (ECT) (H8E and LAL ECT)	
1o	Health and Economic Recovery Omnibus Emergency Solutions Act (HEROES)/Health, Economic Assistance, Liability Protection and Schools Act (HEALS)	
1p	Other COVID-19-Related Funding from BPHC (specify ____)	
1q	**Total COVID-19 Supplemental** (Sum of Lines 1l through 1p)	
1	**Total BPHC Grants** (Sum of Lines 1g + 1k + 1q)	
	Other Federal Grants	
2	Ryan White Part C HIV Early Intervention	
3	Other Federal Grants (specify ____)	
3a	Medicare and Medicaid EHR Incentive Payments for Eligible Providers	
3b	Provider Relief Fund (specify ____)	
5	**Total Other Federal Grants** (Sum of Lines 2 through 3b)	
	Non-Federal Grants or Contracts	
6	State Government Grants and Contracts (specify ____)	
6a	State/Local Indigent Care Programs (specify ____)	
7	Local Government Grants and Contracts (specify ____)	
8	Foundation/Private Grants and Contracts (specify ____)	
9	**Total Non-Federal Grants and Contracts** (Sum of Lines 6 + 6a + 7 + 8)	
10	Other Revenue (non-patient related revenue not reported elsewhere) (specify ____)	
11	**Total Revenue** (Sum of Lines 1 + 5 + 9 + 10)	

Table 9E: COVID-19 Funding Lines

- New COVID-19 Supplemental lines (Lines 1l-1p) capture monies received from BPHC which may have included:
  - H8C funding from the COVID Supplemental Appropriations in early March
  - H8D funding from CARES Act in late March
  - H8E funding from the Paycheck Protection Program and Health Care Enhancement Act (PPHCEA) in May
  - Provider Relief Fund (Line 3b)

Line	Source	Amount (a)
	BPHC Grants (Enter Amount Drawn Down—Consistent with PMS 272)	
1k	Capital Development Grants, including School-Based Health Center Capital Grants	
1l	Coronavirus Preparedness and Response Supplemental Appropriations Act (H8C)	
1m	Coronavirus Aid, Relief, and Economic Security Act (CARES) (H8D)	
1n	Expanding Capacity for Coronavirus Testing (ECT) (H8E and LAL ECT)	
1o	Health and Economic Recovery Omnibus Emergency Solutions Act (HEROES)/Health, Economic Assistance, Liability Protection and Schools Act (HEALS)	
1p	Other COVID-19-Related Funding from BPHC (specify ____)	
1q	**Total COVID-19 Supplemental** (Sum of Lines 1l through 1p)	
1	**Total BPHC Grants** (Sum of Lines 1g + 1k + 1q)	

Line	Source	Amount (a)
	Other Federal Grants	
3b	Provider Relief Fund (specify ____)	
5	**Total Other Federal Grants** (Sum of Lines 2 through 3b)	

Revenue Categories

- **State and Local Government**: Funds received from a state or local government, taxing district, or sovereign tribal entity (e.g., state public health grant)
- **State/Local Indigent Care Programs**: Funds received from state/local indigent care programs that subsidize services rendered to patients who are uninsured (e.g., New Mexico Tobacco Tax Program)
- **Foundation/Private:** Funds from foundations and private organizations (e.g., hospital, United Way)
- **Other Revenue**: Miscellaneous non-patient-related revenues
  - Do not report bad debt recovery or 340B payments here—these revenues are reported on Table 9D

Line	Source
Non-Federal Grants Or Contracts	
6	State Government Grants and Contracts (specify:____)
6a	State/Local Indigent Care Programs (specify:____)
7	Local Government Grants and Contracts (specify:____)
8	Foundation/Private Grants and Contracts (specify:____)
9	**Total Non-Federal Grants and Contracts (Sum Lines 6 + 6a + 7 + 8)**
10	Other Revenue (non-patient related revenue not reported elsewhere) (specify:____)
11	**Total Revenue (Lines 1+5+9+10)**

HRSA Health Center Program

Tips for Financial Tables (Table 8A, 9D, and 9E)

DO…

- ✓ Use at least a two-step process for allocating overhead in Column B of Table 8A.
- ✓ Ensure you have or are receiving detailed payer information for your 340B or contract pharmacy, to accurately report Table 9D.
- ✓ Be sure Table 9D, Column A is reported based solely on your set fee schedule or the fee schedule of any contractor you are paying (such as a pharmacy), not based on your PPS rate or other adjusted rates.

DON'T…

- Report patient-generated revenue, such as contract/340B pharmacy revenue or pay for performance distributions on Table 9E.
- Forget to compare managed care reporting on Table 9D to managed care member months on Table 4.
- Report adjustments on anything except contractual adjustments, adjusted by Columns C1 through C4.

Resources to Support Financial and Operational Reporting

- UDS Training Website
  - Operational Costs and Revenue training module
  - Reporting Donations guide
  - Financial Tables Guidance handout (common error checks)
  - Table 8A Fact Sheet
  - Table 9D Fact Sheet
  - Table 9E Fact Sheet
- Two-part Financial Series Webinar

HRSA Health Center Program

Other Forms to Complete

Health Center Health Information Technology (HIT) Capabilities

Appendix D

- **Revised for 2020 reporting**
  - Question on use of multiple EHRs or data system revised
  - Revised question for number of providers using EHR to understand if the EHR has been updated with latest software
  - Electronic communications for prescriptions and alerts questions removed
  - Additional options added to electronic exchange of clinical information question and the social risk factor screener question
  - Includes new questions to quantify patients screened positive to social risk factor screener questions
  - Question added to support tracking how health centers are optimizing PDMPs

Positive Screens for Selected Social Risks

- In addition to asking whether you are using a standardized social risk screener, the HIT form now also collects the **number of patients who screened positive** in four areas:
  - ❑Food insecurity
  - ❑Housing insecurity
  - ❑Financial strain
  - ❑Lack of transportation/access to public transportation
- A crosswalk has been created identifying the questions on each standardized screener that would be a positive screen in each of these areas.

UDS: UNIFORM DATA SYSTEM

Crosswalk of Standardized Social Risk Factor Screeners and UDS Appendix D: Health Center Information Technology (HIT) Capabilities Questions 12 and 12a

The information below is intended give health centers more information about where to find information on each standardized social risk screener. This also helps health centers ascertain which question(s) and which related responses from each standardized social risk screening would be counted toward the four categories listed in Question 12a. The question number listed in the cell refers to the question number on the screening tool; not all screeners are numbered. Not all screeners have questions for all four reporting categories. Responses listed under the screening question as "*Count if=*" should be counted toward the category in the column heading for Question 12a. For example, if a housing insecurity question is followed by *Count if= yes*, then all 'yes' responses to that question should be counted as patients who screened positive for housing insecurity.

Standardized screeners for social risk factors	Food Insecurity	Housing Insecurity	Financial Strain	Lack of transportation/ access to public transportation
Accountable Health Communities Screening Tools	*Question 3:* Within the past 12 months, you worried that your food would run out before you got money to buy more. *Count if= Often true OR Sometimes true* *Question 4:* Within the past 12 months, the food you bought just didn't last and you didn't have money to get more. *Count if= Often true OR Sometimes true*	*Question 1:* What is your living situation today? *Count if=I have a place to live today, but I am worried about losing it in the future OR I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)*	*Question 11:* How hard is it for you to pay for the very basics like food, housing, medical care, and heating? *Count if= Very hard OR Somewhat hard*	*Question 5:* In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? *Count if = yes*

Other Data Elements

Appendix E

- **Telemedicine**
- **Medication-assisted treatment (MAT)**
  - Number of providers who have obtained a Drug Addiction Treatment Act of 2000 (DATA) waiver to provide MAT
  - Number of patients who received MAT from provider with a DATA waiver working on behalf of the health center
    - ✓ Count only MAT (specifically buprenorphine) provided by providers with a DATA waiver
    - ✓ Check information with reporting on Table 5
- **Outreach and enrollment assistance**
  - Assists reported here do not count as visits on the UDS tables
- **New: COVID-19 vaccine**
  - Number of patients who received an FDA-approved COVID-19 vaccine administered at the health center during the reporting period.

HRSA
Health Center Program

Telemedicine Reporting

- **Do you use telemedicine?**
  - Meaning, do you provide clinical services via remote technology?
  - This might be a yes, even if you don't have virtual visits on Table 5, if you do eConsults, for example.
- **Who do you use telehealth to communicate with?**
  - Patients
  - Specialists
- **What telehealth technologies do you use?**
  - Real time, store-and-forward, remote patient monitoring, mobile health
- **What services are provided via telemedicine?**
  - Primary care, oral health, mental health, substance use disorder, dermatology, etc.
- **If you do not offer telemedicine services, why not?**
  - Policy barriers, inadequate broadband, funding, training, etc.

There may be significant changes from last year as it relates to this.

Report on your telemedicine offerings in 2020 specifically.

HRSA Health Center Program

Workforce Form

Appendix F

- Helps clarify current state of health center workforce training and staffing models
- Topics include:
  - Professional education/training
  - Satisfaction surveys

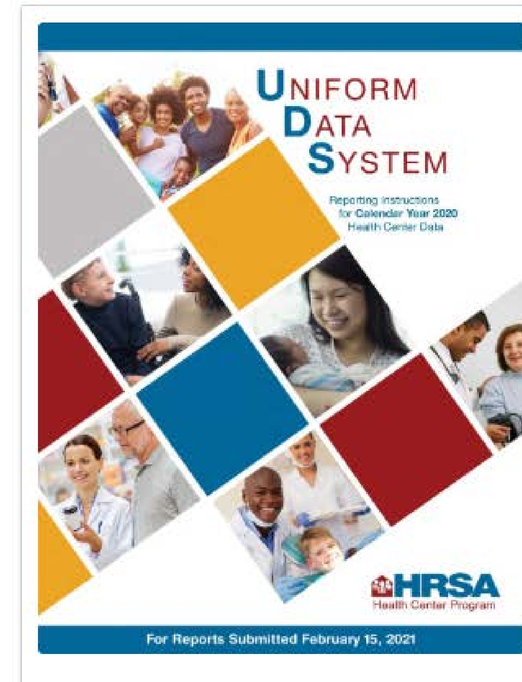
Available Resources

UDS Training Website: BPHCdata.net

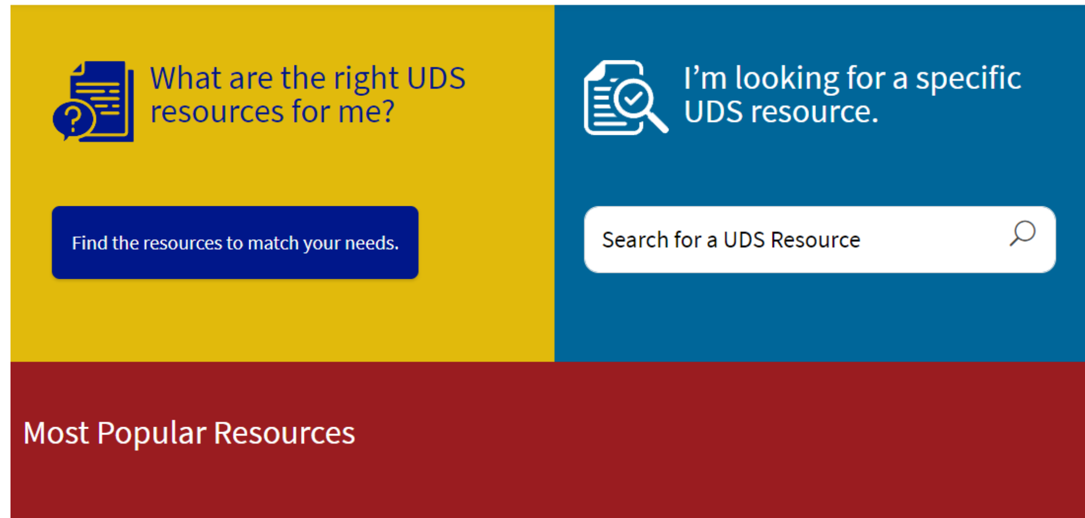
UDS Content Support

About Calendar EHBs Data Resources Contact Us

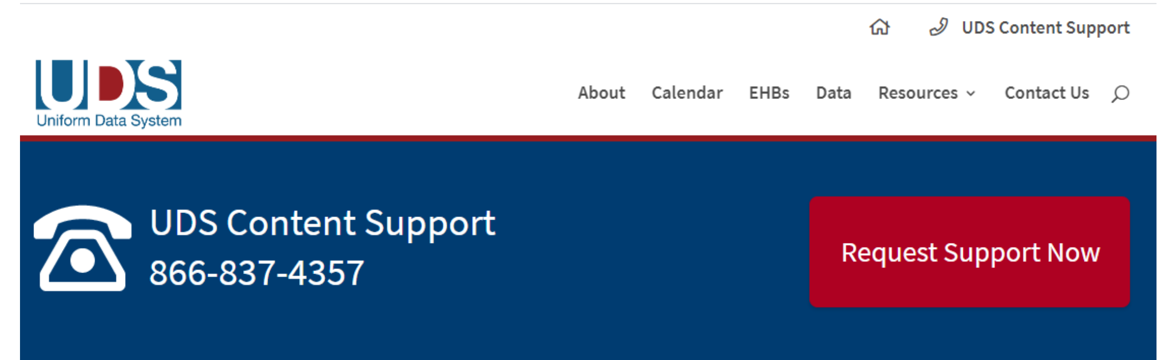
COVID-19 UDS Reporting Guidance – Health centers are an important resource to the national COVID-19 response. For guidance on how COVID-19 may impact your health center's 2020 UDS report, please refer to the UDS Reporting Category on the Bureau of Primary Health Care's COVID-19 Frequently Asked Questions (FAQs) webpage.



Finding Support on BPHCdata.net



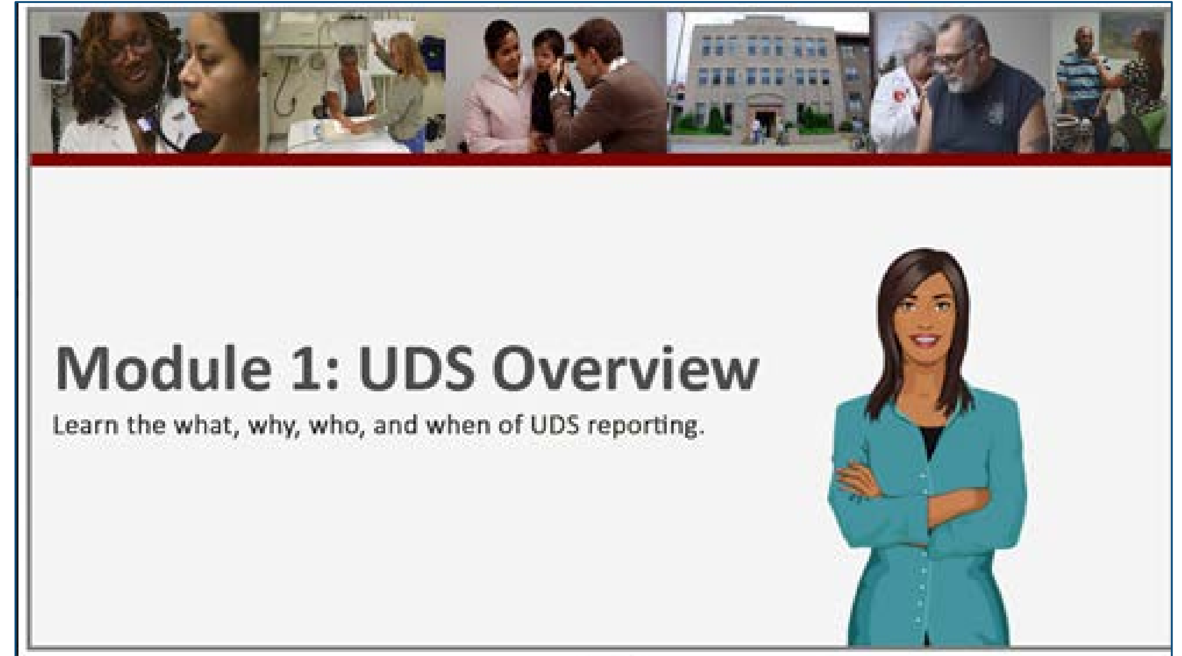
Scroll down on the home page for options to help you navigate to the resources you need.



Scroll to the bottom of the page for the UDS Support Line phone number and contact form.

Recorded Training Modules

1. UDS Overview
2. Patient Characteristics
3. Clinical Services and Performance
4. Operational Costs and Revenues
5. Submission Success



Find the modules on the resource page: https://bphcdata.net/resources/

Training Webinar Series for 2020 UDS Reporting

- Reporting Visits in the UDS
- UDS Clinical Tables Part 1: Screening and Preventive Care
- UDS Clinical Tables Part 2: Maternal Care and Children’s Health
- UDS Clinical Tables Part 3: Disease Management
- Reporting UDS Financial and Operational Tables
- Comparison Performance Metrics from UDS Financial Tables
- COVID-19 UDS Reporting Office Hour
- UDS Reporting for BHWs

All webinars are archived on the HRSA website.

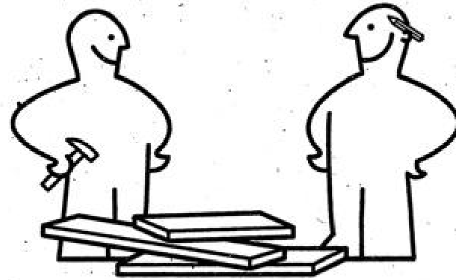
Support Available

	UDS Support Center	Health Center Program Support	HRSA Call Center
Purpose	Assistance with content and reporting requirements of the UDS Report or about the use of UDS data (e.g., defining patients or visits, questions about clinical measures, questions on how to complete various tables, how to make use of finalized UDS data)	Assistance for health centers when completing the UDS Report in the EHBs (e.g., report access/submission, diagnosing system issues, technical assistance materials, triage)	Assistance with getting an EHBs account, password assistance, setting up the roles and privileges associated with your EHBs account, and determining whether a competing application is with Grants.gov or HRSA
Contact	866-837-4357/866-UDS-HELP udshelp330@bphcdata.net	877-464-4772, Option 1	877-464-4772, Option 3
Website	http://bphcdata.net	http://www.hrsa.gov/about/contact/bphc.aspx	http://www.hrsa.gov/about/contact/ehbhelp.aspx
Hours of Operation	8:30 a.m. to 5:00 p.m. EST, M–F Extended hours during UDS reporting period	7:00 a.m. to 8:00 p.m. EST, M–F Extended hours during UDS reporting period	8:00 a.m. to 8:00 p.m. EST, M–F

Tips for Success

Tips for Success

- **Tables are interrelated**, so sit with team to agree what will be reported.
  - Sites
  - Staff, FTEs, and roles
  - Patients and services
  - Expenses
  - Revenues



- Adhere to **definitions and instructions.**
- **Check your data** before submitting.
  - Refer to last year's reviewer's letter emailed to the UDS Contact.
  - Compare with benchmarks/trends.
  - Review the Comparison Tool.
  - Understand system changes that justify the data.
- Address **edits** in EHBs by correcting or providing explanations that demonstrate your understanding.
- Work with your **reviewer.**

HRSA Health Center Program

Administering Program Conditions

Health centers must demonstrate program compliance with these requirements:

- The health center has a system in place to collect and organize data related to the HRSA-approved scope of project, as required to meet Health and Human Services (HHS) reporting requirements, including those data elements for UDS reporting; and
- The health center submits timely, accurate, and complete UDS reports in accordance with HRSA instructions and submits any other required HHS and Health Center Program reports.

Source: Chapter 18: Program Monitoring and Data Reporting Systems of the Health Center Compliance Manual

Conditions will be applied to health centers who fail to submit by February 15.

- **February 16–April 1:** The Office of Quality Improvement (OQI) will finalize and confirm the list of "late," "inaccurate," or "incomplete" UDS reporters.
- **Mid-April:** OQI will notify the respective Health Services Offices (HSO) project officers of the health centers that are on the non-compliant list.
- **Late April/Early May:** HSOs will issue the related Progressive Action condition.

HRSA Health Center Program

Please Complete an Evaluation!

Please be sure to select your PCA at the top of the evaluation.

https://redcap.link/UDSWebinarEvaluation

Your input is important to us.

HRSA
Health Center Program

Question and Answer Session

- Expectations for asking questions
  - Submission to PCA
  - Q+A Session date, time, format

Contact Information

Remember to call the UDS Support Line if you have additional content questions:

1-866-UDS-HELP

or

1-866-837-4357

udshelp330@bphcdata.net

Reporting Instructions
for **Calendar Year 2020**
Health Center Data

Updated on August 21, 2020

For Reports Submitted February 15, 2021

Bureau of Primary Health Care

Uniform Data System Reporting Instructions for 2020 Health Center Data

Letter from the Associate Administrator

Dear Health Center Program Participant:

On behalf of the Health Resources and Services Administration (HRSA), thank you for your continued dedication and efforts to deliver primary health care services to medically underserved and vulnerable populations. Health centers have played a critical role in responding to the spectrum of patients' needs during the COVID-19 public health emergency, from testing and treating patients with COVID-19, to transitioning or scaling telemedicine to provide routine care to patients, and keeping staff and the nation's most vulnerable populations cared for and safe.

The Health Center Program supports over 1,400 health centers and approximately 13,000 service delivery sites across the United States, the District of Columbia, Puerto Rico, the Virgin Islands, and the Pacific Basin that ensure access to affordable, comprehensive, high-quality primary care services for patients regardless of their ability to pay. In 2018, health centers served over 28 million patients, which represents, 1 in 12 people, 1 in 9 children, 1 in 5 rural residents, 1 in 3 individuals living in poverty, and more than 385,000 veterans across the country.

Health centers are well-positioned to meet the nation's most pressing health care needs, as well as emerging health priorities. In 2018, health centers screened and identified nearly 1.1 million people for substance use disorder and ultimately provided medication-assisted treatment to nearly 95,000 patients nationwide, an increase of 143% since 2017. Health centers are playing a key role in the Ending the HIV Epidemic Initiative by serving as a point of entry for early detection and diagnosis of people living with HIV. In 2018, health centers provided over 2.4 million HIV tests to more than 2 million patients and treated 1 in 6 patients diagnosed with HIV nationally.

Data use is central to HRSA's quality-improvement activities. The Uniform Data System (UDS) data are instrumental for promoting quality initiatives like the Quality Improvement Awards. In 2019, HRSA provided nearly $107 million in Quality Improvement Awards to health centers that demonstrated improved quality of care across a range of areas. Health centers used these funds to further expand their achievements in clinical quality improvement, care delivery efficiency, and the overall value of health care in the communities they serve. Given the essential role data plays for the Health Center Program, I am truly appreciative of your contributions to ensuring high quality data are reported.

Annual performance reporting is vital to achieve HRSA's mission and understanding the impact of the Health Center Program. We have updated the 2020 UDS Manual in response to your feedback and the changing healthcare landscape. The notable changes for 2020 UDS reporting, as outlined in the Program Assistance Letter 2020-04, include capturing more detailed information on depression, HIV, breast cancer, social determinants of health, and the use of Prescription Drug Monitoring Programs. We recognize that COVID-19 has impacted all of us. As you work on your 2020 UDS Report and compare data to prior years, the impact and experiences of COVID-19 will be evident. HRSA is mindful of contextual factors that impact UDS data which are used to evaluate Health Center Program initiatives and provide progress updates.

We continue to modernize the UDS reporting process to increase data standardization across national programs, reduce reporting burden, increase data quality, and expand data use to improve clinical care and operations to benefit you and the patients you serve. Your insights are critical to further advance the Health Center Program, and I encourage you to continue providing feedback.

I would like to extend my gratitude once again for your support of the Health Center Program, for your critical role in providing health care to millions of people across the country, and for serving on the front lines during the COVID-19 pandemic. Your work in primary health care delivery is critical to the communities you serve and the health of the Nation.

Sincerely,

/James Macrae/

James Macrae
Associate Administrator
Bureau of Primary Health Care

Bureau of Primary Health Care

Uniform Data System Reporting Instructions

For Calendar Year 2020 UDS Data

For help contact: 866-837-4357 (866-UDS-HELP), https://bphcdata.net/, or udshelp330@bphcdata.net

Health Resources and Services Administration

Bureau of Primary Health Care

5600 Fishers Lane, Rockville, Maryland 20857

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PUBLIC BURDEN STATEMENT
The Uniform Data System (UDS) provides consistent information about health centers including patient demographics, services provided, clinical processes and health outcomes, patients' use of services, costs, and revenues. It is the source of unduplicated data for the entire scope of services included in the grant or designation for the reporting year. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0915-0193 and it is valid until 02/28/2023. 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 238 hours 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 the Health Resources and Services Administration (HRSA) Reports Clearance Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland, 20857 or paperwork@hrsa.gov.

DISCLAIMER
"This publication lists non-federal resources to provide additional information to consumers. Neither the U.S. Department of Health and Human Services (HHS) nor the Health Resources and Services Administration (HRSA) has formally approved the non-federal resources in this manual. Listing these is not an endorsement by HHS or HRSA."

Introduction

This manual describes the annual Uniform Data System (UDS) reporting requirements for all health centers that receive federal award funds ("awardees") under the Health Center Program authorized by section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b) ("section 330"), as amended (including sections 330(e), (g), (h), and (i)), as well as for health centers considered Health Center Program look-alikes. Look-alikes do not receive federal funding under section 330 of the PHS Act but meet the Health Center Program requirements for designation under the program (42 U.S.C. 1395x(aa)(4)(A)(ii) and 42 U.S.C. 1396d(l)(2)(B)(ii)). Certain health centers funded under the Health Resources and Services Administration's (HRSA) Bureau of Health Workforce (BHW) are also required to complete the UDS. Unless otherwise noted, for the remainder of this manual the term "health center" will refer to all the entities listed above that are required to submit a UDS Report.

These instructions detail the submission of required data and highlight changes to the tables that have been implemented for the current year. The approved UDS Changes for Calendar Year 2020 Program Assistance Letter (PAL) 2020-04 provides an overview of changes that apply to the calendar year 2020 UDS Report due February 15, 2021. In addition to detailed table instructions, frequently asked questions (FAQs) are included in Appendix B1. Nine appendices are included that provide the following:

- a list of personnel by category and identification of personnel by job title who may be able to produce countable "visits" for the UDS;
- FAQs by table;
- information addressing specific issues that affect multiple tables;
- sampling methods for selecting patient charts for clinical reviews;
- reporting instructions for the Health Information Technology (HIT) Capabilities Form;
- reporting instructions for the Other Data Elements Form;
- reporting instructions for the Workforce Form;
- a list of resources to assist health centers, including links to electronic clinical quality measures (eCQMs); and
- a glossary of terms.

About the UDS

The UDS is a standard data set that is reported annually and provides consistent information about health centers. This core set of information includes patient demographics, services provided, clinical processes and health outcomes, patients' use of services, costs, and revenues. It is the source of unduplicated data for the entire scope of services included in the grant or designation for the reporting year. If the health center brings services or sites into scope during the calendar year, data must be included from the period after the date of the scope change.

HRSA routinely reports these data and related analyses, making them available to health centers in HRSA's Electronic Handbooks (EHBs) and to the public through HRSA's Bureau of Primary Health Care (BPHC) website.

General Instructions

What to Submit

The UDS includes 11 tables and 3 forms (in the appendices) designed to yield consistent demographic, clinical, operational, and financial data. As a requirement to participate in the Health Center Program, health centers must complete the following:

- ZIP Codes: Patients served reported by ZIP code and by primary third-party medical insurance source, if any
- Table 3A: Patients by age and by sex assigned at birth
- Table 3B: Patients by race, Hispanic or Latino/a ethnicity, language barriers, sexual orientation, and gender identity
- Table 4: Patients by income (as measured by percentage of the federal poverty guidelines [FPG]) and primary third-party medical insurance source; the number of “special population” patients receiving services; and managed care enrollment, if any
- Table 5: The annualized full-time equivalent (FTE) of program staff by position category, visits by provider type, patients by service type, and mental health and substance use disorder selected services detail
- Table 6A: Visits and patients for selected medical, mental health, substance use disorder, vision, and dental diagnoses and services
- Table 6B: Clinical quality-of-care measures
- Table 7: Health outcome measures by race and ethnicity
- Table 8A: Direct and indirect expenses by service categories
- Table 9D: Full charges, collections, and adjustments by payer type; sliding fee discounts; and bad debt write-offs for patients
- Table 9E: Other, non-patient-service-related income
- Appendix D: Health Information Technology (HIT) Capabilities Form: HIT capabilities, including the use of electronic health record (EHR) information
- Appendix E: Other Data Elements Form: Medication-assisted treatment (MAT), telehealth, and outreach and enrollment assists
- Appendix F: Workforce Form: Health center workforce training and provider and staff satisfaction surveys

The UDS Support Center is available to provide training, technical assistance, and resources about the UDS data and reporting requirements at **866-UDS-HELP or udshelp330@bphcdata.net**.

What to File

The UDS includes two parts that health centers submit through the EHBs:

- All health centers use the Universal Report, which consists of the UDS tables, the HIT Form, the Other Data Elements Form, and the Workforce Form.
- Health Center Program awardees that receive section 330 grants under multiple program funding authorities (Community Health Center [CHC] [330(e)] program, Migrant Health Center [MHC] [330(g)] program, Health Care for the Homeless [HCH] [330(h)] program, and/or Public Housing Primary Care [PHPC] [330(i)]) also complete separate Grant Reports. The Grant Reports provide data comparable to the Universal Report for Tables 3A, 3B, 4, 6A, and part of Table 5, but for only that portion of the program that falls within the scope of a project funded under a particular funding authority. Awardees **DO NOT** file a Grant Report for the scope of

project supported under the CHC (330(e)) program.

The EHBs reporting system will automatically identify all the required reports needed to complete the UDS reporting requirements. Please contact the Health Center Program Support line at 877-464-4772 if there appear to be errors.

The Universal Report is an unduplicated count of all patients served by the health center regardless of funding source; the Grant Report is a subset of patients reported on the Universal Report served under a special population funding authority. Thus, no cell in a Grant Report may have a number larger than the same cell in the Universal Report.

Report all the data for any patient who receives services under *sections 330(g), (h), or (i)* in the proper Grant Report. Include services provided to these patients, regardless of the funding source. For example, if patients experiencing homelessness receive medical services in the homeless medical van and all dental services at the clinic, their dental services and diagnoses would be reported on the Homeless Grant Report Tables 5 and 6A regardless of the dental funding source.

In summary, health centers that receive funds under only one BPHC funding authority complete the Universal Report and no Grant Reports. Health centers funded through multiple BPHC funding authorities complete a Universal Report for the combined projects and a separate Grant Report for activity covered by their MHC, HCH, and/or PHPC program grant(s).

Examples include the following:

- A CHC awardee (section 330(e)) that also has HCH funding (section 330(h)) completes a Universal Report for all in-scope activity and a Grant Report for activity under the HCH program but does not complete a Grant Report for the CHC funding.
- A CHC awardee (section 330(e)) that also has MHC (section 330(g)) and HCH (section 330(h)) funding completes a Universal Report, a Grant Report for the HCH program, and a Grant Report for the MHC program.
- An HCH awardee (section 330(h)) that also receives PHPC (section 330(i)) funding completes a Universal Report and two Grant Reports—one for the HCH program and one for the PHPC program.
- An HCH awardee (section 330(h)) that receives no other Health Center Program funding will file a Universal Report and will not file a Grant Report.

Tables Shown in Each Report

The table below shows which tables and data appear in the Universal Report and Grant Reports.

Table	Data Reported	Universal Report	Grant Reports
Service Area			
ZIP Code Table	Patients by ZIP Code	X	
Patient Profile			
Table 3A	Patients by Age and by Sex Assigned at Birth	X	X
Table 3B	Demographic Characteristics	X	X
Table 4	Selected Patient Characteristics	X	X
Staffing and Utilization			
Table 5	Staffing and Utilization	X	partial
Table 5 Addendum	Selected Service Detail Addendum	X	
Clinical			
Table 6A	Selected Diagnoses and Services Rendered	X	X
Table 6B	Quality of Care Measures	X	
Table 7	Health Outcomes and Disparities	X	
Financial			
Table 8A	Financial Costs	X	
Table 9D	Patient Related Revenue	X	
Table 9E	Other Revenue	X	
Other			
HIT Form	HIT Capabilities	X	
Other Form	Other Data Elements	X	
Workforce Form	Training and Satisfaction Surveys	X	

Calendar Year Reporting Period

All health centers **funded or designated in whole or in part before October 1** must report on their approved scope, even if they did not draw down grant funds for some or all of their program during the calendar year. Health centers funded or designated for the first time on or after October 1 of the reporting year will not file a 2020 UDS Report.

The UDS is a calendar year report. Health centers—including those whose designation or funding begins, either in whole or in part, after January 1—must report on the entire calendar year. Similarly, health centers with a fiscal year or grant period other than January 1 to December 31 will still report on the calendar year, not on their fiscal or grant year. Health centers whose designation or funding ends during the year should discuss any reporting issues with their project officer.

If one or more sites of a health center designated as a look-alike received section 330 New Access Point (NAP) funding before October, exclude all the data related to those funded sites from the look-alike UDS Report for 2020 **and** report the data related to the funded sites in the awardee UDS Report for 2020. If the entire look-alike program became funded, report only an awardee UDS Report for the year.

In-Scope Reporting

All health centers must submit data that reflects activities in the HRSA health center project, as defined in approved applications and reflected in the official Notice of Award/Designation.

Due Dates and Revisions to Reports

The period for submission of complete and accurate UDS Reports is January 1 through ***February 15, 2021, 11:59 p.m. local time***.

From February 15 through March 31, 2021, a Health Center Program UDS Reviewer will work with you, as needed, to correct or explain data reported. Communications and data change requests are sent by the UDS Reviewer to the health center contact through EHBs using a non-HRSA.gov email address. Communicate directly with the assigned UDS Reviewer during this time to address questions raised. Final, corrected submissions are due no later than March 31, 2021. **HRSA does not accept changes after this date.**

HRSA may grant a reporting exemption under extraordinary circumstances, such as the physical destruction of a health center. Health centers must request such exemptions directly from the BPHC Office of Quality Improvement through the **Health Center Program Support**.

For report deadline and exemption help at any time, please contact Health Center Program Support at 877-464-4772.

How and Where to Submit Data

Health center staff will use their username and password to log into the EHBs to complete and submit their UDS Reports. The system supports the use of standard web browsers.[1] It provides electronic forms necessary to complete the reports. The Preliminary Reporting Environment (PRE) provides early access to the EHBs and is available in the fall. This allows health centers to enter available UDS data, help identify potential data reporting errors, and provide additional preparation time to compile UDS data.

Health center staff with EHBs access can work on the forms in sections, saving interim or partial versions online as they work and returning to complete them later.

[1] While most browsers should work with the EHBs, it is certified to work with Internet Explorer (IE) Version 8.0 through 11.0 or Firefox 3.6 or higher. Health centers having a problem with other browsers should consider using IE-8, 9, 10, or 11 or Firefox 3.6 for this task. More information about EHBs' recommended settings is available.

Health centers may give data entry responsibility to several people, each using separate login credentials. To facilitate a team-based approach, there are also offline reporting templates available within the EHBs. For more information on these tools, visit UDS Modernization Initiative web page. In addition, health centers designate one person as the UDS contact. The UDS contact receives all communications about the UDS Report. This person may be asked to explain the data reported on the UDS tables during the review. Be sure the UDS contact information is updated in the EHBs. Health center staff may receive "view" or "edit" privileges. These apply to the whole report, not just specific tables.

The system saves work in the EHBs until the health center makes a formal submission. The chief executive officer (CEO) or project director usually does this but may delegate the authority to someone else. At the time of submission, the UDS requires that the submitter acknowledge that the health center reviewed and verified the accuracy and validity of the data. Failure to submit a timely, accurate, and complete UDS Report by February 15, 2021, 11:59 p.m. (local time) will result in a condition being placed on your grant award. Additional restrictions, including the requirement that all drawdowns of Health Center Program grant award funds from the Payment Management System (PMS) have the prior approval of the HRSA Division of Grants Management Operations (DGMO) and/or limits on future funding (e.g., HRSA Quality Improvement Awards, base adjustments), may also be placed on your grant award.

Reports must be complete to be submitted into the EHBs. To ensure accuracy, the EHBs will check for potential inconsistencies or questionable data. The system will provide a summary of which tables are complete, as well as a list of audit questions. Health center staff must address each of the data audit findings, even if the audit question does not apply to their health center's unique circumstances. If staff believe the data is correct as submitted, they should clearly explain any unique circumstances.

Note: *Health centers should retain their UDS reporting backup documentation and files for a minimum of one year or through a date determined by the health center.*

Please refer to Appendix G: Health Center Resources for resources that may be helpful for completing the UDS Report. Support contacts and links, such as contact information for the UDS Support Center, web links to a complete set of the UDS tables, training opportunities and resources, and other materials, are included.

Instructions for Tables that Report Visits, Patients, and Providers

Visits

Visits determine who to count as a patient on the ZIP Code Table, Tables 3A, 3B, 4, 5, 6A, 6B, and 7; visits are reported by type of provider on Table 5 and for selected diagnoses and selected services on Table 6A.

Countable visits are documented, individual,[2] face-to-face or virtual[3] contacts between a patient and a licensed or credentialed provider who exercises independent, professional judgment in providing services. Health centers should count only visits that meet all these criteria.

To count visits, the services must be documented in a chart that stays in the possession of the health center (see further details below). Services must be provided by an individual classified as a "provider" for purposes of providing countable visits. Not all health center staff who interact with patients qualify as a provider. Appendix A provides a list of health center personnel and the *usual* status of each as a provider or non-provider for UDS reporting purposes.

Visits provided by contractors and **paid for by or billed through the health center** are counted in the UDS if they meet all other criteria. These include migrant voucher visits, as well as outpatient or inpatient specialty care associated with an at-risk managed care contract. In these instances, if the visit is not documented in the patient's medical record, a summary of the visit (rather than the complete record) must appear in the patient's medical record, including all appropriate Current Procedural Terminology (CPT) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes.

Below are definitions and criteria for reporting visits. Table 5 provides further clarifications. See Clinic Visits, Column B.

Documentation

To meet the criterion for documentation, health centers must record the service (and associated patient information) in print or electronic form in a system that permits ready retrieval of current data for the patient. The patient record does not have to be complete to meet this standard.

For example, a patient receiving documented emergency services counts even if some portions of the health record are incomplete. Providers who see their established patients at a hospital or respite care facility and make a note in the institutional file can satisfy this criterion by including a summary discharge note showing activities for each of the visit dates.

Independent Professional Judgment

To meet the criterion for independent professional judgment, providers must be acting on their own, not assisting another provider, when serving the patient.

Independent judgment is the use of the professional skills gained through formal training and experience and unique to that provider or other similarly or more intensively trained providers.

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[2] An exception is allowed for behavioral health visits, which may be conducted in a group setting.

[3] Only interactive, synchronous audio and/or video telecommunication systems that permit real-time communication between a distant provider and a patient may be considered and coded as telemedicine services. The term "telehealth" includes telemedicine services but encompasses a broader scope of remote health care services. Telemedicine is specific to remote clinical services, whereas telehealth may include remote non-clinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services.

For example, a nurse assisting a physician during a physical examination by taking vital signs, recording a history, or drawing a blood sample does not receive credit as a separate visit. Eligible medical visits usually involve one of the "Evaluation and Management" billing codes (99201–99205 or 99211–99215) or one of the health maintenance codes (99381–99387, 99391–99397).

Behavioral Health Group Visits

A behavioral health provider who provides services to several patients simultaneously receives credit for a visit for each person only if the service is documented in each person's health record.

Examples of "group visits" include family therapy or counseling sessions, group mental health counseling, and group substance use disorder counseling where several people receive services that are documented in each person's health record.

Other considerations:

- The health center normally bills each patient, even if another grant or contract covers the costs.
- If only one person is billed (for example, when a relative participates in a patient's counseling session), count only the billed person as a patient and count the visit for that one patient.
- When a behavioral health provider conducts services via telemedicine, the provider can be credited with a visit only if the service is documented in the patient's record. The session will normally be billed to the patient or a third party.
- Do not count group medical visits.

Location of Services Provided

A visit must take place in health center approved sites (e.g., clinics, schools, homeless shelters, as listed on Form 5B) or in other locations that do not meet HRSA's site criteria but are included in the health center's scope of project, such as hospitals, nursing homes, or extended care facilities. In addition, virtual visits may occur from other locations. See instructions for Virtual Visits.

A health center may not count more than one inpatient visit per patient per day regardless of how many clinic providers see the patient or how often they do so.

Other considerations:

- Visits also include contacts with existing hospitalized patients, when health center medical staff "follow" the patient during the hospital stay as provider of record or when they provide consultation to the provider of record. This applies when the health center pays medical staff and bills the patient either for the specific service or through a global fee.
- When a patient's first encounter is in a hospital, in respite care, or in a similar facility *that is not specifically approved in Form 5B as a service delivery site under the scope of the Health Center Program*, none of the services for that patient are counted in the UDS.

Counting Multiple Visits by Category of Service

Multiple visits occur when a patient has more than one visit with the health center in a day. On any given day, a patient may have only one visit per service category, as described in the table on the following page.

Other considerations:

- If multiple medical providers in a single category deliver multiple services on a single day (e.g., an obstetrician/gynecologist [OB/GYN] who provides prenatal care to a patient and an internist who treats that same patient's hypertension), count only one visit even if third-party payers may recognize these as separate billable services.
- Health centers can count medical services provided by two *different* medical providers located at two *different* sites on the same day. This is the only exception to the rule. This permits patients who are in challenging environments (e.g., in parks or migrant camps) to receive services outside the health center from a licensed/credentialed health center provider and receive services again on the same day at the health center from a different licensed/credentialed provider.
- A provider receives credit for no more than one visit with a given patient in a single day, regardless of the types or number of services provided or where they occur.

Maximum Number of Visits per Patient per Day

# of Visits	Visit Type	Provider Examples
1	Medical	physician, nurse practitioner, physician assistant, certified nurse midwife, nurse
1	Dental	dentist, dental hygienist, dental therapist
1	Mental health	psychiatrist, licensed clinical psychologist, licensed clinical social worker, psychiatric nurse practitioner, other licensed or unlicensed mental health providers
1	Substance use disorder	alcohol and substance use disorder specialist, psychologist, social worker
1 for each provider type	Other professional	nutritionist, podiatrist, speech therapist, acupuncturist
1	Vision	ophthalmologist, optometrist
1 for each provider type	Enabling	case manager, health educator

Patient

Patients are people who have at least one reportable visit during the reporting year. The term "patient" applies to everyone who receives clinic or virtual visits, not just those who receive medical or dental services.

The **Universal Report** includes all patients who had at least one visit during the year within the scope of activities supported by the grant/designation.

- Report these patients and their visits on Tables 5 and 6A for each type of service (e.g., medical, dental, enabling) received during the year.
- On the ZIP Code Table, Tables 3A and 3B, in each section of Tables 4 and 5, and for each service of Table 6A, count each patient once and only once. This applies even if they received more than one service (e.g., medical, dental, enabling) or received services supported by more than one program authority (e.g., section 330(g), section 330(h), section 330(i)).

For each **Grant Report**, patients reported are those who have at least one visit during the year within the scope of project activities supported by the specific section 330 program authority. The number of patients reported in any cell on the Universal Report includes patients reported in the same cell in the Grant Report.

Services and Persons Not Reported on the UDS Report

Some services *do not count* as a visit for UDS reporting.

Similarly, someone who only receives one of the services described below ***is not a patient for purposes of UDS reporting.***

If an individual receives additional services that require independent judgement from a health center provider and the services are documented, they may be considered a patient of the health center.

These situations include the following:

Health screenings or outreach

- Screenings frequently occur as part of community activities that involve conducting outreach or group education.
- Examples include information sessions for prospective patients; health presentations to community groups; information presentations about available health services at the center; services conducted at health fairs or schools; immunization drives; services provided to groups, such as dental varnishes or sealants provided at schools; hypertension or diabetes testing; or similar public health efforts.
- Do not count screenings (e.g., COVID-19) as reportable visits. However, if an individual receives additional services with the screening that meet visit definitions, the additional service may be considered.

Group visits

- Do not count visits conducted in a group setting, except for behavioral health group visits.
- The most common non-behavioral health group visits are patient education or health education classes (e.g., people with diabetes learning about nutrition).

Tests and other ancillary services

- Tests support the services of the clinical programs.
- Examples include laboratory tests (including purified protein derivatives [PPDs], pregnancy, Hemoglobin A1c [HbA1c], and blood pressure) and imaging (including sonography, radiology, mammography, retinography, or computerized axial tomography).
- Do not count services required to perform such tests, such as drawing blood or collecting urine.
- Do not count tests (e.g., COVID-19) as reportable visits. However, if an individual receives additional services with the test that meet visit definitions, the additional service may be considered.

Note: *Although tests and other ancillary services themselves are not countable as visits on Table 5, selected tests and services are included on Table 6A to reflect selected ancillary services provided to health center patients. If tests and other services are done as part of or following an order to a qualifying visit for a health center patient, report these on Table 6A.*

Dispensing or administering medications

- Do not count dispensing medications, including dispensing from a pharmacy (whether by a clinical pharmacologist or a pharmacist) or administering medications (such as buprenorphine or warfarin).
- Do not count giving any injection (including for vaccines, allergy shots, or family planning), regardless of education provided at the same time.
- Do not count providing narcotic agonists or antagonists or mixes of these, regardless of whether the patient is assessed at the time of the dispensing and regardless of whether these medications are dispensed regularly.

Health status checks

- Do not count follow-up tests or checks (such as patients returning for HbA1c tests or blood pressure checks).
- Do not count wound care (which is follow-up to the original primary care visit).
- Do not count taking health histories.
- Do not count making referrals for or following up on external referrals.

Services under the Women, Infants, and Children (WIC) Program

- Do not count a person whose only contact with a health center is to receive services (including nutrition) under a WIC program.

Provider

A provider is someone who assumes primary responsibility for assessing the patient and documenting services in the patient's record.

- Providers include only those who exercise independent judgment for services rendered to the patient during a visit.
- Only one provider who exercises independent judgment receives credit for the visit, even when two or more providers are present and participate.
- If two or more providers of the same type share the services for a patient (e.g., a family physician and a pediatrician both see a child, or a dental hygienist and a dentist see a patient on the same day), only one provider receives credit for a visit.
- In cases where a preceptor is following and supervising a licensed resident, the resident receives credit. (See Table 5 for further instruction on counting interns and residents.)
- When health center staff are following a patient in the hospital, the primary health center staff person in attendance during the visit is the provider who receives credit for the visit, even if other staff are present.
- Except for physicians and dentists, allocate staff time by function among the major service categories based on time dedicated to other roles (e.g., a nurse who dedicates 20 hours to medical care and 20 hours to providing health education each week would split the 1.0 FTE between medical nurse and health educator).
- Appendix A provides a listing of personnel. Only personnel designated as a "provider" can generate visits for purposes of UDS reporting.
- Table 5 provides further clarifications to these definitions. See Instructions for Table 5: Staffing and Utilization.
- Providers may be employees of the health center, contracted staff, or volunteers.
- Contract providers who are paid by the health center with grant funds or program income and who are part of the scope of the approved grant/designation, serve center patients, and document their services in the center's records count as providers.

Note: *A discharge summary or similar document in the medical record will meet these criteria.*

- Contract providers who are paid for specific visits or services with grant funds or program income and report patient visits to the direct recipient of a BPHC or BHW grant or designation (e.g., under a migrant voucher program or of HCH awardees with sub-awardees) are providers. The direct recipient of the BPHC or BHW grant/designation reports these providers' activities. Since such providers often have no time basis in their report, no FTE would be reported for them if time data were not collected.
- Count providers who volunteer to serve patients at the health center's sites under the supervision of the center's staff and document their services and time in the center's records.

- Individuals or groups who provide services under formal agreement or contract when the health center does not pay for the visit are not credited as providing a health center visit. This is the case even if they provide discharge summaries or report the service in the patient's medical chart, unless they are working at an approved site under the supervision of the appropriate health center staff and are credentialed by the health center.

Note: *These providers are generally providing services noted in Column III of the grant scope of project application Form 5A. See an example of Form 5A.*

Instructions for ZIP Code Data

The ZIP Code Table provides data on patients' origin by primary medical insurance.

Patients by ZIP Code

All health centers must report the number of patients served by ZIP code and medical insurance. This information enables BPHC to better identify areas served by health centers, potential service area overlaps, and possible areas of unmet need. Patients may be mobile during the reporting period; health centers report patients' most recent ZIP code on file. This information is to be updated each calendar year.

ZIP Code of Specific Groups

Residence information may not be available for some patients. This is particularly true for health centers that serve transient groups. Special instructions cover the following groups:

- **Patients experiencing homelessness:** Although many patients experiencing homelessness live doubled up or in shelters, transitional housing, or other fixed locations, others—especially those living on the street—do not know or will not share an exact location. When a ZIP code location is unavailable or the location offered is questionable, health centers should use the service location ZIP code as a proxy. Similarly, if the patient has no other ZIP code and receives services in a mobile van, use the ZIP code of the van's location that day. Health centers might collect the address of a contact person to facilitate communication with the patient; however, while appropriate from a clinical and service delivery perspective, do not use the contact person's address as the patient's address.
- **Patients who are migratory agricultural workers:** Migratory agricultural workers (as opposed to seasonal workers) may have both a temporary address that reflects where they live when they are working in the community, as well as a permanent or "downstream" address that may be far from the location of their current work and the site where they are receiving care. For the UDS Report, health centers are to report the ZIP code of where the patient lived when they received care from the health center. Note that migratory agricultural worker patients may also be seen by health center providers in their home, or "downstream" community. For patients whose precise ZIP code is unavailable (e.g., living in cars or on the land), the ZIP code for the location (fixed site or mobile camp outreach) where they received services should be used.
- **Patients who are foreign nationals:** Report the current ZIP codes for people from other countries who reside in the United States either permanently or temporarily. Tourists and other people who may have a permanent residence outside the country are to be reported under Other ZIP Code.

Unknown ZIP Code

For the small number of patients for whom residence is not known or for whom a proxy is not available, residence should be reported as Unknown.

Ten or Fewer Patients in ZIP Code

Although health centers report residence by ZIP code for all patients, some health centers may have many patients from numerous ZIP codes outside their service area. To ease the burden of reporting, *combine and report patients from ZIP codes with **10 or fewer** patients in the Other category*.

Instructions for Type of Insurance

Report on patients' origin by primary medical insurance. **Health centers are expected to report primary medical insurance status for all patients, regardless of what services they receive.** This even applies to patients who did not receive medical care. For example, health centers must determine the primary medical insurance coverage for a patient who only received case management services. Health centers may not report patients as uninsured simply because they are receiving a service that is not covered by health insurance. Children served in school-based health center settings must have complete clinic intake forms that show insurance status and family income to be reported as patients in the UDS. They must not be considered uninsured unless they are receiving minor consent services or their family is uninsured.

Insurance Categories

Report the patient's *primary medical insurance covering medical care, if any, as of the last visit during the reporting period*. Primary medical insurance is the insurance plan that the health center would typically bill first for medical services. The categories for this table are slightly different from those on Table 4; they combine Medicaid, Children's Health Insurance Program (CHIP), and Other Public into one category. Specific rules guide reporting:

- Report patients who have both Medicare and Medicaid (dually eligible) as Medicare patients, because Medicare is billed before Medicaid. The exception to the Medicare-first rule is the Medicare-enrolled patient who is still working and insured by both an employer-based plan and Medicare. In this case, the principal health insurance is the employer-based plan, which is billed first.
- Report Medicaid and CHIP patients enrolled in a managed care program administered by a private insurance company as Medicaid/CHIP/Other Public.
- Report Medicare administered by a private insurance company as Medicare.
- In rare instances, a patient may have insurance that the health center cannot or does not bill. This might include patients enrolled in Medicaid but assigned to another primary care provider, or patients with private insurance for which the health center's providers have not been credentialed. In these instances, the health center is still to *report the patient by their medical insurance*, even if it does not bill to this insurance.
- Section 330 grant funds used to serve special populations (e.g., MHC, HCH, PHPC) are not a form of medical insurance. Report any third-party insurance that patients carry.
- Classify patients who are incarcerated as uninsured (whether they were seen in the correctional facility or at the health center), unless Medicaid or other insurance covers them, and at the ZIP code of the jail or prison. Do not classify patients in residential drug programs, college dorms, military barracks, etc. as uninsured. In these instances, report the patient by primary medical insurance and record the ZIP code of the residential program, dorm, or barrack.

- Count patients whose care is subsidized by state or local government indigent care programs as uninsured. Examples include New Jersey's Uncompensated Care Program, New York's Public Goods Pool Funding, and Colorado's Indigent Care Program.
- Affordable Care Act subsidies (i.e., cost-sharing reductions and premium tax credits) do not affect insurance categories. Classify patients by their third-party insurer. Report patients who received insurance through the Health Insurance Marketplace as Private.

Additional information is available to clarify reporting. **View FAQs for the ZIP Code Table.**

Table: Patients by ZIP Code

Reporting Period: January 1, 2020, through December 31, 2020

ZIP Code (a)	None/ Uninsured (b)	Medicaid/ CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
Other ZIP Codes					
Unknown Residence					
Total					

Note: *This is a representation of the form. The actual online output from the EHBs will display ZIP codes entered by the health center in Column A.*

Instructions for Tables 3A and 3B

Tables 3A and 3B provide demographic data on patients who accessed services during the calendar year. This information must be collected from patients initially as part of the patient registration or intake process and then must be updated or confirmed annually thereafter.

Table 3A: Patients by Age and by Sex Assigned at Birth

Report the number of patients by appropriate categories for age and sex assigned at birth.

- Use the individual's age on June 30 of the reporting period.
- Report patients according to their sex at birth or sex reported on a birth certificate. In states that permit this to be changed, the birth certificate sex may still be used.
- Report date of birth and sex listed on the birth certificate for all patients. There is no "unknown" category on this table.

***Note:** On the non-prenatal portions of Tables 6B and 7, age is generally defined as the patient's age as of January 1 except where noted. Thus, the numbers on Table 3A will not be the same as those on Tables 6B and 7 even if all the patients at a health center were medical patients, though they will usually be similar.*

Table 3B: Demographic Characteristics

Report the number of patients by their self-identified race, ethnicity, language preference, sexual orientation, and gender identity.

Patients by Hispanic or Latino/a Ethnicity and Race (Lines 1–8)

Table 3B displays the race and ethnicity (i.e., Hispanic or Latino/a) of the patient population in a matrix format. This permits the reporting of the racial and ethnic identification of all patients.

Hispanic or Latino/a Ethnicity

Table 3B collects information on whether or not patients consider themselves to be of Hispanic or Latino/a ethnicity, regardless of their race.

- Column A (Hispanic or Latino/a): Report the number of persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, broken out by their racial identification. Include in this count Hispanic or Latino/a patients born in the United States.
  - Do not count persons from Portugal, Brazil, or Haiti whose ethnicity is not tied to the Spanish language.
- Column B (Non-Hispanic or Latino/a): Report the number of patients who indicate that they are not Hispanic or Latino/a. If a patient self-reported a race (described below) but has not made a selection for the Hispanic/non-Hispanic or Latino/a question, presume that the patient is not Hispanic or Latino/a.
- Column C (Unreported/Refused to Report Ethnicity): Only one cell is available in this column. Report on Line 7, Column C, only those patients who left the entire race and Hispanic or Latino/a ethnicity part of the intake form blank or those who indicated that they refuse to report this data.
- Patients who self-report as being of Hispanic or Latino/a ethnicity but do not separately select a race must be reported on Line 7, Column A, as Hispanic or Latino/a ethnicity with “Unreported/Refused to Report” race. Health centers should not default these patients to “White,” “Native American,” “more than one race,” or any other category.

Race

All patients must be classified in one of the racial categories.

- Presume patients who self-report race but do not indicate if they are Hispanic or Latino/a as not Hispanic or Latino/a, and report on the appropriate race line in Column B.
- Patients sometimes categorized as “Asian/Other Pacific Islander” in other systems are reported on the UDS in one of three distinct categories:
  - **Line 1, Asian**: Persons having origins in any of the original peoples of Asia, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Indonesia, Thailand, or Vietnam
  - **Line 2a, Native Hawaiian**: Persons having origins to any of the original peoples of Hawai’i
  - **Line 2b, Other Pacific Islander**: Persons having origins in any of the original peoples of Guam, Samoa, Tonga, Palau, Chuuk, Yap, Saipan, Kosrae, Ebeye, Pohnpei or other Pacific Islands in Micronesia, Melanesia, or Polynesia
- **Line 4, American Indian/Alaska Native**: Persons who trace their origins to any of the original peoples of North, South, and Central America and who maintain tribal affiliation or community attachment

- **Line 6, More than one race**: Use this line only if your system captures multiple races (but not a race and an ethnicity) and the patient has chosen two or more races. This is usually done with an intake form that lists the races and tells the patient to "check one or more" or "check all that apply." "More than one race" must not appear as a selection option on your intake form.
    - Do not use "More than one race" for Hispanic or Latino/a people who do not select a race. Report these patients on Line 7 (Unreported/Refused to Report), as noted above.

Patients Best Served in a Language Other than English (Line 12)

This section of Table 3B identifies the patients who have linguistic barriers to care.

Report on Line 12 the number of patients who are best served in a language other than English, including those who are best served in sign language.

- Include those patients who were served in a second language by a bilingual provider and those who may have brought their own interpreter.
- Include patients residing in areas where a language other than English is the dominant language, such as Puerto Rico or the Pacific Islands.

Note:** Data reported on Line 12, Patients Best Served in a Language Other than English, may be estimated if the health center does not maintain actual data in its HIT. If an estimate is required, the estimate should be based on a sample where possible. **This is the only place on the UDS where an estimate is accepted.

Patients by Sexual Orientation (Lines 13–19)

Sexual orientation is how a person describes their emotional and sexual attraction to others. Collecting sexual orientation data is an important part of identifying and reducing health disparities and promoting culturally competent care in health centers.

Health centers are encouraged to establish routine data collection systems to support patient-centered, high-quality care for patients of all sexual orientations. As with all demographic data, this information is self-reported by patients (or by their caregivers if the patient cannot answer the questions themselves). Collection of sexual orientation data from patients younger than 18 years of age is not mandated, but the opportunity to report this information must be provided to all patients regardless of age. Furthermore, patients have the choice not to disclose their sexual orientation. When sexual orientation information is not collected, report the patient on Table 3B as "Unknown" on Line 18a. Patients may change how they identify themselves over time. The following descriptions may assist with data collection.

- **Line 13, Lesbian or Gay:** Report patients who are emotionally and sexually attracted to people of their own gender.
- **Line 14, Heterosexual (or straight):** Report patients who are emotionally and sexually attracted to people of a different gender.
- **Line 15, Bisexual:** Report patients who are emotionally and sexually attracted to people of their own gender and people of other genders.
- **Line 16, Something else:** Report patients who are emotionally and sexually attracted to people who identify themselves as queer, asexual, pansexual, or another sexual orientation not captured in Lines 13–15 above or Lines 17–18 below.
- **Line 17, Don't know:** Report patients who self-report that they do not know their sexual orientation.
- **Line 18, Chose not to disclose:** Report patients who chose not to disclose their sexual orientation.

- **Line 18a, Unknown:** Report patients for whom the health center does not know the sexual orientation (i.e., the health center did not implement systems to permit patients to state their sexual orientation).
- **Line 19, Total Patients:** Sum of Lines 13 through 18a.

Patients by Gender Identity (Lines 20–26)

Gender identity is the internal sense of gender. A person may be male, female, a combination of male and female, or another gender that may not be congruent with a patient's sex assigned at birth. Collecting gender identity data is an important part of identifying and reducing health disparities and promoting culturally competent care in health centers. This section helps to characterize populations served by health centers. Note that the gender identity reported on Table 3B is the patient's *current* gender identity. A patient's sex assigned at birth is reported on Table 3A.

As with all demographic data, this information is self-reported by patients (or by their caregivers if the patient cannot answer the questions themselves). Collection of gender identity data from patients younger than 18 years of age is not mandated, but the opportunity to provide this information must be provided to all patients regardless of age. Furthermore, patients have the choice not to disclose their gender identity. When gender identity information is not collected, report the patient on Table 3B as "Unknown" on Line 25a. **Do not use sex assigned at birth to identify the gender of patients.** Report sex assigned at birth on Table 3A. The following descriptions may assist with data collection, but it is important to note that terminology is evolving and patients may change how they identify themselves over time.

- **Line 20, Male:** Report patients who identify themselves as a man/male.
- **Line 21, Female:** Report patients who identify themselves as a woman/female.
- **Line 22, Transgender Man/Transgender Male:** Report transgender patients who describe their gender identity as man/male. (Some may just use the term "man").
- **Line 23, Transgender Woman/Transgender Female:** Report transgender patients who describe their gender identity as woman/female. (Some may just use the term "woman").
- **Line 24, Other:** Report patients who do not think that one of the four categories above adequately describes them. Include patients who identify themselves as genderqueer or non-binary.
- **Line 25, Chose not to disclose:** Report patients who chose not to disclose their gender.
- **Line 25a, Unknown:** Report patients for whom the health center does not know the gender identity (i.e., the health center did not implement systems to permit patients to state their gender identity).
- **Line 26, Total Patients:** Sum of Lines 20 through 25a.

Additional information is available to clarify reporting. **View FAQs for Tables 3A and 3B.**

Table 3A: Patients by Age and by Sex Assigned at Birth

Reporting Period: January 1, 2020, through December 31, 2020

Line	Age Groups	Male Patients (a)	Female Patients (b)
1	Under age 1		
2	Age 1		
3	Age 2		
4	Age 3		
5	Age 4		
6	Age 5		
7	Age 6		
8	Age 7		
9	Age 8		
10	Age 9		
11	Age 10		
12	Age 11		
13	Age 12		
14	Age 13		
15	Age 14		
16	Age 15		
17	Age 16		
18	Age 17		
19	Age 18		
20	Age 19		
21	Age 20		
22	Age 21		
23	Age 22		
24	Age 23		
25	Age 24		
26	Ages 25–29		
27	Ages 30–34		
28	Ages 35–39		
29	Ages 40–44		
30	Ages 45–49		
31	Ages 50–54		
32	Ages 55–59		
33	Ages 60–64		
34	Ages 65–69		
35	Ages 70–74		
36	Ages 75–79		
37	Ages 80–84		
38	Age 85 and over		
39	**Total Patients** (Sum of Lines 1-38)		

Table 3B: Demographic Characteristics

Reporting Period: January 1, 2020, through December 31, 2020

Patients by Race and Hispanic or Latino/a Ethnicity

Line	Patients by Race	Hispanic or Latino/a (a)	Non-Hispanic or Latino/a (b)	Unreported/Refused to Report Ethnicity (c)	Total (d) (Sum Columns a+b+c)
1	Asian				
2a	Native Hawaiian				
2b	Other Pacific Islander				
2	Total Native Hawaiian/Other Pacific Islander (Sum Lines 2a + 2b)				
3	Black/African American				
4	American Indian/Alaska Native				
5	White				
6	More than one race				
7	Unreported/Refused to report race				
8	**Total Patients** (Sum of Lines 1 + 2 + 3 to 7)				

Line	Patients Best Served in a Language Other than English	Number (a)
12	Patients Best Served in a Language Other than English	

Line	Patients by Sexual Orientation	Number (a)
13	Lesbian or Gay	
14	Heterosexual (or straight)	
15	Bisexual	
16	Something else	
17	Don’t know	
18	Chose not to disclose	
18a	Unknown	
19	**Total Patients** (Sum of Lines 13 to 18a)	

Line	Patients by Gender Identity	Number (a)
20	Male	
21	Female	
22	Transgender Man/Transgender Male	
23	Transgender Woman/Transgender Female	
24	Other	
25	Chose not to disclose	
25a	Unknown	
26	**Total Patients** (Sum of Lines 20 to 25a)	

Instructions for Table 4: Selected Patient Characteristics

Table 4 provides descriptive data on selected characteristics of health center patients.

Income as a Percent of Poverty Guideline, Lines 1–6

Collect income data from all patients (not only from patients applying for a sliding fee discount) at least once during the year. The report should include the most current information, which must have been collected as part of intake or as sliding fee income eligibility verification within 12 months prior to the most recent calendar year visit.

Determine a patient's income relative to the federal poverty guidelines (FPG), which are revised annually.

- Income, as defined by the health center's board policy consistent with the Health Center Program Compliance Manual, is used. Children, not including emancipated minors or those presenting for minor consent services, should be classified in terms of their parents' income.
- Report patients whose information was not collected within one year of their last visit in the calendar year on Line 5, "Unknown."
- Self-declaration of income from patients may be acceptable if it is consistent with the health center's board-approved policies and procedures. This is particularly important for those patients whose wages are paid in cash and who have no other means of proving their income. If income information consistent with the health center's board policy is lacking, report the patient as having unknown income.
- Do not attempt to allocate patients with unknown income to income groups.
- Do not classify a patient who is experiencing homelessness, is a migratory agricultural worker, or is on Medicaid as having income below the FPG based on these factors.

Principal Third-Party Medical Insurance, Lines 7–12

This portion of the table provides data on patients classified by their age and primary source of insurance for *medical* care. Note that there is no "unknown" insurance classification on this table. Obtain medical insurance information each calendar year from all patients to maximize third-party payments.

- Report the primary **medical** insurance patients had at the time of their last visit *regardless of whether that insurance was billed or paid for any or all of the visit services*. (Do not report other forms of insurance such as dental, mental health, or vision coverage).
- Patients are divided into two age groups: 0–17 (Column A) and 18 and older (Column B) based on their age on June 30 (consistent with ages reported on Table 3A).
- Patient primary medical insurance is classified into seven types, as shown on the following pages.
- In rare instances, a patient may have insurance that the health center cannot or does not bill. Even in these instances, report the patient as being insured and report the type of insurance.
- Be aware that states often rename federal programs, such as CHIP and Medicaid.
- Do not report public programs that reimburse for selected services, such as the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program; Breast and Cervical Cancer Control Program (BCCCP); or Title X, as a patient's primary medical insurance.

Note: *The revenue from public programs that reimburse for selected services are, however, reported as Other Public payers on Table 9D.*

None/Uninsured (Line 7)

Report patients who did not have *medical insurance* at the time of their last visit on Line 7. This may include patients who were insured earlier in the year or patients whose visit was paid for by a third-party source that was not insurance, such as EPSDT, BCCCP, Title X, or some state or local safety net or indigent care programs. *Do not count* patients as uninsured if they have medical insurance that did not pay for their visit.

Some examples follow:

- Classify a patient with Medicare who was seen for a dental visit that was not paid for by Medicare as having Medicare for this table.
- Report a patient with private insurance who had not reached their deductible as a private insurance patient.
- Classify a Medicaid patient who is assigned to another provider such that the health center cannot bill Medicaid for the visit as having Medicaid.
- Children seen in a school-based program who do not know their parent's health insurance status must obtain that information if they are to be included in the count of patients, unless they are emancipated minors or seeking minor-consent services permitted in the state, such as family planning or mental health services. In the case of an emancipated minor, record the minor child's status as uninsured if they do not have access to the parent's information.

Note: *A minor receiving these same services with parental consent must be reported under the family's insurance.*

Presume a patient with Medicaid, Private, or Other Public dental insurance to have the same kind of medical insurance. If a patient does not have dental insurance, you may not assume that they are uninsured for medical care. Instead, obtain this information from the patient.

Obtain the coverage information of patients in facilities (other than correctional) such as residential drug programs, college dorms, and military barracks. Do not assume them to be uninsured.

Note: *Patients served in correctional facilities may be classified as uninsured unless they have some form of insurance such as Medicaid or Medicare, whether seen in the correctional facility or at the health center.*

Medicaid (Line 8a)

Report patients covered by state-run programs operating under the guidelines of Titles XIX and XXI (as appropriate) of the Social Security Act.

- Include Medicaid programs known by state-specific names (e.g., California's "Medi-Cal" program).
- Include patients covered by "state-only" programs covering individuals who are ineligible for federal matching funds (e.g., undocumented children, pregnant women).
- Report patients enrolled in both Medicaid and Medicare on Lines 9 (Medicare) and 9a (Dually Eligible), *but not on Line 8a.*

Note: *Report patients who are enrolled in Medicaid but receive services through a private managed care plan that contracts with the state Medicaid agency on Line 8a, not as privately insured (Line 11). This also applies in states that have a Medicaid waiver permitting funds to be used to purchase private insurance for services.*

CHIP-Medicaid (Line 8b)

Report patients covered by the Children's Health Insurance Program (CHIP) Reauthorization Act and provided through the state's Medicaid program.

- In states that use Medicaid to handle the CHIP program, it is sometimes difficult or impossible to distinguish between "Medicaid" and "CHIP-Medicaid." In other states, the distinction is readily apparent (e.g., they have different cards). Even where it is not obvious, CHIP patients may still be identifiable from a "plan" code or some other embedded code in the membership number. This may also vary from county to county within a state. Obtain information on coding practice from the state and/or county.
- If there is no way to distinguish between Medicaid and CHIP administered through Medicaid, classify all covered patients as Medicaid (Line 8a).

Medicare (Line 9)

Report patients covered by the federal insurance program for the aged, blind, and disabled (Title XVIII of the Social Security Act).

- Report patients who have Medicare and Medicaid ("dually eligible") on Line 9. *In addition*, report as Dually Eligible on Line 9a.
- Report patients who have Medicare and a private ("MediGap") insurance on Line 9. Do not include them as Dually Eligible on Line 9a.
- Report patients enrolled in "Medicare Advantage" products on Line 9, even though their services were paid for by a private insurance company.
- Report Medicare-enrolled patients who are still working and are insured by both an employer-based plan and Medicare as Private Insurance on Line 11 since the employer-based insurance plan is billed first.

Dually Eligible (Medicare and Medicaid) (Line 9a)

Report patients with both Medicare and Medicaid insurance.

- This line is a subset of Line 9 (Medicare). Report patients who are dually eligible on Line 9a ***and*** include them on Line 9.
- Do not include MediGap enrollees on Line 9a. Report them only on Line 9.

Other Public Insurance (Non-CHIP) (Line 10a)

Report state and/or local government programs, such as Massachusetts' CommonHealth plan, that provide a broad set of benefits for eligible individuals. Include any public-paid or subsidized private insurance not reported elsewhere on Table 4.

- Classify Medicaid expansion programs using Medicaid funds to help patients purchase their insurance through exchanges as Medicaid (Line 8a) if it is possible to identify them. Otherwise, report them as Private Insurance (Line 11).
- Do not include any CHIP, Medicaid, or Medicare patients on Line 10a.
- Do not include uninsured individuals whose visit may be covered by a public source with limited benefits, such as Title X, EPSDT, BCCCP, AIDS Drug Assistance Program providing pharmaceutical coverage for HIV patients, etc.

Note: *Public programs that reimburse for selected services are, however, considered Other Public payers on Table 9D.*

- Do not include persons covered by workers' compensation (which is liability insurance for the employer—not health insurance for the patient).

Other Public Insurance CHIP (Line 10b)

- In states where CHIP is contracted through a private third-party payer, classify participants as Other Public Insurance CHIP (Line 10b), not as Private Insurance.

- CHIP programs that are run through the private sector are often administered through health maintenance organizations (HMOs). Coverage may appear to be a private insurance plan (such as Blue Cross/Blue Shield) but is funded through CHIP and is to be counted on Line 10b.
- Include CHIP patients who are on plans administered by Medicaid coordinated care organizations (CCOs).
- Do not include patients who have insurance through federal or state insurance exchanges, regardless of the extent to which their premium cost is subsidized (in whole or in part). Report them as Private Insurance (Line 11).

Private Insurance (Line 11)

Report patients with health insurance provided by commercial and not-for-profit companies.

- Individuals may obtain insurance through employers or on their own.
- Include patients who purchase insurance through the federal or state exchanges.
- In states using Medicaid expansion to support the purchase of insurance through exchanges, report patients covered under these plans on Line 8a (Medicaid). Report patients who are not identifiable as Medicaid patients on Line 11 (Private Insurance).
- Private insurance includes insurance purchased for public employees or retirees, such as Tricare, Trigon, or the Federal Employees Benefits Program.

Managed Care Utilization, Lines 13a–13c

This part of Table 4 provides data on managed care enrollment during the calendar year and specifically reports on patient member months in contracted comprehensive medical managed care plans.

- If patients are enrolled in a managed care program that permits them to receive care from any number of providers, including providers other than the health center and its clinicians, this is not to be considered managed care, and no member months are reported in this situation.
- Do not report in this section enrollees in primary care case management (PCCM) programs, the Centers for Medicare & Medicaid Services (CMS) patient-centered medical home (PCMH) demonstration grants, or other third-party plans that pay a monthly fee (often as low as $5 to $10 per member per month) to “manage” patient care.
- Do not include managed care enrollees whose capitation or enrollment is limited to behavioral health or dental services only. (However, an enrollee who has medical and dental is counted).

Member Months

A member month is defined as one individual enrolled in a managed care plan for one month. An individual who is a member of a plan for a full year generates 12 member months; a family of five enrolled for six months generates 30 member months (5 × 6). Member month information is most often obtained from monthly enrollment lists generally supplied by managed care companies to their providers. Health centers should always save these documents. In the event they have not been saved, health centers should request duplicates early to permit timely filing of the UDS Report.

Note: *It is possible for an individual to be enrolled in a managed care plan, assigned to a health center, and yet not be seen during the calendar year. The member months for such individuals are still to be reported in this section.* ***This is the only place in the UDS where an individual is reported who is not being counted as a patient.***

Capitated Member Months (Line 13a)

Enter the total capitated member months by source of payment. This is derived by adding the total enrollment reported from each capitated plan for each month.

- A patient is in a capitated plan if the contract between the health center and the HMO, accountable care organization (ACO), or other similar plan stipulates that, for a flat payment per month, the health center will provide the patient all the services on a negotiated list. (Oregon programs should include enrollees in CCOs on this line).
- This usually includes, at a minimum, all office visits.
- Payments are received (and reported on Table 9D) regardless of whether any service is rendered to the patient in that month. The capitated member months reported on Line 13a relate to the net capitated income reported on Table 9D, Lines 2a, 5a, 8a, and/or 11a.

Fee-for-Service Member Months (Line 13b)

Enter the total fee-for-service member months by source of payment.

- A fee-for-service member month is defined as one patient being assigned to a health center or health center service delivery provider for one month, during which time the patient may receive basic primary care services only from the health center but for whom the services are paid on a fee-for-service basis.
- It is common for patients to have their primary care covered by capitation, but other services, such as behavioral health or pharmacy, paid separately on a fee-for-service basis as a "carve-out" in addition to the capitation. Do not include member months for individuals who receive "carved-out" services under a fee-for-service arrangement on Line 13b if those individuals have already been counted for the same month as a capitated member on Line 13a.
- There is a relationship between the fee-for-service member months reported on Line 13b and the income reported on Table 9D on Lines 2b, 5b, 8b, and/or 11b.

Special Populations, Lines 14–26

This section asks for a count of patients from special populations, including migratory and seasonal agricultural workers and their family members, persons who are experiencing homelessness, patients who are served by school-based health centers, patients who are veterans, and patients served at a health center located in or immediately accessible to a public housing site. Awardees who receive funding from section 330(g) (MHC) and section 330(h) (HCH) must provide additional information on their agricultural employment and/or housing characteristics.

- All health centers report these populations, regardless of whether they directly receive special population funding.
- Migratory or seasonal agricultural workers' status must be verified at least every 2 years by MHC awardees.
- Housing status must be collected by HCH awardees at the first visit of the year when the patient was identified to be experiencing homelessness.
- The special populations detailed below are not mutually exclusive. Patients can be reported in more than one category, as appropriate (e.g., a person can be reported as both a veteran and experiencing homelessness).

Total Migratory and Seasonal Agricultural Workers and Their Family Members, Lines 14–16

Total Agricultural Workers or Dependents, Line 16: Report the number of patients seen during the reporting period who were either migratory or seasonal agricultural workers, dependent family members of migratory or seasonal agricultural workers, or aged or disabled former migratory agricultural workers (as described in the statute section 330(g)(1)(B)).

- For either migratory or seasonal agricultural workers, report patients who meet the definition of agriculture farming in all its branches, as defined by the Office of Management and Budget (OMB)-developed North American Industry Classification System (NAICS), and include seasonal workers included in codes 111 and 112 and all sub-codes therein, including sub-codes 1151 and 1152.

Only health centers that receive section 330(g) (MHC) funding must provide separate totals for migratory and seasonal agricultural workers on Lines 14 and 15. For section 330(g) awardees, the sum of Lines 14 + 15 = Line 16.

Instructions for reporting migratory and seasonal agricultural workers:

- **Migratory Agricultural Workers, Line 14:** Report patients whose principal employment is in agriculture and who establish a temporary home for the purposes of such employment as a migratory agricultural worker, as defined by section 330(g) of the PHS Act. Migratory agricultural workers are usually hired laborers who are paid piecework, hourly, or daily wages. Include patients who had such work as their principal employment within 24 months of their last visit, as well as their dependent family members who have also used the center. The family members may or may not move with the worker or establish a temporary home. Note that agricultural workers who leave a community to work elsewhere are classified as migratory workers in their home community, as are those who migrate to a community to work there.
  - Include aged and disabled former migratory agricultural workers, as defined in section 330(g)(1)(B), and their family members. Aged and disabled former agricultural workers include those who were previously migratory agricultural workers but who no longer work in agriculture because of age or disability.
- **Seasonal Agricultural Workers, Line 15:** Report patients whose principal employment is in agriculture on a seasonal basis (e.g., picking fruit during the limited months of a picking season) but who do not establish a temporary home for purposes of such employment. Seasonal agricultural workers are usually hired laborers who are paid piecework, hourly, or daily wages. Include patients who have been so employed within 24 months of their last visit, as well as their dependent family members who are patients of the health center.

  Note: *Seasonal agricultural workers may be employed throughout the year for multiple crop seasons and as a result might work full-time.*

Total Homeless Patients, Lines 17–23

Total Homeless, Line 23: Report the total number of patients known to have experienced homelessness at the time of any service provided during the reporting period.

- Report patients who lack housing (without regard to whether the individual is a member of a family). Include patients whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations. Include patients who reside in transitional housing or permanent supportive housing.

- Children and youth at risk of homelessness, homeless veterans, and veterans at risk of homelessness may be included.[4]

Only health centers receiving section 330(h) (HCH) funding provide separate totals for patients by housing location on Lines 17–22. For section 330(h) awardees, the sum of Lines 17 through 22 = Line 23.

HCH awardees will provide detail on patients experiencing homelessness by the type of shelter arrangement the patients had when they were *first encountered for a visit during the reporting year*. The following applies when categorizing patients for Lines 17 through 22:

- Report the patient's shelter arrangement as of the first visit during the reporting period when the patient was experiencing homelessness. The shelter arrangement is reported as where the person was housed the prior night.
- Report persons who spent the prior night incarcerated, in an institutional treatment program (e.g., mental health, substance use disorder), or in a hospital based on where they intend to spend the night *after* their visit/release. If they do not know, report their shelter arrangement as Street, on Line 20.
- Patients currently residing in a jail or an institutional treatment program *are not considered homeless* until they are released to the street with no housing arrangement.
- Patients who are part of the foster system program and are placed with a family, group home, or in some other arrangement are *not considered to be homeless*.
- **Shelter, Line 17:** Report patients who are living in an organized shelter for persons experiencing homelessness. Shelters that generally provide meals and a place to sleep are regarded as temporary and often limit the number of days or the hours of the day that a resident may stay at the shelter.
- **Transitional Housing, Line 18:** Transitional housing units are generally small units (six people is common) where people transition from a shelter and are provided extended, but temporary, housing stays (generally between 6 months and 2 years) in a service-rich environment. Transitional housing provides a greater level of independence than traditional shelters and may require the resident to pay some or all of the rent, participate in the maintenance of the facility, and/or cook their own meals. Count only those persons who are transitioning from a homeless environment. *Do not include those who are transitioning from jail or those residing in or transitioning from an institutional treatment program, the military, schools, or other institutions.*
- **Doubled Up, Line 19:** Count patients who are living with others. The arrangement is generally considered to be temporary and unstable, though a patient may live in a succession of such arrangements over a protracted period. Do not count the person who invites a person experiencing homelessness to stay in their home for the night.
- **Street, Line 20:** Include in this category patients who are living outdoors, in a vehicle, in an encampment, in makeshift housing/shelter, or in other places generally not deemed safe or fit for human occupancy.

[4] Health centers may use criteria as defined by the U.S. Department of Housing and Urban Development (HUD) to assist in defining "children and youth at risk of homelessness, homeless veterans, and veterans at risk of homelessness."

- **Permanent Supportive Housing,** [5] **Line 21a:** Report patients who are in permanent supportive housing in this category. Permanent supportive housing usually is in service-rich environments, does not have time limits, and may be restricted to people with some type of disabling condition.
- **Other, Line 21:** Report patients who were housed when first seen during the year but who were still eligible for the program because they previously experienced homelessness. HCH-funded programs may continue to serve patients who no longer experience homelessness due to becoming residents of permanent housing for 12 months after their last visit as homeless. Include them in this category. Also include patients who reside in single-room-occupancy (SRO) hotels or motels and patients who reside in other day-to-day paid housing or other housing programs that are targeted to homeless populations.
- **Unknown, Line 22:** Report patients known to be experiencing homelessness whose housing arrangements are unknown.

Total School-Based Health Center Patients, Line 24

All health centers that identified a school-based health center as a service delivery site in their scope of project (as documented on Form 5B) are to report the total number of patients who received primary health care services at the approved school service delivery site(s).

- Count patients served at in-scope school-based health centers located on or near school grounds, including preschool, kindergarten, and primary through secondary schools, that provide on-site comprehensive preventive and primary health services.
- Services are targeted to the students at the school but may also be provided to siblings or parents and may occasionally include persons residing in the immediate vicinity of the school.
- Do not include as patients students who only receive screening services or mass treatment, such as vaccinations or fluoride treatments, at a school.

Total Veterans, Line 25

All health centers report the total number of patients who served in the active military, naval, or air service, which includes full-time service in the Air Force, Army, Coast Guard, Marines, Navy, or as a commissioned officer of the Public Health Service or National Oceanic and Atmospheric Administration. In addition, include patients who served in the National Guard or Reserves on active duty status.

Include this information in the patient information/intake form at each center.

- Report only those who were discharged or released under conditions other than dishonorable.
- Report only those who affirmatively indicate they previously served in these branches of the military or armed forces.
- Do not count persons who do not respond, regardless of other indicators.
- Do not count veterans of other nations' militaries, even if they served in wars in which the United States was also involved.

[5] Health centers may use criteria as defined by HUD to assist in defining permanent supportive housing.

Total Patients Served at a Health Center Site Located in or Immediately Accessible to a Public Housing Site, Line 26

All health centers are to report **all patients seen at a *service delivery site* located in or immediately accessible to public housing**, regardless of whether the patients are residents of public housing or the health center receives funding under section 330(i) PHPC.

- Count patients on this line if they are served at health center *sites* that meet the statutory definition for the PHPC program (located in or immediately accessible to public housing).
- This is the only field in the UDS Report that requires you to **provide a count of all patients based on the health center *site's* proximity to public housing**. You are to report all patients seen at the health center *site* if it is located in or is immediately accessible to agency-developed, owned, or assisted low-income housing, including mixed finance projects.
- Exclude from the count Section 8 housing units that receive no public housing agency support other than Section 8 housing vouchers.

Additional information is available to clarify reporting. View **FAQs for Table 4**.

Table 4: Selected Patient Characteristics

Reporting Period: January 1, 2020, through December 31, 2020

Line	Income as Percent of Poverty Guideline	Number of Patients (a)
1	100% and below	
2	101–150%	
3	151–200%	
4	Over 200%	
5	Unknown	
6	**TOTAL** (Sum of Lines 1–5)	

Line	Principal Third-Party Medical Insurance	0-17 years old (a)	18 and older (b)
7	**None/Uninsured**		
8a	Medicaid (Title XIX)		
8b	CHIP Medicaid		
8	**Total Medicaid** (Line 8a + 8b)		
9a	Dually Eligible (Medicare and Medicaid)		
9	**Medicare** (Inclusive of dually eligible and other Title XVIII beneficiaries)		
10a	Other Public Insurance (Non-CHIP) (specify___)		
10b	Other Public Insurance CHIP		
10	**Total Public Insurance** (Line 10a + 10b)		
11	**Private Insurance**		
12	**TOTAL** (Sum of Lines 7 + 8 + 9 +10 +11)		

Line	Managed Care Utilization	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	TOTAL (e)
13a	Capitated Member Months					
13b	Fee-for-service Member Months					
13c	**Total Member Months** (Sum of Lines 13a + 13b)					

Table 4: Selected Patient Characteristics (continued)

Reporting Period: January 1, 2020, through December 31, 2020

Line	Special Populations	Number of Patients (a)
14	Migratory (330g awardees only)	
15	Seasonal (330g awardees only)	
16	**Total Agricultural Workers or Dependents** (All health centers report this line)	
17	Homeless Shelter (330h awardees only)	
18	Transitional (330h awardees only)	
19	Doubling Up (330h awardees only)	
20	Street (330h awardees only)	
21a	Permanent Supportive Housing (330h awardees only)	
21	Other (330h awardees only)	
22	Unknown (330h awardees only)	
23	**Total Homeless** (All health centers report this line)	
24	**Total School-Based Health Center Patients** (All health centers report this line)	
25	**Total Veterans** (All health centers report this line)	
26	**Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site** (All health centers report this line)	

Instructions for Table 5: Staffing and Utilization

Table 5 and the Selected Service Detail addendum provide data on services provided to patients during the calendar year.

Table 5: Staffing and Utilization

This table provides a profile of health center staff (Column A), the number of face-to-face clinic visits they render (Column B), the number of virtual visits they render (Column B2), and the number of patients served in each service category (Column C). Column C is designed to report the number of unduplicated patients by category:

- Medical
- Dental
- Mental health
- Substance use disorder
- Vision
- Other professional
- Enabling

The patient count will often involve duplication *across* service categories, though it is always unduplicated *within* service categories. This is unlike Tables 3A, 3B, and 4, where an unduplicated count of all patients is reported.

The staffing information in Table 5 is designed to be compatible with approaches used to describe staff for financial reporting while ensuring adequate detail on staff categories for program planning and evaluation purposes.

Staffing data are reported only on the Universal Report table, not the Grant Report tables. Grant Reports provide data on patients served in whole or in part with section 330(h) (HCH), section 330(g) (MHC), and/or section 330(i) (PHPC) funding and the visits they had during the year. This includes all visits supported with either grant or non-grant funds.

Staff Full-Time Equivalents (FTEs), Column A

Table 5 includes FTE staffing information on all individuals who work in programs and activities that are within the scope of project for all sites covered by the UDS. Report all staff in terms of ***annualized*** FTEs.

FTEs reported on Table 5, Column A include all staff supporting health center operations defined by the scope of the project. Staff may provide services on behalf of the health center under many different arrangements, including but not limited to salaried full-time, salaried part-time, hourly wages, National Health Service Corps (NHSC) assignment, under contract (paid based on worked hours or FTE), interns, residents, preceptors, or donated time.

Do not count individuals who are paid by the health center on a fee-for-service basis in the FTE column since there is no basis for determining their hours. Their visits are still reported in Column B and the patients who received services are reported in Column C.

The following describes the basis for determining someone's employment status for purposes of reporting on FTEs:

- One full-time equivalent (FTE = 1.0) describes staff who worked the equivalent of full-time for one year. Each health center defines the number of hours for "full-time" work and may define it differently for different positions.
- The FTE is based on employment contracts for clinicians and other staff. For example, a physician hired as a full-time employee who is only required to work nine 4-hour sessions (36 hours) per week is full-time. Similarly, clinicians may routinely stay late in the clinic or see hospitalized patients before or after normal workdays, but they would still be considered 1.0 FTE.
- In some health centers, different positions have different time expectations. Positions with different time expectations should be calculated on whatever they have as a base for that position. For example, if licensed clinical psychologists work 36 hours per week, 36 hours would be considered 1.0 FTE. An 18-hour-per-week licensed clinical psychologist would be considered 0.5 FTE regardless of whether other employees in other roles work 40-hour weeks.
- The FTE of staff working fewer than 40 hours per week can often be determined by their benefits status. If they receive full-time benefits (e.g., 8 hours' pay for New Year's Day), then they would be considered full-time.
- The FTE of staff with no or reduced benefits (i.e., no or reduced vacation, holidays, and sick benefits) is calculated based on paid hours. FTEs are adjusted for part-time work or for part-year employment. For example, in a health center that has a 40-hour workweek (2,080 hours/year), a person who works 20 hours per week (i.e., 50 percent time) is reported as 0.5 FTE; a person who works full-time for 4 months out of the year is reported as 0.33 FTE (4 months ÷ 12 months).
- A staff person with no or reduced benefits who works more than full-time (i.e., overtime) will have an FTE greater than 1.0. For example, a person who works 2,200 hours out of 2,080 full-time hours is reported as 1.06 FTE.
- For staff who are not paid for leave, the effective FTE is calculated by dividing worked hours by adjusted full-time hours (full-time hours minus leave hours).

Allocate all staff time by **function** among the major service categories listed. For example, a full-time nurse who works solely in the provision of direct medical services would be counted as 1.0 FTE on Line 11 (Nurses). If that nurse provided case management services during 10 dedicated hours per week and provided medical care services for the other 30 hours per week, the time would be allocated as 0.25 FTE case manager (Line 24) and 0.75 FTE nurse (Line 11). Do not, however, attempt to parse out the components of an interaction. The nurse who handles a referral after a visit as a part of that visit would not be allocated out of nursing. The nurse who collects vitals on a patient, who is then placed in the exam room, and later provides instructions on wound care, for example, would not have a portion of the time counted as health education—it is all a part of nursing.

Count an individual who is hired as a full-time clinician as 1.0 FTE regardless of the number of direct patient care hours they provide. Providers who have released time to compensate for on-call hours, have weekly administrative sessions when they do not see patients, or who receive paid leave for continuing education or other reasons

are still considered full-time if that is how they were hired. (Similarly, do not count providers who are routinely required to work more than 40 hours per week as more than 1.0 FTE). Count the time spent by providers performing tasks in what could be considered non-direct-service clinical activities, such as charting, reviewing labs, filling or renewing prescriptions, returning phone calls, arranging for referrals, participating in quality improvement (QI) activities, supervising nurses, etc., as part of their overall medical care services time and not in a non-clinical support category.

The one exception to this rule is when a chief medical officer/medical director is engaged in non-clinical activities at the corporate level (e.g., attending board of directors or senior management meetings, advocating for the health center before the city council or Congress, writing grant applications, participating in labor negotiations, negotiating fees with insurance companies), in which case time can be allocated to the non-clinical support services category. This does not, however, include non-clinical activities in the medical area, such as supervising the clinical staff, chairing or attending clinical meetings, or writing clinical protocols.

Staff by Major Service Category

Staff members are distributed into categories that reflect the types of services they provide as independent providers. Whenever possible, the contents of major service categories have been defined to be consistent with definitions used by Medicare. The following summarizes the personnel categories; a more detailed, though not exhaustive, list appears in Appendix A.

Medical Care Services (Lines 1–15)

- **Physicians (Lines 1–7):** Report medical doctors (MDs) and doctors of osteopathic medicine (DOs), including licensed residents, on Lines 1–7. Do not report psychiatrists, ophthalmologists, pathologists, or radiologists here. They are separately reported on Lines 20a, 22a, 13, and 14, respectively. Report licensed interns and residents on the line designated for the specialty designation they are working toward and credit them with their own visits. (Thus, count a family practice intern as a family physician on Line 1). Do not count naturopaths, acupuncturists, community health aides/practitioners, or chiropractors on these lines. Report these providers on Line 22 (Other Professionals).
- **Nurse Practitioners (Line 9a):** Report nurse practitioners (NPs) and advanced practice nurses (APNs) on Line 9a. Do not include psychiatric NPs (included on Line 20b, Other Licensed Mental Health Providers) or certified nurse midwives (CNMs, reported on Line 10).
- **Physician Assistants (Line 9b):** Report physician assistants (PAs) on Line 9b. Do not include psychiatric PAs (included on Line 20b, Other Licensed Mental Health Providers).
- **Certified Nurse Midwives (Line 10)**
- **Nurses (Line 11):** Report licensed registered nurses, licensed practical and vocational nurses, home health and visiting nurses, clinical nurse specialists, and public health nurses.
- **Other Medical Personnel (Line 12):** Report medical assistants, nurses' aides, and all other personnel, including unlicensed interns or residents, providing services in conjunction with services provided by a physician, NP, PA, CNM, or nurse.

  Other medical personnel considerations:

  - Do not report staff dedicated to QI or HIT/EHR informatics here. Report them on Line 29b, Quality Improvement Staff.
  - Do not report medical records or patient support staff here. Report them on Line 32, Patient Support Staff.
- **Laboratory Personnel (Line 13):** Report pathologists, medical technologists,

laboratory technicians and assistants, and phlebotomists. Some or all of licensed nurses' time may be in this category if they are assigned to this responsibility, but none of the time of a physician should be included on Line 13.

- **X-ray Personnel (Line 14):** Report radiologists, X-ray technologists, and X-ray technicians. Physician time would not be included here even if they were taking X-rays or performing sonograms.

Dental Services (Lines 16–19)

- **Dentists (Line 16):** Report general practitioners, oral surgeons, periodontists, and endodontists providing prevention, assessment, or treatment of a dental problem, including restoration. Do not classify dental therapists here. Report them on Line 17a, Dental Therapists.
- **Dental Hygienists (Line 17)**
- **Dental Therapists (Line 17a):** Only a few states license dental therapists. Classify staff to this line based on state licensing and function.
- **Other Dental Personnel (Line 18):** Report dental assistants, advanced dental assistants, aides, and technicians.

Behavioral Health Services

The term "behavioral health" is synonymous with the prevention or treatment of mental health and substance use disorders. All visits, providers, and costs classified by health centers as "behavioral health" must be parsed into mental health or substance use disorders. Centers may choose to identify all behavioral health services as Mental Health Services if there is no way to parse these services.

Mental Health Services (Lines 20a–20c)

Mental health services include psychiatric, psychological, psychosocial, or crisis intervention services.

- **Psychiatrists (Line 20a)**
- **Licensed Clinical Psychologists (Line 20a1)**
- **Licensed Clinical Social Workers (Line 20a2)**
- **Other Licensed Mental Health Providers (Line 20b):** Report other licensed mental health providers, including psychiatric social workers, psychiatric NPs, family therapists, and other licensed master's degree-prepared clinicians.
- **Other Mental Health Staff (Line 20c):** Report unlicensed individuals and support staff, including "certified" individuals, who provide counseling, treatment, or support to mental health providers.

  Mental health service personnel considerations:

  - Unlicensed interns or residents in any of the professions listed on Lines 20a through 20b are counted on Line 20c, unless they possess a separate license under which they are practicing. Thus, a licensed clinical social worker (LCSW) doing a psychology internship may be counted on Line 20a2 until they receive a license to practice as a psychologist.

Substance Use Disorder Services (Line 21)

Report individuals who provide substance use disorder services, including substance use disorder workers, psychiatric nurses, psychiatric social workers, mental health nurses, clinical psychologists, clinical social workers, alcohol and drug abuse counselors, family therapists, and other individuals providing alcohol or drug abuse counseling and/or treatment services.

Substance use disorder service personnel considerations:

- Neither licenses nor credentials are required by the UDS. Providers are credentialed according to the health center's standards.

- Report medical providers treating patients with substance use diagnoses on Lines 1 through 10, not as substance use disorder providers.
- Do not include physicians, NPs, or PAs who obtained a Drug Addiction Treatment Act of 2000 (DATA) waiver to treat opioid use disorder with medications *(medication-assisted treatment [MAT])* specifically approved by the U.S. Food and Drug Administration (FDA) here. Include MAT providers on Lines 1–9b (if medical), Line 20a for psychiatrists, or Line 20b for psychiatric NPs.

Other Professional Health Services (Line 22)

Report individuals who provide other professional health services. Some common professions include occupational, speech, and physical therapists; registered dieticians; nutritionists; podiatrists; naturopaths; chiropractors; acupuncturists; and community health aides and practitioners. A more complete list is included in Appendix A.

Other professional health personnel considerations:

- These professionals are usually, but not always, licensed by some entity. They are also generally credentialed and privileged by the health center's governing board to act in accordance with their approved job descriptions.
- Report WIC nutritionists and other professionals working in WIC programs on Line 29a, Other Programs and Services Staff.

Vision Services (Lines 22a–22d)

Report providers who perform eye exams for early detection, care, treatment, and prevention of vision problems, including those that relate to chronic diseases such as diabetes, hypertension, thyroid disease, and arthritis, or for the prescription of corrective lenses.

- **Ophthalmologists (Line 22a):** Report MDs specializing in the provision of medical and surgical eye care.
- **Optometrists (Line 22b)**
- **Other Vision Care Staff (Line 22c):** Report ophthalmologist and optometric assistants, aides, and technicians.

Pharmacy Services (Line 23)

Report pharmacists (including clinical pharmacists), pharmacy technicians, pharmacist assistants, and others supporting pharmaceutical services.

Pharmacy services considerations:

- Report licensed clinical pharmacists on Line 23. Do not allocate to other clinical or non-clinical lines.
- Allocate an individual employee who works as a pharmacy assistant (for example) and also provides pharmacy assistance program (PAP) enrollment assistance by time spent in each category.
- Do not report the time (or cost) of individuals spending all or part of their time in assisting patients to apply for free drugs from pharmaceutical companies (PAPs) here. Report them on Line 27a, Eligibility Assistance Workers.
- Do not include time for individuals who work at a 340B contract pharmacy.

Enabling Services (Lines 24–29)

- **Case Managers (Line 24):** Report staff who assist patients in the management of their health and social needs, including assessment of patient medical and/or social service needs; establishment of service plans; and maintenance of referral, tracking, and follow-up systems. Case managers may, at times, provide health education and/or eligibility assistance in the course of their case management functions. Include individuals

who are trained as—and specifically called—case managers, as well as individuals called care coordinators, referral coordinators, and other local titles.

- **Patient and Community Education Specialists (Line 25):** Report health educators with or without specific degrees.
- **Outreach Workers (Line 26):** Report individuals conducting case finding, education, or other services to identify potential patients or clients and/or facilitate access or referral of potential health center patients to available health center services.
- **Transportation Workers (Line 27):** Report individuals who provide transportation for patients (van drivers) or arrange for transportation, including persons who provide for long-distance transportation to major cities in extremely remote clinic locations.
- **Eligibility Assistance Workers (Line 27a):** Report staff who provide assistance in securing access to available health, social service, pharmacy, and other assistance programs, including Medicaid, Medicare, WIC, Supplemental Security Income (SSI), food stamps through the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), PAPs, and related assistance programs, as well as staff hired under the HRSA Outreach and Enrollment grants.
- **Interpretation Staff (Line 27b):** Report staff whose full-time or dedicated time is devoted to translation and/or interpretation services. Do not include the portion of the time a nurse, medical assistant, or other support staff who provides interpretation, translation, or bilingual services during his/her other activities on this line.
- **Community Health Workers (Line 27c):** Report lay members of communities who work in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status, and/or life experiences with the community members they serve. Staff may be called community health workers, community health advisors, lay health advocates, *promotoras*, community health representatives, peer health promoters, or peer health educators.

  Community health worker considerations:

  - They may perform some or all of the tasks of other enabling services workers.
  - Do not include individuals better classified under other categories, such as Other Medical Personnel (Line 12) or Other Dental Personnel (Line 18).
- **Personnel Performing Other Enabling Service Activities (Line 28):** Report all other staff performing enabling services not described above.

  Other enabling services considerations:

  - If a service does not fit the strict descriptions for Lines 24 through 27b, its inclusion on Line 28 must include a clear detailed statement of what is being reported; complete the “specify” field to describe what these staff are doing.
  - Check such services with the UDS Support Center or UDS Reviewer prior to submission.
  - Do not use enabling services, especially Other Enabling Services (Line 28), as a catchall, all-inclusive category for services that are not included on other lines. Often, such services belong on Line 29a (Other Programs and Related Services Staff) or are services that are not separately reported on the UDS.

Other Programs and Related Services Staff (Line 29a)

Some health centers, especially "umbrella agencies," operate programs that, although within their scope of service and often important to the overall health of their patients, are not directly a part of the listed medical, dental, behavioral, or other health services. Include WIC programs, job training programs, Head Start or Early Head Start programs, shelters, housing programs, child care, frail elderly support programs, adult day health care (ADHC) programs, fitness or exercise programs, public/retail pharmacies, etc. Use the "specify" field to describe what these staff members are doing.

Quality Improvement Staff (Line 29b)

Although QI is a part of virtually all clinical and administrative roles, some individuals have specific responsibility for the design and oversight of QI systems. Report individuals that spend all or a substantial portion of their time dedicated to these activities. They may have clinical, information technology (IT), or research backgrounds, and may include QI nurses, data specialists, statisticians, and designers of HIT (including EHRs and electronic medical records [EMRs]).

QI staff considerations:

- *Do not include on this line* the time of clinicians such as physicians or dentists who are involved in the QI process. Their time is to remain on the service delivery lines.
- Report staff who support HIT to the extent that they are working with the QI system on Line 29b.
- Continue to report staff who document services in the HIT in the appropriate service category, not here.

Non-Clinical Support Services (Lines 30a–32)

- **Management and Support Staff (Line 30a):** Report the management team, including the CEO, chief financial officer (CFO), chief information officer, chief medical officer, chief operations officer (COO), and human resources (HR) director, as well as other non-clinical support staff and office support (secretaries, administrative assistants, file clerks, et al.). For medical directors or other individuals whose time is split between clinical and non-clinical activities, report only that portion of their FTE corresponding to the corporate management function. (See limits on non-clinical time above).
- **Fiscal and Billing Staff (Line 30b):** Report staff performing accounting and billing functions in support of health center operations for services performed within the scope of the program, excluding the CFO (who is reported on Line 30a).
- **IT Staff (Line 30c):** Report technical information systems staff supporting the maintenance and operation of the computing systems that support functions performed within the scope of the program.

  IT staff considerations:

  - Report IT staff managing the hardware and software of an HIT (including EHR/EMR) system on Line 30c.
  - Do not report IT staff designing medical forms and conducting analysis of HIT data here. Report as part of the QI functions on Line 29b.
  - Include IT staff performing data entry as well as providing help-desk, training, and technical assistance functions as part of the other medical personnel or appropriate service category for which they perform these functions.

- **Facility Staff (Line 31):** Report staff with facility support and maintenance responsibilities, including custodians, housekeeping staff, security staff, and other maintenance staff. If facility functions are contracted (e.g., janitorial services), do not attempt to create an FTE, but report the costs on the facility Line 14 on Table 8A.
- **Patient Services Support Staff (Line 32):** Report intake staff, front desk staff, and medical/patient records.

Note: *The non-clinical category for this report is more comprehensive than that used in some other program definitions and includes **all** such personnel working in a health center, whether an individual's salary was supported by the BPHC grant or other funds included in the scope of project. Where appropriate, and when identifiable, report staff included in a health center's federally approved indirect cost rate here.*

Clinic Visits, Column B

Report documented **face-to-face** contact between a patient and a licensed or credentialed provider who exercises their independent, professional judgment in the provision of services to the patient as a **visit** in Column B. Report face-to-face visits that occurred during the reporting year rendered by salaried, contracted, or volunteer providers. Most visits reported in Column B will be provided by staff identified in Column A. (See the Definitions of Visits, Patients, and Providers section for further details on the definition of "visits.") Visits purchased from contracted providers on a fee-for-service basis will also be reported.

Virtual Visits, Column B2

Report documented **virtual (telemedicine)** contact between a patient and a licensed or credentialed provider who exercises their independent, professional judgment in the provision of services to the patient as a **visit** in Column B2. Report virtual visits that occurred during the reporting year rendered by salaried, contracted, or volunteer staff. Most visits reported in Column B2 will be provided by staff identified in Column A. Virtual visits purchased from contracted providers on a fee-for-service basis will also be reported.

Note: *Telemedicine is a growing model of care delivery. It will be important to remember that state and federal telehealth definitions and regulations regarding the acceptable modes of care delivery, types of providers, informed consent, and location of the patient and/or provider are not applicable in determining virtual visits for UDS reporting.*

Virtual Visit Considerations

- Virtual visit reporting should be consistent with the health center's scope of project.
- Virtual visits must meet the countable visit definitions. (See the Definitions of Visits, Patients, and Providers section for further details on the definition of "visits.").
- All rules regarding multiple visits in the same service category in the same day apply *except* if there are two different providers at two different locations.
- Report virtual visits where:
    - The health center provider virtually provided care to a patient who was elsewhere (i.e., not physically at their health center).
    - The health center authorized patient services by a non-health-center provider or volunteer provider who provided care to a patient who was at the health center through telemedicine, and the health center paid for the services. Do not report a clinic visit.
    - A provider who was not physically present at the health center provided care to a patient, if this is consistent with their scope of project. The provider would need access to the health center's HIT/EHR to record their activities and review the patient's record.

- Interactive, synchronous audio and/or video telecommunication systems permitting real-time communication between the provider and a patient were used. Do not count other modes of telemedicine services (e.g., store and forward, remote patient monitoring, mobile health) or provider-to-provider consultations.
- The visit is coded and charged as telehealth services, even if third-party payers may not recognize or pay for such services. Generally, these charges would be comparable to a clinic visit charge.

Note: *Use telehealth-specific codes **with** the CPT or Healthcare Common Procedure Coding System (HCPCS) codes such as G0071, G0406-G0408, G0425-G0427, G2025, modifier ".95," or Place of Service code "02" or"50" to identify virtual visits.*

- Do not count as a virtual visit situations in which the health center does not pay for virtual services provided by a non-health-center provider (referral).

Note: *Clinic Visits (Column B) and Virtual Visits (Column B2) are mutually exclusive. Total visits are calculated by adding Columns B and B2.*

Visits Purchased from Non-Staff Providers on a Fee-For-Service Basis

Count these visits in Column B (clinic) or B2 (virtual) even though no corresponding FTEs are included in Column A. To count, the visit must meet the following criteria:

- the service was provided to a patient of the health center by a provider who is not part of the health center's staff (neither salaried nor contracted on the basis of time worked) although they meet the center's credentialing policies,
- the service was paid for in full by the health center, and
- the service otherwise met the definition of a visit.

Note: *Do not include unpaid referrals, referrals where a third party (e.g., the patient's insurance company) will make the payment directly to the provider, or referrals where only nominal amounts, including facility fees, are paid although the negotiated payment may be less than the provider's "usual, customary, and reasonable" (UCR) rates.*

Visit Considerations

Nurses, Line 11:

- Services may be provided under standing orders of a medical provider, under specific instructions from a previous visit, or under the general supervision of a physician, NP, PA, or CNM who has no direct contact with the patient during the visit. These services must meet the requirement of exercising independent professional judgment.
- Report nurse visits that meet all visit criteria. See Instructions for Visits.
- Report triage services provided by nurses and visiting nurse services when a nurse sees patients independently in the patients' homes to evaluate their condition(s).
- Count visits charged and coded as CPT 99211 only when all components of visit requirements were met.
- Do not count if the service is attendant to another visit (e.g., nurse calls to check up on how a patient is doing after a visit), even if it occurs on a subsequent day.
- Do not count interactions with a nurse where the primary purpose is to conduct a lab test, give an injection, or dispense or administer a drug, regardless of the level of observation needed.
- Do not count services provided by medical assistants, aides, or other non-nursing personnel here.

- Most states prohibit a licensed vocational nurse or licensed practical nurse from exercising independent judgment; do not count visits for them.

Other medical personnel, Line 12:

- Do not count services provided by medical assistants, aides, or other non-nursing personnel here.

Dentists, dental hygienists, and dental therapists, Lines 16, 17, and 17a:

- Report only one visit per patient per day, regardless of the number of clinicians who provide services (e.g., dentist and dental hygienist both see the patient) or the volume of service (i.e., number of procedures) provided.
- Do not count the application of dental varnishes, fluoride treatments, or dental screenings, absent other comprehensive dental services, as a visit.
- Do not count as a dental visit medical providers who examine a patient's dentition or provide fluoride treatments.
- Do not credit services of dental students or anyone other than a licensed dental provider with dental visits, even if these individuals are working under the supervision of a licensed dental provider.
- *Exception*: Count the visits of a supervising dentist's student (i.e., one who is overseeing dental students enrolled in a graduate education program leading to a license as a dentist) as long as the supervising dentist:
  - has no other responsibilities, including the supervision of other personnel at the time services are furnished by the students,
  - has primary responsibility for the patients,
  - reviews the care furnished by the students during or immediately after each visit, and
  - documents the extent of their participation in the review and direction of the services furnished to each patient.

Other mental health, Line 20c:

- Credit these individuals with their own visits regardless of any billing practices at the center. No other person is to be credited with these visits.

Substance use disorder, Line 21:

- In programs that include the regular use of narcotic agonists or antagonists or other medications on a regular basis (daily, every three days, weekly, etc.), count the counseling services as visits.
- Do not count the dispensing of the drugs, regardless of the level of oversight that occurs during that activity.
- Report the counseling of patients to determine or diagnose their medical needs, including medication assistance, as medical or psychiatry visits based on the provider providing these services, not on Line 21 as substance use disorder visits.

Other professional, Line 22:

- Describe all services in a clear, detailed statement using the "specify" box.
- Include the services of professional health service providers included in Appendix A.
- Check the reporting of other professional services with the UDS Support Center or UDS Reviewer.

Vision services, Lines 22a–22d:

- Do not count the services of students or anyone other than a licensed vision service provider as vision services visits.
- Do not count retinography (imaging of the retina), whether performed by a licensed vision services provider or anyone else, as a visit absent a comprehensive vision exam.

- Do not count fitting glasses as a visit, regardless of who performs the fitting.

Pharmacy, Line 23:

- Some states license clinical pharmacists whose scope of practice may include ordering labs and reviewing and altering medications or dosages. Despite this expanded scope of practice, do not record clinical pharmacist interactions with patients as visits

Case managers, Line 24:

- When a case manager serves an entire family (e.g., helping with housing or Medicaid eligibility), count only one visit, generally for an adult member of the family, regardless of documentation in other charts.
- Case management is rarely the only type of service provided to a patient during the year.
- Case managers often contact third parties in the provision of their services. Do not count these contacts or interactions, even though they are recognized as important.

Patient and community education, Line 25:

- Report only services provided one-on-one with the patient.
- Health education is provided to support the delivery of other health care services and is rarely the only type of service provided to a patient during the year.
- Do not report group education classes or visits.

Do Not Record Visits or Patients for Services Provided by the Following:

- Other Medical Personnel, Line 12
- Laboratory Personnel, Line 13
- X-ray Personnel, Line 14
- Other Dental Personnel, Line 18
- Other Vision Care Staff, Line 22c
- Pharmacy Personnel, Line 23
- Outreach Workers, Line 26
- Transportation Staff, Line 27
- Eligibility Assistance Workers, Line 27a
- Interpretation Staff, Line 27b
- Community Health Workers, Line 27c
- Other Enabling Services, Line 28
- Other Programs and Services, Line 29a
- Quality Improvement Staff, Line 29b
- Management and Support Staff, Line 30a
- Fiscal and Billing Staff, Line 30b
- IT Staff, Line 30c
- Facility Staff, Line 31
- Patient Support Staff, Line 32

Additionally, some interactions cannot be reported as visits regardless of who provides them. Please review the Services and Persons Not Reported on the UDS Report section for specifics.

Patients, Column C

A patient is an individual who has at least one reportable visit during the reporting year. For further details, see the Instructions for Tables that Report Visits, Patients, and Providers section.

- Report an unduplicated patient count in Column C for each of the seven categories of services shown below for which patients had visits reported in Column B during the reporting year.
    - Medical services (Line 15)
    - Dental services (Line 19)
    - Mental health services (Line 20)
    - Substance use disorder services (Line 21)
    - Vision services (Line 22d)
    - Other professional services (Line 22)
    - Enabling services (Line 29)
- Within each service category, count an individual only once as a patient regardless of the number of visits. A patient who receives multiple types of services will be reported once (and only once) for each service category.
- Because patients must have at least one documented visit, the number of patients may not exceed the number of visits.
- Patients counted on Table 5 must be included as patients on the demographics tables: ZIP Code Table and Tables 3A, 3B, and 4.
- Do not include individuals who only receive services for which no visits are generated (e.g., laboratory, imaging, pharmacy, transportation, and outreach).

Selected Service Detail Addendum

The Table 5 addendum provides data on mental health services provided by medical providers as well as substance use disorder services provided by medical providers and mental health providers. The addendum is reported on the Universal Report only.

The information in this section only reflects **providers and their mental health or substance use disorder treatment services *not already reported in the mental health and substance use disorder sections*** on the main part of Table 5. The sum of mental health and substance use disorder services/visits reported in the main part of Table 5 and the addendum to Table 5 provide a combined count of mental health and substance use disorder services provided.

The Selected Service Details addendum is divided into two service categories: mental health and substance use disorders.

- The Mental Health Services Detail (*by medical providers*), Lines 20a01–20a04, is a subset of medical visits and patients from Lines 1–10 in the main section of Table 5.
- The Substance Use Disorder Detail (*by medical providers*), Lines 21a–21d, is a subset of medical visits and patients from Lines 1–10 in the main section of Table 5.
- The Substance Use Disorder Detail (*by mental health providers*), Lines 21e–21h, is a subset of mental health visits and patients from Lines 20a–20b in the main section of Table 5.

To identify visits where a mental health or substance use disorder treatment service may have been rendered, include at minimum all visits for the reporting providers with ICD-10 codes specified on Table 6A, Lines 18 through 19a for substance use disorder treatment and Lines 20a through 20d for mental health treatment.

The addendum will include duplication across service categories. Some visits may include both mental health and substance use disorder treatment and will be reported as such.

Examples of provider activity reported in the addendum are as follows:

- A physician who sees a patient for treatment of depression.
- An NP seeing a patient for diabetes who is also showing signs of depression.
- A PA providing MAT services to a patient with opioid use disorder.
- A licensed clinical psychologist seeing a patient for mental health problems exacerbated by a substance use disorder.

Providers, Column A1

- Report the number of individual providers (not FTE) by type who provided mental health and/or substance use disorder services. The provider can be counted once in each section if they provide both services.

Note: *If the provider is a contract provider paid by the visit or service, do not count an FTE on the main part of Table 5, but count the provider in the addendum.*

Clinic Visits, Column B

- Report the number of clinic (face-to-face) visits, by provider type, where the service in whole or in part included treatment for mental health (on Lines 20a01 through 20a04) or substance use disorder services (Lines 21a through 21h).

Virtual Visits, Column B2

- Report the number of virtual visits, by provider type, where the service in whole or in part included treatment for mental health (on Lines 20a01 through 20a04) or substance use disorder services (Lines 21a through 21h).

Patients, Column C

- Report the number of patients seen for a clinic or virtual mental health or substance use disorder service.
- Report patients (and their visits) for each type of provider listed that they saw during the year for these services. This may result in the same patient appearing on more than one line in the addendum.

Relationship Between Tables 5 and 8A

The staffing on Table 5 is routinely compared to the costs on Table 8A. See the crosswalk of comparable fields in Appendix B.

Additional information is available to clarify reporting. View **FAQs for Table 5**.

Table 5: Staffing and Utilization

Reporting Period: January 1, 2020, through December 31, 2020

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1	Family Physicians				<cell not reported>
2	General Practitioners				<cell not reported>
3	Internists				<cell not reported>
4	Obstetrician/Gynecologists				<cell not reported>
5	Pediatricians				<cell not reported>
7	Other Specialty Physicians				<cell not reported>
8	**Total Physicians** (Lines 1–7)				<cell not reported>
9a	Nurse Practitioners				<cell not reported>
9b	Physician Assistants				<cell not reported>
10	Certified Nurse Midwives				<cell not reported>
10a	**Total NPs, PAs, and CNMs** (Lines 9a–10)				<cell not reported>
11	Nurses				<cell not reported>
12	Other Medical Personnel		<cell not reported>	<cell not reported>	<cell not reported>
13	Laboratory Personnel		<cell not reported>	<cell not reported>	<cell not reported>
14	X-ray Personnel		<cell not reported>	<cell not reported>	<cell not reported>
15	**Total Medical Care Services** (Lines 8 + 10a through 14)				
16	Dentists				<cell not reported>
17	Dental Hygienists				<cell not reported>
17a	Dental Therapists				<cell not reported>
18	Other Dental Personnel				<cell not reported>
19	**Total Dental Services** (Lines 16–18)				
20a	Psychiatrists				<cell not reported>
20a1	Licensed Clinical Psychologists				<cell not reported>
20a2	Licensed Clinical Social Workers				<cell not reported>
20b	Other Licensed Mental Health Providers				<cell not reported>
20c	Other Mental Health Staff				<cell not reported>
20	**Total Mental Health Services** (Lines 20a–c)				
21	**Substance Use Disorder Services**				
22	**Other Professional Services** (specify___)				

Table 5: Staffing and Utilization (continued)

Reporting Period: January 1, 2020, through December 31, 2020

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
22a	Ophthalmologists				
22b	Optometrists				<cell not reported>
22c	Other Vision Care Staff		<cell not reported>	<cell not reported>	<cell not reported>
22d	**Total Vision Services** (Lines 22a–c)				
23	**Pharmacy Personnel**		<cell not reported>	<cell not reported>	<cell not reported>
24	Case Managers				<cell not reported>
25	Patient and Community Education Specialists				<cell not reported>
26	Outreach Workers		<cell not reported>	<cell not reported>	<cell not reported>
27	Transportation Staff		<cell not reported>	<cell not reported>	<cell not reported>
27a	Eligibility Assistance Workers		<cell not reported>	<cell not reported>	<cell not reported>
27b	Interpretation Staff		<cell not reported>	<cell not reported>	<cell not reported>
27c	Community Health Workers		<cell not reported>	<cell not reported>	<cell not reported>
28	Other Enabling Services (specify___)		<cell not reported>	<cell not reported>	<cell not reported>
29	**Total Enabling Services** (Lines 24–28)				
29a	**Other Programs and Services** (specify___)		<cell not reported>	<cell not reported>	<cell not reported>
29b	**Quality Improvement Staff**		<cell not reported>	<cell not reported>	<cell not reported>
30a	Management and Support Staff		<cell not reported>	<cell not reported>	<cell not reported>
30b	Fiscal and Billing Staff		<cell not reported>	<cell not reported>	<cell not reported>
30c	IT Staff		<cell not reported>	<cell not reported>	<cell not reported>
31	Facility Staff		<cell not reported>	<cell not reported>	<cell not reported>
32	Patient Support Staff		<cell not reported>	<cell not reported>	<cell not reported>
33	**Total Facility and Non-Clinical Support Staff** (Lines 30a–32)		<cell not reported>	<cell not reported>	<cell not reported>
34	**Grand Total** (Lines 15+19+20+21+22+22d+23+29+29a+29b+33)				<cell not reported>

Table 5: Selected Service Detail Addendum

Reporting Period: January 1, 2020, through December 31, 2020

Line	Personnel by Major Service Category: Mental Health Service Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
20a01	Physicians (other than Psychiatrists)				
20a02	Nurse Practitioners				
20a03	Physician Assistants				
20a04	Certified Nurse Midwives				
Line	**Personnel by Major Service Category: Substance Use Disorder Detail**	**Personnel (a1)**	**Clinic Visits (b)**	**Virtual Visits (b2)**	**Patients (c)**
21a	Physicians (other than Psychiatrists)				
21b	Nurse Practitioners (Medical)				
21c	Physician Assistants				
21d	Certified Nurse Midwives				
21e	Psychiatrists				
21f	Licensed Clinical Psychologists				
21g	Licensed Clinical Social Workers				
21h	Other Licensed Mental Health Providers				

Instructions for Table 6A: Selected Diagnoses and Services Rendered

This table is designed to provide data on selected diagnoses and selected services rendered. The data source is data maintained for billing purposes, lab reports, and/or in HIT systems, including EHRs. Table 6A is not expected to reflect the full range of diagnoses and services rendered by a health center. The selected diagnoses and services represent those that are prevalent among Health Center Program patients, have been regarded as sentinel indicators of access to primary care, or are of special interest to HRSA.

Report diagnoses on this table that were made as part of documented visits with licensed or credentialed medical, dental, mental health, substance use disorder, or vision providers only. For example, do not count a diagnosis for diabetes if a case manager or a health educator sees the patient with diabetes or if a diagnosis of hypertension is listed (but not diagnosed) by a mental health provider.

Report all diagnoses rendered at a specific visit. For example, if a physician shows a diagnosis of hypertension and diabetes, record the visit and the patient on both the line for hypertension and the line for diabetes. **However, *do not* count "active diagnoses" present at the time of a visit but not addressed during the visit.**

Note: *Use age at time of visit for diagnoses and tests with specified age ranges.*

Visits and Patients, Columns A and B

Visits and Patients by Selected Diagnoses, Lines 1–20f

Lines 1 through 20f present the name and applicable ICD-10-CM codes for the diagnosis or diagnostic range/group. Wherever possible, diagnoses have been grouped into code ranges. Report all visits and patients where the provider-assigned diagnostic code is included in the range/group of ICD-10-CM codes shown.

Column A, Number of Visits by Diagnosis Regardless of Primacy

- Report the total number of visits (in-person clinic and/or virtual) during the reporting period where the indicated diagnosis, regardless of primacy, is listed in the HIT/EHR or visit/billing record.
- Count on Lines 1–20f each included diagnosis made at a visit, regardless of the number of diagnoses listed for the visit. For example, count a patient visit with a diagnosis of hypertension and a diagnosis of diabetes once on Line 9 and once on Line 11.
- Do not report a visit if it includes only diagnoses that are not listed on Table 6A.

Column B, Number of Patients with Diagnosis

- Report each individual who had one or more visits (in-person clinic and/or virtual) during the year that were reported in the corresponding Column A.
- Count a patient only once on any given line, regardless of the number of visits made for that specific diagnosis or family of diagnoses.
- Report patients with multiple diagnoses in Column B only once for each diagnosis used during the year. For example, count a patient with one or more visits with a diagnosis of hypertension and one or more visits with a diagnosis of diabetes once as a patient in Column B on both Lines 9 and 11.

Visits and Patients by Selected Tests/Screenings, Lines 21–26d

Lines 21 through 26d present the name and applicable ICD-10-CM diagnostic and/or CPT procedure codes for selected tests, screenings, and preventive services that are important to the populations served or are of interest to HRSA. On several lines, both CPT codes and ICD-10-CM codes are provided. Use ***either*** the CPT codes ***or***

the ICD-10-CM codes for any specific visit, ***but not both***. Report *all visits meeting the selection criteria that are part of a reportable visit or as follow-up to a reportable visit*.

Only report tests or procedures (e.g., mammograms, X-rays, tomography) that are:

- performed by the health center, or
- not performed by the health center, but paid for by the health center, or
- not performed by the health center or paid for by the health center, but whose results are returned to the health center provider to evaluate and provide results to the patient.

Note: *During a visit with the provider, selected screenings or tests may be ordered. Count completed services in this section even if they were done at a later date.*

Note: *ICD-10-CM codes for some services (such as mammography and Pap tests) are listed to ensure capture of procedures that are done by the health center but may be coded with a different CPT code for state reimbursement under Title X or BCCCP. In some instances, payers (especially governmental payers) and labs ask health centers to use different codes for services. In these instances, health centers should internally map these codes to the published list for reporting purposes.*

The following examples illustrate these rules:

- Count a test paid for by a third-party only if the health center performed the test in its lab (e.g., point-of-care testing), collected the sample and transferred it to a reference lab, or the result is returned to the health center provider to evaluate and provide results back to the patient.
- Count Pap tests performed by a health center but read by an outside pathologist who then bills a third party.
- Do not count the referral of a woman to the local hospital or county health department for a mammogram whose providers perform the test and provide results to the patient.

Column A, Number of Visits

- Report the total number of visits (in-person clinic and/or virtual) at which one or more of the listed diagnostic tests, screenings, and/or preventive services were provided. Note that codes for these services may either be diagnostic (ICD-10-CM) codes or procedure (CPT) codes.
- During one visit, more than one test, screening, or preventive service may be provided. Count each procedure or test on each applicable line. If they are on the same line, only count one visit.

Column B, Number of Patients

- Report patients who had at least one visit (in-person clinic and/or virtual) during the reporting period where the selected diagnostic tests, screenings, and/or preventive services listed on Lines 21–26d were provided.
- Count patients who receive more than one type of service during a single visit. For example, if a patient had a Pap test and contraceptive management during the same visit, this patient would be counted on both Lines 23 and 25.
- Count a patient only once per service, regardless of the number of times a patient receives a given service. For example, an infant who has an immunization at each of several well-child visits in the year has each visit reported in Column A but is counted only once in Column B.

The following examples illustrate these rules:

- If both an HIV test and a Pap test were provided during a visit, then report a visit on both Line 21 (HIV test) and Line 23 (Pap test).
- If a patient receives multiple immunizations at one visit, report only one visit on Line 24.

- Count a hypertensive patient who also receives an HIV test on Line 11 (hypertension) and on Line 21 (HIV test).
- Count a patient who comes in for an annual physical and a flu shot. Report this patient on Line 24a (flu shot) but not on any diagnostic line.

***Note: Include follow-up services** related to a countable visit. Thus, if a provider asks that a patient return in 30 days for a flu shot, when that patient presents, the shot is counted because it is legally considered to be a part of the initial visit. **Do not report an interaction** with another person who is not a clinic patient who comes in just for a flu shot during a health center-run flu clinic and without a specific referral from a prior visit.*

Visits and Patients by Dental Services, Lines 27–34

Lines 27 through 34 present the name and applicable American Dental Association (ADA) procedure codes for selected dental services. These services *may be performed only by a dental provider who is reported on Lines 16–17a on Table 5 or by an in-scope dental contractor paid by the health center*. Wherever appropriate, services have been grouped into code ranges. For these lines, the concept of a "primary" code is neither relevant nor used. All services are reported.

Column A, Number of Visits

- Report the total number of visits at which one or more of the listed diagnostic tests, screenings, and/or dental services were provided.
- During one visit, more than one test, screening, or dental service may be provided. Count each procedure, screening, or test on each applicable line. If they are on the same line, only count one visit. For example, if a patient had more than one tooth filled during a visit, report only one visit for restorative services (Line 32), not one per tooth.

Column B, Number of Patients

- Report patients who had at least one visit with a dental professional during the reporting period for each of the selected dental services listed.
- Only report services that are provided at or as follow-up to countable visits (e.g., a comprehensive oral exam).
- Count a patient who had two teeth repaired and sealants applied during a visit once on Line 30 and once on Line 32.
- Do not report services provided by persons other than a licensed dentist, dental hygienist, dental therapist, or individual working under his or her direct supervision.

***Note**: Do not count fluoride treatments or varnishes that are applied outside of a comprehensive treatment plan, including when provided as part of a community service at schools, on this table or as a visit on Table 5.*

Services Provided by Multiple Entities

Take care when multiple entities are involved with a service. Use the following rules and general examples to guide reporting:

- Count the service if a health center provider orders and performs the service. For example, count a rapid HbA1c test ordered by a physician and performed in the clinic lab.
- If the health center provider orders a test (e.g., HIV test) and the sample is collected at the health center and then sent to a reference lab for processing, count the test regardless of whether the test is paid for by the patient, the

patient's insurance company,[6] a government entity, or the health center.

- Count a test when the health center provider asks a patient to get that test from a third party and the health center provider receives and reviews the test results with the patient. For example, count mammograms performed by a third-party provider that a health center contracts with and for which the health center reviews the result with the patient.
- Do not report vaccinations performed by the health department when children are referred to a city or county health department and the health center does not pay for the service, including referrals where a third party (e.g., the patient's insurance company) will make the payment.
- Do not count a test or service that a provider asks the patient to get from a third-party provider (e.g., for an HIV test to a Ryan White program) that *does not bill the health center*, including referrals where a third party (e.g., the patient's insurance company) will make the payment if the test or service results are reviewed by the third party. For example, do not count mammograms performed by the county health department for which the county will follow up with the patient directly and the health center did not pay for the service. (These are generally noted in Column III: Formal Written Referral Arrangement [Health center does not pay] of Form 5A: Services Provided).

Additional information is available to clarify reporting. View **FAQs for Table 6A**.

[6] Billing rules require that the charge for a lab test ordered by a provider be sent directly to a third party (including Medicaid and Medicare) and not to the provider or the health center.

Table 6A: Selected Diagnoses and Services Rendered

Reporting Period: January 1, 2020, through December 31, 2020

Selected Diagnoses

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
	Selected Infectious and Parasitic Diseases			
1-2	Symptomatic/Asymptomatic human immunodeficiency virus (HIV)	B20, B97.35, O98.7-, Z21		
3	Tuberculosis	A15- through A19-, O98.0-		
4	Sexually transmitted infections	A50- through A64-		
4a	Hepatitis B	B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.1-, O98.4-		
4b	Hepatitis C	B17.1-, B18.2, B19.2-		
4c	Novel coronavirus (SARS-CoV-2) disease	U07.1		
	Selected Diseases of the Respiratory System			
5	Asthma	J45-		
6	Chronic lower respiratory diseases	J40 (count only when code U07.1 **is not** present), J41- through J44-, J47-		
6a	Acute respiratory illness due to novel coronavirus (SARS-CoV-2) disease	J12.89, J20.8, J40, J22, J98.8, J80 (count only when code U07.1 **is** present)		
	Selected Other Medical Conditions			
7	Abnormal breast findings, female	C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.81, D05-, D48.6-, D49.3, N60-, N63-, R92-		
8	Abnormal cervical findings	C53-, C79.82, D06-, R87.61-, R87.629, R87.810, R87.820		
9	Diabetes mellitus	E08- through E13-, O24- (exclude O24.41-)		
10	Heart disease (selected)	I01-, I02- (exclude I02.9), I20- through I25-, I27-, I28-, I30- through I52-		
11	Hypertension	I10- through I16-, O10-, O11-		
12	Contact dermatitis and other eczema	L23- through L25-, L30- (exclude L30.1, L30.3, L30.4, L30.5), L58-		
13	Dehydration	E86-		
14	Exposure to heat or cold	T33-, T34-, T67-, T68-, T69-, W92-, W93-		
14a	Overweight and obesity	E66-, Z68- (exclude Z68.1, Z68.20 through Z68.24, Z68.51, Z68.52)		

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
	Selected Childhood Conditions (limited to ages 0 through 17)			
15	Otitis media and Eustachian tube disorders	H65- through H69-		
16	Selected perinatal/neonatal medical conditions	A33-, P19-, P22- through P29- (exclude P29.3), P35- through P96- (exclude P54-, P91.6-, P92-, P96.81), R78.81, R78.89		
17	Lack of expected normal physiological development (such as delayed milestone, failure to gain weight, failure to thrive); nutritional deficiencies in children only. Does not include sexual or mental development.	E40- through E46-, E50- through E63-, P92-, R62- (exclude R62.7), R63.3		
	Selected Mental Health Conditions, Substance Use Disorders, and Exploitations			
18	Alcohol-related disorders	F10-, G62.1, O99.31-		
19	Other substance-related disorders (excluding tobacco use disorders)	F11- through F19- (exclude F17-), G62.0, O99.32-		
19a	Tobacco use disorder	F17-, O99.33-		
20a	Depression and other mood disorders	F30- through F39-		
20b	Anxiety disorders, including post-traumatic stress disorder (PTSD)	F06.4, F40- through F42-, F43.0, F43.1-, F93.0		
20c	Attention deficit and disruptive behavior disorders	F90- through F91-		
20d	Other mental disorders, excluding drug or alcohol dependence	F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0- and F43.1-), F50- through F99- (exclude F55-, F84.2, F90-, F91-, F93.0, F98-), O99.34-, R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0		
20e	Human trafficking	T74.5- through T74.6-, T76.5- through T76.6-, Z04.81, Z04.82, Z62.813, Z91.42		
20f	Intimate partner violence	T74.11, T74.21, T74.31, Z69.11, Y07.0		

Selected Services Rendered

Line	Service Category	Applicable ICD-10-CM, CPT-4/II/PLA, or HCPCS Code	Number of Visits (a)	Number of Patients (b)
	Selected Diagnostic Tests/ Screening/Preventive Services			
21	HIV test	**CPT-4**: 86689, 86701 through 86703, 87389 through 87391, 87534 through 87539, 87806		
21a	Hepatitis B test	**CPT-4**: 86704 through 86707, 87340, 87341, 87350		
21b	Hepatitis C test	**CPT-4**: 86803, 86804, 87520 through 87522		
21c	Novel coronavirus (SARS-CoV-2) diagnostic test	**CPT-4**: 87426, 87635 **HCPCS**: U0001, U0002, U0003, U0004 **CPT PLA**: 0202U, 0223U, 0225U		
21d	Novel coronavirus (SARS-CoV-2) antibody test	**CPT-4**: 86328, 86408, 86409, 86769 **CPT PLA**: 0224U, 0226U		
21e	Pre-Exposure Prophylaxis (PrEP)-associated management of **all** PrEP patients	**CPT-4**: 99401-99404 **ICD-10**: Z11.3, Z11.4, Z20.2, Z20.6, Z51.81, Z71.51, Z71.7, Z79.899 Limit to emtricitabine/tenofovir disoproxil fumarate (FTC/TDF) or emtricitabine/tenofovir alafenamide (FTC/TAF) for PrEP		
22	Mammogram	**CPT-4**: 77065, 77066, 77067 **ICD-10**: Z12.31		
23	Pap test	**CPT-4**: 88141 through 88153, 88155, 88164 through 88167, 88174, 88175 **ICD-10**: Z01.41-, Z01.42, Z12.4 (exclude Z01.411 and Z01.419)		
24	Selected immunizations: hepatitis A; haemophilus influenzae B (HiB); pneumococcal, diphtheria, tetanus, pertussis (DTaP) (DTP) (DT); measles, mumps, rubella (MMR); poliovirus; varicella; hepatitis B	**CPT-4**: 90632, 90633, 90634, 90636, 90643, 90644, 90645, 90646, 90647, 90648, 90669, 90670, 90696, 90697, 90698, 90700, 90701, 90702, 90703, 90704, 90705, 90706, 90707, 90708, 90710, 90712, 90713, 90714, 90715, 90716, 90718, 90720, 90721, 90723, 90730, 90731, 90732, 90740, 90743, 90744, 90745, 90746, 90747, 90748		
24a	Seasonal flu vaccine	**CPT-4**: 90630, 90653 through 90657, 90658, 90661, 90662, 90672, 90673, 90674, 90682, 90685 through 90689, 90756		
25	Contraceptive management	**ICD-10**: Z30-		
26	Health supervision of infant or child (ages 0 through 11)	**CPT-4**: 99381 through 99383, 99391 through 99393 **ICD-10**: Z00.1-		

Line	Service Category	Applicable ICD-10-CM, CPT-4/II/PLA, or HCPCS Code	Number of Visits (a)	Number of Patients (b)
26a	Childhood lead test screening (9 to 72 months)	**ICD-10:** Z13.88 **CPT-4**: 83655		
26b	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	**CPT-4**: 99408, 99409 **HCPCS**: G0396, G0397, G0443, H0050		
26c	Smoke and tobacco use cessation counseling	**CPT-4**: 99406, 99407 **HCPCS**: S9075 **CPT-II**: 4000F, 4001F, 4004F		
26d	Comprehensive and intermediate eye exams	**CPT-4**: 92002, 92004, 92012, 92014		

Line	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)
	Selected Dental Services			
27	Emergency services	**CDT:** D0140, D9110		
28	Oral exams	**CDT:** D0120, DO145, D0150, D0160, D0170, D0171, D0180		
29	Prophylaxis—adult or child	**CDT:** D1110, D1120		
30	Sealants	**CDT:** D1351		
31	Fluoride treatment—adult or child	**CDT:** D1206, D1208 **CPT-4:** 99188		
32	Restorative services	**CDT:** D21xx through D29xx		
33	Oral surgery (extractions and other surgical procedures)	**CDT:** D7xxx		
34	Rehabilitative services (Endo, Perio, Prostho, Ortho)	**CDT:** D3xxx, D4xxx, D5xxx, D6xxx, D8xxx		

Sources of Codes

- ICD-10-CM (2020)–National Center for Health Statistics (NCHS)
- CPT (2020)–American Medical Association (AMA)
- Code on Dental Procedures and Nomenclature CDT Code (2020)–Dental Procedure Codes. American Dental Association (ADA)

Note: *"X" in a code denotes any number, including the absence of a number in that place. Dashes (-) in a code indicate that additional characters are required. ICD-10-CM codes all have at least four digits. These codes are not intended to reflect whether or not a code is billable. Instead, they are used to point out that other codes in the series are to be considered.*

Instructions for Tables 6B and 7

Tables 6B and 7 provide data on selected quality of care and clinical health outcome and disparity measures. BPHC first implemented these measures in 2008 and continues to update them. BPHC will continue to revise and expand these measures consistent with the National Quality Strategy, CMS electronic Clinical Quality Measures (eCQMs), and other national quality initiatives.

The clinical quality measures (CQMs) described in this manual must be reported by all health centers using specifications detailed in the measure definitions described below. The majority of the UDS clinical measures are aligned with CMS 2020 Performance Period Eligible Professional/Eligible Clinical eCQMs. Use the most current CMS-issued eCQM specifications for the eCQM number and version referenced in the UDS Manual for 2020 reporting and measurement period. Although there are other year and version updates available from CMS, *they are not to be used* for 2020 reporting.

Note: *The phrases "measurement year" and "measurement period" may be used interchangeably in this section. These have the same meaning and are intended to represent calendar year 2020 unless another timeframe is specifically noted. For UDS clinical measure reporting, include and evaluate patients who had at least one or two medical visits, depending on the measure, (dental visits for the dental sealant measure) during the measurement period.*

The measure specifications can be found at the CMS Electronic Clinical Quality Improvement (eCQI) Resource Center. The eCQM measure numbers and links are provided to assist you, when applicable. Further clarification or interpretation of CMS eCQMs may be provided by the measure steward (listed in Appendix G). Additionally, the use of official versions of vocabulary value sets as contained in the Value Set Authority Center (VSAC)[7] is encouraged for health centers capable of appropriately using this resource as defined to support the data reporting of these clinical measures.

Note: *CMS uses logic statements describing the criteria for eCQM reporting using Clinical Quality Language (CQL) in an effort to standardize reporting workflows. Health centers are advised to review workflows to ensure that required data are being captured correctly to calculate measures. It is important to note that data results may be impacted by the change. To address the impacts of these changes, health centers should work with HIT/EHR vendors and IT staff to understand any unexpected changes in the data results.*

Column Logic Instructions

Column A (A, 2A, or 3A): Number of Patients in the Universe (Denominator)

Report the total number of patients who fulfill the detailed criteria described for the specified measure. *Consider patients meeting the criteria in the health center's total patient population, including all sites, all programs, and all providers.*

Note: *eCQM uses the term "initial patient population" to describe the universe (denominator).*

Because the initial patient population for each measure is defined in whole or in part in terms of age (or age and sex assigned at birth), comparisons to the numbers on Tables 3A, 6B, and 7 will be made when evaluating your submission. The numbers in Column A of Tables 6B and 7 will not be equal to those that might be calculated on Table 3A for the following reasons:

(1) All patients seen for reportable services (i.e., medical, dental, mental health) are counted on Table 3A, but only patients seen for medical care (or dental for the one dental measure) are considered for the clinical measures reported on Tables 6B and 7. The more dental-, mental

[7] Requires free user account and login.

health-, or substance use disorder-only patients a health center has, the less comparable the data will be.

(2) Table 3A measures age as of June 30 of the calendar year, but Tables 6B and 7 define other time periods (e.g., as of January 1) to measure age.

Although comparisons may be made between the numbers on Table 6A and Tables 6B and 7, the numbers in Column A of Tables 6B and 7 will not be equal to those reported in Column B of Table 6A for the following reasons:

(1) All patients, regardless of age, seen for all reportable services and diagnoses, count on Table 6A, but Tables 6B and 7 relate only to patients of specific age ranges.

(2) Table 6A reflects diagnoses and services during the calendar year, but in Tables 6B and 7 measures may require patients to be considered based on active diagnoses or look-back period of completed services.

Additionally, pregnancy outcomes on Table 7 are compared to prenatal care patients on Table 6B.

Column B (B, 2B, or 3B): Number of Charts/Records Sampled or EHR Total

Report the total number of health center patients from the universe (Column A) for whom data have been reviewed. The number will essentially become the denominator in evaluating the measurement standard and will be:

- all patients who fit the criteria (the same number as the universe reported in Column A), or
- a number equal to or greater than 80 percent* of all patients who fit the criteria (a value no less than 80 percent of the universe reported in Column A), or
- a scientifically drawn *sample* of 70 patients selected from all patients who fit the criteria. Please refer to Appendix C for specifics on sampling methodology.

**To streamline the process for reporting on the CQMs, and to encourage the use of HIT to report on the full universe of patients, health centers may use all of the records available in the HIT/EHR in lieu of a chart sample if at least 80 percent of all health center patient's records are included in the HIT/EHR for any given measure and patients missing from the HIT/EHR are not related to any target group or variable involved with any given measure. For example, if the patients from a pediatric site are missing in the HIT/EHR, it cannot be used for the childhood immunization measure.*

If a sample is to be used, it *must* be a random sample of 70 patient charts and *must* be drawn from the health center's entire patient population identified as the universe. Larger samples will not be accepted. Health centers may not choose to select the same number of charts from each site or the same number for each provider or use other stratification mechanisms because this will result in oversampling some group of patients.

Note: *Health centers using a sample for any CQM will be ineligible for HRSA's Quality Improvement Awards.*

Use a review of a sample of charts in lieu of full-universe reporting from an HIT/EHR if:

- the HIT/EHR system does not include a minimum of 80 percent of health center patients who meet the criteria described below for inclusion in the specific measure's universe,
- the HIT/EHR system does not exclude every health center patient who meets one or more exclusion criteria described below for exclusion from the universe,

- the HIT/EHR system has not been in place long enough to be able to find the data required in prior year's activities (look-back period data are necessary for many of the UDS CQMs [e.g., cervical cancer screening, colorectal cancer screening, childhood immunizations]), or
- the required data were not collected from the patient as part of the visit or searchable in discrete data fields at the time of the visit.

Records for new patients should be obtained from their former providers to document prior treatment, including data for look-back periods. Medical records obtained from other providers may be recorded in the health center's HIT/EHR system consistent with internal medical records policies, at which point they could be used in the calculated performance rate for the applicable measure.

If the HIT/EHR system is used, the number in Column B (records reviewed) must be no less than 80 percent of the number in Column A when the total universe is greater than 70. The reduced total (in Column B) may not be the result of excluding patients based on a variable related to the measure.

Note: *Health centers reporting on less than 100 percent of the universe for any CQM will be ineligible for HRSA's Quality Improvement Awards.*

Column C (C or 2C): Number of Charts/Records Meeting the Measurement Standard (Numerator)

Report the total number of records (included in the count for Column B) that meet the measurement standard for the specified measure. The number in Column C (records meeting the measurement standard) may never exceed the number in Column B (patient records reviewed).

Note: *The percentage of patient records meeting the measurement standard can be calculated by dividing Column C by Column B.*

Column 3F (Table 7 only): Number of Charts/Records that Do Not Meet the Measurement Standard (Numerator)

Report the total number of records that ***do not*** meet the measurement standard as discussed for the specified measure (e.g., Diabetes: Hemoglobin A1c [HbA1c)] Poor Control). The number in Column 3F (patients not meeting the measurement standard) may never exceed the number in Column 3B (patient records reviewed).

Note: *The percentage of patient records not meeting the measurement standard can be calculated by dividing Column 3F by Column 3B.*

Criteria vs. Exceptions and Exclusions in HITs/EHRs vs. Chart Reviews

In the information that follows, "conditions" or "criteria" are at times interchanged with "exceptions" or "exclusions." This is partly because of the differing language and procedures in an HIT/EHR (or practice management system)-based report versus a chart audit report. In an HIT/EHR or PMS review, all criteria for a measure must be locatable in the HIT/EHR and must be in the HIT/EHR for each patient at the health center. If they cannot be found, findings will be distorted and the HIT/EHR cannot be used. If, for example, the HIT/EHR cannot differentiate between a medical patient and a dental-only patient, then the HIT/EHR cannot be used to review the immunization of 2-year-old children because the universe cannot be limited to medical patients.

In a sample chart review process, items listed as "criteria" may be used as "exclusions." For example, if you are unable to use HIT/EHR, you are to randomly select 70 patient charts of all 2-year-old patients listed and, if your sample includes someone who turns out to be a dental (only) patient, you can "exclude" that chart from the sample and replace it with another chart. (In a computer search, include as criterion that they must be medical patients for the child immunization measure).

And vs. Or

In this section, conditions linked with "*and*" mean that each of the conditions must be met. If some but not all conditions are met, the services for that patient are considered to have failed to meet the measurement standard. Conditions linked with "*or*" mean that if any of the conditions is met, the measure is satisfied.

Detailed Instructions for Clinical Measures

The clinical measures reported in the UDS relate only to medical patients (or dental patients in the case of one dental measure). Health centers are to report each measure using the criteria outlined below. Each measure has been organized in the same way to assist with data collection and reporting.

- **Measure Description:** The quantifiable indicator to be evaluated.
- **Denominator (Universe):** Patients who fit the detailed criteria described for inclusion in the specific measure to be evaluated.
- **Numerator:** Records (from the denominator) that meet the measurement standard for the specified measure.
- **Exclusions/Exceptions:** Patients not to be considered and who should be removed from the denominator.
- **Specification Guidance:** CMS measure guidance that assists with understanding and implementing eCQMs.
- **UDS Reporting Considerations:** BPHC requirements and guidance to be applied to the specific measure and that may differ from or expand on the eCQM specifications.

Instructions for Table 6B: Quality of Care Measures

The quality of care measures reported on Table 6B are "process measures." This means they document services that have been shown to be correlated with and serve as a proxy for positive long-term health outcomes. Individuals who receive routine preventive care and timely chronic care are more likely to have positive outcomes.

By increasing the proportion of health center patients who receive timely preventive care and routine acute and chronic care, an improved health status of the patient population is expected in the future. Specifically:

- **Early Entry into Prenatal Care:** The probability of adverse birth outcomes will be reduced if patients enter care in their first trimester.
- **Childhood Immunization Status:** Children will be less likely to contract vaccine-preventable diseases or to suffer from the sequelae of these diseases if they receive their vaccinations in a timely fashion.
- **Cervical Cancer Screening:** Early detection and treatment of cervical abnormalities can occur and women will be less likely to suffer adverse outcomes from cervical cancer if they receive Pap tests as recommended.
- **Breast Cancer Screening:** Early detection and treatment of breast abnormalities can occur and patients will be less likely to suffer adverse outcomes from breast cancer if they receive mammograms as recommended.
- **Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents:** The likelihood of obesity and its sequelae will be reduced if clinicians ensure their patients' body mass index (BMI) percentile is recorded and if patients (and parents) are counseled on nutrition and physical activity (regardless of the patient's weight).
- **Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** The likelihood of the debilitating sequelae of serious weight problems can be reduced if clinicians routinely calculate and record the BMI for their adult patients and if clinicians identify patients with weight problems and develop a follow-up plan for overweight and underweight patients.
- **Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Patients will be more likely to quit using tobacco and will therefore have a lower risk of cancer, asthma, emphysema, and other tobacco-related illnesses if they are routinely queried about their tobacco use and are provided with cessation counseling and/or pharmacologic intervention if they are tobacco users.
- **Statin Therapy for the Prevention and Treatment of Cardiovascular Disease:** The likelihood of cardiovascular-related clinical events will be reduced if clinicians ensure patients at high risk of cardiovascular events receive lipid-lowering statin therapy.
- **Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet:** The likelihood of myocardial infarctions and other vascular events can be reduced if clinicians ensure patients with established IVD use aspirin or another antiplatelet drug.
- **Colorectal Cancer Screening:** Early intervention is possible and premature death can be averted if patients receive appropriate colorectal cancer screening.
- **HIV Linkage to Care:** The probability of HIV-related complications and transmission are reduced if patients found to be HIV positive are seen for follow-up care within 30 days of the initial HIV diagnosis.

- **HIV Screening:** Detection of HIV by screening patients will permit interventions to prevent the transmission and progression of HIV in patients if found to be HIV positive or at high risk for being exposed to HIV.
- **Preventive Care and Screening: Screening for Depression and Follow-Up Plan:** Patients will be more likely to receive needed treatment and less likely to suffer from the sequelae of depression if they are routinely screened for depression and are provided with a follow-up plan when screened as positive.
- **Depression Remission at Twelve Months:** Patients who receive routine follow-up assessment for their depression can be provided additional treatment, reducing the sequelae of patients who suffer from depression.
- **Dental Sealants for Children between 6–9 Years:** Children with moderate to high risk for caries will be less likely to experience dental decay if they are provided sealants on first permanent molars.

Sections A and B: Demographic Characteristics of Prenatal Care Patients

Report on all patients who are either provided direct prenatal care or referred for prenatal care.

Report on the age and trimester of entry into prenatal care for all prenatal care patients, regardless of whether they receive all or some of their prenatal services in the health center or are referred elsewhere.

Note: *Do not include women who had a positive pregnancy test but did not initiate prenatal care with the health center or its referral network.*

Prenatal Care by Referral Only (check box)

Check the "Prenatal Care by Referral Only" check box if you provide prenatal care to patients *only* through direct referral to another provider. Do not select this flag if your health center providers provide some or all prenatal care to patients directly.

Note: *All health centers are required to provide prenatal care to patients, either directly or by referral. Do not include patients who did not receive prenatal care from a health center provider or who were not referred by the health center to another provider for prenatal care. Do not include patients who chose to go outside of the health center's referral network. Do not include patients who receive care unrelated to their pregnancy who are being seen elsewhere for prenatal care.*

Section A: Age of Prenatal Care Patients (Lines 1–6)

Report the total number of patients by age group who received or were referred for prenatal care services at any time during the reporting period. Include all patients receiving any prenatal care, including the delivery of their child, during the reporting year, regardless of when that care was initiated. Include patients who:

- receive all their prenatal care from the health center,
- were referred by the health center to another provider for all their prenatal care,
- began prenatal care with another provider but transferred to the health center at some point during their prenatal care,
- began prenatal care with the health center but were transferred to another provider at some point during their prenatal care,
- were provided with all their prenatal care by a health center provider but were delivered by another provider,
- began or were referred for care during the previous reporting year or in this reporting year and delivered during the reporting year, or
- began or were referred for their care in this reporting period but will not or did not deliver until the next year.

To determine the appropriate age group, use the patient's age on June 30 of the reporting period.

***Note:** As many as half of all prenatal care patients reported will usually have been reported in the prior year or will be reported in the next year.*

Section B: Early Entry into Prenatal Care (Lines 7–9), No eCQM

Measure Description

Percentage of prenatal care patients who entered prenatal care during their first trimester.

Calculate as follows:

Denominator (Universe): Line 7 + Line 8 + Line 9, Columns A + B

- Patients seen for prenatal care during the year

Numerator: Line 7, Columns A + B

- Patients beginning prenatal care at the health center or with a referral provider (Column A), or with another prenatal provider (Column B), during their first trimester

Exclusions/Exceptions

- Denominator
  - Not applicable
- Numerator
  - Not applicable

Specification Guidance

- Not applicable

UDS Reporting Considerations

- Report on Lines 7–9 all patients who received prenatal care, either directly or through a referral, including but not limited to the delivery of a baby during the reporting period.
  - **First Trimester (Line 7):** Report patients who were prenatal patients during the reporting period and whose first visit occurred when they were estimated to be pregnant up through the end of the 13th week after the first day of their last menstrual period.
  - **Second Trimester (Line 8):** Report patients who were prenatal patients during the reporting period whose first visit occurred when they were estimated to be between the start of the 14th week and the end of the 27th week after the first day of their last menstrual period.
  - **Third Trimester (Line 9):** Report patients who were prenatal care patients during the reporting period and whose first visit occurred when they were estimated to be 28 weeks or more after the first day of their last menstrual period.

***Note:** It is unusual for the number in Column B to be very large or larger than that in Column A. This is especially true for the third trimester, because it would require patients to have begun care and then be transferred in a very short period of time.*

The sum of the numbers in the six cells of Lines 7 through 9 represents the total number of patients who received prenatal care from the health center during the calendar year and is equal to the number reported on Line 6.

- Criteria used to identify how prenatal patients are reported:
  - Determine the trimester by the trimester of pregnancy that the patient was in when they began prenatal care either at one of the health center's service delivery locations or with another provider, including a referral provider. For example:
    - If the patient began prenatal care during the first trimester at the health center's service delivery location or with a provider the patient was referred to by the health center, report the patient on Line 7 in Column A.
    - If the patient received prenatal care from another provider during the first trimester before coming to the health center's service delivery location, the patient is reported on Line 7 in Column

B, regardless of when the patient begins care with the health center.

- Report a patient who begins prenatal care with the health center or is referred by the health center to another provider only once in Column A (not Column B).
- Report a patient who begins prenatal care on their own with another provider and then transfers to the health center only once in Column B ***and not*** in Column A.
- In the event a patient is referred to another provider for care by a health center that does not have its own prenatal care program, count as the first visit the visit at which the patient receives a complete, comprehensive prenatal exam from the referral provider.
- Prenatal care is considered to have begun at the time the patient has their first visit with a physician or NP, PA, or CNM provider who initiates prenatal care with a complete prenatal exam. Consider this the first prenatal care visit for UDS purposes.
- Patient self-report of trimester of entry is permitted.
- In those rare instances when a patient receives prenatal care services for two separate pregnancies in the same calendar year, count the patient twice as a prenatal patient. For example, this would occur if a woman delivers in January and then becomes pregnant again in October.
- Most patients will have one or more interactions with the health center prior to that visit, including pregnancy and other lab tests, dispensing vitamins, taking a health history, and/or obtaining a nutritional or psychosocial assessment. Do not count these interactions as the start of prenatal care.
- Do not count as the first prenatal visit when the patient first contacts the prenatal referral provider, lab tests only, or when psychosocial or nutritional assessments are done absent of a complete, comprehensive prenatal exam.

Sections C through M: Other Quality of Care Measures

In these sections, report on the findings of your reviews of services provided to targeted populations.

- For sections C through L, specifically assess the current medical patients (i.e., patients who had a medical visit at least once during the reporting period). Do not include patients whose *only* visits were for dental, mental health, or something other than medical care in the universe for these measures.
- For section M, assess current dental patients (i.e., patients who had a dental visit at least once during the reporting period). Do not include patients whose *only* visits were for medical, mental health, or something other than dental care in the universe for this measure.
- For these measures, base age on the patient's age before the start of January 1 of the reporting year (or patient's age during the reporting year, as noted in specified measures).
- Using the specified measure criteria, include patients seen for medical care even if the only care provided was in an urgent care setting, if patients were seen only once for acute care, or if patients were seen only for specialty care.
- For measures requiring the completion of screening, tests, or procedures to meet the measurement standard, test results or procedures must be documented in the patient record.

Note: *In this section, the term "measurement period" is the same as the term "reporting period" and is intended to capture calendar year 2020 data.*

Childhood Immunization Status (Line 10), CMS117v8

Measure Description

Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three or four H influenza type B (HiB); three Hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one Hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

Calculate as follows:

Denominator (Universe): Columns A and B

- Children who turn 2 years of age during the measurement period and who had a *medical* visit during the measurement period

Note: *Include children with birthdate on or after January 1, 2018, children with birthdate on or before December 31, 2018,* ***and*** *children who turn 2 during the measurement period.*

Numerator: Column C

- Children who have evidence showing they received recommended vaccines, had documented history of the illness, had a seropositive test result, or had an allergic reaction to the vaccine by their second birthday

Exclusions/Exceptions

- Denominator
  - Patients who were in hospice care during the measurement period
- Numerator
  - Not applicable

Specification Guidance

- Include patients in the numerator in these situations:
  - MMR, Hep B, VZV, and Hep A vaccines: evidence of receipt of the recommended vaccine, documented history of the illness, or a seropositive test result for the antigen
  - DTaP, IPV, HiB, pneumococcal conjugate, rotavirus, and influenza vaccines: evidence of receipt of the recommended vaccine.
  - For a particular antigen: patients had an anaphylactic reaction or adverse reaction to the vaccine
  - For DTaP vaccine: patients have encephalopathy
  - For IPV vaccine: patients have had an anaphylactic reaction to streptomycin, polymyxin B, or neomycin
  - For Influenza, MMR, or VZV vaccines: if patients have cancer of lymphoreticular or histiocytic tissue, multiple myeloma, or leukemia; have had an anaphylactic reaction to neomycin; have immunodeficiency or have HIV
  - For Hep B vaccine: patients have had an anaphylactic reaction to common baker's yeast
- The measure allows a grace period by measuring compliance with these recommendations between birth and age 2.

UDS Reporting Considerations

- Include children who turned 2 years of age during the measurement period, regardless of when they were seen for medical care during the year. Specifically, include them in the assessment whether the medical visit in the year occurred before or after they turned 2.

- Include children in the universe if they came to the health center for well-child[8] services or for any other medical services, including vaccinations or treatment of an injury or illness.
- Include children in the universe for whom no vaccination information is available and/or who were first seen at a point when there was not enough time to fully immunize them prior to their second birthday.
- Include children who had a contraindication for a specific vaccine in the universe. Count them as being "compliant" for that specific vaccine, if the guidance (Specification Guidance) permits it, and then review for the administration of the rest of the vaccines.
- To count as meeting the measure, a child's medical record must be documented as being compliant for each vaccine.
- Registries can be used to fill any voids in the immunization record if the search is routinely done prior to or immediately after a visit and before the end of the measurement period. For example, you may use an immunization registry maintained by the state or other public entity that shows comparable information.
- **Do not include children here or anywhere on the UDS who only received a vaccination and never received other services.**
- Do not count as meeting the measurement standard charts that only state that the "patient is up to date" with all immunizations and that do not list the dates of all immunizations and the names of immunization agents.
- Do not count toward the measurement standard verbal assurance from a parent or other person that a vaccine has been given.
- Good-faith efforts to get a child immunized that fail do not meet the measurement standard. These include the following:
    - Parental failure to bring in the patient
    - Parents who refuse due to personal beliefs about vaccines or for religious reasons
    - Patients lost to inadequate follow-up

Cervical Cancer Screening (Line 11), CMS124v8

Measure Description

Percentage of women 21*–64 years of age who were screened for cervical cancer using **either** of the following criteria:

- Women age 21*–64 who had cervical cytology performed every 3 years
- Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years

Calculate as follows:

Denominator (Universe): Columns A and B

- Women 23 through 64 years of age with a *medical* visit during the measurement period

    Note: *Include women with birthdate on or after January 2, 1955, and birthdate on or before January 1, 1997.*

    Note: **Use 23 as the initial age to include in assessment. See Specification Guidance for further detail.*

[8] Health centers should add to their universe those patients whose only visits were well-child visits (99381, 99382, 99391, 99392) if their automated system does not include them. In addition, if your state uses different codes for EPSDT visits, those codes should be added.

Numerator: Column C

- Women with one or more screenings for cervical cancer. Appropriate screenings are defined by any one of the following criteria:
  - Cervical cytology performed during the measurement period or the 2 years prior to the measurement period for women who are at least 21 years old at the time of the test.
  - Cervical cytology/HPV co-testing performed during the measurement period or the 4 years prior to the measurement period for women who are at least 30 years old at the time of the test.

Exclusions/Exceptions

- Denominator
  - Women who had a hysterectomy with no residual cervix or a congenital absence of cervix
  - Women who were in hospice care during the measurement period
- Numerator
  - Not applicable

Specification Guidance

- The measure only evaluates whether tests were performed after a woman turned 21 years of age. The youngest age in the initial population is 23.
- Do not include reflex HPV testing. In addition, if the medical record indicates the HPV test was performed only after determining the cytology result, this is considered reflex testing and does not meet measurement standard.

UDS Reporting Considerations

- Include documentation in the medical record of a cervical cytology and HPV tests performed outside of the health center with the date the test was performed, who performed it, and the result of the finding provided by the agency that conducted the test or a copy of the lab test.
- Include patients of all genders who have a cervix.
- If a system cannot determine exclusions, include them in the universe and later exclude and replace them from the sample, if identified.
- Do not count as compliant charts that note the refusal of the patient to have the test.

Breast Cancer Screening (Line 11a), CMS125v8

Measure Description

Percentage of women 50–74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period

Calculate as follows:

Denominator (Universe): Columns A and B

- Women 51* through 73 years of age with a *medical* visit during the measurement period

  Note: *Include women with birthdate on or after January 2, 1946, and birthdate on or before January 1, 1969.*

  Note: **Use 51 as the initial age to include in assessment. See UDS Reporting Considerations for further detail.*

Numerator: Column C

- Women with one or more mammograms during the 27 months prior to the end of the measurement period

Exclusions/Exceptions

- Denominator
  - Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy
  - Patients who were in hospice care during the measurement period
  - Patients aged 66 or older who were living long-term in an institution for more than 90 days during the measurement period
  - Patients aged 66 and older with advanced illness and frailty
- Numerator
  - Not applicable

Specification Guidance

- The measure evaluates primary screening.
- Do not count biopsies, breast ultrasounds, or magnetic resonance imaging, because they are not appropriate methods for primary breast cancer screening.

UDS Reporting Considerations

- The measure only evaluates whether tests were performed after a woman turned 50 years of age. The youngest age in the initial population is 51.
- Include documentation in the medical record of a mammogram performed outside of the health center with the date the test was performed, who performed it, and the result of the finding provided by the agency that conducted the diagnostic study or a copy of the results.
- If a system cannot determine exclusions, include them in the universe and later exclude and replace them from the sample, if identified.
- Include patients according to sex at birth.
- Do not count as compliant charts that note the refusal of the patient to have the test.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (Line 12), CMS155v8

Measure Description

Percentage of patients 3–17 years of age who had an outpatient *medical* visit and who had evidence of height, weight, and body mass index (BMI) percentile documentation ***and*** who had documentation of counseling for nutrition ***and*** who had documentation of counseling for physical activity during the measurement period

Calculate as follows:

Denominator (Universe): Columns A and B

- Patients 3 through 16* years of age with at least one outpatient *medical* visit during the measurement period

Note: *Include children and adolescents with birthdate on or after January 2, 2003, and birthdate on or before January 1, 2017.*

Note: **Use 16 as the final age at the start of the measurement year to include in assessment.*

Numerator: Column C

- Children and adolescents who have had:
  - their BMI percentile (not just BMI or height and weight) recorded during the measurement period ***and***
  - counseling for nutrition during the measurement period ***and***
  - counseling for physical activity during the measurement period

Exclusions/Exceptions

- Denominator
  - Patients who have a diagnosis of pregnancy during the measurement period

- Patients who were in hospice care during the measurement period
- Numerator
    - Not applicable

Specification Guidance

- Because BMI norms for youth vary with age and sex, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

UDS Reporting Considerations

- Include medical visits performed by any medical provider. Note that this is different from the eCQM, which requires that the visit be performed by a primary care physician or an OB/GYN. For example, include patients who had a medical visit with an NP.
- The UDS numerator differs from the eCQM in that the eCQM requires the numerator elements to be reported separately against two age strata (age 3–11, age 12–17). For UDS purposes, the patients must have had all three numerator components completed in order to meet the measurement standard against one age strata (age 3–17).
- Do not count as meeting the performance measure charts that show only that a well-child visit was scheduled, provided, or billed. The electronic or paper well-child visit template/form must document each of the elements noted above.

Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (Line 13), CMS69v8

Measure Description

Percentage of patients aged 18 years and older with BMI documented during the most recent visit or within the previous 12 months to that visit ***and***, when the BMI is outside of normal parameters, a follow-up plan is documented during the visit or during the previous 12 months of that visit

Note: *Normal parameters: For age 18 years and older, BMI greater than or equal to 18.5 and less than 25 kg/m²*

Calculate as follows:

Denominator (Universe): Columns A and B

- Patients 18 years of age or older on the date of the visit with at least one *medical* visit during the measurement period

Note: *Include patients with birthdate on or before January 1, 2002,* ***and*** *who were 18 years of age or older on the date of their last visit.*

Numerator: Column C

- Patients with:
    - a documented BMI (not just height and weight) during their most recent visit in the measurement period ***or*** during the previous 12 months of that visit, ***and***
    - when the BMI is outside of normal parameters, a follow-up plan is documented during the visit or during the previous 12 months of the current visit

Note: *Include in the numerator patients within normal parameters who had their BMI documented* ***and*** *those with a follow-up plan if BMI is outside normal parameters.*

Exclusions/Exceptions

- Denominator
    - Patients who are pregnant during the measurement period
    - Patients receiving palliative care during or prior to the visit
    - Patients who refuse measurement of height and/or weight
    - Patients with a documented medical reason (see Specification Guidance)

- Patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Numerator
  - Not applicable

Specification Guidance

- Report this measure for all patients seen during the reporting period.
- An eligible professional or their staff is required to measure both height and weight. Both height and weight must be measured within 12 months of the current encounter and may be obtained from separate visits.
- Do not use self-reported height and weight values.
- BMI may be documented in the medical record at the health center or in outside medical records obtained by the health center.
- If more than one BMI is reported during the measurement period, use the most recent BMI to determine if the performance has been met.
- Document the follow-up plan based on the most recent documented BMI outside of normal parameters.
- Documented medical reasons include, but are not limited to:
  - Elderly patients (65 years or older) for whom weight reduction or gain would complicate other underlying health conditions, such as the following examples:
    - Illness or physical disability
    - Mental illness, dementia, confusion
    - Nutritional deficiency, such as vitamin or mineral deficiency

UDS Reporting Considerations

- Documentation in the medical record must show the actual BMI, or the template normally viewed by a clinician must display BMI.
- Do not count as meeting the measurement standard charts or templates that display only height and weight. The fact that an HIT/EHR can calculate BMI does not replace the presence of the BMI itself.

Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Line 14a), CMS138v8

Measure Description

Percentage of patients aged 18 and older who were screened for tobacco use one or more times within 24 months ***and*** who received cessation counseling intervention if defined as a tobacco user

Calculate as follows:

Denominator (Universe): Columns A and B

- Patients aged 18 years and older seen for at least two *medical* visits in the measurement period or at least one preventive *medical* visit during the measurement period.

Note: *Include patients with birthdate on or before January 1, 2002.*

Numerator: Column C

- Patients who were screened for tobacco use at least once within 24 months before the end of the measurement period ***and***
- Who received tobacco cessation intervention if identified as a tobacco user

Note: *Include in the numerator patients with a negative screening* ***and*** *those with a positive screening who had cessation intervention if a tobacco user.*

Exclusions/Exceptions

- Denominator
  - Documentation of medical reason(s) for not screening for tobacco use or for not providing tobacco cessation intervention (e.g., limited life expectancy, other medical reason)
- Numerator
  - Not applicable

Specification Guidance

- If patients use any type of tobacco (i.e., smokes or uses smokeless tobacco), tobacco cessation intervention (counseling and/or pharmacotherapy) is expected.
- In order to promote a team-based approach to patient care, the tobacco cessation intervention can be performed by another health care provider; therefore, the tobacco use screening and tobacco cessation intervention do not need to be performed by the same provider or clinician.
- If a patient has multiple tobacco use screenings during the 24-month period, use the most recent screening that has a documented status of tobacco user or non-user.
- If tobacco use status of a patient is unknown, the patient does not meet the screening component required to be counted in the numerator and has not met the measurement standard. "Unknown" includes patients who were not screened or patients with indefinite answers.
- If the patient does not meet the screening component of the numerator but has an allowable medical exception, remove the patient from the denominator.
- The medical reason exception applies to the screening data element of the measure or to any of the tobacco cessation intervention (counseling and/or pharmacotherapy) data elements.
- If a patient has a diagnosis of limited life expectancy, that patient has a valid denominator exception for not being screened for tobacco use or for not receiving tobacco use cessation intervention (counseling and/or pharmacotherapy) if identified as a tobacco user.
- Electronic nicotine delivery systems (ENDS), including electronic cigarettes for tobacco cessation, are not currently classified as tobacco. They are not to be evaluated for this measure.

UDS Reporting Considerations

- Include in the numerator records that demonstrate that the patient had been asked about their use of all forms of tobacco within 24 months before the end of the measurement period.
- Cessation counseling intervention for a tobacco user must occur at or following the most recent screening and before the end of the measurement year. If the cessation intervention is pharmacotherapy, then the prescription must be active (one that has not expired).
- Include patients who receive tobacco cessation intervention by any provider, including those who:
  - received tobacco use cessation counseling services, ***or***
  - received an order for (a prescription or a recommendation to purchase an over-the-counter [OTC] product) a tobacco use cessation medication, ***or***
  - are on (using) a tobacco use cessation agent.
- Identify preventive visits using "Preventive Care Services" CPT codes listed in the eCQM.

- The UDS denominator differs from the eCQM in that the eCQM requires the patient population and numerator to be reported separately; for UDS purposes, the patients must be evaluated as one group.
- Do not count as meeting the measurement standard written self-help materials.

Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Line 17a), CMS347v3

Measure Description

Percentage of the following patients at high risk of cardiovascular events aged 21 years and older who were prescribed or were on statin therapy during the measurement period:

- Patients 21 years of age or older who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD), or
- Patients 21 years of age or older who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level greater than or equal to 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia, or
- Patients 40 through 75 years of age with a diagnosis of diabetes with a fasting or direct LDL-C level of 70–189 mg/dL

Calculate as follows:

Denominator (Universe): Columns A and B

- Patients 21 years of age and older who have an active diagnosis of ASCVD or ever had a fasting or direct laboratory result of LDL-C greater than or equal to 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia, or patients 40 through 75 years of age with Type 1 or Type 2 diabetes and with an LDL-C result of 70–189 mg/dL recorded as the highest fasting or direct laboratory test result in the measurement year or the 2 years prior; with a *medical* visit during the measurement period

Note: *Include patients with birthdate on or before January 1, 1999.*

Numerator: Column C

- Patients who are actively using or who received an order (prescription) for statin therapy at any point during the measurement period

Exclusions/Exceptions

- Denominator
  - Patients who have a diagnosis of pregnancy
  - Patients who are breastfeeding
  - Patients who have a diagnosis of rhabdomyolysis
  - Patients with adverse effect, allergy, or intolerance to statin medication
  - Patients who are receiving palliative care
  - Patients with active liver disease or hepatic disease or insufficiency
  - Patients with end-stage renal disease (ESRD)
  - Patients 40 through 75 years of age with diabetes whose most recent fasting or direct LDL-C laboratory test result was less than 70 mg/dL and who are not taking statin therapy
- Numerator
  - Not applicable

Specification Guidance

- Current statin therapy use (including statin medication samples provided to patients) must be documented in the patient’s current medication list or ordered during the measurement period.

- Ensure patients are not counted in the denominator more than once. Once a patient meets one set of denominator criteria (check from first listed in Measure Description to last), they are included and further risk checks are not needed.
- Do not count other cholesterol-lowering medications as meeting the measurement standard; only statin therapy meets the measurement standard.
- Intensity of statin therapy or lifestyle modification coaching is not being assessed for this measure; only prescription of any statin therapy is being assessed.

UDS Reporting Considerations

- Not applicable

Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet (Line 18), CMS164v7[9]

Measure Description

Percentage of patients aged 18 years of age and older who were diagnosed with acute myocardial infarction (AMI), or who had a coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCIs) in the 12 months prior to the measurement period, ***or*** who had an *active* diagnosis of IVD during the measurement period, and who had documentation of use of aspirin or another antiplatelet during the measurement period

Calculate as follows:

Denominator (Universe): Columns A and B

- Patients 18 years of age and older with a *medical* visit during the measurement period who had an AMI, CABG, or PCI during the 12 months prior to the measurement year or who had a diagnosis of IVD overlapping the measurement period

Note: *Include patients with birthdate on or before January 1, 2002.*

Numerator: Column C

- Patients who had an active medication of aspirin or another antiplatelet during the measurement period

Exclusions/Exceptions

- Denominator
  - Patients who had documentation of use of anticoagulant medications overlapping the measurement period
  - Patients who were in hospice care during the measurement period
- Numerator
  - Not applicable

Specification Guidance

- Not applicable

UDS Reporting Considerations

- Include in the numerator patients who received a prescription for, were given, or were using aspirin or another antiplatelet drug.
- The electronic specifications for this measure have not been updated. Follow the CMS164v7 specifications for UDS reporting.

Colorectal Cancer Screening (Line 19), CMS130v8

Measure Description

Percentage of adults 50–75 years of age who had appropriate screening for colorectal cancer

[9] Requires a free user login to the United States Health Information Knowledgebase (USHIK) to access measure details.

Calculate as follows:

Denominator (Universe): Columns A and B

- Patients 50 through 74 years of age with a *medical* visit during the measurement period

Note: *Include patients with birthdate on or after January 2, 1945, and birthdate on or before January 1, 1970.*

Numerator: Column C

- Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any *one* of the following criteria:
    - Fecal occult blood test (FOBT) during the measurement period
    - Fecal immunochemical test (FIT)-deoxyribonucleic acid (DNA) during the measurement period or the 2 years prior to the measurement period
    - Flexible sigmoidoscopy during the measurement period or the 4 years prior to the measurement period
    - Computerized tomography (CT) colonography during the measurement period or the 4 years prior to the measurement period
    - Colonoscopy during the measurement period or the 9 years prior to the measurement period

Exclusions/Exceptions

- Denominator
    - Patients with a diagnosis of colorectal cancer or a history of total colectomy
    - Patients who were in hospice care during the measurement period
    - Patients aged 66 or older who were living long-term in an institution for more than 90 days during the measurement period
    - Patients aged 66 and older with advanced illness and frailty
- Numerator
    - Not applicable

Specification Guidance

- Do not count digital rectal exam (DRE) or FOBT tests performed in an office setting or performed on a sample collected via DRE.

UDS Reporting Considerations

- There are two FOBT test options: Guaiac fecal occult blood test (gFOBT) and the immunochemical-based fecal occult blood test (iFOBT).
- Lab tests (FOBT and FIT-DNA) performed elsewhere must be confirmed by documentation in the chart: either a copy of the test results or correspondence between the clinic staff and the performing lab/clinician showing the results.
- FOBTs can be used to document meeting the measurement standard. This test, if performed, is required each measurement year. For example, a patient who had an FOBT in November 2019 would still need one in 2020.
- Collect stool specimens for FOBT and FIT-DNA, as recommended by the manufacturer.
- FOBT and FIT-DNA test kits can be mailed to patients, but receipt, processing, and documentation of the test sample is required.
- Do not use self-reported test results.

HIV Linkage to Care (Line 20), No eCQM

Measure Description

Percentage of patients newly diagnosed with HIV who were seen for follow-up treatment within 30 days of diagnosis[10]

Calculate as follows:

Denominator (Universe): Columns A and B

- Patients first diagnosed with HIV by the health center between December 1 of the prior year through November 30 of the current measurement year and who had at least one *medical* visit during the measurement period or prior year

Note: *Include patients who were diagnosed with HIV for the first time ever[11] by the health center between December 1, 2019, and November 30, 2020,[12] and had at least one medical visit during 2020 or 2019.*

Numerator: Column C

- Newly diagnosed HIV patients that received treatment within 30 days of diagnosis. Include patients who were newly diagnosed by your health center providers ***and***:
    - had a medical visit with your health center provider who initiates treatment for HIV, ***or***
    - had a visit with a referral resource who initiates treatment for HIV.

Exclusions/Exceptions

- Denominator
    - Not applicable
- Numerator
    - Not applicable

Specification Guidance

- Not applicable

UDS Reporting Considerations

- *Treatment must be initiated* within 30 days of the HIV diagnosis (not just a referral made, education provided, or retest at a referral site).
- Include patients in the numerator only if they received treatment for HIV care within 30 days of the diagnosis. If the treatment is by referral to another clinician or organization (such as a Ryan White provider), the medical treatment at the referral source must begin the referral loop and it must be closed during the 30-day period. Closing the referral loop means the referring provider received documented confirmation that the visit was completed from the provider to whom the patient was referred.
- Identification of patients for this measure crosses years and may include prior-year patients.
- Reactive initial HIV tests and patients who self-identify as being HIV positive without documentation must be followed by a supplemental test to confirm diagnosis.
- Do not include patients who:
    - Were diagnosed elsewhere, even if they can provide documentation of the positive test result
    - Had a positive reactive initial screening test but not a positive supplemental test
    - Were positive on an initial screening test provided by you but were then sent to

[10] Note that this measure does not conform to the calendar year reporting requirement.

[11] "Patients first diagnosed with HIV" is defined as patients without a previous HIV diagnosis who received a reactive initial HIV test confirmed by a positive supplemental antibody immunoassay HIV test.

[12] Because the measure allows up to 30 days to complete the follow-up, look back 30 days to find the entire universe of patients who should have had a follow-up during the measurement year.

another provider for definitive testing and treatment

Note: *There are no ICD-10-CM or CPT codes to identify newly diagnosed HIV patients. It is strongly encouraged that you modify your HIT/EHR to record this information or keep track of the patients who are identified in a separate system.*

HIV Screening (Line 20a), CMS349v2

Measure Description

Percentage of patients aged 15–65 at the start of the measurement period who were between 15–65 years old when tested for HIV

This is calculated as follows:

Denominator (Universe): Columns A and B

- Patients aged 15 through 65 years of age at the start of the measurement period and with at least one outpatient *medical* visit during the measurement period

Note: *Include patients with birthdate on or after January 2, 1954, and birthdate on or before January 1, 2005.*

Numerator: Column C

- Patients with documentation of an HIV test performed on or after their 15th birthday and before their 66th birthday

Exclusions/Exceptions

- Denominator
  - Patients diagnosed with HIV prior to the start of the measurement period
- Numerator
  - Not applicable

Specification Guidance

- This measure evaluates the proportion of patients aged 15–65 at the start of the measurement period who have documentation of having received an HIV test at least once on or after their 15th birthday and before their 66th birthday.
- In order to satisfy the measure, the health center must have documentation of the administration of the laboratory test present in the patient's medical record.
- HIV tests performed elsewhere must be confirmed by documentation in the chart: either a copy of the test results or correspondence between the clinic staff and the performing lab/clinician showing the results.
- Patient attestation or self-report to meet the measure requirements is not permitted.

UDS Reporting Considerations

- Not applicable

Preventive Care and Screening: Screening for Depression and Follow-Up Plan (Line 21), CMS2v9

Measure Description

Percentage of patients aged 12 years and older screened for depression on the date of the visit or 14 days prior to the visit using an age-appropriate standardized depression screening tool ***and***, if positive, had a follow-up plan documented on the date of the visit

This is calculated as follows:

Denominator (Universe): Columns A and B

- Patients aged 12 years and older with at least one *medical* visit during the measurement period

Note: *Include patients with birthdate on or before January 1, 2008.*

Numerator: Column C

- Patients who:
  - were screened for depression on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized tool ***and***,
  - if screened positive for depression, had a follow-up plan documented on the date of the visit.

Note: *Include in the numerator patients with a negative screening and those with a positive screening who had a follow-up plan documented.*

Exclusions/Exceptions

- Denominator
  - Patients with an active diagnosis for depression or a diagnosis of bipolar disorder
  - Patients:
    - Who refuse to participate
    - Who are in urgent or emergent situations[13] where time is of the essence and to delay treatment would jeopardize the patient's health status
    - Whose cognitive or functional capacity or motivation to improve may impact the accuracy of results of standardized assessment tools
- Numerator
  - Not applicable

Specification Guidance

- The depression screening must be completed on the date of the visit or up to 14 days prior to the date of the visit and must be reviewed and addressed in the office of the provider on the date of the visit.
- If the screening result is positive, additional evaluation, assessment, referral, treatment, pharmacological intervention, or other interventions or follow-up must be addressed in the office of the provider on the date of the visit.
- Standardized depression screening tools[14] are normalized and validated for the age-appropriate patient population in which they are used and must be documented in the medical record.
  - Examples of depression screening tools for adolescents, adults, and perinatal patients are included in the FAQs for Table 6B.
- Use the most recent screening results.
- The follow-up plan must be related to a positive depression screening.
- Follow-up for a positive depression screening must include one or more of the following:
  - Additional evaluation or assessment for depression.
  - Suicide risk assessment.
  - Referral to a practitioner who is qualified to diagnose and treat depression.
  - Pharmacological interventions.
  - Other interventions or follow-up for the diagnosis or treatment of depression.

UDS Reporting Considerations

- Although a Patient Health Questionnaire (PHQ-9) may follow a PHQ-2 as a *new screening*, if the result is positive, then a compliant follow-up plan is still required.
- Documentation of a follow-up plan "on the date of the visit" can refer to any reportable visit, not only a medical visit.

[13] Do not exclude patients seen for routine care in urgent care centers or emergency rooms you operate.

[14] Refer to the publisher and the health center clinical team to interpret the results of screening tools.

- Do not count patients who are re-screened as meeting the measurement standard as a follow-up plan to a positive screen.
- Do not count a PHQ-9 screening that follows a positive PHQ-2 screening during the measurement period as meeting the measurement standard for a *follow-up* plan to a positive depression screening.

Depression Remission at Twelve Months (Line 21a), CMS159v8

Measure Description

Percentage of patients aged 12 years and older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event

This is calculated as follows:

Denominator (Universe): Columns A and B

- Patients aged 12 years and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 or PHQ-9 modified for teens (PHQ-9M) score greater than 9 during the index event between November 1, 2018 through October 31, 2019 and at least one *medical* visit during the measurement period

Note: *Include patients with birthdate on or before January 1, 2008 who were 12 years of age or older on the date of their visit.*

Numerator: Column C

- Patients who achieved remission at 12 months as demonstrated by the most recent 12 month (+/- 60 days) PHQ-9 or PHQ-9M score of less than 5

Note: *Patients may be screened using PHQ-9 and PHQ-9M up to 7 days prior to the office visit, including the day of the visit.*

Exclusions/Exceptions

- Denominator
  - Patients with a diagnosis of bipolar disorder, personality disorder, schizophrenia, psychotic disorder, or pervasive developmental disorder
  - Patients:
    - Who died
    - Who received hospice or palliative care services
    - Who were permanent nursing home residents
- Numerator
  - Not applicable

Specification Guidance

- Not applicable

UDS Reporting Considerations

- It is possible that the PHQ-9M has been mislabeled as PHQ modified for adolescents (PHQ-A). The PHQ-A is an 80+ item questionnaire (not a 9-question tool). Use a PHQ-9M version that is approved by the developers of the PHQ-9 for adolescents.
- Although PHQ-9 is not the only screening tool approved for the *Screening for Depression and Follow-Up Plan* measure, performance for the *Depression Remission at Twelve Months* must be evaluated using a PHQ-9 or PHQ-9M screening tool.

Dental Sealants for Children between 6–9 Years (Line 22), CMS277v0[15]

Measure Description

Percentage of children, age 6–9 years, at moderate to high risk for caries who received a sealant on a first permanent molar during the measurement period

Calculate as follows:

Denominator (Universe): Columns A and B

- Children 6 through 9 years of age with an oral assessment or comprehensive or periodic oral evaluation *dental* visit who are at moderate to high risk for caries in the measurement period

Note: *Include children with birthdate on or after January 2, 2010, and birthdate on or before January 1, 2014.*

Numerator: Column C

- Children who received a sealant on a permanent first molar tooth during the measurement period

Exclusions/Exceptions

- Denominator
  - Children for whom all first permanent molars are non-sealable (i.e., molars are either decayed, filled, currently sealed, or un-erupted/missing)
- Numerator
  - Not applicable

Specification Guidance

- The intent is to measure whether a child received a sealant on at least one of the four permanent first molars.
- "Elevated risk" is a finding at the patient level, not a population-based factor such as low socioeconomic status.
- Look for tooth-level data for sealant placement. Capture sealant application within buccal pits on a first permanent molar in the numerator.

UDS Reporting Considerations

- Include dental visits with the health center or with another dental provider who saw patients through a paid referral.
- Use ADA codes to document caries risk level determined through an assessment.

Note: *Although draft eCQM reflects 5 through 9 years of age, use ages 6 through 9 as measure steward intended.*

Additional information is available to clarify reporting. View **FAQs for Table 6B**.

[15] Requires a free user login to the United States Health Information Knowledgebase (USHIK) to access measure details.

Table 6B: Quality of Care Measures

Reporting Period: January 1, 2020, through December 31, 2020

0	**Prenatal Care Provided by Referral Only (Check if Yes)**	

Section A—Age Categories for Prenatal Care Patients: Demographic Characteristics of Prenatal Care Patients

Line	Age	Number of Patients (a)
1	Less than 15 years	
2	Ages 15-19	
3	Ages 20-24	
4	Ages 25-44	
5	Ages 45 and over	
6	**Total Patients (Sum of Lines 1-5)**	

Section B—Early Entry into Prenatal Care

Line	Early Entry into Prenatal Care	Patients Having First Visit with Health Center (a)	Patients Having First Visit with Another Provider (b)
7	First Trimester		
8	Second Trimester		
9	Third Trimester		

Section C—Childhood Immunization Status

Line	Childhood Immunization Status	Total Patients with 2nd Birthday (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Immunized (c)
10	MEASURE: Percentage of children 2 years of age who received age appropriate vaccines by their 2nd birthday			

Section D—Cervical and Breast Cancer Screening

Line	Cervical Cancer Screening	Total Female Patients Aged 23 through 64 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Tested (c)
11	MEASURE: Percentage of women 23–64 years of age who were screened for cervical cancer			
Line	**Breast Cancer Screening**	**Total Female Patients Aged 51 through 73 (a)**	**Number Charts Sampled or EHR Total (b)**	**Number of Patients with Mammogram (c)**
11a	MEASURE: Percentage of women 51–73 years of age who had a mammogram to screen for breast cancer			

Section E—Weight Assessment and Counseling for Nutrition and Physical Activity of Children and Adolescents

Line	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Total Patients Aged 3 through 16 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Counseling and BMI Documented (c)
12	MEASURE: Percentage of patients 3–16 years of age with a BMI percentile *and* counseling on nutrition *and* physical activity documented			

Section F—Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Line	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate (c)
13	MEASURE: Percentage of patients 18 years of age and older with (1) BMI documented and (2) follow-up plan documented if BMI is outside normal parameters			

Section G—Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Line	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Assessed for Tobacco Use *and* Provided Intervention if a Tobacco User (c)
14a	MEASURE: Percentage of patients aged 18 years of age and older who (1) were screened for tobacco use one or more times within 24 months, *and* (2) if identified to be a tobacco user received cessation counseling intervention			

Section H—Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Line	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Total Patients Aged 21 and Older at High Risk of Cardiovascular Events (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Prescribed or On Statin Therapy (c)
17a	MEASURE: Percentage of patients 21 years of age and older at high risk of cardiovascular events who were prescribed or were on statin therapy			

Section I—Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet

Line	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Total Patients Aged 18 and Older with IVD Diagnosis or AMI, CABG, or PCI Procedure (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Documentation of Aspirin or Other Antiplatelet Therapy (c)
18	MEASURE: Percentage of patients 18 years of age and older with a diagnosis of IVD or AMI, CABG, or PCI procedure with aspirin or another antiplatelet			

Section J—Colorectal Cancer Screening

Line	Colorectal Cancer Screening	Total Patients Aged 50 through 74 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Appropriate Screening for Colorectal Cancer(c)
19	MEASURE: Percentage of patients 50 through 74 years of age who had appropriate screening for colorectal cancer			

Section K—HIV Measures

Line	HIV Linkage to Care	Total Patients First Diagnosed with HIV (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Seen Within 30 Days of First Diagnosis of HIV (c)
20	MEASURE: Percentage of patients whose first-ever HIV diagnosis was made by health center staff between December 1 of the prior year and November 30 of the measurement year and who were seen for follow-up treatment within 30 days of that first-ever diagnosis			
Line	**HIV Screening**	**Total Patients Aged 15 through 65 (a)**	**Number Charts Sampled or EHR Total (b)**	**Number of Patients Tested for HIV (c)**
20a	MEASURE: Percentage of patients 15 through 65 years of age who were tested for HIV when within age range			

Section L—Depression Measures

Line	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Total Patients Aged 12 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Screened for Depression and Follow-Up Plan Documented as Appropriate (c)
21	MEASURE: Percentage of patients 12 years of age and older who were (1) screened for depression with a standardized tool *and,* if screening was positive, (2) had a follow-up plan documented			
Line	**Depression Remission at Twelve Months**	**Total Patients Aged 12 and Older with Major Depression or Dysthymia (a)**	**Number Charts Sampled or EHR Total (b)**	**Number of Patients who Reached Remission (c)**
21a	MEASURE: Percentage of patients 12 years of age and older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event			

Section M—Dental Sealants for Children between 6–9 Years

Line	Dental Sealants for Children between 6–9 Years	Total Patients Aged 6 through 9 at Moderate to High Risk for Caries (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Sealants to First Molars (c)
22	MEASURE: Percentage of children 6 through 9 years of age at moderate to high risk of caries who received a sealant on a first permanent molar			

Instructions for Table 7: Health Outcomes and Disparities

This table reports data on health status measures by race and Hispanic or Latino/a ethnicity. The health outcome and disparity measures reported are "clinical process and outcome measures," which means they document measurable outcomes of clinical intervention as a surrogate for good long-term health outcomes. Use and analysis of CQMs by health centers in their Plan, Do, Study, Act (PDSA) cycles is one tool that can lead to improved health care for patients.

Increasing the proportion of health center patients who have a good intermediate health outcome generally leads to improved health status of the patient population in the future. Specifically:

- **Low Birth Weight:** There will be fewer children who suffer the multiple negative sequelae of low birth weight, such as delayed or diminished intellectual and/or physical development, if fewer babies have low birth weight.
- **Controlling High Blood Pressure:** There will be less cardiovascular damage, fewer heart attacks, and less organ damage later in life if there is less uncontrolled hypertension.
- **Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%):** There will be fewer long-term complications, such as amputations, blindness, and end-organ damage, if there are fewer cases of poorly controlled diabetes.

Race and Ethnicity Reporting

Table 7 reports health outcome data by race and Hispanic or Latino/a ethnicity to provide information on health centers' efforts to help reduce health disparities. Race and Hispanic or Latino/a ethnicity is self-reported by patients and should be collected as part of a standard registration process. Care must be taken by health centers that have separate reporting systems for patient registration and clinical data to ensure race and ethnicity data across the systems are aligned. For example, do not report more Hispanic or Latino/a patients with hypertension or more patients with hypertension of any given race on Table 7 than are reported for that race or for the Hispanic or Latino/a ethnicity on Table 3B.

Because the initial patient population for each measure is defined in terms of race and ethnicity, comparisons to the numbers on Tables 3B and 7 will be made when evaluating your submission. The numbers in Column A of Table 7 will not be equal to those that might be calculated on Table 3B because all patients seen for all reportable services are counted on Table 3B by race and ethnicity, but the clinical measures reported on Table 7 relate to medical patients of that race and ethnicity with specific conditions. See the crosswalk of comparable fields in Appendix B.

Health centers that report on a sample of patients—and even those who report on their entire universe of patients—are cautioned against using their data to evaluate disparities in their own systems given small sample sizes. On a national level, however, reported data permits HRSA to evaluate the impact of health center services on disparate outcomes for target populations.

HIV-Positive Pregnant Patients, Top Line (Line 0)

Report the total number of HIV-positive pregnant patients served by the health center during the reporting year on Line "0," regardless of whether the health center provides prenatal care or HIV treatment for these patients.

Deliveries Performed by Health Center Provider (Line 2)

Report the total number of deliveries performed by health center clinicians.

- On this line ONLY, include deliveries, regardless of outcome, of patients who were either part of or not part of the health center's prenatal care program during the calendar year. Include such circumstances as:
  - the delivery of another doctor's patients when the health center provider participates in a call group and is on call at the time of delivery,
  - emergency deliveries when the health center provider is on call for the emergency room,
  - deliveries of "undoctored" patients performed by a health center provider as a requirement for privileging at a hospital, and
  - deliveries by any clinician who is considered to be the health center's employee during the delivery.
- Do not include deliveries for which a clinic provider separately bills, receives, and retains payment for the delivery.

Section A: Deliveries and Birth Weight Measure by Race and Hispanic or Latino/a Ethnicity, Columns 1a–1d

Report on *all* prenatal care patients who are either provided direct care or referred for care. No sampling is permitted on this measure. Report all health center patients who delivered during the reporting period and all babies born to them in Columns 1a–1d. Include any patient who is a patient of the health center and is referred to another provider for some or all of their prenatal care.

Report patients delivering (Column 1a) and babies (Columns 1b, 1c, and 1d) separately by their race and ethnicity. Obtain race and ethnicity of mothers from the information on their patient registration forms. Obtain race and ethnicity of children from their registration forms, their birth certificates, or from their parent.

Prenatal Care Patients and Referred Prenatal Care Patients Who Delivered During the Year (Column 1a)

Report all health center prenatal care patients who delivered during the reporting period, including those who health center staff cared for and delivered and those who had some or all of their care provided by a referral provider.

- Include all patients who had deliveries, regardless of the outcome.
- Do not include deliveries when you have no documentation that the delivery occurred (patients lost to inadequate follow-up).
- Do not include patients who, based on their due date, should have delivered but for whom you do not have explicit documentation of the delivery.
- Do not include miscarriages as deliveries.
- This column collects data on "patients who delivered." Report only one patient as having delivered, even if the delivery results in multiple births (e.g., twins or triplets), or is a stillbirth.

Note: *The percentage of prenatal care patients who delivered can be calculated by dividing Table 7, Line i, Column 1a by Table 6B, Line 6, Column A.*

Birth Weight of Infants Born to Prenatal Care Patients Who Delivered During the Year (Columns 1b–1d)

Low Birth Weight (Columns 1b and 1c), no eCQM

Measure Description

Percentage of babies of health center prenatal care patients born whose birth weight was below normal (less than 2,500 grams)

Note: *The reporting of this measure captures all birth weight categories, not only those birth weights that meet the performance measurement.*

Calculate as follows:

Denominator (Universe): Columns 1b + 1c + 1d

- Babies born during the measurement period to prenatal care patients

Numerator: Columns 1b + 1c

- Babies born with a birth weight below normal (under 2,500 grams)

Exclusions/Exceptions

- Denominator
  - Stillbirths or miscarriages
- Numerator
  - Not applicable

Specification Guidance

- Not applicable

UDS Reporting Considerations

- Report the total number of LIVE births during the reporting period for women who received prenatal care from the health center or a referral provider during the reporting period, according to the appropriate birth weight group (in grams):
  - **Very Low Birth Weight (Column 1b):** Weight at birth was less than 1,500 grams.
  - **Low Birth Weight (Column 1c):** Weight at birth was 1,500 grams through 2,499 grams.
  - **Normal Birth Weight (Column 1d):** Weight at birth was equal to or greater than 2,500 grams.

  Note: *Be careful not to confuse pounds and ounces for grams when reporting these numbers. Include neonatal demises.*

- If the delivery is of multiple babies (e.g., twins or triplets), report the birth weight of each child separately.

  Note: *Report data regardless of whether the health center did the delivery or referred the delivery to another provider, and regardless of whether the patient transferred to another provider on their own. Follow-up on all patients is required.*

- In rare instances, there may be no birth outcomes recorded although there may be evidence (i.e., records indicate delivery occurred) that the patient delivered. Count the patient as having delivered with no birth outcomes.
- The number of deliveries reported in Column 1a will normally be different than the total number of infants reported in Columns 1b–1d because of multiple births and still births.

Note: *This is a "negative" measure: The higher the number of infants born below normal birth weight, the worse the performance on the measure.*

Although data are provided for each racial and ethnicity category, the performance measure looks only at the totals.[16]

Sections B and C: Other Health Outcome and Disparity Measures

In these sections, report the findings of reviews of services provided to targeted populations.

- Sections B and C specifically assess the health center's current medical patients (i.e., patients who had a medical visit at least once during the reporting period).
- Do not include patients whose *only* visits were for dental, mental health, or something other than medical care.

[16] However, during the review of the UDS Report, reviewers may question unusually high or low proportion of low birth weight babies for individual race or ethnicity categories.

- Using the specified measure criteria, include patients seen for medical care even if the only care provided was in an urgent care setting, if patients were seen only once for acute care, or if patients were seen only for specialty care.
- For measures that require the completion of tests or procedures to meet the measurement standard, test results or procedures must be evidenced by documented results. Patient-self report is not accepted.

Note: *In this section, the term "measurement period" is the same as the term "reporting period" and is intended to capture calendar year 2020 data.*

Controlling High Blood Pressure (Columns 2a–2c), CMS165v8

Measure Description

Percentage of patients 18–85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure (BP) was adequately controlled (less than 140/90 mmHg) during the measurement period

Calculate as follows:

Denominator (Universe): Columns 2a and 2b

- Patients 18 through 84 years of age who had a diagnosis of essential hypertension overlapping the measurement period with a *medical* visit during the measurement period

Note: *Include patients with birthdate on or after January 2, 1935, and birthdate on or before January 1, 2002.*

Numerator: Column 2c

- Patients whose most recent blood pressure is adequately controlled (systolic blood pressure less than 140 mmHg and diastolic blood pressure less than 90 mmHg) during the measurement period

Exclusions/Exceptions

- Denominator
  - Patients with evidence of ESRD, dialysis, or renal transplant before or during the measurement period
  - Patients with a diagnosis of pregnancy during the measurement period
  - Patients who were in hospice care during the measurement period
  - Patients aged 66 or older who were living long-term in an institution for more than 90 days during the measurement period
  - Patients aged 66 and older with advanced illness and frailty
- Numerator
  - Not applicable

Specification Guidance

- Only blood pressure readings performed by a clinician or remote monitoring device are acceptable for numerator compliance with this measure.
- If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading.
- Do not include blood pressure readings:
  - taken during an acute inpatient stay or emergency department visit,
  - taken on the same day as a diagnostic test or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure (with the exception of fasting blood tests), or
  - reported by or taken by the patient

- If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled." Count them in Columns 2a and 2b, but not in Column 2c.

UDS Reporting Considerations

- Include patients who have an active diagnosis of hypertension even if their medical visits during the year were unrelated to the diagnosis.
- Include blood pressure readings taken at any visit type at the health center as long as the result is from the most recent visit.

Note: *Although the* ***measure's CQL*** *was not updated in 2020 to reflect the removal of the diagnosis limit to within the first 6 months or prior to the measurement year, health centers should adjust the denominator to reflect patients with diagnosis overlapping the measurement year, as the measure steward intended.*

Note: *Health centers that have Office of the National Coordinator for Health IT (ONC)-certified I2I-Track, personal computer dimensional measurement inspection software (PC-DMIS), a patient electronic care system (PECS), population health management systems, or other supporting systems may use them to report the universe only if it can be limited to the measurement period and only if it includes all required data elements (i.e., it includes data for the required time frame for all patients with hypertension from all service sites).*

Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9 percent) (Columns 3a–3f), CMS122v8

Measure Description

Percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c (HbA1c) greater than 9.0 percent during the measurement period

Calculate as follows:

Denominator (Universe): Columns 3a and 3b

Patients 18 through 74 years of age with diabetes with a *medical* visit during the measurement period

Note: *Include patients with birthdate on or after January 2, 1945, and birthdate on or before January 1, 2002.*

Numerator: Column 3f

- Patients whose most recent HbA1c level performed during the measurement year was greater than 9.0 percent or patients who had no test conducted during the measurement period

Exclusions/Exceptions

- Denominator
  - Patients who were in hospice care during the measurement period
  - Patients aged 66 or older who were living long-term in an institution for more than 90 days during the measurement period
  - Patients aged 66 and older with advanced illness and frailty
- Numerator
  - Not applicable

Specification Guidance

- Include patients in the numerator whose most recent HbA1c level is greater than 9 percent, for whom the most recent HbA1c result is missing, or when no HbA1c tests were performed or documented during the measurement period.
- Only include patients with an active diagnosis of Type 1 or Type 2 diabetes in the denominator of this measure.

- Do not include patients with a diagnosis of secondary diabetes due to another condition (such as gestational diabetes) in the denominator.

UDS Reporting Considerations

- Include patients who have an active diagnosis of diabetes even if their medical visits during the year were unrelated to the diagnosis.
- Even if the treatment of the patient's diabetes has been referred to a non-health center provider, the health center is expected to have the current lab test results in its records.

Note: *This is a "negative" measure: The lower the number of adult patients with diabetes with poor diabetes control, the better the performance on the measure.*

Although data are provided for each race and ethnicity category, the performance measure looks only at the totals.

Additional information is available to clarify reporting. View **FAQs for Table 7**.

Table 7: Health Outcomes and Disparities

Reporting Period: January 1, 2020, through December 31, 2020

Section A: Deliveries and Birth Weight

Line	Description	Patients (a)
0	HIV-Positive Pregnant Patients	
2	Deliveries Performed by Health Center's Providers	

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: <1500 grams (1b)	Live Births: 1500–2499 grams (1c)	Live Births: ≥2500 grams (1d)
	Hispanic or Latino/a				
1a	Asian				
1b1	Native Hawaiian				
1b2	Other Pacific Islander				
1c	Black/African American				
1d	American Indian/Alaska Native				
1e	White				
1f	More than One Race				
1g	Unreported/Refused to Report Race				
	Subtotal Hispanic or Latino/a				
	Non-Hispanic or Latino/a				
2a	Asian				
2b1	Native Hawaiian				
2b2	Other Pacific Islander				
2c	Black/African American				
2d	American Indian/Alaska Native				
2e	White				
2f	More than One Race				
2g	Unreported/Refused to Report Race				
	Subtotal Non-Hispanic or Latino/a				
	Unreported/Refused to Report Race & Ethnicity				
h	Unreported/Refused to Report Race and Ethnicity				
i	**Total**				

Section B: Controlling High Blood Pressure

Line	Race and Ethnicity	Total Patients 18 through 84 Years of Age with Hypertension (2a)	Number Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)
	Hispanic or Latino/a			
1a	Asian			
1b1	Native Hawaiian			
1b2	Other Pacific Islander			
1c	Black/African American			
1d	American Indian/Alaska Native			
1e	White			
1f	More than One Race			
1g	Unreported/Refused to Report Race			
	Subtotal Hispanic or Latino/a			
	Non-Hispanic or Latino/a			
2a	Asian			
2b1	Native Hawaiian			
2b2	Other Pacific Islander			
2c	Black/African American			
2d	American Indian/Alaska Native			
2e	White			
2f	More than One Race			
2g	Unreported/Refused to Report Race			
	Subtotal Non-Hispanic or Latino/a			
	Unreported/Refused to Report Race and Ethnicity			
h	Unreported/Refused to Report Race and Ethnicity			
i	**Total**			

Section C: Diabetes: Hemoglobin A1c Poor Control

Line	Race and Ethnicity	Total Patients 18 through 74 Years of Age with Diabetes (3a)	Number Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)
	Hispanic or Latino/a			
1a	Asian			
1b1	Native Hawaiian			
1b2	Other Pacific Islander			
1c	Black/African American			
1d	American Indian/Alaska Native			
1e	White			
1f	More than One Race			
1g	Unreported/Refused to Report Race			
	Subtotal Hispanic or Latino/a			
	Non-Hispanic or Latino/a			
2a	Asian			
2b1	Native Hawaiian			
2b2	Other Pacific Islander			
2c	Black/African American			
2d	American Indian/Alaska Native			
2e	White			
2f	More than One Race			
2g	Unreported/Refused to Report Race			
	Subtotal Non-Hispanic or Latino/a			
	Unreported/Refused to Report Race and Ethnicity			
h	Unreported/Refused to Report Race and Ethnicity			
i	**Total**			

Instructions for Table 8A: Financial Costs

Table 8A reports the total cost of all activities attributable to the reporting period that are within the scope of the project. Total costs include all costs within the health center program scope, regardless of source of funding (e.g., the Health Center Program award, or other grants and contracts). Thus, Table 8A describes what it costs to operate the health center's approved scope of services.

Column Definitions

Report the costs accrued in the reporting period, including depreciation, regardless of when (or, in the case of donations on Line 18, if) actual cash payments were made.

Note: *Only report depreciation for capital expenditures, including BPHC capital grants. Do not report bad debts or the repayment of the principal of a loan, but do report interest payments on any such loans as an expense.*

This table is made up of three columns: Accrued Costs (Column A), Allocation of Facility and Non-Clinical Support Services (Column B), and the Total Cost after Allocation (Column C).

Note: *A table summarizing the cost columns is included in* **FAQs for Table 8A**.

Column A: Accrued Costs

In this column, report the accrued direct costs associated with each of the service delivery cost centers listed. See Line Definitions for costs to include in each category. Report the total facility cost and the total cost of non-clinical support services (also referred to as administrative costs) separately on Lines 14 and 15.

Column B: Allocation of Facility Costs and Non-Clinical Support Service Costs

In this column, report the allocation of facility and non-clinical support services costs (from Lines 14 and 15, Column A) to each of the cost centers. See Allocation Methods at the end of the instructions for this table for guidance on allocating facility and non-clinical support service costs.

Column C: Total Cost After Allocation of Facility and Non-Clinical Support Services

This column reports the cost of each of the cost centers listed on Lines 1–13. This cost is the sum of the direct cost, reported in Column A, plus the allocation of facility and non-clinical support services, reported in Column B.

Note: *All UDS calculations for cost centers, such as medical costs per medical visit, are based on "total cost" (Column C). Total costs are calculated using costs reported on Line 17 and do not include the value of donated services, supplies, or facilities.*

Cost Center Definitions

Align costs reported on Table 8A with FTEs and services reported on Table 5. A crosswalk that aligns the line items is available in Appendix B.

Note: *If an individual's FTE is split across multiple lines on Table 5, the same proportional allocation must be used for that individual's personnel costs on this table.*

Medical Staff Costs (Line 1)

Report all medical staff costs, including salaries, fringe benefits, and training for medical care personnel reported on Table 5, Lines 1–12, supported directly or under contract.

- Include medical interns and residents who were paid either directly or through a contract with their teaching institution.
- Include vouchered or contracted medical services, including the cost of any medical visit paid for directly by the center, such as at-risk specialty care from a managed care organization (MCO) contract or other specialty care.

- Include Promoting Interoperability EHR incentive payments in the amount the health center permits the provider to retain. (Also, report Promoting Interoperability EHR incentive payments received during the calendar year from Medicare or Medicaid as cash receipts on Table 9E, Line 3a.)
- Do not include the costs of medical lab and X-ray staff (report on Line 2) or dedicated HIT/EHR informatics and QI staff (report on Line 12a).
- Do not include the costs of intake, medical records, and billing and collections, as these are considered non-clinical support costs (report on Line 15).

Medical Lab and X-Ray Costs (Line 2)

Report all costs for the provision of medical labs and X-rays reported on Table 5, Lines 13 and 14 (including sonography, mammography, and any advanced forms of tomography), including salaries, fringe benefits, and training provided directly or under contract.

- Do not include other direct medical costs, including but not limited to medical supplies, equipment depreciation, and related travel (report on Line 3).
- Do not include dental lab and X-ray costs (report as Dental, Line 5).
- Do not include costs for retinography (most commonly for diabetic patients) (report as Vision Services, Line 9a).

Other Direct Medical Costs (Line 3)

Report all non-personnel direct costs for medical care, including but not limited to supplies, equipment depreciation, related travel, continuing medical education (CME) registration and travel, uniform laundering, recruitment, membership in professional societies, books, and journal subscriptions.

- Include the cost of the medical aspects of an HIT/EHR system, including but not limited to the depreciation of software and hardware, training costs, and licensing fees.

Note: *If the HIT/EHR system is used in other service categories (e.g., mental health, dental), allocate costs to each of the services in which it is used.*

- Do not report non-clinical support services and facility costs associated with these cost centers (report on Lines 14 and 15, Column A, and then allocate them to the cost center in Column B). (See also FAQs for Table 5).

Total Medical (Line 4)

Sum Lines 1 + 2 + 3.

Other Clinical Services (Lines 5–10)

This category includes staff and related costs for dental, mental health, substance use disorder, pharmacy, vision, and services rendered by other professional personnel (e.g., chiropractors, naturopaths, occupational and physical therapists, speech and hearing therapists, podiatrists). Unlike medical, all costs are included on a single line.

- Report all direct costs for the provision of services in the listed service area, including but not limited to staff, fringe benefits, training, contracted services, office supplies, equipment depreciation, related travel, HIT/EHR, lab services, and X-ray.
- Do not report non-clinical support services and facility costs associated with these cost centers (report on Lines 14 and 15, Column A, and then allocate them to the cost center in Column B). (See also FAQs for Table 5).

Dental (Line 5)

Report all direct costs for the provision of dental services reported on Table 5, Lines 16–18.

Mental Health (Line 6)

Report all direct costs for the provision of mental health services reported on Table 5, Lines 20a–20c, *other than substance use disorder services*.

- If a behavioral health program provides both mental health and substance use disorder services, the cost should be allocated between the two services. Allocations must align with staffing and/or visits (from Table 5).

Substance Use Disorders (Line 7)

Report all direct costs for the provision of substance use disorder services reported on Table 5, Line 20.

- If a behavioral health program provides both mental health and substance use disorder services, the cost should be allocated between the two services. Allocations must align with staffing and/or visits (from Table 5).

Pharmacy (Not Including Pharmaceuticals) (Line 8a)

Report all direct costs for the provision of pharmacy services reported on Table 5, Line 23.

If 340B drugs are purchased by or on behalf of a clinic and dispensed by a contract pharmacy, report the full dispensing fee and any other service fees (such as "share of profit," pharmacy benefit manager costs, inventory fees, ordering fees, or a charge of pharmacy computer services) on this line, regardless of whether the health center pays the full amount, pays a net after subtraction of income at the contract pharmacy, or simply receives a reduced net payment from the pharmacy.

- Do not include the cost of pharmaceuticals (report on Line 8b).
- Do not report the cost of personnel engaged in assisting patients to become eligible for free pharmaceuticals from manufacturers (often called PAPs) (report as Eligibility Assistance on Line 11e).

Pharmaceuticals (Line 8b)

Report all costs for the purchase of pharmaceuticals only.

- Include vaccines and other stock drugs (e.g., penicillin, Depo-Provera, buprenorphine).
- Report the full cost of 340B drugs purchased by or on behalf of the clinic and dispensed by a contract pharmacy. This includes 340B drugs paid for in full by the health center, net payment after subtraction of income at the contract pharmacy, or receipt of a reduced net payment from the pharmacy.
- Do not include other supplies here (report on Line 8a, Pharmacy).
- Do not include the value of donated pharmaceuticals (report on Line 18, Column C).

Other Professional (Line 9)

Report all direct costs for the provision of other professional and ancillary health care services reported on Table 5, Line 22, including but not limited to podiatry, chiropractic, acupuncture, naturopathy, speech and hearing pathology, or occupational and physical therapy. (A more complete list appears in Appendix A.)

***Note:** There is a cell to specify the detail of other professional costs reported on this line.*

Vision (Line 9a)

Report all direct costs for the provision of vision services reported on Table 5, Lines 22a–22c, including optometry, ophthalmology, and vision support staff.

- Include frames and lenses.
- Include costs for retinography (e.g., for diabetic patients) and any contracted costs with reading the results.

Total Other Clinical (Line 10)

Sum Lines 5 + 6 + 7 + 8a + 8b + 9a.

Enabling (Lines 11a–11h, 11)

Enabling services include a wide range of services that support and assist primary care and facilitate patient access to care. Report all direct costs for the provision of enabling services reported on Table 5, Lines 24–28, including salary, fringe benefits, supplies, equipment depreciation, related travel, and contracted services.

Use Lines 11a–11h to detail the cost of seven specific types of enabling services and an "other" category for all other forms of enabling services.

- Case management (11a)
- Transportation (11b)
- Outreach (11c)
- Patient and community education (11d)
- Eligibility assistance (including PAP eligibility and health insurance coverage options) (11e)
- Translation/interpretation services (11f)
- Other (specify the other forms of enabling services included on this line if used) (11g)
- Community health workers (11h)

Note: *Descriptions of the services and staff that belong in each of these categories are included in the Table 5 instructions.*

Be sure costs are allocated in each of these enabling categories consistent with the staff and (for Lines 11a and 11d) visits reported on Table 5. If they are not (perhaps because the expenses are for non-personnel items or because of donated services, staff, or supplies), provide an explanation.

Total Enabling Services (Line 11)

Sum Lines 11a + 11b + 11c + 11d + 11e + 11f + 11g + 11h.

Other Program-Related (Line 12)

Report all direct costs of programs that, although within the health center scope of service, are not directly a part of the listed medical, dental, behavioral, or other health services listed and reported on Table 5, Line 29a.

- Include programs and items such as WIC, child care centers, ADHC centers, fitness centers, Head Start and Early Head Start, housing, clinical trials, research, employment training, the cost of space leased to others, retail pharmacy services provided to non-health-center patients, the amount of grant funds passed through to other agencies (if not already including in other cost center categories on this table), and similar activities.
- Include salaries, fringe benefits, supplies, equipment depreciation, related travel, and contracted services.
- Include the estimated cost of facilities, programs, or services that may be part of the health center scope but are not tied to health center patient activity. Examples might include renting out space in the health center or providing retail pharmacy services to non-patient members of the community.

Note: *Describe the program costs in the "specify" field provided.*

Quality Improvement (QI) (Line 12a)

Report all direct costs for the health center's QI program reported on Table 5, Line 29b, including all personnel who are dedicated in whole or in part to QI.

- Include costs of staff dedicated to the QI program and/or HIT/EHR system development and analysis, their fringe benefits, supplies, equipment depreciation, related travel, and contracted services.

- Do not allocate portions of time that QI staff spend attending meetings, participating in peer review, designing or interpreting QI findings, and so on to other service categories.

Total Enabling, Other Program-Related, and Quality Improvement Services (Line 13)

Sum Lines 11 + 12 +12a.

Facility Costs (Line 14)

Report facility costs reported on Table 5, Line 31, including all staff dedicated to facility services, their fringe benefits, supplies, equipment depreciation, related travel, and contracted services.

- Include rent and/or depreciation (not gross cost), facility mortgage interest (but not principal) payments, utilities, security, grounds keeping, facility maintenance and repairs, janitorial services, and all other related costs.
- Do not report space leased to others on this line. Instead, report it as Other Program-Related costs on Line 12.

Non-Clinical Support Services Costs (Line 15)

Report non-clinical support services costs (sometimes referred to as administrative costs) reported on Table 5, Lines 30a–30c and 32, including the cost of all non-clinical support services staff, senior administrative staff (CEO, CFO, COO, HR director, et al.), billing and collections staff, medical records and intake staff, and the costs associated with them.

- Include salaries, fringe benefits, supplies, equipment depreciation, related travel, and contracted services.
- Include corporate costs (e.g., purchase of facility and liability insurance not including malpractice insurance, audits, legal fees, interest payments on non-facility loans, and communication costs including phone and internet).
- Include costs attributable to the board of directors, including travel, expenses, meetings, directors' and officers' insurance, registration and attendance at state or national meetings, and so forth.

Note: *Do not include the "cost" of bad debts here or report them on this table in any way. (Report bad debt as an adjustment to patient self-pay charges on Table 9D on Line 13).*

Note: Some grant programs limit the proportion of grant funds that may be used for non-clinical support services. **Do not consider those limits on "administrative" costs for those programs when completing Lines 14 and 15.** The non-clinical support services and facility categories for this report include all such personnel working at the health center, whether or not that cost was identified as "administrative" in any other grant application.

Total Facility and Non-Clinical Support Services (Line 16)

Sum Lines 14 + 15.

Total Accrued Cost (Line 17)[17]

Sum Lines 4 + 10 + 13 + 16.

[17] This is the amount used in any BPHC calculation that is based on total cost.

Value of Donated Facilities, Services, and Supplies (Line 18, Column C)

Include the total imputed value of all in-kind and donated services, facilities, and supplies that are necessary to the health center's operation applicable to the reporting period and within your scope of project as follows.

Note: *Do not include the value of these services in Column A on the lines above.*

- Report the estimated reasonable acquisition cost of donated personnel, supplies, services, space rental, and depreciation for the use of donated equipment.
- Report donated pharmaceuticals (including vaccines) at the price that would be paid under the federal Section 340B Drug Pricing Program, not the manufacturer's suggested retail price.
- Estimate reasonable acquisition cost of donated personnel at the cost of hiring comparable staff.
- If the health center is not paying NHSC for assignees, include the full market value of NHSC federal assignee(s), including "ready responders." Capitalize NHSC-furnished equipment, including a dental operatory, at the amount reported on the NHSC Equipment Inventory Document, and report the appropriate depreciation expense for the reporting period.
- Do not include pharmaceuticals donated directly to the patient by the donor, even if the health center may have assisted in obtaining the donation.
- Do not use the usual and customary charge to value clinical personnel who donate their services.

Note: *Describe the donated items and amounts in detail using the "specify" field provided.*

Total with Donations (Line 19)

Sum Lines 17 + 18, Column C.

Facility and Non-Clinical Support Services Allocation Instructions

There are multiple ways that facility and non-clinical support services (Lines 14 and 15, Column A) may be allocated to the cost centers in Column B (Lines 1–13). Use the simplest method that produces reasonably accurate results that are comparable to those obtained by a more complex method. Use the method described below if a more accurate method is not available.

There may be facility and non-clinical support costs that the organization can directly associate with a cost center. For instance, the facility and non-clinical support costs of a site that only provides dental services can be directly associated with Dental, Line 5. The EHR support staff who support the medical department can be directly allocated to Medical, Line 1. It is recommended that these direct allocations be done when they are a significant portion of facility and non-clinical support. The remaining allocation of indirect costs can be done using a single or multi-step allocation process such as those described below.

Facility

The indirect facility cost is commonly allocated based upon the proportion of square feet used by each cost center at each location.

Note: *The record of square feet used by each cost center at each location should be updated each year.*

Non-Clinical Support Services

Some of the indirect non-clinical support costs may be allocated separately based on known use or other factors.

- Adjust for decentralized front desk staff, billing and collection systems and staff, etc.
- Allocate costs for billing and accounting systems based on use.

- Allocate various components of non-clinical services based on their use when these amounts are significant and the use is not shared equally.
- Allocate a lesser percentage of non-clinical costs to large purchased service costs that are known to consume less overhead.

Allocate the remaining indirect non-clinical support cost to each cost center based on the proportion each cost center's direct cost plus previously allocated overhead cost is of the total of those costs.

Note: A simple one-step method may be used if the result is comparable to more complex allocation methods. One method is to use the proportion each cost center's direct cost is of total cost (minus facility, non-clinical support, and pharmaceuticals). The resulting percentage is multiplied by the total Facility and Non-Clinical Support Services cost (Line 16) to arrive at the overhead allocation for that cost center.

Other Allocation Considerations

- Lines 1 and 3 both refer to aspects of the medical practice. It is acceptable to report the allocation of all medical facility and non-clinical support services on Line 1 if a more appropriate allocation between Lines 1 and 3 is not available.
- Pharmaceuticals (Line 8b) does not have an open cell to report an allocation. This is because pharmaceuticals are a purchased service that consumes a significantly lesser facility and non-clinical support charge than services involving personnel. Any allocation of overhead (which is usually minimal) that you choose to make for pharmaceuticals must be reported on Line 8a.
- There may be sizable contracted or purchased services that use less facility and non-clinical support. A lesser allocation may be appropriate.

Additional information is available to clarify reporting. View **FAQs for Table 8A**.

Table 8A: Financial Costs

Reporting Period: January 1, 2020, through December 31, 2020

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
	Financial Costs of Medical Care			
1	Medical Staff			
2	Lab and X-ray			
3	Medical/Other Direct			
4	**Total Medical Care Services** (Sum of Lines 1 through 3)			
	Financial Costs of Other Clinical Services			
5	Dental			
6	Mental Health			
7	Substance Use Disorder			
8a	Pharmacy (not including pharmaceuticals)			
8b	Pharmaceuticals			
9	Other Professional (specify___)			
9a	Vision			
10	**Total Other Clinical Services** (Sum of Lines 5 through 9a)			
	Financial Costs of Enabling and Other Services			
11a	Case Management			
11b	Transportation			
11c	Outreach			
11d	Patient and Community Education			
11e	Eligibility Assistance			
11f	Interpretation Services			
11g	Other Enabling Services (specify___)			
11h	Community Health Workers			
11	**Total Enabling Services** (Sum of Lines 11a through 11h)			
12	Other Program-Related Services (specify___)			
12a	Quality Improvement			
13	**Total Enabling and Other Services** (Sum of Lines 11, 12, and 12a)			

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
	Facility and Non-Clinical Support Services and Totals			
14	Facility			
15	Non-Clinical Support Services			
16	**Total Facility and Non-Clinical Support Services** (Sum of Lines 14 and 15)			
17	**Total Accrued Costs** (Sum of Lines 4 + 10 + 13 + 16)			
18	Value of Donated Facilities, Services, and Supplies (specify___)			
19	**Total with Donations** (Sum of Lines 17 and 18)			

Instructions for Table 9D: Patient-Related Revenue

This table reports patient service revenue, including charges, collections, and adjustments attributable to the reporting period.

The statute requires that *all* health centers have a fee schedule, based on locally prevailing rates and actual health center costs, and that they discount these fees (see discussion regarding sliding fee discounts), based on a patient's income and family size. Health centers are also required to make reasonable efforts to collect payment from patients and/or their third-party payers, consistent with Health Center Program Compliance Manual requirements.

Revenue reported on Table 9D generally aligns with patient insurance enrollment reported on Table 4. A crosswalk that shows this alignment is available in Appendix B.

Rows: Payer Categories and Form of Payment

Five major payer categories are listed: Medicaid, Medicare, Other Public, Private, and Self-Pay. Except for Self-Pay, each category has three sub-categories: non-managed care, capitated managed care, and fee-for-service managed care.

Form of Payment

Non-Managed Care—Fee-for-Service

A payment model in which procedures and services are separately charged and paid for. Third-party payers pay some or all of the bill, generally based on agreed-upon maximums or discounts.

Managed Care—Capitated

A payment model in which a health center contracts with an MCO for a list of services covered under contract. The MCO pays the health center a monthly capitation fee (a set amount for each patient enrolled with the health center) *regardless of whether any services were rendered during the month*. No further payment is provided if the services rendered are on a list of services covered by the capitation in the agreement between the health center and the MCO.

Note: *A supplemental wraparound payment may be made for each visit to adjust total payment to equal federally qualified health center (FQHC) cost-based rates.*

Managed Care—Fee-for-Service

A payment model in which a health center contracts with an MCO, is assigned patients who must receive their primary care from the health center, and is reimbursed on a fee-for-service (or encounter-rate) basis for covered services.

Note: *A supplemental wraparound payment may also be paid for Medicaid and Medicare services.*

Note: Only report as managed care if the health center has a contract with an MCO.

Payer Categories

Medicaid (Lines 1–3)

Report all services billed to and paid for by Medicaid (Title XIX), including:

- Medicaid managed care programs run by commercial (private) insurers. For example, in states with a capitated Medicaid program, where the health center has a contract with a private plan like Blue Cross, the payer would be Medicaid, even though the actual payment may have come from Blue Cross.
- EPSDT, which has various names in different states and is a part of Title XIX. The EPSDT program includes some children who are eligible for the screening services only and are not included in the rest of the Medicaid program. Report their charges on Line 1.
- CHIP, which has different names in different states, if paid through Medicaid.
- Medicaid expansion programs that provide funds for eligible individuals to purchase their own insurance, if it is possible to identify them. Otherwise report as Private.
- The portion of charges for dually eligible patients that are reclassified to Medicaid after being initially submitted to Medicare.
- Medicaid patients enrolled in a “share of cost” program in which they pay some portion of the fee as a co-payment or a deductible. In this case, reclassify the patient’s share of the cost to Self-Pay, Line 13.
- Recognize charges and collections for patients enrolled in ADHC or Program of All-Inclusive Care for the Elderly (PACE) if administered by Medicaid. Treat as discussed in Appendix B.

Medicare (Lines 4–6)

Report all services billed to and paid for by Medicare (Title XVIII), including:

- Medicare managed care programs, including Medicare Advantage run by commercial insurers. For example, where the health center has a contract with a private plan like Blue Cross for Medicare Advantage, consider the payer to be Medicare, even though the actual payment may come from Blue Cross.
- The portion of charges for patients covered through multiple insurances (e.g., Medicare and Medicaid, Medicare and Private) that are initially paid for by Medicare.
- Recognize charges and collections for patients enrolled in ADHC or PACE if administered by Medicare. Treat as discussed in Appendix B.

Other Public (Lines 7–9)

Report all services billed to and paid for by state or local government programs, including:

- CHIP *when paid for through commercial carriers*. (See Lines 1–3 if CHIP is paid through Medicaid.)
- Family planning programs such as Title X programs, BCCCPs (with various state names), and other dedicated state or local programs. Although these programs are considered Other Public payers, patients are generally classified as Uninsured on Table 4.
- State-run insurance plans, such as the Massachusetts CommonHealth plan.
- Municipal or county jails and state prisons.
- Public schools that engage with the clinic on a fee-for-service or other service-based contract basis.

- Testing and treatment associated with caring for uninsured patients with suspected or actual COVID-19 administered by HRSA under the COVID-19 Uninsured Program on Line 8c.

Do not include:

- State or local indigent care programs. Report patients whose only payment source is a state or local indigent care program as Uninsured on Table 4 and their charges, any associated self-pay collections, etc. on the Self-Pay line, Line 13, as described below.
- Third-party coverage purchased through state or federal exchanges (which may be subsidized). Report as Private unless determined to be enrolled through subsidies from a Medicaid expansion program, which are to be reported as Medicaid.

Private (Lines 10–12)

Report all services billed to and paid for by commercial insurance companies or by other third-party payers, including:

- Insurance purchased for public employees or retirees, such as Tricare, Trigon, and the Federal Employees Insurance Program, as well as workers' compensation, as these are benefits belonging to the patient.
- Insurance purchased through state exchanges, unless you can identify the patient as being enrolled through purchased subsidies from a Medicaid expansion program.
- Contract payments from other organizations who engage the clinic on a fee-for-service or other reimbursement basis, such as a Head Start program that pays for annual physical exams at a contracted rate or a private school, private jail, or large company that pays for a provision of medical care at a per-session or other negotiated rate.
- Supplemental insurance (typically covers some amounts not paid or disallowed by Medicare).

Do not report Medicaid, Medicare, or Other Public managed care programs administered by commercial insurers.

Self-Pay (Line 13)

Report all charges and collections where the patient is responsible, including:

- Co-payments, deductibles, and charges to insured individuals for uncovered services that become the patient's personal responsibility.
- State or local indigent care programs that subsidize services rendered to the uninsured.
  - Report all charges for these services and collections from patients on the Self-Pay line (Line 13, Columns A and B).
  - Report all amounts not collected or due from the patients as sliding fee discounts or bad debt write-off, as appropriate, on Line 13, Columns E and F.
  - Report collections from the associated state and local indigent care programs on Table 9E, Line 6a, and specify the name of the program paying for the services.

Columns: Charges, Payments, and Adjustments Related to Services Delivered (Reported on a Cash Basis)

Column A: Full Charges this Period

Report total charges for each payer source. This will initially reflect the total full charges (per the health center's fee schedule) for services rendered to patients in that payer category during the calendar year.

- Record charges based on the organization's fee schedule for services that are billed to and covered in whole or in part by a payer, or the patient, even if some or all of them are

subsequently written off as contractual adjustments, sliding fee discounts, or bad debts. Always report full gross charges according to the health center fee schedule, not a contracted or negotiated rate.

Note: *Under no circumstances should the actual amount paid by Medicaid or Medicare (such as FQHC, G code, or T code rates) or the amount paid by any other payer be used as the actual charges. Charges must come from the health center's schedule of fees, typically based on CPT codes, or retail charge (for pharmacy).*

- Report pharmaceuticals dispensed through a (340B) contract pharmacy at the pharmacy's UCR gross charge, even though they are sold at a discount to clinic patients.
- Include charges for eyeglasses, pharmaceuticals, durable medical equipment, and other similar supply items.
- Include charges for *dispensing or injecting* donated pharmaceuticals to the health center or directly to a patient through the health center if they appear on bills and are collected from first and third parties.
- Report charges for services that are "carved out" of managed care capitation contracts (i.e., not included in the listed services under contract) as managed care fee-for-service.
- Do not record "contractual adjustments" as a charge. Instead, report the difference between gross charges and contracted payments from third parties as described in Adjustments.
- Do not include charges that are generally not billable to or covered by traditional third-party payers. Some examples include WIC services, parking or job training, and transportation and similar enabling services (not generally included in Column A, except where the payer [e.g., Medicaid] accepts billing and pays for these services).

Reclassifying Charges

Some patients have more than one source of payment for their services. In these instances, a charge goes to one carrier, who may deny some or all of the charge. Move the unpaid portion of charges to the secondary payer and to a tertiary payer if one exists and, eventually, to the patient as a self-pay charge.

Only report the amount owed by each payer after reclassifying charges to the appropriate payer. Your management information system should reclassify charges automatically, but if this cannot be done for charges rejected by a payer that need reclassification (including deductibles and coinsurance), manually reverse as negative charges to that payer before reclassifying to the next payer.

Reclassifying these charges by utilizing an adjustment and rebilling to another payer category is an incorrect procedure since it will result in an overstatement of total gross charges by including the charges twice, in addition to the adjustments and payments.

Column B: Amount Collected This Period

Report in Column B the gross receipts for the calendar year on a cash basis, regardless of the period in which the paid services were rendered.

- Include FQHC reconciliations, managed care pool distributions, pay-for-performance (P4P) payments, quality bonuses (excluding HRSA's Quality Improvement Awards), court settlements, and other payments. Report these additional payments in Column B **and** in Columns c1, c2, c3, and/or c4.
- When a contract pharmacy is dispensing 340B drugs on behalf of the health center, report the total cash received by the pharmacy from patients and third parties.

- Report the managed care capitation (monthly payment) received during the reporting period as a collection, not as an additional charge, on the capitation line.

Note: *Record charges and collections for deductibles and co-payments that are charged to, paid by, and/or due from patients as Self-Pay on Line 13.*

Columns C1–C4: Retroactive Settlements, Receipts, or Paybacks

Report in Columns c1–c4 retroactive settlements, receipts, and paybacks, *in addition to including them in Column B.*

- Payments by third parties from a current or prior period are included in Column B, reduced from Column D, and also broken out and reported in Columns c1–c4.
- The most common are Medicaid, Medicare, and CHIP FQHC prospective payment system (PPS) reconciliations and wraparound payments.
- In addition, include managed care pool distributions, P4P payments, quality bonuses (excluding HRSA's Quality Improvement Awards), and paybacks to FQHC payers or HMOs.
- In states that pay the FQHC rate upon billing, no wraparound payments will generally be reported.

Column C1: Collection of Reconciliation/Wrap-Around, Current Year

Report FQHC cash receipts from reconciliations (lump sum retroactive adjustments based on the filing of a cost report) and wrap-around payments (additional amounts for each visit to bring payment up to FQHC level) from Medicare, Medicaid, or Other Public payers that are for services *provided during the current reporting period. Include the current-year component, if any, of multi-year settlements here*.

Column C2: Collection of Reconciliation/Wraparound, Previous Years

Report FQHC cash receipts from reconciliations (lump sum retroactive adjustments based on the filing of a cost report) and wraparound payments (additional amounts for each visit to bring payment up to FQHC level) from Medicare, Medicaid, or Other Public payers that are for *services provided during previous reporting periods. Include the prior-year component of multiyear settlements here*.

Note: *Apportion settlement data reported in Columns c1 and c2 between the fee-for-service lines and the managed care lines when both payment reimbursement methods are used. You may use the percent distribution of visits, charges, or net charges as the basis for the allocation.*

Column C3: Collection of Other Payments Including Pay for Performance, Quality Bonuses, Risk Pools, and Incentives

Report other cash payments, including managed care risk pool redistribution, incentives including P4P incentives, and quality bonuses from any payer.

CMS primary care demonstration funds may include payment for a person being enrolled in the grant. Include these payments here, regardless of whether there is a visit involved.

Include settlements that may result from a court decision that requires a payer to make a settlement, including a multiyear settlement. These payments may apply to either a managed care or non-managed care payer.

Note: *Do not include eligible provider payments from CMS for implementing EHRs (commonly referred to as Promoting Interoperability payments). Record these payments separately on Line 3a of Table 9E.*

Column C4: Penalty/Payback

Report payments made by the health center to payers because of overpayments collected earlier.

In addition, enter "penalty" payments made to managed care plans for overutilization of the inpatient or specialty pool funds.

Do *not* include as paybacks anticipated bonuses or payouts that were not earned because P4P goals were not met, regardless of whether they were budgeted.

Note: *Only report amounts paid back during the reporting period. The payback amount is reported in Column c4. Assuming a check was written for the payback reported, subtract this amount from Column B and add it to Column D as an adjustment. Assuming the payback amount is deducted from a remittance, report it in Column c4, but do not adjust Columns B or D.*

Column D: Adjustments

Report in Column D adjustments granted as part of an agreement with a third-party payer. Virtually all insurance companies have a maximum amount they pay for a given service and the center agrees to write off the difference between what they charge and that contracted amount. These are considered contractual adjustments.

- Adjustments are a reduction in the amount of charges in the current reporting period that an organization expects to receive and are reported in Column D, typically as a positive number. The EHBs will recognize the amount as a reduction.
- Reduce the initial adjustment by the amount of retroactive settlements and receipts (reported in Columns c1, c2, and c3), including current- and prior-year FQHC reconciliations, managed care pool distributions, quality or P4P awards, and other payments. This may result in a negative number as the adjustment in Column D.

Note: *FQHC cost-based reimbursements are often greater than the amount charged.*

- Line 13 (self-pay adjustments) is grayed out because self-pay adjustments are recognized as either sliding fee discounts (Line 13, Column E) or as self-pay bad debt (Line 13, Column F).

Note: *Do not report amounts for which another third party or a private individual can be billed (e.g., amounts due from patients or "MediGap" payers for co-payments) as adjustments. Reduce these amounts from the initial charges to the primary payer and record or reclassify them as charges due from the secondary source of payment.*

- The adjustments for capitated managed care plans (Lines 2a, 5a, 8a, and 11a only) equal the difference between the charges for the capitated services provided and the capitation earned during the reporting period. Since most capitation plans reimburse at the beginning or during the month of enrollment, the capitation receipts in Column B are usually equal to the capitation earned. Assuming there are no early or late capitation payments, the adjustments (Column D) will equal the difference between Column A and Column B.
- Capitation plans typically pay on a per-member, per-month basis and make payments in the current month of enrollment, which means these plans do not carry significant receivables.
- If your organization records capitation receipts in the general ledger and not in the PMS, remove all charges associated with capitated services with an adjustment from the PMS. Those adjustments are not to be reported.

Column E: Sliding Fee Discounts

Report reductions to patient charges based on the patient's ability to pay using patient's income and family size. Processes detailed in the health center's sliding fee discount policies and procedures determine these discounts. Include discounts to required co-payments and deductibles, as applicable.

- Report prompt pay discounts provided under a hardship fee waiver program as a sliding fee discount.
- Do not report automatic discounting of charges for specific categories of patients (e.g., students, persons experiencing homelessness, or agricultural workers).
- Do not consider bad debt write-off or forgiveness to be a sliding fee discount.

***Note:** Only patients may be granted a sliding fee discount based on their ability to pay. Column E is grayed out on all other lines. When a sliding fee discount is used to write off part of a charge originally made to a third party, such as Medicare or a private insurance company's co-payment or deductible, first reclassify the charge to self-pay.*

To reclassify, first reduce the third-party charge by the amount due from the patient and then increase the self-pay charges by the same amount. No other type of discounts should be wrapped into or included in the sliding fee discount.

Column F: Bad Debt Write-Off

Report amounts billed to and defaulted on by any patient. **Record bad debts from *patients only*.**

Bad debt write-off may occur due to the health center's inability to locate persons, a patient's refusal to pay, a patient's inability to pay when their income is greater than 200 percent of the poverty guideline, or a patient's inability to pay even after the sliding fee discount is granted.

***Note:** The bad debt associated with third parties, which may include charges that were not billed within the time permitted by the payer, charges for services rendered to insured patients by clinicians who were not credentialed by that payer, charges due from payers who are bankrupt, and similar bad debts, are not currently reported on the UDS.*

Total Patient-Related Income (Line 14)

Sum Lines 3 + 6 + 9 + 12 + 13.

Additional information is available to clarify reporting. View **FAQs for Table 9D**.

Table 9D: Patient-Related Revenue

Reporting Period: January 1, 2020, through December 31, 2020

				Retroactive Settlements, Receipts, and Paybacks (c)						
Line	**Payer Category**	**Full Charges This Period (a)**	**Amount Collected This Period (b)**	**Collection of Reconciliation/ Wraparound Current Year (c1)**	**Collection of Reconciliation/ Wraparound Previous Years (c2)**	**Collection of Other Payments: P4P, Risk Pools, etc. (c3)**	**Penalty/ Payback (c4)**	**Adjustments (d)**	**Sliding Fee Discounts (e)**	**Bad Debt Write -Off (f)**
1	Medicaid Non-Managed Care									
2a	Medicaid Managed Care (capitated)									
2b	Medicaid Managed Care (fee-for-service)									
3	**Total Medicaid** (Sum of Lines 1 + 2a + 2b)									
4	Medicare Non-Managed Care									
5a	Medicare Managed Care (capitated)									
5b	Medicare Managed Care (fee-for-service)									
6	**Total Medicare** (Sum of Lines 4 + 5a + 5b)									
7	Other Public, including Non-Medicaid CHIP, Non-Managed Care									
8a	Other Public, including Non-Medicaid CHIP, Managed Care (capitated)									
8b	Other Public, including Non-Medicaid CHIP, Managed Care (fee-for-service)									
8c	Other Public, including COVID-19 Uninsured Program									
9	**Total Other Public** (Sum of Lines 7 + 8a + 8b + 8c)									

		Retroactive Settlements, Receipts, and Paybacks (c)									
Line	**Payer Category**	**Full Charges This Period (a)**	**Amount Collected This Period (b)**	**Collection of Reconciliation/ Wraparound Current Year (c1)**	**Collection of Reconciliation/ Wraparound Previous Years (c2)**	**Collection of Other Payments: P4P, Risk Pools, etc. (c3)**	**Penalty/ Payback (c4)**	**Adjustments (d)**	**Sliding Fee Discounts (e)**	**Bad Debt Write -Off (f)**
10	Private Non-Managed Care									
11a	Private Managed Care (capitated)									
11b	Private Managed Care (fee-for-service)									
12	**Total Private** (Sum of Lines 10 + 11a + 11b)									
13	**Self-Pay**									
14	**TOTAL** (Sum of Lines 3 + 6 + 9 + 12 + 13)									

Instructions for Table 9E: Other Revenue

Table 9E reports income-related non-patient receipts, including grants, contracts, and other funds received in the reporting period from sources within the scope of project. "Grants and contracts" are defined as all amounts received that are not tied to the delivery of patient services.

Report all non-patient-related funds received during the calendar year that supported the federally approved scope of project, even if the revenue was accrued (earned) during the previous year or received in advance and considered "unearned revenue" in the center's books on December 31.

- Tables 9D and 9E receipts are summed to equal total *cash income* received in the reporting period. Do not report any receipts on both tables as this duplicates and overstates cash income.
- Use the **"**last party rule**"** to classify the receipts. The "last party rule," for UDS reporting purposes, means that grant, contract, and other funds should always be reported based on the entity from which the health center received them, regardless of the source from which they originated. For example, funds awarded to the health center by the state for maternal and child health services usually include a mixture of federal funds, such as Title V, and state funds. Nonetheless, report these funds as state grants on this table.

BPHC Grants

Lines 1a through 1e

Report *drawdowns* received during the reporting period for the Health Center Program (section 330) grant, including:

- Amounts consistent with the PMS-272 federal cash transaction report. Report grant drawdowns as follows:
  - MHC on Line 1a
  - CHC on Line 1b
  - HCH on Line 1c
  - PHPC on Line 1e
- Supplemental funding (with the exception of COVID-19) and Quality Improvement Awards from HRSA are provided as part of the 330 grant. Report these grant funds on the appropriate 330 grant Lines 1a–1e, as specified in the health center Notice of Award.
- Reflect direct funding, including NAP or expansion funds, only on the BPHC Grant lines.
- Include amounts that the health center received and passed through to another Health Center Program awardee.
- Do not reduce the drawdown by the amount the health center passed through to another health center, including sub-awardees or sub-recipients.
- BHW primary care clinics will file this table but will have no income from the BPHC Health Center Grant program on Line 1.

Total Health Center Program (Line 1g)

Sum Lines 1a through 1e.

Capital Development Grants (Line 1k)

Report the amount of Capital Development Grant dollars drawn down.

- This includes funds from the Health Center Program facility program as well as funds from the HRSA-administered school-based health center capital grant program.
- Report Capital Assistance for Hurricane Response and Recovery Efforts (CARE) and other funds awarded by HRSA to assist in the reconstruction and repair of facilities destroyed or damaged by natural disasters.

COVID-19 Supplemental Funding

Lines 1l through 1p

Report *drawdowns* received during the reporting period for COVID-19 supplemental funding, including:

- Amounts consistent with the PMS-272 federal cash transaction report. Report grant drawdowns as follows:
  - Coronavirus Preparedness and Response Supplemental Appropriations Act (activity code H8C) on Line 1l
  - Coronavirus Aid, Relief, and Economic Security (CARES) Act (activity code H8D) on Line 1m
  - Expanding Capacity for Coronavirus Testing (activity code ECT) on line 1n
  - Health and Economic Recovery Omnibus Emergency Solutions Act (HEROES)/ Health, Economic Assistance, Liability Protection and Schools Act (HEALS) on line 1o
  - Other COVID-19-related funding from BPHC on Line 1p

Note: *There is a cell to specify the detail (include names and amounts) of Other COVID-19-related funding, Line 1p.*

Total COVID-19 Supplemental (Line 1q)

Sum Lines 1l through 1p.

Total BPHC Grants (Line 1)

Sum Lines 1g + 1k + 1q.

Other Federal Grants

Ryan White Part C—HIV Early Intervention Grants (Line 2)

Report drawdowns received during the reporting period for Ryan White Part C funds.

Guidance for reporting *other* Ryan White funds is as follows:

- Report Ryan White Part A, Impacted Area grants, from county or city governments on Line 7. (If they are first sent to a third party, report the funds on Line 8. Report on Line 3 when the reporting entity is a county or city government and the funds were received directly from the Ryan White Part A federal program).
- Report Part B grants from the state on Line 6, unless they are first sent to a county or city government (in which case, report on Line 7) or to a third party (in which case, report the funds on Line 8).
- Report Part D funds from the HIV/AIDS Bureau on Line 3.
- Report Special Projects of National Significance grants, which are generally received from the federal government, on Line 3.

Other Federal Grants (Line 3)

Report drawdowns received during the reporting period for any other federal grants that are within the scope of project. These grants include only those funds received directly by the health center from the U.S. Treasury.

The most common "other federal" grants reported are from the Office of Minority Health (OMH), the Indian Health Service (IHS), the Department of Housing and Urban Development (HUD), and the Substance Abuse and Mental Health Services Administration (SAMHSA).

Note: *There is a cell to specify the detail (include names and amounts) of Other Federal Grants.*

- Report IHS funds (not including PL 93-638 Compact funds) if dually funded as an IHS/HRSA-funded health center. (Report PL 93-638 Compact funds on Line 6a, Indigent Care.)

Medicare and Medicaid EHR Incentive Grants for Eligible Providers (Line 3a)

Report funds from the Medicare and Medicaid EHR Incentive Program (also known as "Promoting Interoperability program") grants funded through CMS. They provide incentives to Eligible Providers (as defined by CMS) for the adoption, implementation, upgrading, and improvement of interoperability of certified EHRs.

In rare cases, these payments go directly to the clinic's providers, but they are most commonly paid to the providers' designee (generally, the health center). It is presumed that if the payment goes to the employees these funds will be turned over to the health center. Report them on this line even though the payment may come from the provider and not directly from CMS. This is an exception to the "last party" rule. In the event the provider retains some or all of these grants as part of their compensation, record the total amount on this line and the amount retained by the provider on Table 8A, Line 1, as staff compensation.

Provider Relief Fund (Line 3b)

Report funds from the CARES Act Provider Relief Fund through HHS. They provide relief to eligible providers for health care-related expenses or lost revenues that are attributable to coronavirus.

Total Other Federal Grants (Line 5)

Sum Lines 2 + 3 + 3a + 3b.

Non-Federal Grants or Contracts

State Government Grants and Contracts (Line 6)

Report drawdowns received during the reporting period for any state government grants or contracts that are within the scope of project and for which the health center receives funds with no specific tie to services provided.

- Most include line item budgets that support specific staff positions or other costs.
- Do not include receipts from state governments that pay based on the amount of health care services provided or on a negotiated fee for service or fee per visit. Report charges, collections, and adjustments on Table 9D as Other Public services.

Note: *There is a cell to specify the detail (include names and amounts) of State Government Grants and Contracts.*

State/Local Indigent Care Programs (Line 6a)

Report the amount of funds received from state/local indigent care programs that are earmarked to subsidize services rendered to patients who are uninsured.

- Revenue is received as a grant amount, rather than on a fee-for-service basis.
- Include amounts allocated to the health center by tribes from their IHS PL 93-638 Compact funds.
- Examples of state/local indigent care programs include the Massachusetts Free Care Pool, New Jersey Uncompensated Care Program, New York Public Goods Pool Funding, New Mexico Tobacco Tax program, and Colorado Indigent Care Program.
- Do not include revenues received from private contracts between a health center and a tribe. (Report as Private on Table 9D.)

Note: *There is a cell to specify the detail (include names and amounts) of State/Local Indigent Care Programs.*

Cross-Table Reporting Guidance for Indigent Programs

Report on Line 6a payments received from state or local indigent care programs subsidizing services rendered to patients who are uninsured whether the actual payment to the health center is made on a per-visit basis or as a lump sum for services rendered.

Report patients covered by these programs as uninsured on Table 4 unless they have some other form of insurance.

Report all associated charges, sliding fee discounts, and bad debt write-offs on the self-pay line (Line 13) on Table 9D. Monies collected from the patients covered by indigent programs should be reported on Table 9D, Column B.

Do not report funds reported on Line 6a of Table 9E as collections in Table 9D, Column B.

Local Government Grants and Contracts (Line 7)

Report drawdowns received during the reporting period for any local government grants or contracts that are within the scope of project and for which there is no specific tie to patient services provided. Most include line item budgets that support specific staff positions or other costs.

- Do not include revenue received from local governments that pay based on an amount of health care services provided or on a negotiated fee-for-service or fee per visit. (Report charges, collections, and adjustments on Table 9D as Other Public services.)
- Do not include funds from local indigent care programs here.

Note: *There is a cell to specify the detail (include names and amounts) of Local Government Grants and Contracts.*

Foundation/Private Grants and Contracts (Line 8)

Report the amount received from foundations or private organizations during the reporting period that covers costs included within the scope of project.

- Include funds received from a primary care association, another health center, or another community service provider on this line regardless of the funds' origin.

Note: *There is a cell to specify the detail (include names and amounts) of Foundation/Private Grants and Contracts.*

Total Non-Federal Grants and Contracts (Line 9)

Sum Lines 6 + 6a + 7 + 8.

Other Revenue (Line 10)

Report Other Revenue receipts included in the federally approved scope of project that are unrelated to charge-based services or to grants and contracts described above.

- Include fundraising, interest income, rent from tenants, medical records fees, individual monetary donations, receipts from vending machines, pharmacy sales to the public (i.e., non-health center patients), etc.
- Include receipts related to the gain on the sale of an asset.
- *Do not* enter the value of in-kind or other non-monetary donations made to the health center. (Report these only on Table 8A, Line 18.)
- *Do not* report the proceeds of any loan received for operations, a mortgage, or other purposes.
- *Do not* report insurance proceeds related to a loss, unless the loss was recognized as an expense rather than a reduction in the value of an asset.
- *Do not* report the receipt or recognition of in-kind "community benefit" from a third party here or anywhere else on the UDS unless it is received as a cash donation.
- *Under no circumstances* should payments or net payments from a pharmacy contracted to dispense 340B pharmaceuticals appear on this line (or anywhere on Table 9E). Report all revenue from pharmacy services provided to patients on Table 9D and record all expenses on Table 8A. (In addition, see Appendix B for cross-table pharmacy reporting.)

Note: *There is a cell to specify the detail (include names and amounts) of Other Revenue.*

Total Other Revenue (Line 11)

Sum Lines 1 + 5 + 9 + 10.

Additional information is available to clarify reporting. View **FAQs for Table 9E**.

Table 9E: Other Revenues

Reporting Period: January 1, 2020, through December 31, 2020

Line	Source	Amount (a)
	BPHC Grants (Enter Amount Drawn Down—Consistent with PMS 272)	
1a	Migrant Health Center	
1b	Community Health Center	
1c	Health Care for the Homeless	
1e	Public Housing Primary Care	
1g	**Total Health Center** (Sum of Lines 1a through 1e)	
1k	Capital Development Grants, including School-Based Health Center Capital Grants	
1l	Coronavirus Preparedness and Response Supplemental Appropriations Act (H8C)	
1m	Coronavirus Aid, Relief, and Economic Security Act (CARES) (H8D)	
1n	Expanding Capacity for Coronavirus Testing (ECT) (H8E and LAL ECT)	
1o	Health and Economic Recovery Omnibus Emergency Solutions Act (HEROES)/ Health, Economic Assistance, Liability Protection and Schools Act (HEALS)	
1p	Other COVID-19-Related Funding from BPHC (specify_______)	
1q	**Total COVID-19 Supplemental** (Sum of Lines 1l through 1p)	
1	**Total BPHC Grants** (Sum of Lines 1g + 1k + 1q)	
	Other Federal Grants	
2	Ryan White Part C HIV Early Intervention	
3	Other Federal Grants (specify _______)	
3a	Medicare and Medicaid EHR Incentive Payments for Eligible Providers	
3b	Provider Relief Fund (specify _______)	
5	**Total Other Federal Grants** (Sum of Lines 2 through 3b)	
	Non-Federal Grants or Contracts	
6	State Government Grants and Contracts (specify_______)	
6a	State/Local Indigent Care Programs (specify_______)	
7	Local Government Grants and Contracts (specify_______)	
8	Foundation/Private Grants and Contracts (specify_______)	
9	**Total Non-Federal Grants and Contracts** (Sum of Lines 6 + 6a + 7 + 8)	
10	Other Revenue (non-patient related revenue not reported elsewhere) (specify _______)	
11	**Total Revenue** (Sum of Lines 1 + 5 + 9 + 10)	

Appendix A: Listing of Personnel

All line numbers in the following table refer to Table 5. Not all services delivered by a "provider" count as visits. Do not count interactions with "non-providers" as visits. Use the Provider definitions to classify personnel as a "provider" or "non-provider."

Personnel by Major Service Category	Provider	Non-Provider
Physicians		
Family practitioners (Line 1)	X	
General practitioners (Line 2)	X	
Internists (Line 3)	X	
Obstetricians/Gynecologists (Line 4)	X	
Pediatricians (Line 5)	X	
Licensed medical residents—line determined by specialty	X	
Other Specialist Physicians (Line 7)		
Allergists	X	
Cardiologists	X	
Dermatologists	X	
Endocrinologists	X	
Orthopedists	X	
Surgeons	X	
Urologists	X	
Other specialists and sub-specialists	X	
Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives		
Nurse practitioners (Line 9a)	X	
Physician assistants (Line 9b)	X	
Certified nurse midwives (Line 10)	X	
Nurses (Line 11)		
Clinical nurse specialists	X	
Public health nurses	X	
Home health nurses	X	
Visiting nurses	X	
Registered nurses (RNs)	X	
Licensed practical nurses/Licensed vocational nurses		X
Nurse emergency medical services (EMS)/Nurse emergency medical technicians (EMT)	X	
Other Medical Personnel (Line 12)		
Nurse aides/assistants (certified and uncertified)		X
Clinic aides/medical assistants (certified and uncertified medical technologists)		X
Unlicensed interns and residents		X
EMS/EMT staff (not credentialed as a nurse)		X
Laboratory Personnel (Line 13)		
Pathologists		X
Medical technologists		X
Laboratory technicians		X
Laboratory assistants		X
Phlebotomists		X
X-Ray Personnel (Line 14)		
Radiologists		X
X-ray technologists		X
X-ray technicians		X
Radiology assistants		X
Ultrasound technicians		X

Personnel by Major Service Category	Provider	Non-Provider
Dentists (Line 16)		
General practitioners	X	
Oral surgeons	X	
Periodontists	X	
Endodontists	X	
Other Dental		
Dental hygienists (Line 17)	X	
Dental therapists (Line 17a)	X	
Dental assistants, advanced practice dental assistants (Line 18)		X
Dental technicians (Line 18)		X
Dental aides (Line 18)		X
Dental students (including hygienist students) (Line 18)		X
Mental Health (Line 20) **and Substance Use** (Line 21)		
Psychiatrists (Line 20a)	X	
Psychologists (Line 20a1)	X	
Social workers—clinical (Line 20a2 or 21)	X	
Social workers—psychiatric (Line 20b or 21)	X	
Family therapists (Line 20b or 21)	X	
Psychiatric nurse practitioners (Line 20b)	X	
Nurses—psychiatric and mental health (Line 20b)	X	
Unlicensed mental health providers, including trainees (interns or residents) and “certified” staff (Line 20c)	X	
Unlicensed substance use disorder providers, including trainees (interns or residents) and “certified” staff (Line 21)	X	
Alcohol and drug abuse counselors (Line 21)	X	
RN counselors (Line 20b or 21)	X	
All Other Professional Personnel (Line 22)		
Audiologists	X	
Acupuncturists	X	
Chiropractors	X	
Community health aides and practitioners	X	
Herbalists	X	
Massage therapists	X	
Naturopaths	X	
Registered dietitians, including nutritionists/dietitians	X	
Occupational therapists	X	
Podiatrists	X	
Physical therapists	X	
Respiratory therapists	X	
Speech therapists/pathologists	X	
Traditional healers	X	
Vision Services Personnel		
Ophthalmologists (Line 22a)	X	
Optometrists (Line 22b)	X	
Ophthalmologist/optometric assistants (Line 22c)		X
Ophthalmologist/optometric aides (Line 22c)		X
Ophthalmologist/optometric technicians (Line 22c)		X
Pharmacy Personnel (Line 23)		
Pharmacists, clinical pharmacists		X
Pharmacy technicians		X
Pharmacist assistants		X
Pharmacy clerks		X

Personnel by Major Service Category	Provider	Non-Provider
Enabling Services		
Case Managers (Line 24)		
Case managers	X	
Care/referral coordinators	X	
Patient advocates	X	
Social workers	X	
Public health nurses	X	
Home health nurses	X	
Visiting nurses	X	
Registered nurses	X	
Licensed practical nurses/licensed vocational nurses	X	
Health Educators (Line 25)		
Family planning counselors	X	
Health educators	X	
Social workers	X	
Public health nurses	X	
Home health nurses	X	
Visiting nurses	X	
Registered nurses	X	
Licensed practical nurses/licensed vocational nurses	X	
Outreach Workers (Line 26)		
Outreach workers		X
Patient Transportation Workers (Line 27)		
Patient transportation coordinators		X
Drivers, including mobile van drivers		X
Eligibility Assistance Workers (Line 27a)		
Benefits assistance workers		X
Pharmacy assistance program eligibility workers		X
Eligibility workers		X
Patient navigators		X
Patient advocates		X
Registration clerks		X
Certified assisters		X
Interpretation (Line 27b)		
Interpreters		X
Translators		X
Community health workers		X
Community health advisors or representatives		X
Lay health advocates		X
Promotoras		X
Other Enabling Services Personnel (Line 28)		
Other enabling services personnel		X

Personnel by Major Service Category	Provider	Non-Provider
Other Program-Related Services Staff (Line 29a)		
WIC workers		X
Head Start workers		X
Housing assistance workers		X
Child care workers		X
Food bank/meal delivery workers		X
Employment/educational counselors		X
Exercise trainers/fitness center staff		X
Adult day health care, frail elderly support staff		X
Quality Improvement Staff (QI) (Line 29b)		
QI nurses		X
QI technicians		X
QI data specialists		X
Statisticians, analysts		X
Quality assurance/quality improvement and HIT/EHR design and operation staff		X
Management and Support Staff (Line 30a)		
Project directors		X
Chief executive officers/executive directors		X
Chief financial officers/fiscal officers		X
Chief information officers		X
Chief medical officers		X
Secretaries/administrative assistants		X
Administrators		X
Directors of planning and evaluation		X
Clerk typists		X
Personnel directors		X
Receptionists		X
Directors of marketing		X
Marketing representatives		X
Enrollment/service representatives		X
Fiscal and Billing Staff (Line 30b)		
Finance directors		X
Accountants		X
Bookkeepers		X
Billing clerks		X
Cashiers		X
Data entry clerks		X
IT Staff (Line 30c)		
Directors of data processing		X
Programmers		X
IT help desk technicians		X
Data entry clerks		X
Facility (Line 31)		
Janitors/custodians		X
Security guards		X
Groundskeepers		X
Equipment maintenance personnel		X
Housekeeping personnel		X

Personnel by Major Service Category	Provider	Non-Provider
Patient Services Support Staff (Line 32)		
Medical and dental team clerks		X
Medical and dental team secretaries		X
Medical and dental appointment clerks		X
Medical and dental patient records clerks		X
Patient records supervisors		X
Patient records technicians		X
Patient records clerks		X
Patient records transcriptionists		X
Registration clerks		X
Appointments clerks		X

Appendix B1: Frequently Asked Questions (FAQs)

The following section, which is organized by table, provides guidance on common questions about UDS data reporting. We encourage health center staff completing the UDS Report to review this section after reading the corresponding table chapter to best understand the reporting requirements.

FAQs for ZIP Code by Medical Insurance

1. **Are there any changes to the table this year?**
   No.

2. **Do we need to collect information and report on the ZIP code of all our patients?**
   Yes. Although health centers report residence by ZIP code for all patients, some centers may draw patients from many ZIP codes outside of their normal service area. To ease the burden of reporting, consolidate ZIP codes with 10 or fewer patients in the "Other" category.

3. **Do we need to collect information and report on the primary medical insurance of all our patients?**
   Yes. Although the ZIP code of a patient may be "unknown," medical insurance information must be obtained for every person counted as a patient.

4. **If a patient did not receive medical care, do we still need their medical insurance information? What about dental patients?**
   Yes. This information is about patients' primary insurance resources, not billing. Obtain medical insurance information for *all* patients, even dental-only patients. The primary medical insurance is typically the first insurance billed.

5. **Does the number of patients reported by ZIP code need to equal the total number of unduplicated patients reported on Tables 3A, 3B, and 4?**
   Yes. Several tables and sections must match:
   - The total number of patients reported by ZIP code (including "unknown" and "other") on the ZIP Code Table must equal the number of total unduplicated patients reported on Table 3A and sections of Tables 3B and 4.
   - The insurance totals reported on the ZIP Code Table must equal insurance reported on Table 4. Specifically:
     - The total for ZIP Code Table Column B (Uninsured) must equal Table 4, Line 7, Columns A + B.
     - The total for ZIP Code Table Column C (Medicaid, CHIP, Other Public) must equal the sum of Table 4, Line 8, Columns A + B and Line 10, Columns A + B.
     - The total for ZIP Code Table Column D (Medicare) must equal Table 4, Line 9, Columns A + B.
     - The total for ZIP Code Table Column E (Private) must equal Table 4, Line 11, Columns A + B.

6. **We had a site that closed and is no longer in-scope. Do we report sites or services that are removed from scope in the UDS Report?**
   Yes. If services or sites are removed from your scope of service, report on all activities (visits, staff, income, etc.) up until the date they were removed.

FAQs for Tables 3A and 3B

1. **Are there any changes to Tables 3A or 3B this year?**
   No.

2. **Our health center collects more robust race and ethnicity data than required by the UDS. Why is the data limited?**
   The UDS classifications are consistent with those used by the Census Bureau and HHS as per the October 2011, guidance entitled "U.S. Department of Health and Human Services Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status" issued by OMB. These standards govern the categories used to collect and present federal data on race and ethnicity. OMB requires a minimum of five categories (White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander) for race. In addition to the five race groups, OMB states that respondents should be offered the option of selecting more than one race. Line 6 permits reporting of those people who have chosen to report two or more races.

3. **Do we have to report the race and Hispanic or Latino/a ethnicity of all of our patients?**
   Yes. The UDS requires the classification of race and Hispanic or Latino/a ethnicity information to assess health disparities across sub-populations. OMB has stipulated the format for the classification of this information, and the UDS follows these standards. Health centers whose data systems do not support such reporting must enhance their systems to permit the required level of reporting, rather than using the "unreported/refused to report" categories.

4. **How are patients of Hispanic or Latino/a ethnicity reported?**
   Race and ethnicity data appear in a matrix on Table 3B. Patients who in other systems might be reported as Hispanic or Latino/a independent of race are reported in Column A of the UDS as Hispanic or Latino/a and reported on Lines 1 through 7 based on their race. If Hispanic or Latino/a is the only identification recorded in the center's patient files, report these patients in Column A on Line 7 as having an "unreported" racial identification, and update your data system to permit the collection of both race and ethnicity.

5. **Can we have a choice on our registration form of "more than one race"?**
   No. To count patients as being of "more than one race," they must have the option of checking two or more boxes under race and must have indeed checked more than one. This methodology is the same used in the Census and mandated by OMB. The purpose of these standards is to have comparable race and ethnicity data across the federal government.

6. **How are individuals who receive different types of services or use more than one of our health center's service delivery sites reported? For example, how do we report a person who receives both medical and dental services or a patient who receives primary care from one clinic site but gets prenatal care at another?**
   The ZIP Code Table and Tables 3A, 3B, and 4 each provide an unduplicated patient count. Count each person who has at least one visit reported on Table 5 only once on ZIP Code, Table 3A, 3B, and 4, regardless of the type or number of services they receive or where they receive them. We define visits in detail in the Instructions for Visits, Patients, and Providers section. Note the following:

   - Do not count people who receive WIC services and no other services at the health center as patients on Table 3A or 3B (or anywhere on the UDS).

- Do not count people who only receive imaging or lab services or whose only service was an immunization or screening test as patients on Table 3A or 3B (or anywhere on the UDS).
- Do not count people who only receive health status checks and health screenings as patients on Table 3A or 3B (or anywhere on the UDS).

7. **Should the numbers on Tables 3A and 3B tie to UDS data reported on other tables?**
Yes.

The sum of Table 3A, Line 39, Columns A and B (total patients by age and by sex assigned at birth) must equal:

- Total Patients by ZIP Code;
- Table 3B, Line 8, Column D (total patients by Hispanic or Latino/a ethnicity and race);
- Table 3B, Line 19 (total patients by sexual orientation);
- Table 3B, Line 26 (total patients by gender identity);
- Table 4, Line 6 (total patients by income); and
- Table 4, Line 12, Columns A and B (total patients by insurance status).

The sum of Table 3A, Lines 1–18, Columns A and B (total patients age 0–17 years) must equal:

- Table 4, Line 12, Column A (total patients age 0–17 years).

The sum of Table 3A, Lines 19–38, Columns A and B (total patients age 18 and older) must equal:

- Table 4, Line 12, Column B (total patients age 18 and older).

8. **I have multiple, separate data systems. How do I include their data on these tables?**
It is the health center's responsibility to ensure there is no duplication of data. Count patients only once, regardless of the number of different types of services they receive. This may require the downloading and merging of data from each system to eliminate duplicates or checking them manually. This can be a time-consuming and potentially expensive process and should start as soon as the year ends to ensure sufficient time for completion prior to the submission due date.

9. **What do we do if we did not collect sexual orientation and/or gender identity elements?**
All health centers are required to include these data elements in the registration or intake forms or during the visit. If you did not implement the gathering of sexual orientation and/or gender identity data, report patients on Table 3B as "Don't know" (Line 17, sexual orientation) and as "Other" (Line 24, gender identity). Do not use sex at birth reported on Table 3A to complete gender on Table 3B.

10. **Does the UDS require health care providers to ask minors for sexual orientation and gender identity data?**
The collection of sexual orientation and gender identity data is not required for minors. The information should be included in the system and in the corresponding lines if a patient chooses to self-report their sexual orientation and gender identity.

11. **Will parents be able to access their child's response to a UDS sexual orientation and gender identity inquiry?**
There are specific provisions about protecting confidentiality of minors for patient visits related to sexual health. Generally, these are "minor consent" laws that permit treatment to be provided to and data collected from minors without their parent's knowledge or approval. Contact your state Primary Care Association for state-specific rules and regulations.

12. **How are the categories for sexual orientation and gender identity defined?**
The UDS classifications are based on the guidance provided in the 2015 Edition Health Information Technology (HIT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications.

FAQs for Table 4

1. **Are there any changes to the table this year?**
No.

2. **If we do not receive direct funding under the HCH, MHC, or PHPC programs, do we need to report the total number of special population patients served?**
Yes. Even health centers that do not receive grant funding for special populations are required to complete the following:

    - Line 16 (the total number of patients seen during the reporting period who were agricultural workers or their family members)
    - Line 23 (total number of patients known to have experienced homelessness at the time of any service during the year)
    - Line 24 (patients of a school-based health center)
    - Line 25 (veterans)
    - Line 26 (total number of patients served at a health center located in or immediately accessible to a public housing site)

    You will not complete the details on Lines 17–22 if you did not receive HCH funding—only enter the total.

    You will not complete the details on Lines 14 and 15 if you did not receive MHC funding—only enter the total.

3. **Should the number of patients by income and insurance source equal the total number of unduplicated patients reported on Tables 3A and 3B and the ZIP Code Table?**
Yes.

4. **Who do we report as Patients Served at a Health Center Located in or Immediately Accessible to a Public Housing Site on Line 26?**
Report the total number of patients who are served at any health center site that *you consider* (based on your definitions) to be located in or immediately accessible to public housing, regardless of whether or not the health center receives funding under section 330(i), PHPC. This is a site-based count, and the patient's address or residence in public housing is not to be considered.

5. **If a patient is seen only for dental care, do we report the patient's dental insurance on Lines 7–12?**
No. Table 4 reports only patients' medical coverage. All health centers must collect medical coverage information from all patients, even if they have not been provided medical services.

    Note: *If a patient has Medicaid, Private, or Other Public dental insurance, you* ***may*** *assume they have the same kind of medical insurance. If they do not have dental insurance, you* ***may not*** *assume they are uninsured for medical care.*

6. **Patients who are experiencing homelessness or who are agricultural workers generally do not have income verification. Can we report them as having income at 100 percent and below poverty?**
No. You can report them as having unknown income, but not as having income below poverty unless you verify this at least annually. However, subject to your health center's financial policies and procedures, you may document their income in your system based on their verbal attestation of their income.

7. **We serve students at a school-based health center. They often do not know what insurance they have, if any, and they have no information on their family's income. Can we report them as having income at 100 percent and below poverty and uninsured?**
No. You may not report them as having income below poverty and uninsured. Obtain insurance information from the parents of students served at school-based health centers, unless they are exclusively receiving minor consent services. Minor consent services are defined by state law and are generally limited to a very specific range of services, such as those related to contraception, sexually transmitted diseases, and mental health. Not all states provide for them. For all other services, children will require parental consent, and the consent form should include income and insurance information.

__Note:__ Subject to the health center's policies and procedures, it is acceptable to ask for this information and to assure parents that you will not bill the insurance without their knowledge. If you do not obtain parental consent, report the child as having unknown income. The patient's health insurance is required, even if it is not billed.

8. **Our state is using Medicaid expansion provisions to assist patients with buying private insurance. Should we count them as Medicaid or Private?**
If patients are Medicaid expansion patients, report them as Medicaid, Line 8a. (This may require looking for specific plan numbers or other identifying characteristics in patients' insurance enrollment.) If you are unable to identify Medicaid expansion patients, report them as Private, Line 11.

9. **What timing determines a patient's homeless status and shelter arrangement?**
For all health centers (regardless of HCH funding status), include the total number of patients who experienced homelessness at any point of service during the year on Line 23.

   For awardees that receive HCH funding, continue to count patients seen who are no longer experiencing homelessness due to becoming residents of permanent housing for 12 months after their last visit as homeless.

   For awardees that receive HCH funding, report all patients reported on Line 23 by their shelter arrangement on Lines 17–22.

   Asking health centers to report patients experiencing homelessness by their sheltering arrangements as of their first visit during the reporting year is intended to help health centers determine to which shelter arrangement they should report a patient if shelter status changes during the year.

10. **Do the totals need to equal other sections or tables?**
The following totals must be equal across tables and sections:

    - ZIP Code Table, Column B must equal Table 4, Line 7, Columns A and B.
    - ZIP Code Table, Column C must equal Table 4, Lines 8 and 10, Columns A and B.

- ZIP Code Table, Column D must equal Table 4, Line 9, Columns A and B.
- ZIP Code Table, Column E must equal Table 4, Line 11, Columns A and B.
- The sum of Table 3A, Line 39, Columns A and B (total patients by age and gender) must equal Table 3B, Line 8, Column D (total patients by race and Hispanic or Latino/a ethnicity); Table 3B, Line 19 (total patients by sexual orientation); Table 3B, Line 26 (total patients by gender identity); Table 4, Line 6 (total patients by income); and Table 4, Line 12, Columns A and B (total patients by medical insurance status).
- The sum of Table 3A, Lines 1–18, Columns A and B (total patients age 0–17 years) must equal Table 4, Line 12, Column A (total patients age 0–17 years).
- The sum of Table 3A, Lines 19–38, Columns A and B (total patients age 18 and older) must equal Table 4, Line 12, Column B (total patients age 18 and older).
- The sum of Table 3A, Line 39, Columns A and B (total patients by age and gender) must equal Table 4, Line 12, Columns A and B (total patients by insurance status).

The same is true for Grant Reports.

11. **Do we determine a patient's income relative to the FPG based on the location of the health center or the residence of the patient?**
Use the FPG based on the location of the health center. All states (except Alaska and Hawaii) and the U.S. territories use the standard poverty guidelines. For patients being served in Alaska or Hawaii, use the FPG established for those locations.

12. **Is it possible to have more members in one month (average) than total patients in an insurance category?**
It is possible, although it would be unusual, for the number of member months for any one payer (e.g., Medicaid) to exceed 12 times the number of patients reported on the corresponding insurance line. As a rule, there is a relationship between the member months reported on Lines 13a and 13b and the insured persons reported on Lines 7 through 11.

FAQs for Table 5

1. **Are there any changes to the table this year?**
No.

2. **How do I count participants in a group session?**
Only group treatment sessions for substance use disorders, mental health, or behavioral health may be counted. The visit must be recorded in each participant's chart. Do not count a group interaction with an individual that is not recorded in a participant's chart. Each patient charted in a group session must be billed and the service must be paid consistent with health center policy by either the patient, insurance, or another contract maintained by the health center. If some patients or visits are billed and others are not, count only those that are billed.

   Do not count group medical visits or group health education visits. Although in some instances they may be billable, the UDS specifically does not count these as visits.

3. **How do I report the FTEs for a clinician who regularly sees patients 75 percent of the time and covers after-hours call for the remaining 25 percent of their salary?**
Count staff who are hired as full-time clinicians as 1.0 FTE regardless of the number of direct patient care hours they provide. Count providers hired as full-time

who have released time to compensate for on-call hours, hours spent on clinical committees, or who receive leave for continuing education or other activities as 1.0 FTE.

Do not adjust the time spent by a physician (for example) while not in contact with the patient, such as charting, reviewing labs, filling prescriptions, returning phone calls, or arranging for referrals. These tasks are considered part of their time as a physician. The exception to this rule is when a medical director or chief medical officer is engaged in non-clinical activities at the corporate level, in which case time is allocated to the non-clinical category. This does not, however, include non-clinical activities in the medical area, such as chairing or attending meetings, supervising staff, writing clinical protocols, designing formularies, setting hours, or approving specialty referrals.

Note: *Count loan-repayment recipients as full-time. Note that the FQHC Medicare intermediary has different definitions for full-time providers; these are not to be used in reporting on the UDS.*

4. **Our physicians work 35-hour weeks. Do we report as 0.875 (35 divided by 40) FTE?**
   No. Count them as 1.0 FTE. BPHC does not require 40-hour workweeks. Use whatever workweek time is considered full-time.

5. **Should the total number of patients reported on Table 3A be equal to the sum of the several types of service patients on Table 5?**
   Not unless the only services you provide are medical services. On Table 5, report patients for each type of service received. For example, count a patient who receives both medical and dental services once as a medical patient on Line 15 and once as a dental patient on Line 19.

6. **If I report costs for case management services on Table 8A, do I have to report case managers on Table 5?**
   If a health center reports the costs for case management services, one would expect to see case managers reported on Table 5, unless the service was contracted with no staff time specifically identified. Similarly, if there are staff members on Table 5, one would expect costs on Table 8A unless staff are volunteers. Some services do not involve staff. Spending funds on bus tokens, for example, would involve transportation costs on Table 8A, but no staff on Table 5.

7. **How are contracted providers and their activities reported on Table 5?**
   If the contracted provider is paid based on time worked (for example, one day per week), report the FTE on Table 5, Column A, as well as the visits and patients receiving services from this provider. (See Appendix B for a more complete discussion of calculating the FTE of these providers.) If the contracted provider is paid on a fee-for-service basis, do not report FTE on Table 5, Column A, but report the visits and patients. This may require additional explanation in your UDS Report, but it is not an error.

8. **Where should we report behavioral health?**
   In some systems, behavioral health is another name for mental health, and the staff and visits are reported on Lines 20a through 20c. However, some health centers have merged the roles of mental health provider and substance use disorder provider into a single role, which they call a behavioral health provider. In this instance, the health center has two choices. The first is to assert that substance use disorder problems are mental health problems and classify its behavioral health staff as mental health staff on Lines 20a, 20a1, 20a2, 20b, or 20c. Another method is to carefully record the time and activities of these dual function providers. In this case, identify each visit as either a mental health

visit or a substance use disorder visit so the patients and visits can be correctly classified. In addition, keep track of providers' time so that FTEs on Table 5 (and associated costs on Table 8A) can be accurately allocated and recorded to the appropriate line.

9. **If a psychiatric NP provides mental health and substance use disorder (behavioral health) services to the same patient during a visit, how should we count this?**
   Because substance use disorder is also seen as a mental health diagnosis, count the visit under mental health for the main part of Table 5. Do not count the visits as one of each type. In the addendum, separately report the substance use disorder service provided by the clinician during the visits. Classify the provider and costs (on Table 8A) as mental health.

10. **Do I count the time of volunteer clinicians, interns, or residents?**
    Yes. Volunteers, interns, and residents are licensed practitioners and their time is counted like any other practitioner. Note, however, that some may work shorter days because they are in educational sessions, may have more vacation time or other time off than other practitioners, or, in the case of volunteers, do not have vacations or holidays. This would make them less than full-time. See the more complete discussion of counting volunteers, interns, and residents in Appendix B.

11. **We contract with many licensed physicians to read our test results: an ophthalmologist reads the retinal photos that our medical assistant takes, a radiologist over-reads the X-rays that our X-ray tech takes, the outside laboratory's pathologist provides the test results from their machines, and a consulting cardiologist confirms findings of our electrocardiograms (EKGs). Should we report them as staff, and do we count what they do as visits?**
    Tests are not counted as visits anywhere in the UDS. Do not count the time (FTE) of any person who is working on a contract basis when the payment is not for their time worked but, rather, for the activity that they perform. Do not count these activities, *which are important to the provision of comprehensive care to patients,* separately. Count the costs on Table 8A, but note that, under some circumstances, the EHBs may identify an exception (costs with no staff) that you will need to explain.

12. **Where do we report community health workers that we employ?**
    Report staff with responsibility as community health workers on Line 27c. If, however, you are using this term to describe someone who is performing the tasks normally associated with a medical assistant, an outreach worker, or another job title, count them in the corresponding category.

13. **Where do we report medical providers whose only activity at a visit is providing MAT?**
    Report this activity on the line of the credentialed staff providing this treatment (i.e., physicians are counted in medical [Lines 1–8], even if they only provide substance use disorder services at the visit). Do not count them on the substance use disorder line of the main part of Table 5. Additionally, report the activity in the substance use disorder section of the addendum (i.e., physicians are counted on Line 21a of the addendum).

14. **Are virtual/telemedicine visits only permitted after a clinic visit at the health center?**
    No, although most telemedicine visits will occur from a referral from a clinic visit. If the first or only visit is a reportable virtual visit, the health center must register the patient and collect and report all relevant demographic, service, clinical, and financial data on the UDS tables.

FAQs for Table 6A

1. **Are there any changes to the table this year?**
   Yes. Some diagnosis and service codes have been updated.

   Additional data will also be reported on human trafficking, intimate partner violence, coronavirus, and pre-exposure prophylaxis (PrEP) management.

2. **If a case manager or health educator serves a patient who, for example, has diabetes, we often report that diagnostic code for the visit. Should we report this on Table 6A?**
   No. Report only visits with medical, dental, mental health, substance use disorder, and vision providers who are diagnosing according to their own field on Table 6A.

3. **The instructions call for diagnoses and services at visits. If we provide the service but it is not counted as a visit (such as an immunization given at a health fair), should it be reported on this table?**
   Count the visit if a service is provided because of a prescription or plan from an earlier counted visit, such as if a provider asks a patient to come back in four months for a mammogram.

   Do not count services given at health fairs, regardless of who provides the service or the level of documentation that is done, such as an HIV test at a health fair.

   Do not count services that are self-referrals where no clinical visit is necessary or provided, such as a person coming in for a flu shot.

4. **Some diagnostic and/or procedure codes in our system are different from the codes listed. What do we do?**
   It is possible that information for Table 6A is not available using the codes shown because of idiosyncrasies in state or clinic billing systems. Generally, these involve situations where (a) the state uses unique billing codes other than the normal CPT code for state billing purposes (e.g., EPSDT) or (b) internal or state confidentiality rules mask certain diagnostic data. The following table provides examples of problems and solutions:

Line	Problem	Potential Solution
1	HIV diagnoses are kept confidential, and alternative diagnostic codes are used.	Include the alternative codes used at your center on these lines as well.
23	Pap tests are charged to a state BCCCP using a special code.	Add these special codes to the other codes listed.
26	Well-child visits are charged to the state EPSDT program using a special code (often starting with W, X, Y, or Z).	Add these special codes to the other codes listed and count all such visits. Do not count EPSDT follow-up visits in this category.

5. **The instructions specifically say that the source of information for Table 6A is "billing systems or HITs." There are some services for which we do not bill and/or for which there are no visits in our system. What do we do?**
   Do not count referrals for which you do not pay (e.g., sending women to the county health department for a mammogram). Although health centers are only required to report data derived from billing systems or HITs, the reported data may understate services in the circumstances described below. In today's EHRs, diagnoses and/or services should be captured in one of the templates available. To more accurately reflect the level of service, use other codes in the system to enable the tracking.

Line	Problem	Potential Solution
21	HIV test samples are collected by us but processed and paid for by the state and do not show on the visit form or in the billing system.	Preferred: Use the correct code, but report a zero charge.
Multiple	Tests (such as HIV tests, Pap tests, etc.) are ordered and samples collected by us. We send samples to a reference lab for processing, but the lab bills Medicaid or Medicare directly.	Preferred: Use the correct code, but report a zero charge.
22	Mammograms are paid for by us but are conducted by a contractor and do not show in the billing system for individual patients.	Preferred: Use the correct code, but report a zero charge. Alternative: Use the bills from the independent contractor to identify the mammograms conducted and the patients who received them and report these numbers.
23	Pap tests are processed and paid for by the state and do not show on the visit form or in the billing system.	Preferred: Use the correct code, but report a zero charge.
24	Flu shots and other vaccinations are not counted because the vaccines are obtained at no cost to the health center.	Preferred: Use the correct code, but report a zero charge.
25	Contraceptive management is funded under Title X or a state family planning program and does not have a Z30- diagnosis or ICD V25- attached to it.	Preferred: Add a “dummy code” you can map to the Z30- or V25- code. Alternative: Code with both the Z30- (or V25-) and the state-mandated code, but suppress printing of the Z30- or V25- code. Take care not to count the same visit twice.

6. **Are we required to report all diagnoses and services rendered during a visit?**
   Yes and no. No, because there are many diagnoses that may be used but not reported on Table 6A. Yes, because documentation and reporting of all diagnoses (not just primary diagnosis) and services rendered during all UDS-countable visits are required. It is important that you appropriately document the breadth of comprehensive services delivered during each visit, including behavioral health services provided during a medical visit (e.g., SBIRT and/or treatment and counseling for mental health and substance use disorders).

7. **What happens if the CPT or ICD-10-CM codes change again?**
   The codes are reviewed annually by the UDS Support Center staff. If you think a CPT, ICD, or ADA code for a measure is not reflected in the list, contact the UDS Support Center at udshelp330@bphcdata.net. Staff will review the code(s) with BPHC and incorporate approved changes to codes in the manual for future reporting.

8. **Are there ICD-10-CM codes for PrEP management?**
   No. The following ICD, CPT, and HCPCS codes could be utilized by health centers to help identify patient visits that may include counseling on or initiation of PrEP or that may be associated with currently prescribed PrEP, based on risk for HIV exposure.

   Possible ICD-10 codes: Z11.3, Z11.4, Z20.2, Z20.6, Z51.81, Z71.51, Z71.7, Z79.899

   Possible CPT codes: 99401 through 99404

   Possible RxNORM Codes: 1721603, 1747692, 276237, 322248, 495430

   Please note, this is not an exhaustive list. Limit to emtricitabine/tenofovir disoproxil fumarate (FTC/TDF) or emtricitabine/ tenofovir alafenamide (FTC/TAF) for PrEP.

   Do not report these ICD, CPT, or RxNORM codes on Table 6A. They *only* serve as a recommendation to help health centers identify reportable PrEP management.

9. **Should suspected, possible, probably, or inconclusive novel coronavirus (SARS-CoV-2) disease screening and/or tests be reported as diagnosed?**
   No. If the provider documents "suspected," "possible," "probable," or "inconclusive" coronavirus (SARS-CoV-2) disease, do not assign code U07.1 *and* do not report the patient as having this diagnosis. Only report confirmed novel coronavirus cases.

10. **If a patient presents to the health center with pneumonia or other health conditions cause by coronavirus (SARS-CoV-2) disease is the other health condition reported on Table 6B?**
    Assign code U07.1 *and* the appropriate ICD-10 code associated with the other health condition. Documentation in the medical record and reporting of all diagnoses (not just primary diagnosis) and services rendered during the visit are required, if applicable. For example, if a patient has pneumonia confirmed due to coronavirus (SARS-CoV-2) disease, assign and report codes U07.1 (coronavirus disease) on line 4c and J12.89 (other viral pneumonia) on line 6a.

FAQs for Table 6B

1. **Are there any changes to the table this year?**
   Yes. The specifications for the clinical measures reported have been revised to align with the CMS eCQMs. The quality of care measures are aligned with the most current eCQMs for Eligible Professionals for the 2020 version number referenced in the UDS Manual for the reporting period. (Other updates are available, but they should not be used for the 2020 reporting.)

   The HIV Linkage to Care measure has been revised from 90 days to 30 days for the follow-up treatment timeline for patients whose first-ever HIV diagnosis was made by the health center.

   The Use of Appropriate Medications for Asthma measure has been removed.

   Additionally, Breast Cancer Screening, HIV Screening, and Depression Remission at Twelve Months have been added.

2. **A child came in only once during the year for an injury and never returned for well-child care. Do we have to consider the child's chart to not have met the measurement standard since we only treated for the injury?**
   Yes. After a patient enters a health center's system of medical care, the center is expected to provide all needed preventive health care and/or document that the patient has received it. Report the patient in the universe (denominator) but not the numerator, since the record did not meet the measurement standard.

3. **What if a woman we treat for hypertension and diabetes goes to an OB/GYN in the community for her women's health care? Do we still have to consider her in our universe for the Pap test measure? What if we do not offer Pap tests?**
   After the patient has been seen in your clinic, you are responsible for ensuring that she has the appropriate cervical cancer screening. This can be done by providing the Pap test or documenting the results of a test that someone else performed. Health centers are encouraged to coordinate care and document Pap test results by contacting providers. The health center may obtain a copy of the patient's test result to include in her record for future care. Consider the woman as part of your universe if she received *any* medical visit(s) in the measurement year. If there is no evidence of a timely cervical cancer screening included in her chart, consider this as not having met the measurement standard.

4. **If we inform parents of the importance of immunizations but they refuse to have their child immunized, may we count the record as having met the measurement standard if the refusal is documented?**
   No. A child is fully immunized only if there is documentation that the child received the vaccine or there is contraindication for the vaccine, evidence of the antigen, or history of illness.

5. **Are parents required to bring to the health center documentation of childhood immunizations received outside the health center?**
   Parents are encouraged to provide documentation of immunizations that their children received elsewhere, but other mechanisms of obtaining this information are also acceptable as long as all immunizations are appropriately reviewed and documented in your system. Document childhood immunizations by contacting providers of immunizations directly to obtain documentation by fax, by requesting health center patients mail a copy of their immunization history, through receipt of payment for the vaccine from the pharmacy, by finding the child in a state or county immunization registry, or through other appropriate means.

6. **Some of the immunization details are different from those used by the Centers for Disease Control and Prevention (CDC) in the Clinic Assessment Software Application (CASA) or Comprehensive-CASA reviews of our clinic. May we use these CDC standards to report on the UDS?**
   No. HRSA is now using the CMS eCQM standards to evaluate provision of vaccines to children. Using a different set of standards will distort the data. A center *may* use a different set of standards for its own internal QI/quality assurance program, but these may not be substituted for the UDS reporting definitions.

7. **We want to use data from the clinical measures to compare our sites and our providers to one another. As a result, we would like to sample using a larger universe. Is this permitted?**
   No. A sample size of 70 charts must be used. This facilitates the development of state, national, and other roll-up reports. Additionally, any change in the sample size would bias the sample and provide distortions in the data set. Most health center systems can provide these results without modifying the reporting requirements.

8. **Is the Pap test review for women starting at age 21 or at age 23?**
For this measure, look only at women who were age 23 through age 64 at some point in the measurement year. Because the measure asks about Pap tests *administered* in 2020, 2019, or in 2018, it is possible that a 23-year-old woman assessed under this measure would have been 21 in 2017. If she received a Pap test in that year, she would be considered to have met the measurement standard. Although you look only at women who are 23 through 64, their qualifying test may have been done when they were 21 through 64.

9. **Does "counseling for nutrition and . . . physical activity" include specific content that must be provided? Does it need to be provided if the child is within the normal range?**
No, the counseling has no specific required content, although it does have specific CPT coding requirements. It is tailored by the clinician given the patient's BMI percentile and other clinical and social data.

   Yes, the counseling must be provided to all children and adolescents. Counseling is aimed at promoting routine physical activity and healthy eating for *all* children and adolescents. For younger children, counseling will be provided to the parent or caregiver.

10. **For adult patients, our protocol calls for weight to be measured at every visit but height to be measured "at least once every 2 years." Is this acceptable?**
BMI is calculated from current height and weight. Both height and weight must be measured within 12 months of the most recent visit and may be obtained from separate visits.

11. **The measure says that there must be intervention for tobacco users. What specific interventions must be used?**
A broad range of counseling and pharmacotherapy is available for tobacco use. Which intervention to use is at the discretion of each clinician.

12. **How should we collect data for measures that require a look-back period?**
Many of the UDS CQMs (e.g., cervical cancer screening, colorectal cancer screening, childhood immunizations, and others) require a look-back period. It is important that this information is noted in patient records. It is recommended that you obtain records for new patients from their former providers to document their prior treatment, including data for look-back periods. Medical records obtained from other providers may be recorded in the health center's HIT/EHR consistent with internal medical records policies, at which point they could be used in the performance review. Additionally, if you change EHRs, ensure that the prior data is transferred over to the new system.

13. **Can we use National Quality Forum (NQF) or Healthcare Effectiveness Data and Information Set (HEDIS) directly to report on the clinical measures?**
No. For UDS reporting, you must report on the clinical measures defined by UDS and outlined in this manual, most of which align with CMS's Promoting Interoperability eCQMs.

14. **Which patients are we required to report in the universe for the dental sealants measure?**
    Health centers providing dental services directly on-site or through paid referral under contract must report on all dental patients age 6 through 9 who are at elevated risk for caries in the universe count. Caries risk assessment must be based on patient-level factors and documented with appropriate ADA codes. This may not be based on population-based factors, such as low socioeconomic status.

15. **Do DNA colorectal cancer screening tests meet the measurement standard for the colorectal cancer screening measure?**
    Yes. FIT-DNA colorectal cancer screening tests (such as Cologuard) meet the standard for colorectal cancer screening measure when performed during the measurement period or in the 2 years prior.

16. **What should we do if we do not have adequate documentation about the tooth on which a sealant was placed?**
    In these situations, pull 70 patient charts using a random sample and have the reviewer evaluate the chart records to find evidence for the sealant being applied to a permanent first molar. If the tooth descriptor (or tooth number) is undocumented and there is insufficient documentation to determine whether at least one of the sealant(s) was placed on a permanent first molar, the record will not be included in the numerator and may lower the overall measure score (percentage).

17. **If a patient who is newly diagnosed with HIV dies before they receive treatment, do we count them in the HIV linkage measure?**
    Yes. Include the patient in the denominator (universe), assuming they met the diagnosis criteria. If they died before receiving the first visit for initiation of treatment, do not count them in the numerator.

18. **Do quit lines meet the measurement standard for tobacco cessation?**
    Yes. Tobacco cessation services provided by quit lines do meet the standard for the tobacco screening and cessation intervention measure if the intervention is documented in the medical records.

19. **Can brand-name prescriptions meet the measurement standard for measures that include a pharmaceutical component?**
    Yes. Since only scientific or generic names are stored in the RxNORM value sets, the health center and vendor need to map the generic and brand names when a new equivalent or brand name is discovered missing from RxNORM.

20. **What does "diagnosis that overlaps the measurement period" mean, as stated for some of the measures?**
    The overlap statement means that if patients had the diagnosis at any point during the measurement period, they are to be included in the denominator and assessed for meeting the measurement standard.

21. **We would like to recommend changes to specific eCQM requirements being collected in the UDS. Can HRSA make the changes based on our feedback?**
    Although HRSA is interested in learning about eCQM changes you would recommend, you should contact the measure steward through the ONC Issue Tracking System to submit recommendations to existing eCQM logic. Appendix G contains the list of measure stewards.

22. **What standardized depression screenings comply with the Screening for Depression and Follow-Up Plan measure?**
    Use a standardized depression screening tool, which is a normalized and validated tool developed for the patient population in which it is to be utilized. Examples of depression screening tools include, but are not limited to:

- Adolescent Screening Tools (12–17 years)
  - Patient Health Questionnaire for Adolescents (PHQ-A)
  - Beck Depression Inventory-Primary Care Version (BDI-PC)
  - Mood Feeling Questionnaire (MFQ)
  - Center for Epidemiologic Studies Depression Scale (CES-D)
  - Patient Health Questionnaire (PHQ-9)
  - Pediatric Symptom Checklist (PSC-17)
  - Primary Care Evaluation of Mental Disorders (PRIME MD)-PHQ-2
- Adult Screening Tools (18 years and older)
  - PHQ-9
  - Beck Depression Inventory (BDI or BDI-II)
  - CES-D
  - Depression Scale (DEPS)
  - Duke Anxiety-Depression Scale (DADS)
  - Geriatric Depression Scale (GDS)
  - Cornell Scale for Depression in Dementia (CSDD)
  - PRIME MD-PHQ-2
  - Hamilton Rating Scale for Depression (HAM-D)
  - Quick Inventory of Depressive Symptomatology Self-Report (QID-SR)
  - Computerized Adaptive Testing Depression Inventory (CAT-DI)
  - Computerized Adaptive Diagnostic Screener (CAD-MDD)
- Perinatal Screening Tools
  - Edinburgh Postnatal Depression Scale
  - Postpartum Depression Screening Scale
  - PHQ-9
  - BDI
  - BDI-II
  - CES-D
  - Zung Self-Rating Depression Scale

FAQs for Table 7

1. **Are there any changes to the table this year?**
   Yes. The specifications for the clinical measures reported have been revised to align with CMS's eCQMs. The quality of care measures are aligned with the most current eCQMs for Eligible Professionals for the 2020 version number referenced in the UDS Manual for the reporting period. Although there are other updates available, they are not to be used for the 2020 reporting.

   The Controlling High Blood Pressure measure denominator has been revised from diagnosis of hypertension within the first six months of the measurement period or any time prior to the measurement period to diagnosis overlapping the measurement period.

2. **When would we use Row h, "Unreported/Refused to Report" race and ethnicity?**
   Use Row h only in those instances where patients do not provide their race *and* do not state whether they are Hispanic or Latino/a. Report patients who provide a race but do not affirmatively answer a question about Hispanic or Latino/a ethnicity as Non-Hispanic or Latino/a on the appropriate race line (Lines 2a–2g). Report patients who indicate they are Hispanic or Latino/a but do not provide a race on Line 1g.

3. **Data are requested by race and Hispanic or Latino/a ethnicity. How are these to be coded?**
   Code race and Hispanic or Latino/a ethnicity on this table in the same manner coded on Table 3B. Refer to instructions for Table 3B for further information. Ensure the same information is recorded in both the medical chart and the registration form to avoid errors.

4. **Are patients with diabetes required to bring to the health center documentation of HbA1c tests received from outside the health center?**
   The health center is required to have HbA1c test results in patient charts. If the health center does not perform the test, contact the provider who performed the tests. The documentation can be brought in by the patient, but can also be obtained by fax, by requesting that the patient mail a copy of test results, or through other appropriate means.

5. **We want to use the data from the clinical measures to compare our sites and our providers to one another. As a result, we would like to use a larger universe. Is this permitted?**
   A sample size of 70 charts must be used for UDS reporting. This facilitates the development of state, national, and other roll-up reports. Additionally, any change in the sample size would bias the sample and provide distortions in the data set. Most health center systems can provide these results without modifying the reporting requirements. Health centers can use larger sample sizes for their own tracking and QI projects outside of UDS.

6. **In Section A, Deliveries and Birth Outcomes, should the race and ethnicity of the baby be the same as that of the mother?**
   Not necessarily. Report the race and ethnicity of the mother (Column 1a) separately from the child (Column 1b, 1c, or 1d). The baby's race and ethnicity may differ from the mother's.

7. **How do we report miscarriages and pregnancy terminations?**
   You don't. Report all pregnant women in your (direct or by referral) prenatal care program on Table 6B, but report only those women who deliver on Table 7. Consider a stillbirth to be a delivery for purposes of reporting in Column 1a, but do not report the baby in Columns 1b, 1c, or 1d.

8. **How do we determine "active diagnosis" that is required for some measures?**
   Patient health records frequently contain a "problem list," a list of "active diagnoses," or lists by other names. Any diagnosis on the list for part or all of the measurement year is considered "active."

FAQs for Table 8A

1. **Are there any changes to the table this year?**
   No.

2. **How do we account for donated services?**
   If a provider comes to your health center and renders a service to your patients, report both the FTE (on Table 5) and the value, which is determined by "what a reasonable person would pay" *for the time* (not the service), on Table 8A, Line 18. For example, if an optometrist sees 5 patients in a 2-hour period, report as the amount what you would pay an optometrist for 2 hours of work, not the total charges for the 5 visits.

However, if you refer a patient for a service to a provider outside your site who donates these services, *do not report the activity, the charge, or the value of the time or service on the UDS*. For example, if you refer a patient to a cardiologist who provides free consultation, do not count the visit or the monetary value of the provider's service.

3. **How do we account for donated drugs?**
   If drugs are donated directly to the health center, which then dispenses them to a patient, calculate and report on Line 18 the value of the drug *at what a reasonable payer would pay for them*. This is NOT the retail cost of the drug; it is the 340B price of the drug—an amount that is generally 40–60 percent of the average wholesale price (AWP). *Technically*, if the drug is donated directly to the patient, even though it may be sent to the health center, this is not a donation to the center. However, since we are interested in knowing the total value of supplies provided to the health center *directly or indirectly*, we encourage you to include the value on Line 18.

4. **We get most of our vaccines through Vaccines for Children (VFC) or other state and county programs. Are these considered donated drugs and accounted for here?**
   Yes. Report the value of donated drugs that are used in the clinic, such as vaccines, on Line 18 in Table 8A—again, at the reasonable cost based on 340B drug pricing or a discounted price off the average wholesale price.

5. **My doctors were paid the EHR incentive payments directly by CMS. If we let them keep some or all of these dollars, are they reported anywhere on Table 8A?**
   Yes. Establish reporting mechanisms whereby your providers inform you of payments received and account for these funds. If providers are permitted to retain some or all of these funds, report the amount on Line 1.
   In addition, report the Promoting Interoperability EHR payments received from Medicare or Medicaid on Table 9E, Line 3a.

6. **What method of overhead (facility and non-clinical support services) allocation should we use for this table?**
   It is preferable that you first allocate facility cost to all cost centers, including administration, based on square footage, and then apply administrative cost based on the percent distribution of direct costs.

7. **Do we need to allocate overhead for contracted services?**
   Contracted services do not warrant a full overhead charge, given that they do not involve the management of personnel. However, the procurement and supervision of those arrangements do consume overhead that should be reported. Contracted services are often charged at a rate that covers the accounting and contract management.

8. **Why do our financial statements not tie to the UDS financials?**
   The UDS financials (Tables 8A, 9D, and 9E) will not tie to your financial statements for the following possible reasons:

   (1) The UDS is reported on a calendar year basis, January 1–December 31, but the health center's fiscal year end may be a different period.

   (2) Activity outside the scope of the federal project is included in the health center's financial statements but excluded in the UDS.

   (3) Net patient service revenue that could be estimated from table 9D (charges less adjustments) may differ from the financial statements because the UDS only reports self-pay bad debt rather than the full adjustment for bad debt attributable to all payers and circumstances.

(4) Settlement and wrap income is only reported in the UDS upon its receipt and health centers may be able to recognize this income on an accrual basis in the period it is earned.

(5) Table 9E reports all income other than patient service revenue on a cash basis and health centers may recognize this income on an accrual basis in their financial statements.

9. **What do we need to report in the different columns of this table?**
The column definitions are detailed on Table 8A. Below is a summary of what to include in each column.

Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
Costs attributable to the reporting period by cost center. Include costs of: • staff • fringe benefits • supplies • equipment • depreciation • interest paid • related travel Exclude bad debt and repayment of principal on loans.	Allocation of facility and non-clinical support services (Column A, Lines 14 and 15) to each cost center. ***Note:*** *Total of Column B must be equal to Column A, Line 16).*	Represents cost to operate services. ***Note:*** *Sum of Columns A + B (done automatically in EHBs).*

10. **How are awardee-subrecipient and contractor relationships to be reported?**
Health centers that make a subaward to another Health Center Program awardee or look-alike or purchase goods or services must determine whether the services and sites associated with the subaward or contract are appropriate for inclusion in both the awardee's and the subrecipient's or contractor's scope of project. In general, subrecipient- and contractor-operated sites should only be recorded in the scope of project of the awardee.

In cases when the subrecipient or contractor will be serving both its own patients and the awardee's patients at a subrecipient- or contractor-operated site, the activity may be appropriate for recording within the scope of project of both the awardee and the subrecipient or contractor.

For health centers who are subrecipients or contractors of another Health Center Program awardee, report the costs of services provided on the service lines where the costs were incurred. Similarly, the awardee who purchased or incurred costs for services performed by a subrecipient or contractor are to report costs in the appropriate cost centers.

FAQs for Table 9D

1. **Are there any changes to the table this year?**
Yes. A new line has been added to report patient-related revenue administered by HRSA under the COVID-19 Uninsured Program.

2. **How should charges and collections for patients enrolled in an indigent care program be handled?**
Report such charges as Self-Pay, Line 13 in Column A. Do not report payments received from state or local indigent care programs subsidizing services rendered to patients who are uninsured on this table. Report these payments, whether made on a per-visit basis or as a lump sum for services rendered, on Line 6a of Table 9E. See Table 9E **Cross-Table Reporting Guidance for Indigent Programs** for specific instructions.

Do not classify anything as an indigent care program without first reviewing this in a UDS Training Program, with your UDS Reviewer, or with the UDS Support Center.

3. **Are the data on this table cash- or accrual-based?**
   Table 9D is a "cash" table. Entries represent gross charges and adjustments for the reporting calendar year and actual cash receipts for the year.

4. **Should the lines of the table "balance?"**
   No. Normally, charges (Column A) minus collections (Column B) minus adjustments (Columns D, E, and F) will not equal zero. Because the collections are on a cash basis, the columns for amount collected and for adjustments will include payments and adjustments for services rendered in the prior year. Conversely, some of the charges for the current year will remain in accounts receivable at the end of the year. The one exception is on the capitated lines (Lines 2a, 5a, 8a, and 11a), where adjustments are defined in the UDS to be the difference between charges and collections, provided there are no early or late capitation payments that cross the calendar year.

5. **If we have not received any reconciliation payments for the reporting period, what do we report in Column c1 (current year reconciliations)?**
   Since you report only current *reconciliations* in Column c1, do not report any reconciliation (although you may have received wraparound payments, which are reported here).

6. **We often use our sliding fee discount program to write off the co-payment portion of the Medicare charge for our certified low-income patients. The sliding fee discount column (Column E) is grayed out for Medicare. How do we record this write-off?**
   Remove the amount of the co-payment from the charge column of the Medicare line (Lines 4–6, as appropriate), and then add it to the Self-Pay line (Line 13). It can then be written off as a sliding fee discount on Line 13. Use the same process for any other co-payment or deductible write-off.

7. **Our system does not automatically reclassify amounts due from other carriers or from the patient. Must we, for example, reclassify Medicare charges that become co-payments or Medicaid charges?**
   Yes. Regardless of whether it is done automatically by your PMS/HIT/EHR or manually, reflect this reclassification of charges that end up being the responsibility of a party other than the initial party. As a rule, your system will make this adjustment in some way, but you may need to work with your vendor to get a report on the amounts transferred.

8. **How do we report the charges and collections for pharmaceuticals dispensed at our contract pharmacies?**
   We discuss contract pharmacy reporting at length in Appendix B. In general, report the full charge in Column A by payer. Then, report the amount received from the patient (on Line 13) or insurance company (on Line 10) in Column B. Report the amount that is written off for an insurance company in Column D. Report the amount written off for a patient as a sliding fee discount in Column E. Similar rules apply if drugs are billable to Medicaid and Medicare.

9. **How should we report the charges associated with "G-codes"?**
   G-codes specify a reimbursement rate associated with a package of services that your health center has described to Medicare. (Similar amounts may be paid to you by other third-party payers as well.) For UDS, report these in:

   - Column A: The sum of actual fee schedule/CPT-related charges for visits
   - Column B: What your health center received for payment

- Column D: The discounted amount disallowed between charges and the amount received

Remember to reduce the charges by the Medicare co-payment (20 percent of the allowable charge). The payment from Medicare will be similarly adjusted. See discussion of reclassifying co-payments.

Note: *If both the actual charge and the G-code charge are routinely used in your system, you must remove the G-code charges by running a report to get the total for G-code charges for the year and then subtracting this number from the total charges (actual plus G-code). Report the difference in Column A. Reduce Column D by the G-code amount if it was adjusted using a similar process.*

FAQs for Table 9E

1. **Are there any changes to the table this year?**
   Yes. New lines have been added to report draw-downs of COVID-19-related supplemental and provider-relief funding.

2. **Are there any important issues to keep in mind for this table?**
   This table collects information on cash receipts for the reporting period that supported activities described in the scope of project covered by any of the Health Center Program awards, the look-alike designation, or the BHW primary care clinics program. Report only cash receipts received during the calendar year. In the case of a grant, this amount equals the cash amount received during the year, not the award amount (unless the full award was paid/drawn down during the year).

3. **How should we report indigent care funds?**
   Report payments received from state or local indigent care programs subsidizing services rendered to patients who are uninsured (including patients covered by a tribe's 638 funds) on Line 6a of Table 9E, whether the actual payment to the health center is made on a per-visit basis or as a lump sum for services rendered.

   Report patients covered by these programs as Uninsured on Table 4.

   Report all charges, self-pay patient collections, sliding fee discounts, and bad debt write-offs on the Self-Pay line (Line 13) on Table 9D.

   Report monies collected from the patients covered by indigent programs on Table 9D. However, do not report funds reported on Line 6a of Table 9E on Table 9D.

Appendix B: Special Multi-Table Situations

Several conditions require special consideration in the UDS because they affect multiple tables that must then be reconciled. This appendix presents some situations along with instructions on how to deal with them, including:

- Contracted care (specialty, dental, mental health, etc.) that is paid for by the reporting health center
- Services provided by a volunteer provider
- Interns and residents
- WIC
- In-house pharmacy or dispensary services for health center patients
- In-house pharmacy for community (i.e., for non-patients)
- Contract pharmacies
- Donated drugs
- Clinical dispensing of drugs
- ADHC/PACE
- Medi-Medi crossovers
- Certain grant-supported clinical care programs (BCCCP, Title X, etc.)
- State or local safety net programs
- Workers' compensation
- Tricare, Trigon, Public Employees Insurance, etc.
- Contract sites
- CHIP
- Carved-out services
- Migrant voucher programs and other voucher programs
- Incarcerated patients
- New start or new access point
- Relationship between staff on Table 5 and costs on Table 8A
- Relationship between insurance on Table 4 and revenue on Table 9D
- Relationship between Prenatal Care on Table 6B and Deliveries on Table 7
- Relationship between race and ethnicity on Table 3B and Table 7

Contracted Care (specialty, dental, mental health, etc.)

Contracted care is services paid for by the health center.

Tables Affected	Treatment
5	Count providers (Column A) if the contract is for a portion of an FTE (e.g., one-day-a-week OB/GYN = 0.20 FTE). Do *not* count if the contract is for a service (e.g., $X per visit or $55 per resource-based relative value unit [RBRVU]). *Always* count visits (Column B or B2), regardless of method of provider payment or location of service (health center's site or contract provider's office).
6A	The health center receives encounter form or equivalent from contract provider and reports diagnoses and/or services provided as applicable.
6B, 7	If a contract clinician provides any services that are subject to quality measures, collect and report all data from contractor (e.g., birth weight of a child from contract obstetrician, last HbA1c from an endocrinologist, sealants placed from a dentist).
8A	Column A, Accrued Cost: Report cost of provider/service on the applicable line. If the provider receives a "co-payment" or a "nominal fee" from the patient, report the sum of that and what the health center pays. Column B, Facility and Non-Clinical Support Services: The health center will generally use a lower facility and non-clinical support services allocation rate for off-site services. Include all facility and non-clinical support costs in the direct charge (Column A) if the provider is off-site.
9D	Column A, Charge: The health center's UCR charge if on-site; use the contractor's UCR charge if off-site. Column B, Collection: The amount received by *either* the health center *or* contractor from first or third parties. Column D, Adjustment: The amount disallowed by a third party for the charge (if on Lines 1–12). Column E, Sliding Fee Discount: The amount written off for eligible patients per the center's fiscal policies (Line 13), if applicable. Calculate as UCR charge, minus amount collected from patients, minus amount owed by patients as their share of payment. Do not include payment by the health center here.

Services Provided by a Volunteer Provider

Volunteers are not paid by the health center for services, which they provide on-site. This includes volunteer staff (including AmeriCorps/HealthCorps, but not NHSC) who provide services on- or off-site on behalf of the health center. FTE can be included in the UDS Report when there is a basis for determining their hours.

Tables Affected	Treatment
5	Column A, Provider FTE: Report FTE for services provided on-site at the health center's clinic. FTE must be calculated. Use hours volunteered as the numerator. Because volunteers do not receive paid leave benefits, the denominator is the number of hours that a comparable employee spends performing their job. Reduce a full-time schedule of 2,080 hours (for example) by vacation, sick leave, holidays, and continuing education normally provided to employees. As a rule of thumb, use hours worked divided by a number somewhere around 1,800. Do not count providers who provide services at their own offices. Column B, Clinic Visits, and Column B2, Virtual Visits: Count visits only for services provided at a site in the health center's scope of service and under its control.
6A	Count diagnoses and/or services provided on-site, as applicable.
8A	Column C, Line 18: Report the value of the time donated by volunteers on this line *only*.
9D	The charges for their services are treated the same as for staff if the provider is on-site. Do not include charges for volunteer providers who are off-site.

Interns and Residents

Health centers often use people who are in training, referred to variously as interns or residents depending on their field and their licensing. Medical residents are generally licensed practitioners. Some mental health interns, as well as other providers, may be licensed practitioners who are training for a higher level of certification or licensing.

Tables Affected	Treatment
5	Column A: Count licensed interns and residents in the credentialing category they are *pursuing*. For example, count a family practice resident on Line 1 as a Family Physician. Depending on the arrangement, FTEs may be calculated like any other employee (if they are being paid by the health center) or like a volunteer (if they are *not* being paid). See volunteer providers on the preceding page. Columns B and B2: Record visits between a medical resident and a patient as visits to that resident or intern. Do not credit the visits to the supervisor of the resident or intern under any circumstance. Count visits of a licensed mental health provider on Lines 20a, 20a1, 20a2, or 20b. Count unlicensed mental health providers on Line 20c.
8A	*If the intern or resident is paid by the health center or* their cost is being paid through a contract that pays a third party for the interns or residents, report the cost in Column A on the appropriate line (Line 1 for medical, Line 5 for dental, etc.). If the health center is not paying an intern, resident, *or* third party, report the *value of the donated time* on Line 18. Be sure to describe the nature of the donation on the table.

Women, Infants, and Children (WIC)

Tables Affected	Treatment
3A, 3B, 4	Do not count clients whose only contact with the health center is for WIC services and who receive no other services listed on Table 5 from providers outside of WIC. Do not count as patients anyone whose only health center contact is for WIC nutritional, health education, or enabling services.
5	Count staff (Column A) on Line 29a. Do not report visits and patients (Columns B, B2, and C).
8A	Column A, Net (Accrued) Cost: Include the total cost of the program on Line 12 in Column A. Column B, Facility and Non-Clinical Support Services: Since much of the non-clinical support services cost of the program will be included in the direct costs, it is presumed that overhead will be at a significantly lower rate.
9D	Do not report anything associated with the WIC program.
9E	Income for WIC programs, though originally federal, generally comes to health centers from the state, though some receive it from a lower-level intermediary. If the health center *is* receiving WIC funds from a state government, the grant/contract funds received go on Line 6. Report funds from an intermediary on Line 8.

In-House Pharmacy or Dispensary Services for Health Center Patients

Include only that part of the pharmacy that is paid by the health center and dispensed by in-house staff (see below for other situations).

Tables Affected	Treatment
5	Column A, Staff: Report pharmacy staff on Line 23. If they have only an incidental responsibility to provide assistance in enrolling patients in PAPs, include them on Line 23. Include clinical pharmacists on Line 23 even if they spend time outside of the pharmacy. Report staff members other than pharmacists who spend time with PAP programs on Line 27a, Eligibility Assistance. Columns B and B2, Visits: The UDS does not count interactions with pharmacy staff as visits, whether it is for filling prescriptions or associated education or other patient/provider support. This is true for clinical pharmacists with expanded clinical privileges, as well.
8A	Line 8a, Column A, Other Pharmacy Direct (Accrued) Costs: Report all other operating costs of the pharmacy on Line 8a. Include salaries, benefits, pharmacy computers, supplies, etc. Line 8b, Column A, Pharmaceutical Direct (Accrued) Costs: Place the actual cost of drugs the pharmacy bought on Line 8b. Include the cost of vaccines, contraceptives, injectable antibiotics, and other drugs dispensed in the clinic and not in a pharmacy on Line 8b. The value of donated drugs is *not* reported here. That amount is reported on Line 18 in Column C. Line 11e, Column A, Eligibility Assistance Direct (Accrued) Costs: Report on Line 11e the cost of staff (full-time, part-time, or allocated time) helping patients become eligible for PAPs and of all related supplies, equipment depreciation, etc. Column B, Facility and Non-Clinical Support Services: Report all facility and non-clinical support services costs associated with pharmacy and pharmaceuticals (Lines 8a and 8b) on Line 8a. Although there may be some facility and non-clinical support services costs associated with the actual purchase of the drugs, these costs are generally minimal when compared to the total cost of the drugs. Column C, Line 18: Report the value of donated drugs, including vaccines, (generally calculated at 340B rates) on this line *only*.
9D	Column A: Charge is the health center's full retail charge for dispensed drugs. Column B: Collection is the amount received from patients or other third parties/insurance companies. Column D: Adjustment is the amount a third party disallows for the charge (if on Lines 1–12). Column E: Sliding fee discount is the amount written off for eligible patients per health center policies (Line 13). Calculate as retail charge, minus amount collected from patients if any, minus amount owed by patients if any, as their share of payment.
9E	Do *not* report the value of donated drugs on this table; report on Table 8A, Line 18 (see below). The charges for drugs dispensed to patients go on Table 9D, not on this table.

In-House Pharmacy for Community (i.e., for non-patients)

Many health centers that own licensed pharmacies also provide services to members of the community at large who are not health center patients. Careful records must be maintained at these pharmacies to ensure that non-patients do not receive drugs purchased under section 340B provisions. Some of these pharmacies are totally in scope, while others have their "public" portion out of scope. If the public aspect is out of scope, do not report its activities on the UDS. If it is in scope, treat the public portion as an "other activity," as follows:

Tables Affected	Treatment
5	Column A, Staff: Report allocated public portion of staff on Line 29a: Other Programs and Services.
8A	Report all related staff and pharmacy costs, including cost of pharmaceuticals, on Line 12: Other Related Services.
9E	Report all income from public pharmacy on Line 10, Other, and specify from "Public access pharmacy."

Contract Pharmacy Dispensing to Clinic Patients, Generally Using 340B Purchased Drugs

Tables Affected	Treatment
5	Do not report staff, visits, or patients for pharmacy dispensing.
8A	Report the amount the pharmacy charges for managing dispensing of drugs on Line 8a. Report the full amount paid for pharmaceuticals, either directly by the clinic or indirectly by the pharmacy, on Line 8b. If the pharmacy buys prepackaged drugs *and there is no reasonable way to separate the pharmaceutical costs from the dispensing/administrative costs*, report all costs on Line 8b. Associated non-clinical support services (overhead) costs will go on Line 8a in Column B, even though Line 8a Column A is blank. Report payments to pharmacy benefit managers on Line 8a. Share of profits: Some pharmacies engage in fee splitting and keep a share of profit. Report this as a payment to the pharmacy on Line 8a.
9D	Column A, Charge: The health center/contract pharmacy's full retail charge for the drugs dispensed. If retail is unknown, ask the pharmacy for retail prices for the drugs dispensed. Column B, Collection: The amount received from patients or insurance companies. Health centers must collect this information from the contract pharmacy. (Note: Most health centers do not have this sort of arrangement for Medicaid patients, unless explicitly stated.) Column D, Adjustment: The amount disallowed by a third party for the charge (if on Lines 1–12). Column E, Sliding Fee Discount: The amount written off for eligible patients per health center policies (Line 13). Calculate as retail charge (or pharmacy charge), minus amount collected from patients (by pharmacy or health center), minus amount owed by patients as their share of payment.
9E	Do not report pharmacy income on Table 9E, and *do not use Table 9E to report net income from the pharmacy*. Report actual gross income on Table 9D.

Donated Drugs, Including Vaccines

Tables Affected	Treatment
8A	If the drugs are donated to the health center and then dispensed to patients, report their value (generally calculated at 340B rates) on Line 18, Column C. If the drugs are donated directly to the patient, the health center is not required to report the value of the drugs; however, it is preferred that the value be included for a better understanding of the program.
9D	If the health center charges patients a dispensing fee, report only this amount and its collection and/or write-off.
9E	Do not report any amount, even though generally accepted accounting principles (GAAP) might suggest another treatment for the value.

Clinical Dispensing of Drugs

Clinic areas of health centers dispense many pharmaceuticals, including vaccines, allergy shots, contraceptives, and drugs used in MAT of opiate use. This may be a service associated with the visit or, in the case of vaccinations, a community service. These services do not count as a visit, but charging patients for them is appropriate unless the clinic received the drugs for free.

Tables Affected	Treatment
3A, 3B, 4	Do not count these people as patients if this is the only service they received during the year.
5	Do not count these services as visits.
6A	Do not count these on Table 6A; they are not visits.
8A	Report drug costs on Line 8b, Pharmaceuticals (*not* on Line 3, Other Medical Costs). In the case of vaccines obtained at no cost through Vaccines for Children or other state or local programs, report the value on Line 18, Donated Services and Supplies.
9D	Report full charges, collections, adjustments, and discounts, as appropriate. Note that it is *not appropriate* to charge for a pharmaceutical that has been donated. However, an administration and/or dispensing fee *is* appropriate. Note that Medicare has separate flu vaccine rules.
9E	Do not report any amount.

ADHC and PACE

Medicare, Medicaid, and certain other third-party payers often recognize ADHC programs. They involve caring for an infirm, frail, or elderly patient during the day to permit family members to work and to avoid institutionalization and preserve the health of the patient. They are quite expensive and may involve extraordinary per member per month (PMPM) capitation payments but are cost effective compared to institutionalization. Patients who have both Medicare and Medicaid coverage are treated as Medi-Medi, as described below. PACE is even more expansive and may include ADHC services, as well as services to maintain independence for the elderly.

Tables Affected	Treatment
3A, 3B, 4	Count the people seen during the year in ADHC and PACE programs as patients if the interaction is a reportable visit.
5	When a provider does a formal, separately billable examination of a patient at the ADHC/PACE facility, treat it as any other medical visit. Do not count the nursing, observation, monitoring, and dispensing of medication services that are bundled together to form an ADHC service as a visit for the purposes of reporting. Staff are included on Line 29a, Other Programs and Services.
6A, 6B, 7	Report the clinical activity provided to patients at ADHC and PACE facilities, as appropriate, on the clinical tables.

Tables Affected	Treatment
8A	If the health center provides and bills medical services separately from the ADHC charge, the associated costs are on Lines 1–3. Report all other costs on Line 12. Similarly, include PACE costs over and above medical and pharmacy costs on Line 12.
9D	Report ADHC charges and collections on this table, generally as Medicaid and/or Medicare. Because of FQHC procedures, it is possible that there will also be significant positive or negative adjustments. In addition, see Medi-Medi, below.

Medi-Medi/Dually Eligible

Some individuals are eligible for and enrolled in both Medicare and Medicaid (commonly referred to as Medi-Medi or dually eligible). In this case, Medicare is primary and billed first. After Medicare pays its (usually FQHC-associated Z code or geographic-rate-adjusted) fee, the remainder is billed to Medicaid, which pays an amount based on policy that varies from state to state.

Tables Affected	Treatment
4	Report patients on Line 9, Medicare. Do not report as Medicaid. In addition, report these patients on Line 9a, Dually Eligible (Medicare and Medicaid); this line is a subset of the total reported on Line 9, Medicare.
9D	While the entire charge initially shows as a Medicare charge, after Medicare makes its payment the remaining allowable amount is reclassified to Medicaid. Report the payment received from Medicaid on Line 1 in Column B. Report the difference between the charge and the collection as a positive or negative adjustment, depending on the amount.

Certain Grant-Supported Clinical Care Programs: BCCCP, Title X, etc.

Some programs pay providers on a fee-for-service or fee per visit basis under a contract, which may or may not also have a cap on total payments per grant period (usually the state fiscal year). They cover a very narrow range of services. Breast and cervical cancer control and family planning programs are the most common, but there are others.

These are fee-for service or fee-per-visit programs only.

Tables Affected	Treatment
4	These programs are not insurance. They pay for a service, but health centers must classify patients according to their primary health insurance carrier. Most of these programs do not serve insured patients, so most of the patients would be reported on Line 7 as uninsured.
9D	Although the patient is uninsured, there *is* an "other public" payer for the service. Report the clinic's usual and customary charge for the service (not the negotiated fee paid by the public entity) on Line 7 in Column A and the payment in Column B. Because the payment will almost always be different from the charge, report the difference as an adjustment in Column D.
9E	Do not report the grant or contract covering the fee-for-service or fee-per-visit amount on Table 9E. Fully account for this on Table 9D.

State or Local Safety Net Programs

These pay through a grant for a wide range of clinical services for uninsured patients, generally those under an income limit. Most of these programs set payment caps and often make payments in a different fiscal year than that in which the patient received the service.

Tables Affected	Treatment
4	While patients may need to meet eligibility criteria, these programs are not public insurance. Count patients receiving care through these programs on Line 7 as uninsured, unless they have insurance.
9D	The health center's usual charges for each service are charged directly to patients (reported on Line 13, Column A). If patients pay any co-payment, report it in Column B. If they are responsible for a co-payment but do not pay it, it remains a receivable until it is collected or is written off as bad debt in Column F. Report the rest of the charge (or all the charge if there is no required co-payment) as a sliding fee discount in Column E.
9E	Report the total amount received during the calendar year from the state or local indigent care program on Line 6a.

Workers' Compensation

Workers' compensation is a form of liability insurance for employers and not health insurance for employees.

Tables Affected	Treatment
4	If workers' compensation covers a patient's bills, the patient usually has related insurance. Report that on Table 4 (even if the health center is not billing the insurance). Patients with work-related insurance go on Line 11 (Private). Those without *any* health insurance go on Line 7 (Uninsured).
9D	Report charges, collections, and adjustments for workers' compensation-covered services on Line 10 (Private Non-Managed Care).

Tricare, Trigon, Public Employees Insurance, Etc.

Many government employees have insurance.

Tables Affected	Treatment
4	Report them on Line 11 (Private), *not on Line 10a.*
9D	Report charges, collections, and adjustments on Lines 10–12 (Private), *not on Lines 7–9.*

Contract Sites

Some health centers have included in their scope of service a site (such as a school, workplace, or jail) where they provide services to patients at a contracted flat rate per session or other similar rate *that is not based on the volume of work performed.* The agreement generally stipulates whether and under what circumstances the clinic may bill third parties.

Tables Affected	Treatment
4	Lines 1–6, Income: Obtain information on income from patients. In prisons, assume that all are at 100 percent and below FPG (Line 1). In schools, income should be that of the parent(s) or "unknown." In the case of minor consent services, patients should be reported as below poverty. In the workplace, income is the patient's family income or, if not known, "unknown" (Line 5). Lines 7–12, Insurance: Record the form of medical insurance the patient has, regardless of the clinic's ability to bill that source. (Medicaid often covers children in school-based clinics even though they have another provider. Report these children as Medicaid patients.) The clinic's contracting agency is not an insurer. *Except for confidential minor consent services, it is not acceptable to report a student as uninsured*.
5	Count all visits as appropriate. Do not reduce or reclassify FTEs for travel time.
8A	Costs will generally be considered medical (Lines 1–3) unless other services (mental health, case management, etc.) are being provided. *Do not report on Line 12: Other Related Services.*
9D	*Unless the clinic charges a visit to a third party such as Medicaid*, report the clinic's usual and customary charges on Line 10, Column A (Private). Report the amount paid by the contractor in Column B. Report the difference (positive or negative) in Column D (Adjustments).
9E	Do not report contract revenue on Table 9E.

The Children's Health Insurance Program (CHIP)

CHIP provides health coverage to eligible children through Medicaid and separate CHIP programs. CHIP is administered by states, according to federal requirements. The program is funded jointly by states and the federal government.

Tables Affected	Treatment
4	Medicaid: If Medicaid handles CHIP and the enrolled patients are identifiable, report them on Line 8b. *If it is not possible to differentiate CHIP administered through Medicaid from Medicaid,* report the enrolled patients on Line 8a with all other Medicaid patients. Non-Medicaid: Report CHIP-enrolled patients in states that do not use Medicaid as "Other Public CHIP" on Line 10b. Do not report the enrollees on Line 11 (Private) even if a commercial insurance plan administers the program.
9D	Medicaid: Report on Lines 1–3, as appropriate. Non-Medicaid: Report on Lines 7–9 (Other Public), as appropriate. Do not report on Lines 10–12 (Private), even if a commercial insurance company administers the plan.

Carve-Outs

Relevant to capitated managed care only: The health center has a capitated contract with an HMO that stipulates that one set of CPT codes will be covered by the capitation, regardless of service frequency, and another set of codes (or all other codes) will be paid for by the HMO on a fee-for-service basis (the carve-outs) when appropriate. Most common carve-outs involve mental health, lab, radiology, and pharmacy, but may include specific specialty care or diagnoses (e.g., perinatal care or HIV).

Tables Affected	Treatment
4	Patient Member Months: Member months are reported on Line 13a in the appropriate column, regardless of whether the patient made use of services in any or all of those months. *Make no entry on Line 13b (fee-for-service managed care member months) for the carved-out services, regardless of payments received.*
9D	Lines 2a/b, 5a/b, 8a/b, 11a/b: Report capitation payments on the "a" lines and carve-out payments on the "b" lines. Report wraparound payments on both lines using the health center's allocation process.

Incarcerated Patients

Some health centers contract with jails or prisons to provide health services to inmates. These arrangements can vary in terms of the contractual arrangement and location for providing health services to patients.

Tables Affected	Treatment
4	Assume prisoner income is at or below 100 percent FPL (Line 1). Unless the institution has arranged for inmate Medicaid enrollment, assume that inmates are uninsured. Classify patients according to their primary health insurance carrier regardless of whether the services will be billed to the insurer. These patients are usually uninsured.
9D	The jail or prison pays for the patient's services. Report the clinic's usual and customary charge for the service on Line 10 (Private) if privately run or on Line 9 (Other Public) if a government entity in Column A and the payment in Column B. Because the payment will almost always be different from the charge, report the difference as an adjustment in Column D.
9E	Do not report the grant or contract on Table 9E. Report revenue fully on Table 9D.

HIT/EHR Staff and Costs

HIT, including EHR systems (some of which have integrated PMS), record clinical activities and help clinicians manage and integrate patient services. As such, they are part of a QI program, though some aspects count in other service categories.

Tables Affected	Treatment
5	Include staff who document services in the HIT/EHR or perform help desk, data entry, training, and technical assistance functions as part of the appropriate *service category* for which they perform these functions, not as IT staff or QI staff. Report staff members dedicating some or all of their time to design, operation, and oversight of QI systems; data specialists; statisticians; and HIT/EHR or medical form designers as QI staff on Line 29b. Report staff managing the hardware and software of a practice management billing and collection system as non-clinical support staff under IT, Line 30c.
8A	Report costs for staff who document services in the HIT/EHR or perform help desk, data entry, training, and technical assistance functions as part of the appropriate *service category* for which they perform these functions, not as IT staff or QI staff. Report costs associated with licenses, depreciation of the hardware and software, software support services, and annual fees for other aspects of the HIT/EHR on Line 3 (Other Medical). If the HIT/EHR covers dental and/or mental health, then you may logically allocate some of costs to these lines, as well. Report costs for staff noted above as being included in QI on Line 12a. Report costs for staff managing the hardware and software of a practice management billing and collection system as non-clinical support, Line 15.

Issuance of Vouchers for Payment of Services

Voucher programs have traditionally delivered primary and specialty care services to agricultural workers in geographically dispersed areas. Some homeless and other health center programs also use vouchers to outsource care they cannot provide in-house. This involves contracting with providers outside of the health center. Vouchers authorize a third-party provider to deliver the services, and the voucher goes to the health center for payment. Payment is generally less than the provider's full fee but consistent with other payers, such as Medicaid.

Tables Affected	Treatment
3A, 3B, 4	Count patients even if the only service they receive is a paid vouchered service *if* these services would make the patient eligible for inclusion if the center provided them. A vouchered taxi ride or prescription would *not* make the patient "countable" because health centers do not count transportation or pharmacy services on Table 5, but a vouchered eye exam would count.
5	Column A: There is no way to account for the time of the voucher providers. As a result, report 0 FTEs for these services. If there is a provider who works at the center, count the FTE of that provider. For example, count the one-day-a-week family practitioner as 0.20 FTEs on Line 1. Columns B and B2: Count all visits covered by voucher. DO NOT count visits where the referral is to a provider who is not paid in full for the service (e.g., a "voucher" to a doctor who donates five visits per week or one that pays a portion of the provider's fee with the rest being the patient's responsibility does NOT generate a visit on Table 5).
6A, 6B, 7	Diagnoses and Services: The voucher program should receive a bill from the provider, similar to a Health Care Financing Administration (HCFA)-1500, that lists the services and diagnoses. Health centers should track these and report them on Tables 6A, 6B, and 7.
8A	Cost of Vouchered Services: Report the costs on the appropriate service line(s). Report medical vouchers on Line 1, not Line 3. Report *only* those costs paid directly by the health center. Discounts: Virtually all clinical providers receive less than their full fee. Some health centers report the amount of these discounts as "donated services." *While this is not required,* health centers may report the difference between the voucher provider's full fee and the contracted voucher payment as a donated service on Line 18, Column C.
9D	Column A, Charges: Report the full charge that providers show on their HCFA-1500 on Line 13 (Self-Pay). Do not use the voucher amount as the full charge. Column B, Collections: If the patient paid the voucher program or the voucher provider a nominal or other fee, report this in Column B. Column E, Sliding Fee Discounts: Report the difference between the full charge and the amount that the patient was supposed to pay in Column E. Do not report the full amount in Column E if the patient should have paid the health center or voucher provider but did not. Column F, Bad Debt: Report any amount (such as a nominal fee) that the patient was supposed to pay to the health center but did not. Report bad debts according to the health center's financial policies. Do not report amounts that were due but not paid to the referral provider.

New Start or New Access Point (NAP)

Health center sites may be added in-scope at any point during the reporting period. NAP grants or designations may be added prior to October 1 during the reporting period. Health centers must submit data for the full calendar year, so health center sites or NAPs operational prior to the start of the Notice of Award must submit data on all tables with activity covering January 1 to December 31.

Tables Affected	Treatment
ZIP, 3A, 3B, 4	It is understood that a health center may have never collected some of the data required to be reported in the UDS prior to the start of Notice of Award, such as veteran status, gender identity, member months in managed care, etc. Provide the best data available, but for the first year *only,* you may have some unusual numbers. Work with your UDS Reviewer to explain apparent data inconsistencies.
6B, 7	When it comes to the clinical measures, you may need to use a sampling process instead of relying on your PMS or HIT/EHR. See Appendix C for details. If the added site or health center will transition to a new HIT/EHR during the year, gather the information for the year across the two systems and analyze them in a separate database to remove any duplication in the data.

Relationship Between Staff on Table 5 and Costs on Table 8A

Staff classifications should be consistent with cost classifications. The chart below illustrates the relationship between the two tables. The staffing on Table 5 is routinely compared to the costs on Table 8A during the review and analysis process. If there is a reason why such a comparison would look unusual (e.g., volunteers on Table 5 result in no cost on Table 8A or contractor costs on Table 8A with no corresponding FTEs on Table 5), include an explanation on Table 8A.

FTEs Reported on Table 5, Line:	Have Costs Reported on Table 8A, Line:
1–12: Medical Staff	1: Medical Staff
13–14: Medical Lab and X-ray	2: Medical Lab and X-ray
16–18: Dental	5: Dental
20a–20c: Mental Health	6: Mental Health
21: Substance Use Disorder	7: Substance Use Disorder
22: Other Professional	9: Other Professional
22a–22c: Vision	9a: Vision
23: Pharmacy	8a: Pharmacy
24–28: Enabling*	11a–11h: Enabling*
24: Case Managers	11a: Case Management
25: Patient and Community Education Specialists	11d: Patient and Community Education
26: Outreach Workers	11c: Outreach
27: Transportation Staff	11b: Transportation
27a: Eligibility Assistance Workers	11e: Eligibility Assistance
27b: Interpretation Staff	11f: Interpretation Services
27c: Community Health Workers	11h: Community Health Workers
28: Other Enabling Services	11g: Other Enabling Services
29a: Other Programs and Services	12: Other Program-Related Services
29b: Quality Improvement Staff	12a: Quality Improvement
30a–30c and 32: Non-Clinical Support Services	15: Non-Clinical Support Services
31: Facility Staff	14: Facility

* Note that the cost categories on Table 8A are not in the same sequential order as the staffing categories on Table 5.

Relationship Between Insurance on Table 4 and Revenue on Table 9D

Revenue sources are generally aligned with patient insurance. The chart below illustrates the relationship between the two tables. The insurance on Table 4 is routinely compared to the revenue on Table 9D during the review and analysis process. If there is a reason why such a comparison would look unusual (e.g., large change in insurance coverage), include an explanation on Table 9D.

Principal Third-Party Medical Insurance on Table 4, Line:	Have Revenue Reported on Table 9D, Line:
7: Uninsured—No medical insurance at last visit (includes patients whose service is reimbursed through grant, contract, or uncompensated care fund)	13: Self-Pay—Include co-pays and deductibles, state and local indigent care programs *(does not include revenues from programs with limited benefits; See Other Public, Lines 7-9)*
8a and 8b: Medicaid and Medicaid CHIP (includes Medicaid managed care programs and all forms of state-expanded Medicaid)	1–3: Medicaid (includes Medicaid expansion)
9a and 9: Dually eligible and Medicare	4–6: Medicare
10a: Other Public non-CHIP—State and local government insurance that covers primary care	7–9: Other Public—Include patient revenue from programs with limited benefits, such as family planning (Title X), EPSDT, BCCCP, etc.
10b: Other Public CHIP (commercial carrier outside Medicaid)	7–9: Other Public
11: Private—Commercial insurance, including insurance purchased from state or federal exchanges *(does not include workers' compensation)*	10–12: Private—Charges and collections from contracts with commercial carriers, private schools, private jails, Head Start, tribes, and workers' compensation and state and federal exchanges
13a: Capitated managed care enrollees	"a" lines
13b: Fee-for-service managed care enrollees	"b" lines

Relationship Between Prenatal Care on Table 6B and Deliveries on Table 7

The chart below illustrates the relationship and accounting of prenatal care patients and the delivery outcomes to be reported on Tables 6B and 7. A "Yes" indicates that the information is to be reported in the specified table and section; a "No" indicates the information is not to be reported. The prenatal care patients on Table 6B are routinely compared to the deliveries and birth outcomes on Table 7 during the review and analysis process. If there is a reason why such a comparison would look unusual, include an explanation on the appropriate table.

Prenatal Patient and Delivery Outcome Scenarios	Table 6B, Lines 1-9 (Age and Trimester of Entry)	Table 7, Column 1a (Women who Delivered)	Table 7, Columns 1b–1d (Birth Outcomes—report each baby separately)
Women still in prenatal care	Yes	No	No
Birth outcomes known	Yes	Yes	Yes
Women known to have delivered, but no birth outcomes	Yes	Yes	No
Women who miscarried	Yes	No	No
Still birth outcome	Yes	Yes	No
Women lost to follow-up	Yes	No	No

Relationship Between Race and Ethnicity on Tables 3B and 7

The patient population for each clinical measure on Table 7 is defined in terms of race and ethnicity, and comparisons are made to the race and ethnicity numbers reported on Table 3B. The following table illustrates the crosswalk between the comparable fields across the two tables.

Race	Ethnicity	Table 3B Reference	Table 7 Reference
Asian	Hispanic or Latino/a	Line 1, Column A	Line 1a
	Non-Hispanic or Latino/a	Line 1, Column B	Line 2a
Native Hawaiian	Hispanic or Latino/a	Line 2a, Column A	Line 1b1
	Non-Hispanic or Latino/a	Line 2a, Column B	Line 2b1
Other Pacific Islander	Hispanic or Latino/a	Line 2b, Column A	Line 1b2
	Non-Hispanic or Latino/a	Line 2b, Column B	Line 2b2
Black/African American	Hispanic or Latino/a	Line 3, Column A	Line 1c
	Non-Hispanic or Latino/a	Line 3, Column B	Line 2c
American Indian/Alaska Native	Hispanic or Latino/a	Line 4, Column A	Line 1d
	Non-Hispanic or Latino/a	Line 4, Column B	Line 2d
White	Hispanic or Latino/a	Line 5, Column A	Line 1e
	Non-Hispanic or Latino/a	Line 5, Column B	Line 2e
More than Once Race	Hispanic or Latino/a	Line 6, Column A	Line 1f
	Non-Hispanic or Latino/a	Line 6, Column B	Line 2f
Unreported/Refused to Report Race	Hispanic or Latino/a	Line 7, Column A	Line 1g
	Non-Hispanic or Latino/a	Line 7, Column B	Line 2g
Unreported/Refused to Report Race	Unreported/Refused to Report Ethnicity	Line 7, Column C	Line h

Appendix C: Sampling Methodology for Manual Chart Reviews

Introduction

For each measure discussed on Tables 6B and 7 (except the perinatal measures), health centers have the option of reporting on their entire patient population as a universe or selecting a scientifically drawn random sample. While this is an option, health centers using a sample for any CQM will be ineligible for HRSA's Quality Improvement Awards. Similarly, while a reduced universe containing a minimum of 80 percent of all medical (or dental for the sealants measure) patients from all service delivery sites and grant-funded programs in the defined universe is permitted, full EHR or HIT system reporting is preferred.

***Note:** Data source must cover the review period (e.g., 5 years for Pap tests, 2 years for immunizations) and include information to assess meeting the standard with the clinical measure, as well as to evaluate exclusions.*

If you can meet all conditions, reporting on the universe—even a reduced universe—generally provides access to pre-programmed tools, which can facilitate reporting. You may only use a reduced universe if the factors that required its use are unrelated to the measure variables (see instructions for Tables 6B and 7). This is not a sample, and the methods discussed here are not relevant to these situations.

If the health center cannot report on at least 80 percent of the universe (or chooses not to use its HIT/EHR), a random sample must be used to report.

Random Sample

A random sample is a part of the universe where each member of the universe has the exact same chance of inclusion as every other member.

A true random sample generates outcomes similar to those of the universe of patients because the sample is representative.

Step-by-Step Process for Reporting Clinical Measures Using a Random Sample

Perform the following steps for each sample. Create a new random sample for each measure.

Step 1: Identify the Patient Population to Be Sampled (the Universe)

Define the universe for the measure. The universe must include:

- all active (measurement year) medical patients,
- all sites in the scope of the project,
- all funding streams, and
- any and all contracted medical services.

Identify the number of patients who fit, or who initially appear to fit, the criteria for that measure. Because you will review each record in the sample, you can remove any that was mistakenly included. Create a list and number each member of the patient population in the universe. The list may be in any sequence because randomization will remove any order bias.

Step 2: Prepare the Correct Sample Size

BPHC mandates a sample size of 70.

Step 3: Select the Random Sample

Using one of two recommended sampling methodologies (see below), identify the sample of 70 charts.

Step 4: Review the Sample of Records to Determine Whether Each Record Has Met the Standard for the Clinical Measure

For each measure, review available data sources to identify any automated sources to simplify data collection. Because health centers augment the automated data fields (if any) for these sources with text and scanned documents, they do not need to be available for all patients. Examples of data sources include:

- EHRs
- disease-specific (PC-DMIS, PECs, i2i-track, etc.) databases
- state immunization registries for vaccine histories
- logs
- PMS

For each patient in the sample, determine whether sufficient information is available in these alternative resources to meet the standard. If you cannot meet the standard using the alternative source, review text and scanned information to retrieve required information. For example, consider a woman's chart that shows she is an active medical patient but does not show the CPT or ICD-10-CM code for a Pap test. Review scanned documents to see if there is a copy of a Pap test done by another agency in the record.

Step 5: Replace Patients You Exclude from the Sample

Best practices would dictate that the methodology used to select the sample (or the universe) should be able to test for each required criterion. Some criteria (such as the age of the patient) are easily implemented. Others, such as whether a woman has ever had a hysterectomy, may not be available. When you cannot use criteria to include patients in the universe, you may use them to exclude patients from a sample. If you determine that a record does not meet the standard criteria, remove the case (record). If the review is of a sample of records, then select another record to replace the original.

Replace an excluded record with a substitute. Use the replacement methodology described for the sample selected. Any criteria that was missed in selecting a record (e.g., not noting that the woman had a hysterectomy) may be used to exclude a record.

Methodology for Obtaining a Random Sample

You may use either of the two approved methods for generating a random sample and a sample of replacements for excluded patients:

- Work with a list of random numbers generated for your total patient population.
- Select a random starting point and use a calculated interval to find each next member of the sample.

Use either method to create a "replacement list" to replace records that were excluded during the review process.

Option #1: Random Number List

The preferred method for selecting a random sample is to use a random number list. You can create an individualized list of random numbers at the Randomizer website. The website requires no password or subscription. To obtain a list of random numbers, complete the questions documented below.

Identifying an Initial List

1. Request one list of 70 numbers.
2. Complete the "Number Range" by entering 1 as the first number and the total number of patients in the universe for the particular measure under consideration as "n." For example, if there are 628 children who turn 2 years old in the reporting year in the universe, enter 628 as "n."

3. Click on the button, "Randomize Now!" The site will produce a list of randomly generated numbers. These numbers correspond with the numbered list of patients in the universe prepared in Step 1 above. It is helpful to ask the site to sort the selected random numbers from lowest to highest.

Identifying a Replacement

To create a sample of records to substitute for excluded records, follow the instructions for creating a list of random numbers for a replacement sample. Rather than selecting 70 numbers for the set, select a smaller sample of 5 to 10 charts. In this instance, do not sort the list because doing so will bias the replacement sample toward the lower numbers on the list.

If, upon review, you must exclude a record from the original random sample of 70, replace it with one from the replacement sample. Because of the need to replace ineligible charts, you may have to exclude more than 70 records to meet the standard for a particular measure, but the final sample will include 70 records that meet all the selection criteria.

Alternatively, for example, you can draw a sample of 80 patients and use the first 70. If you must replace one, use the 71st, then the 72nd, and so on. In this instance, do not request a sorted list because it will have a bias toward lower numbers.

Input	Initial Sample	Replacements
Set of numbers	1	1
Number per set	70	At least 5 or more if needed
Number range = 1–n	Last number in sequence	Last sequence number in list
Unique numbers	Yes	Yes
Sort numbers	Yes, least to greatest	No

Option #2: Interval

Identifying an Initial List

Sample interval (SI) size equals population size (number in universe) divided by sample size (70).

The second method uses the same numbered list of records in the universe created in Step 1 (Identify the Patient Population to be Sampled [the Universe]). To generate the sample:

1. Calculate the SI by dividing the number of records in the universe by 70.
2. Randomly pick a record from the first SI. For example, if the SI is 10, the first SI includes charts number 1 through number 10. Randomly select one record from this interval to use as your first record.
3. Then, select every nth record where n is the SI until you reach the desired sample size. In our example, if the first patient selected is number 8, and the SI is 10, then the remaining patients to be selected are numbers 18, 28, 38, and so on.

   First sequence # plus SI equals second #.

4. Continue through the list until you have identified all 70.

Example		Sample interval (SI) = 3
Record #	Account #	
1	951456	**First record** = #2 *Selected at random between 1 and 3*
2	234951	
3	492374	
4	157614	
5	736812	**Next record** = #5 (2+3)
6	453764	
7	416145	
8	801784	**Next record** = #8 (5+3)
9	481454	
10	487151	
11	158124	**Next record** = #11 (8+3)
12	625182	
13	789415	
14	781763	**Next record** = #14 (11+3)
15	745405	

Identifying a Replacement

If a selected record needs to be excluded from the sample, return to the original list and substitute the next record on the list after the excluded record. If the replacement record must be excluded, select the record after that on the list until an eligible record is selected. Resume selection using the next chart you had pre-selected for the sample. If you run out of records on the list, continue your count back at the beginning of the universe. In this manner, more than 70 records may be evaluated for meeting the standard for a particular measure, but 70 records that meet all the selection criteria should be included in the final sample.

Appendix D: Health Center Health Information Technology (HIT) Capabilities

Instructions

The HIT Capabilities Form includes a series of questions on HIT capabilities, including EHR interoperability and eligibility for CMS Promoting Interoperability programs. The HIT Form must be completed and submitted as part of the UDS submission. The form includes questions about the health center's implementation of an EHR, certification of systems, and how widely adopted the system is throughout the health center and its providers.

Questions

The following questions appear in the EHBs. Complete them before you file the UDS Report. Instructions for the HIT questions are on-screen in the EHBs as you complete the form. Respond to each question based on your health center status *as of December 31*.

1. Does your center currently have an electronic health record (EHR) system installed and in use?
    a. Yes, installed at all sites and used by all providers
    b. Yes, but only installed at some sites or used by some providers
    c. No

If the health center installed it, indicate if it was in use by December 31 by indicating:

a. **Installed at all sites and used by all providers:** For the purposes of this response, "providers" mean all medical providers, including physicians, nurse practitioners, physician assistants, and certified nurse midwives. Although some or all of the dental, mental health, or other providers may also be using the system, as may medical support staff, this is not required to choose response (a). For the purposes of this response, "all sites" means all permanent sites where medical providers serve health center medical patients. It does not include administrative-only locations, hospitals or nursing homes, mobile vans, or sites used on a seasonal or temporary basis. You may check this option if a few newly hired, untrained employees are the only ones not using the system.

b. **Installed at some sites or used by some providers:** Select option (b) if one or more permanent sites did not have the EHR installed or in use (even if this is planned), or if one or more medical providers (as defined on this page under [a]) do not yet use the system. When determining if all providers have access to the system, the health center should also consider part-time and locum providers who serve clinic patients. Do not select this option if the only medical providers who did not have access were those who were newly hired and still being trained on the system.

c. **Select "no" if no EHR** was in use on December 31, even if you had the system installed and training had started.

This question seeks to determine whether the health center installed an EHR by December 31 and, if so, which product was in use, how broad system access was, and what features were available and in use. Do not include PMS or other billing systems, even though they can often produce much of the UDS data. If the health center purchased an EHR but has not yet put it into use, answer "no."

If a system is in use (i.e., if [a] or [b] has been selected), indicate that it has been certified by the Office of the National Coordinator—Authorized Testing and Certification Bodies.

1a. Is your system certified by the Office of the National Coordinator for Health IT (ONC) Health IT Certification Program?

a. Yes

b. No

Health centers are to indicate the vendor, product name, version number, and ONC-certified health IT product list number. (More information is available at https://chpl.healthit.gov/#/search.) If you have more than one EHR (if, for example, you acquired another practice with its own EHR), report the EHR that will be the successor system or the EHR used for capturing primary medical care.

1a1. Vendor

1a2. Product Name

1a3. Version Number

1a4. ONC-certified Health IT Product List Number

1b. Did you switch to your current EHR from a previous system this year?

a. Yes

b. No

If "yes, but only at some sites or for some providers" is selected, a box expands for health centers to identify how many sites have the EHR in use and how many (medical) providers are using it. Please enter the number of sites (as defined under question 1) where the EHR is in use and the number of providers who use the system (at all sites). Include part-time and locum medical providers who serve clinic patients. Count a provider who has separate login identities at more than one site as just one provider.

1c. Do you use more than one EHR or data system across your organization?

a. Yes

b. No

1c1. If yes, what is the reason?

a. Second EHR/data system is used during transition to primary EHR

b. Second EHR/data system is specific to one service type (e.g., dental, behavioral health)

c. Second EHR/data system is used at specific sites with no plan to transition

d. Other (please describe ______)

1d. Is your EHR up to date with the latest software and system patches?

1e. When do you plan to update/install the latest EHR software and system patches?

2. Question removed.
3. Question removed.
4. Which of the following key providers/health care settings does your center electronically exchange clinical information with? (Select all that apply.)
   a. Hospitals/Emergency rooms
   b. Specialty clinicians
   c. Other primary care providers
   d. Labs or imaging
   e. Health information exchange (HIE)
   f. None of the above
   g. Other (please describe ______)
5. Does your center engage patients through health IT in any of the following ways? (Select all that apply.)
   a. Patient portals
   b. Kiosks
   c. Secure messaging

   d. Other (please describe _______)
   e. No, we do not engage patients using HIT

6. Question removed.
7. How do you collect data for UDS clinical reporting (Tables 6B and 7)?
   a. We use the EHR to extract automated reports
   b. We use the EHR but only to access individual patient charts
   c. We use the EHR in combination with another data analytic system
   d. We do not use the EHR
8. Question removed.
9. Question removed.
10. How does your health center utilize HIT and EHR data beyond direct patient care? (Select all that apply.)
    a. Quality improvement
    b. Population health management
    c. Program evaluation
    d. Research
    e. Other (please describe ______)
    f. We do not utilize HIT or EHR data beyond direct patient care
11. Does your health center collect data on individual patients' social risk factors, outside of the data reportable in the UDS?
    a. Yes
    b. No, but we are in planning stages to collect this information
    c. No, we are not planning to collect this information
12. Which standardized screener(s) for social risk factors, if any, do you use? (Select all that apply.)
    a. Accountable Health Communities Screening Tools
    b. Upstream Risks Screening Tool and Guide
    c. iHELLP
    d. Recommend Social and Behavioral Domains for EHRs
    e. Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)
    f. Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education (WE CARE)
    g. WellRx
    h. Health Leads Screening Toolkit
    i. Other (please describe __________)
    j. We do not use a standardized screener

12a. Please provide the total number of patients that screened positive for the following:
    a. Food insecurity ___________
    b. Housing insecurity ___________
    c. Financial strain ___________
    d. Lack of transportation/access to public transportation ___________

12b. If you do not use a standardized assessment to collect this information, please indicate why. (Select all that apply.)

a. Have not considered/unfamiliar with assessments

b. Lack of funding for addressing these unmet social needs of patients

c. Lack of training for staff to discuss these issues with patients

d. Inability to include with patient intake and clinical workflow

e. Not needed

f. Other (please describe ___________)

13. Does your center integrate a statewide Prescription Drug Monitoring Program (PDMP) database into the health information systems, such as health information exchanges, EHRs, and/or pharmacy dispensing software (PDS) to streamline provider access to controlled substance prescriptions?

a. Yes

b. No

c. Not sure

Appendix E: Other Data Elements

Instructions

Health centers are becoming increasingly diverse and comprehensive in the care and services they provide. These questions capture the changing landscape of health care centers to include expanded services and delivery systems.

Questions

Report on these data elements as part of your UDS submission. Topics include medication-assisted treatment (MAT), telehealth, and outreach and enrollment assistance. Respond to each question based on your health center status *as of December 31*.

1. Medication-Assisted Treatment (MAT) for Opioid Use Disorder
   a. How many physicians, certified nurse practitioners, physician assistants, and certified nurse midwives,[18] on-site or with whom the health center has contracts, have obtained a Drug Addiction Treatment Act of 2000 (DATA) waiver to treat opioid use disorder with medications specifically approved by the U.S. Food and Drug Administration (FDA) for that indication?
   b. How many patients received MAT for opioid use disorder from a physician, certified nurse practitioner, or physician assistant, with a DATA waiver working on behalf of the health center?

2. Did your organization use telemedicine to provide remote clinical care services?

   (The term "telehealth" includes "telemedicine" services but encompasses a broader scope of remote health care services. Telemedicine is specific to remote clinical services, whereas telehealth may include remote non-clinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services.)

   a. Yes

   2a1. Who did you use telemedicine to communicate with? (Select all that apply.)
   a. Patients at remote locations from your organization (e.g., home telehealth, satellite locations)
   b. Specialists outside your organization (e.g., specialists at referral centers)

   2a2. What telehealth technologies did you use? (Select all that apply.)
   a. Real-time telehealth (e.g., live videoconferencing)
   b. Store-and-forward telehealth (e.g., secure e-mail with photos or videos of patient examinations)
   c. Remote patient monitoring
   d. Mobile Health (mHealth)

[18] With the enactment of the Comprehensive Addiction and Recovery Act of 2016, PL 114-198, opioid treatment prescribing privileges have been extended beyond physicians to include certain qualifying nurse practitioners (NPs), physician assistants (PAs), and certified nurse midwives (CNMs).

2a3. What primary telemedicine services were used at your organization? (Select all that apply.)

a. Primary care

b. Oral health

c. Behavioral health: Mental health

d. Behavioral health: Substance use disorder

e. Dermatology

f. Chronic conditions

g. Disaster management

h. Consumer health education

i. Provider-to-provider consultation

j. Radiology

k. Nutrition and dietary counseling

l. Other (Please specify: ________________)

b. **No.** If you did not have telemedicine services, please comment why. (Select all that apply.)

a. Have not considered/unfamiliar with telehealth service options

b. Policy barriers (Select all that apply)

i. Lack of or limited reimbursement

ii. Credentialing, licensing, or privileging

iii. Privacy and security

iv. Other (Please specify: __________________)

c. Inadequate broadband/ telecommunication service (Select all that apply)

i. Cost of service

ii. Lack of infrastructure

iii. Other (Please specify: __________________)

d. Lack of funding for telehealth equipment

e. Lack of training for telehealth services

f. Not needed

g. Other (Please specify: __________________)

3. Provide the number of all assists provided during the past year by all trained assisters (e.g., certified application counselor or equivalent) working on behalf of the health center (employees, contractors, or volunteers), regardless of the funding source that is supporting the assisters' activities. Outreach and enrollment assists are defined as customizable education sessions about affordable health insurance coverage options (one-on-one or small group) and any other assistance provided by a health center assister to facilitate enrollment.

Enter number of assists _______________

Note: *Assists do not count as visits on the UDS tables.*

4. How many patients received a FDA-approved COVID-19 vaccine during the calendar year at your organization? _______

Note: *Exclude vaccines administered to health center patients while participating in clinical trials.*

Appendix F: Workforce

Instructions

It is important to understand the current state of health center workforce training and different staffing models to better support recruitment and retention of health center professionals. This section includes a series of questions on health center workforce.

Questions

Report on these data elements as part of your UDS submission. Topics include health professional education/training (do not include continuing education units) and satisfaction surveys. Respond to each question based on your health center status *as of December 31*.

1. Does your health center provide health professional education/training that is a hands-on, practical, or clinical experience?
   a. Yes
   b. No

1a. If yes, which category best describes your health center's role in the health professional education/training process? (Select all that apply.)
   a. Sponsor[19]
   b. Training site partner[20]
   c. Other (please describe ________________)

2. Please indicate the range of health professional education/training offered at your health center and how many individuals you have trained in each category[21] within the reporting year.

	a. Pre-Graduate/Certificate	b. Post-Graduate Training
Medical		
1. Physicians		
a. Family Physicians		
b. General Practitioners		
c. Internists		
d. Obstetrician/Gynecologists		
e. Pediatricians		
f. Other Specialty Physicians		
2. Nurse Practitioners		
3. Physician Assistants		
4. Certified Nurse Midwives		
5. Registered Nurses		
6. Licensed Practical Nurses/ Vocational Nurses		
7. Medical Assistants		

[19] A sponsor hosts a comprehensive health profession education and/or training program, the implementation of which may require partnerships with other entities that deliver focused, time-limited education and/or training (e.g., a teaching health center with a family medicine residency program).
[20] A training site partner delivers focused, time-limited education and/or training to learners in support of a comprehensive curriculum hosted by another health profession education provider (e.g., month-long primary care dentistry experience for dental students).
[21] Examples of pre-graduate/certificate training include student clinical rotations or externships. A residency, fellowship, or practicum would be examples of post-graduate training. Include non-health-center individuals trained by your health center.

	a. Pre-Graduate/Certificate	b. Post-Graduate Training
Dental		
8. Dentists		
9. Dental Hygienists		
10. Dental Therapists		
10a. Dental Assistants		
Mental Health and Substance Use Disorder		
11. Psychiatrists		
12. Clinical Psychologists		
13. Clinical Social Workers		
14. Professional Counselors		
15. Marriage and Family Therapists		
16. Psychiatric Nurse Specialists		
17. Mental Health Nurse Practitioners		
18. Mental Health Physician Assistants		
19. Substance Use Disorder Personnel		
Vision		
20. Ophthalmologists		
21. Optometrists		
Other Professionals		
22. Chiropractors		
23. Dieticians/Nutritionists		
24. Pharmacists		
25. Other (please specify ________)		

3. Provide the number of health center staff serving as preceptors at your health center: ____
4. Provide the number of health center staff (non-preceptors) supporting ongoing health center training programs: ____
5. How often does your health center implement satisfaction surveys for providers? (Select one.)
   a. Monthly
   b. Quarterly
   c. Annually
   d. We do not currently conduct provider satisfaction surveys
   e. Other (please describe _________)

6. How often does your health center implement satisfaction surveys for general staff (report provider surveys in question 5 only)? (Select one.)
    a. Monthly
    b. Quarterly
    c. Annually
    d. We do not currently conduct staff satisfaction surveys
    e. Other (please describe __________)

Appendix G: Health Center Resources

Several resources are available to assist health centers with UDS reporting or EHBs system questions:

Description	Contact	E-mail	Phone
UDS reporting questions	UDS Support Center	UDS Support Center or udshelp330@bphcdata.net	866-837-4357 (866-UDS-HELP)
EHBs account and user access questions	HRSA Call Center	HRSA Call Center	877-464-4772 Option 3
EHBs electronic reporting issues	HRSA Call Center	HRSA Call Center	877-464-4772 Option 1

Other data and resource links, including this manual, a complete set of the UDS tables (note that the table view within EHBs may look different but contains the same fields), notifications of changes to reporting criteria, training opportunities, and other reporting materials and guidance can be found on the BPHC website, UDS Training Website, HRSA Digest, or UDS Modernization Initiative page.

Strategic partnerships, including health center-controlled networks, national cooperative agreements, primary care associations, and primary care offices can be found on the BPHC Quality Improvement website.

Resources are available to assist health centers serving special populations with meeting performance requirements and training needs:

Organization	Website	Contact and E-mail	Phone
National Association of Community Health Centers (NACHC)	http://www.nachc.org	Cindy Thomas cthomas@nachc.com	301-347-0400

PHPC Program

Organization	Website	Contact and E-mail	Phone
National Nurse-Led Care Consortium (NNCC)	http://nurseledcare.org/	Kristine Gonnella kgonnella@nncc.us	215-503-7556
National Center for Health in Public Housing (NCHPH)	http://www.nchph.org	Jose Leon info@nchph.org	703-812-8822

MHC Program

Organization	Website	Contact and E-mail	Phone
Migrant Clinicians Network (MCN)	http://www.migrantclinician.org	Theressa Lyons tlyons@migrantclinician.org	512-579-4511
National Center for Farmworker Health (NCFH)	http://www.ncfh.org	Sylvia Partida partida@ncfh.org	512-312-5457

HCH Program

Organization	Website	Contact and E-mail	Phone
National Health Care for the Homeless Council (NHCHC)	http://www.nhchc.org	Dr. Alaina Boyer aboyer@nhchc.org	615-226-2292
Corporation for Supportive Housing (CSH)	http://www.csh.org	Colleen Velez colleen.velez@csh.org	609-802-5765

Other Vulnerable Populations

Organization	Website	Contact and E-mail	Phone
Association of Asian Pacific Community Health Organizations (AAPCHO)	http://www.aapcho.org	Joe Lee joelee@aapcho.org	510-909-9299
National LGBT Health Education Center	http://www.lgbthealtheducation.org	Alex Keuroghlian lgbthealtheducation@fenwayhealth.org	617-927-6354
National Center for Medical-Legal Partnership	http://www.medical-legalpartnership.org	Ellen Lawton ellawton@gwu.edu	617-549-1733
Health Information and Technology, Evaluation, and Quality (HITEQ) Center	http://hiteqcenter.org/	Alyssa Carlisle hiteqinfo@jsi.com	844-305-7440

Oral Health

Organization	Website	Contact and E-mail	Phone
National Network for Oral Health Access	http://www.nnoha.org	Phillip Thompson executivedirector@nnoha.org	303-957-0635 x6

UDS Production Timeline and Report Availability

Health centers can access their current year and prior year UDS Reports, as well as several standard reports, through the EHBs web link.

- UDS Preliminary Reporting Environment: October–December 2020
- UDS annual data collection and reporting: January 1–February 15, 2021
- Deadline for submitting a complete UDS Report: February 15, 2021
- UDS reporting freeze: March 31, 2021
- Standard UDS Reports are available in EHBs, as shown below.
  - Release of UDS Rollup Reports, Awardee and Look-Alike Profiles, and Awardee Comparison Data Views will be available on the BPHC web pages in August 2020.
  - Service area data will be available on the UDS Mapper website in August 2020.

UDS Report Level	Timing	Description	Awardee	Look-Alike
Finalized Health Center Tables and XML Data File	June	Provides health center with data for each of the 11 UDS tables, the HIT, Other Data Elements, and Workforce forms	HC	HC
Health Center Trend Report	July/August	Compares the health center's performance for key measures (in three categories: Access, Quality of Care/Health Outcomes, and Financial Cost/Viability) with national and state averages over a 3-year period	HC, S, N	HC, N
UDS Summary Report	July/August	Summarizes and analyzes the health center's current UDS data using measures across various tables of the UDS Report	HC, S, N	HC, N
UDS Rollup Report	July/August	Compiles annual data reported by health centers and provides summary data for patient demographics, socioeconomic characteristics, staffing, patient diagnoses and services rendered, quality of care, health outcomes and disparities, financial costs, and revenues	S, N	N
Performance Comparison Report	September	Summarizes and analyzes the health center's latest UDS data, giving details at awardee, state, national, urban, and rural levels with trend comparisons and percentiles	Includes all levels	Includes all levels

Abbreviations indicate geographies and detail level for which each report is available.

HC=Health Center, S=State, N=National

UDS CQMs and National Programs Crosswalk

The following table crosswalks the UDS CQMs and other national programs using these measures. Specification details are available at the eCQI Resource Center. Use the Office of National Coordinator Issue Tracking System to report issues or ask questions about eCQM specifications.

ID	Measure Title	Measure Steward	CMS eCQM	NQF #	CMS Medicaid Core Set	Healthy People 2020	MIPS/ QPP
Table 6B, Line 7	**Early Entry to Prenatal Care**	n/a	n/a	n/a	n/a	MICH-10.1	No
Table 6B, Line 10	**Childhood Immunization Status**	National Committee for Quality Assurance	CMS117v8	38	Child Core	n/a	Yes
Table 6B, Line 11	**Cervical Cancer Screening**	National Committee for Quality Assurance	CMS124v8	32	Adult Core	C-15	Yes
Table 6B, Line 11a	**Breast Cancer Screening**	National Committee for Quality Assurance	CMS125v8	2372	Adult Core	C-17	Yes
Table 6B, Line 12	**Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents**	National Committee for Quality Assurance	CMS155v8	24	Child Core	n/a	Yes
Table 6B, Line 13	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan**	Centers for Medicare & Medicaid Services	CMS69v8	421e	n/a	n/a	Yes
Table 6B, Line 14a	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**	Physician Consortium for Performance Improvement	CMS138v8	28e	Adult Core	n/a	Yes
Table 6B, Line 17a	**Statin Therapy for the Prevention and Treatment of Cardiovascular Disease**	Centers for Medicare & Medicaid Services	CMS347v3	n/a	n/a	n/a	Yes
Table 6B, Line 18	**Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet**	National Committee for Quality Assurance	CMS164v7 (no updated eCQM)[22]	68	n/a	n/a	Yes

[22] Requires a free user login to the USHIK to access measure details.

ID	Measure Title	Measure Steward	CMS eCQM	NQF #	CMS Medicaid Core Set	Healthy People 2020	MIPS/ QPP
Table 6B, Line 19	**Colorectal Cancer Screening**	National Committee for Quality Assurance	CMS130v8	34	n/a	C-16	Yes
Table 6B, Line 20	**HIV Linkage to Care**	n/a	n/a	n/a	n/a	HIV-19	No
Table 6B, Line 20a	**HIV Screening**	Centers for Disease Control and Prevention	CMS349v2	n/a	n/a	HIV-13	Yes
Table 6B, Line 21	**Preventive Care and Screening: Screening for Depression and Follow-Up Plan**	Centers for Medicare & Medicaid Services	CMS2v9	418e	Adult Core	n/a	Yes
Table 6B, Line 21a	**Depression Remission at Twelve Months**	Minnesota Community Measurement	CMS159v8	710e	n/a	n/a	Yes
Table 6B, Line 22	**Dental Sealants for Children between 6–9 Years**	Dental Quality Alliance - American Dental Association	CMS277 (draft)[23]	2508 (claims-based measure)	Child Core	OH-12.2	No
Table 7, Section A	**Low Birth Weight**	Centers for Disease Control and Prevention	n/a	1382	n/a	MICH-8.1	No
Table 7, Section B	**Controlling High Blood Pressure**	National Committee for Quality Assurance	CMS165v8	18	Adult Core	HDS-12	Yes
Table 7, Section C	**Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)**	National Committee for Quality Assurance	CMS122v8	59	Adult Core	D-5.1	Yes

Notes: *n/a = Not applicable, NQF = National Quality Forum, MIPS = Merit-based Incentive Payment System, QPP = Quality Payment Program*

[23] Requires a free user login to the USHIK to access measure details.

Appendix H: Glossary

Accrual basis: Reported when the expense occurs, not when the cash is received.

Adjustment: A discount granted to a third-party payer as part of an agreement between the health center and the payer.

Aged and disabled former migratory agricultural workers: As defined in section 330 (g)(1)(B), individuals who have previously been migratory agricultural workers but who no longer work in agriculture because of age or disability.

Bad debt: Amounts billed to and defaulted by a patient responsible for payment.

Capitation: An agreed-upon amount that a managed care payer pays to the provider (health center) for providing all of the services in an agreed-upon list. The payer/HMO pays the health center a set amount monthly, regardless of whether any services were rendered during the month.

Cash basis: Reported when the cash is received or expended, not when an obligation occurs.

CHIP: The Children's Health Insurance Program (CHIP) Reauthorization Act provides primary health care coverage for children and, on a state-by-state basis, others, especially pregnant women, mothers, or parents of these children. CHIP coverage can be provided through the state's Medicaid program and/or through contracts with private insurance plans.

Contract staff: People who work under contract at the health center, as opposed to being on salary. They may or may not work regular assigned hours and may or may not receive benefits. They do not have withholding taxes deducted from their paychecks, and they have their income reported to the Internal Revenue Service (IRS) on a 1099 form.

Denominator (universe): As used in clinical measure reporting, patients who fit the detailed criteria described for inclusion in the specific measure to be evaluated.

Draw down: A formal request for HRSA to release and transmit to the awardee a portion of money awarded to them in their grant.

Dually eligible: Describes a patient enrolled in both Medicare and Medicaid, with Medicare being the primary insurance.

Electronic health record (EHR): A digital record of a patient's status and interactions with a health center, including real-time, patient-centered information available quickly and securely to authorized users.

Exclusions or exceptions: As used in clinical measure reporting, patients not to be considered or included in the denominator (exclusions) or removed if identified (exceptions).

Federal poverty guidelines: An annual statement of the amount of income below which an individual or family of different sizes is considered to be in poverty.

Fee-for-service: Charges that are billed to a third-party payer (or directly to a patient) that list each of the services provided using CPT codes and the charge associated with each of these services.

Fee schedule: A listing of fixed fees for goods or services.

First trimester (prenatal care): Women who were estimated to be pregnant up through the end of the 13th week after the first day of their last menstrual period.

Full-time equivalent (FTE): One person who works full-time for the year. Fractions of an FTE are used to identify part-time or part-year individuals, and multiples of an FTE are used to identify multiple individuals.

Full-time staff: People generally employed 40 hours per week, but subject to organizational definitions. Full-time staff generally receive benefits, have withholding taxes deducted from their paychecks, and have their income reported to the IRS on a W-2 form. Staff may or may not have a contract. Staff are full-time when they are so defined in their contract and/or when their benefits reflect this status.

Gender identity: A person's internal sense of their gender as a male, female, a combination of male and female, or another gender. This may or may not align with one's sex assigned at birth.

Gross charges: The full, undiscounted cost of a product or a service.

Hispanic or Latino/a: Describes persons of specific Spanish or Latino/a heritage, lineage, descent, or country of birth.

Homeless: Describes a person who lacks housing (without regard to whether the individual is a member of a family), including individuals whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and individuals who reside in transitional housing. May include children and youth at risk of homelessness, homeless veterans, and veterans at risk of homelessness.

Income: Earnings over a given period of time used to support an individual or household unit based on a set of criteria of inclusions and exclusions. Income is distinguished from assets, as assets are a fixed economic resource, whereas income comprises earnings.

Indigent care programs: State or local programs that pay in whole or in part for services rendered to people who are uninsured. Indigent care programs include 638 compact programs for tribal groups.

Last party rule: Reporting of grant and contract funds based on the entity from which the health center received them, regardless of their original origin.

Locum tenens: People who work at the health center on an as-needed basis during a part-time absence of another provider and when the center is unable to hire a full- or part-time staff person until the position is filled. Locums are uniquely identifiable because they work for an agency and the center pays the agency rather than the individual. They do not receive benefits from the health center (although they may from the agency they work for) and generally are not covered by the health center's professional liability insurance.

Look-alike: A community-based health care provider that meets the requirements of the HRSA Health Center Program but does not receive Health Center Program section 330 funding.

Managed care: A system in which a premium is paid to an organization that contracts with a health center to provide a range of services to patients assigned to the health center.

Medicaid: Federal and state-run programs operating under the guidelines of Titles XIX and XXI (as appropriate) of the Social Security Act.

Medicaid expansion: A program that makes Medicaid available to more patients and that requires states to opt in to participate.

Medicare: Federal insurance program for the aged, blind, and disabled (Title XVIII of the Social Security Act).

Member month: One person enrolled in a managed care plan for one month.

Migratory agricultural workers: For the purposes of health centers receiving a Health Center Program award or designation under section 330(g) of the Public Health Service Act, individuals whose principal employment is in agriculture, who have been so employed within 24 months, and who establish for the purposes of such employment a temporary abode. This includes dependent family members of the individuals described above and individuals who are no longer employed in migratory or seasonal agriculture because of age or disability who are within such a catchment area.

National Health Service Corps (NHSC) assignees: Members of the NHSC assigned by the Corps to a health center. This includes members of the NHSC Loan Repayment Program. These individuals are employees of the U.S. government.

Numerator: As used in clinical measure reporting, records (a subset of the denominator) that meet the measurement standard for the specified measure.

Off-site contract providers: Providers who are contracted for the services who work at a location that is not an in-scope site as defined in a health center application.

On-call providers: Providers who fill in briefly when someone is absent but may stay for an extended period if the center is unable to hire a full- or part-time staff person for a position. Unlike locums, health centers pay on-call providers directly. They may or may not receive all the usual benefits or a salary and may or may not have payroll and income taxes withheld.

Part-time staff: People employed by the health center for fewer than 40 hours per week. They receive benefits consistent with their FTE, have withholding taxes deducted from their paychecks, and have their income reported to the IRS on a W-2 form. Part-time staff may or may not have a contract.

Part-year staff: Persons employed or contracted for full or part time for a specific period that may be once or recurring.

Patient: A person who has at least one reportable visit in one or more categories of services: medical, dental, mental health, substance use disorder, vision, other professional, or enabling.

Penalty/paybacks: Payments made by health centers to payers because of overpayments collected earlier or for over-utilization of the inpatient or specialty pool funds in managed care plans.

Performance measure: A quantifiable indicator used to evaluate how well the health center is achieving standards.

Prenatal care (first visit): The date a patient has a visit with a physician, NP, PA, or CNM who conducts a prenatal exam to initiate pregnancy-related health care.

Public housing: Public housing agency-developed, -owned, or -assisted low-income housing, including mixed finance projects but excluding housing units with no public housing agency support other than Section 8 housing vouchers.

Race: A physical or social categorization of a person, presumably based on inheritance.

Reclassify: Transfer of amounts due from one payer to another payer, including the patient.

Reconciliations: Lump-sum retroactive adjustments based on the filing of a cost report.

Residents/trainees: Individuals in training for a license or certification who provide services at the health center under the supervision of a more senior person. Many of these trainees (especially medical and dental residents) already have licenses.

Sex: The anatomical and physiological biology of a person assigned at birth.

School-based health center: A health center located on or near school grounds (including pre-school, kindergarten, and primary through secondary schools) that provides comprehensive preventive and primary health services.

Seasonal agricultural workers: For the purposes of health centers receiving a Health Center Program award or designation under section 330(g) of the Public Health Service Act, individuals whose principal employment is in agriculture on a seasonal basis and who do not meet the definition of a migratory agricultural worker.

Second trimester (prenatal care): Women who were pregnant and estimated to be between the start of the 14th week and the end of the 27th week after the first day of their last menstrual period.

Sexual orientation: How a person describes their emotional and sexual attraction to others as straight, lesbian or gay, bisexual, or another sexual orientation.

Sliding fee discount: A discount applied to the fee schedule that adjusts fees based on the patients' ability to pay based on their income.

Straight-line allocation: Allocating non-clinical support services costs based on the proportion of net costs (total costs excluding non-clinical support services and facility cost) that is attributable to (assigned to) each service category.

Third trimester (prenatal care): Women who were estimated to be pregnant for 28 weeks or longer after the first day of their last menstrual period.

Veteran: Persons who served in the active military, naval, or air service, which includes full-time service in the Air Force, Army, Coast Guard, Marines, Navy, or as a commissioned officer of the Public Health Service or National Oceanic and Atmospheric Administration. This also includes persons who served in the National Guard or Reserves on active duty status.

Visit: A documented contact between a patient and a licensed or credentialed provider who exercises their independent, professional judgment in the provision of services to the patient. (Virtual visits are allowable for each of the service categories).

Volunteers: People who work at the health center but are not paid for their work.

Wraparound payments: An amount equal to the difference between the usual payment and an agreed-upon flat fee, known as an FQHC or PPS rate.

Appendix I: Acronyms

- AAPCHO: Association of Asian Pacific Community Health Organizations
- ACO: accountable care organization
- ADA: American Dental Association
- ADHC: adult day health care
- AMA: American Medical Association
- AMI: acute myocardial infarction
- APN: advanced practice nurse
- ASCVD: atherosclerotic cardiovascular disease
- AWP: average wholesale price
- BCCCP: Breast and Cervical Cancer Control Program
- BDI, BDI-II: Beck Depression Inventory
- BDI-PC: Beck Depression Inventory-Primary Care Version
- BHW: Bureau of Health Workforce
- BMI: body mass index
- BP: blood pressure
- BPHC: Bureau of Primary Health Care
- CABG: coronary artery bypass graft
- CAD-MDD: Computerized Adaptive Diagnostic Screener
- CARE: Capital Assistance for Hurricane Response and Recovery Efforts
- CASA: Clinic Assessment Software Application
- CAT-DI: Computerized Adaptive Testing Depression Inventory
- CCO: coordinated care organizations
- CDC: Centers for Disease Control and Prevention
- CEO: chief executive officer
- CES-D: Center for Epidemiologic Studies Depression Scale
- CFO: chief financial officer
- CHC: Community Health Center (program)
- CHIP: Children's Health Insurance Program
- CME: continuing medical education
- CMS: Centers for Medicare & Medicaid Services
- CNM: certified nurse midwife
- COO: chief operations officer
- COVID-19: coronavirus disease 2019
- CPT: Current Procedural Terminology
- CQL: Clinical Quality Language
- CQM: clinical quality measure
- CSDD: Cornell Scale for Depression in Dementia
- CSH: Corporation for Supportive Housing
- CT: computerized tomography
- DADS: Duke Anxiety-Depression Scale
- DATA: Drug Addiction Treatment Act of 2000
- DEPS: Depression Scale
- DGMO: Division of Grants Management Operations
- DNA: deoxyribonucleic acid
- DO: doctor of osteopathic medicine
- DRE: digital rectal exam
- DT, DTaP, DTP: Diphtheria, tetanus, pertussis
- eCQI: Electronic Clinical Quality Improvement
- eCQMs: electronic-specified clinical quality measures
- EHBs: Electronic Handbooks
- EHR: electronic health record
- EKG: electrocardiogram
- EMR: electronic medical records
- EMS: emergency medical service
- EMT: emergency medical technician
- ENDS: electronic nicotine delivery systems
- EPSDT: Early and Periodic Screening, Diagnostic, and Treatment
- ESRD: end-stage renal disease
- FAQ: frequently asked question
- FDA: U.S. Food and Drug Administration
- FIT: fecal immunochemical test
- FOBT: fecal occult blood test
- FPG: federal poverty guidelines
- FQHC: federally qualified health center
- FTE: full-time equivalent

- GAAP: generally accepted accounting principles
- GDS: Geriatric Depression Scale
- gFOBT: guaiac fecal occult blood test
- HAM-D: Hamilton Rating Scale for Depression
- HbA1c: Hemoglobin A1c
- HCFA: Health Care Financing Administration
- HCH: Health Care for the Homeless (program)
- HCPCS: Healthcare Common Procedure Coding System
- HEDIS: Healthcare Effectiveness Data and Information Set
- HHS: U.S. Department of Health and Human Services
- HiB: Haemophilus influenza B
- HIT: health information technology
- HITEQ: Health Information Technology, Evaluation, and Quality Center
- HIV: human immunodeficiency virus
- HMO: health maintenance organizations
- HPV: human papillomavirus
- HR: human resources
- HRSA: Health Resources and Services Administration
- HUD: U.S., Department of Housing and Urban Development
- ICD: International Classification of Diseases
- iFOBT: immunochemical-based fecal occult blood test
- IHS: Indian Health Service
- IPV: inactivated polio vaccine
- IRS: Internal Revenue Service
- IT: information technology
- IVD: Ischemic Vascular Disease
- LAL: look-alike
- LBW: low birth weight
- LCSW: licensed clinical social worker
- LDL-C: low-density lipoprotein cholesterol
- LGBTQIA+: lesbian, gay, bisexual, transgender, queer, intersex, asexual, and all sexual and gender minority people
- MAT: medication-assisted treatment
- MCN: Migrant Clinicians Network
- MCO: managed care organization
- MD: medical doctor
- MFQ: Mood Feeling Questionnaire
- MHC: Migrant Health Center (program)
- MIPS: Merit-based Incentive Payment System
- MMR: mumps, measles, and rubella
- NACHC: National Association of Community Health Centers
- NAICS: North American Industry Classification System
- NAP: New Access Point
- NCFH: National Center for Farmworker Health
- NCHPH: National Center for Health in Public Housing
- NCHS: National Center for Health Statistics
- NHCHC: National Health Care for the Homeless Council
- NHSC: National Health Service Corps
- NNCC: National Nurse-Led Care Consortium
- NP: nurse practitioner
- NQF: National Quality Forum
- OB/GYN: obstetrician/gynecologist
- OMB: Office of Management and Budget
- OMH: Office of Minority Health
- ONC: Office of the National Coordinator for Health IT
- P4P: pay for performance
- PA: physician assistant
- PACE: Program of All-Inclusive Care for the Elderly
- PAL: Program Assistance Letter
- PAP: pharmacy assistance program
- PCCM: primary care case management
- PC-DMIS: personal computer dimensional measurement inspection software

- PCI: percutaneous coronary intervention
- PCMH: patient-centered medical home
- PCV: pneumococcal conjugate
- PDMP: Prescription Drug Monitoring Program
- PDS: pharmacy dispensing software
- PDSA: Plan, Do, Study, Act
- PECS: patient electronic care system
- PHPC: Public Housing Primary Care (program)
- PHQ: Patient Health Questionnaire
  - PHQ-9M: PHQ modified for teens
  - PHQ-A: PHQ for adolescents
- PHS: Public Health Service (Act)
- PMPM: per member per month
- PMS: Payment Management System (PMS-272)
- PPD: purified protein derivatives
- PPS: prospective payment system
- PRAPARE: Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences
- PRE: Preliminary Reporting Environment
- PrEP: Pre-Exposure Prophylaxis
- PRIME MD: Primary Care Evaluation of Mental Disorders
- PSC-17: Pediatric Symptom Checklist
- PTSD: post-traumatic stress disorder
- QI: quality improvement
- QID-SR: Quick Inventory of Depressive Symptomology Self-Report
- RBRVU: resource-based relative value unit
- RN: registered nurse
- RV: rotavirus
- SAMHSA: Substance Abuse and Mental Health Services Administration
- SARS-CoV-2: strain of severe acute respiratory syndrome-related coronavirus
- SBIRT: Screening, Brief Intervention, and Referral to Treatment
- SI: sample interval
- SNAP: Supplemental Nutrition Assistance Program
- SRO: single-room occupancy
- SSI: Supplemental Security Income
- TAF/FTC: tenofovir alafenamide/emtricitabine
- TANF: Temporary Assistance for Needy Families
- TDF/FTC: tenofovir disoproxil fumarate/emtricitabine
- UCR: usual, customary, and reasonable
- UDS: Uniform Data System
- USHIK: United States Health Information Knowledgebase
- VFC: Vaccines for Children
- VSAC: Value Set Authority Center
- VZV: pneumococcal conjugate
- WE CARE: Well Child Care, Evaluation. Community Resources, Advocacy Referral, Education
- WIC: Women, Infants, and Children

2020 UDS Manual—August 21, 2020.
OMB Number: 0915-0193
Expiration Date: 02/28/2023

Reporting Tables for **Calendar Year 2020** Health Center Data

Updated on August 21, 2020

For Reports Submitted February 15, 2021

Table: Patients by ZIP Code

Reporting Period: January 1, 2020, through December 31, 2020

ZIP Code (a)	None/ Uninsured (b)	Medicaid/ CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
Other ZIP Codes					
Unknown Residence					
Total					

Note: *This is a representation of the form. The actual online output from the EHBs will display ZIP codes entered by the health center in Column A.*

Table 3A: Patients by Age and by Sex Assigned at Birth

Reporting Period: January 1, 2020, through December 31, 2020

Line	Age Groups	Male Patients (a)	Female Patients (b)
1	Under age 1		
2	Age 1		
3	Age 2		
4	Age 3		
5	Age 4		
6	Age 5		
7	Age 6		
8	Age 7		
9	Age 8		
10	Age 9		
11	Age 10		
12	Age 11		
13	Age 12		
14	Age 13		
15	Age 14		
16	Age 15		
17	Age 16		
18	Age 17		
19	Age 18		
20	Age 19		
21	Age 20		
22	Age 21		
23	Age 22		
24	Age 23		
25	Age 24		
26	Ages 25–29		
27	Ages 30–34		
28	Ages 35–39		
29	Ages 40–44		
30	Ages 45–49		
31	Ages 50–54		
32	Ages 55–59		
33	Ages 60–64		
34	Ages 65–69		
35	Ages 70–74		
36	Ages 75–79		
37	Ages 80–84		
38	Age 85 and over		
39	**Total Patients** (Sum of Lines 1-38)		

Table 3B: Demographic Characteristics

Reporting Period: January 1, 2020, through December 31, 2020

Patients by Race and Hispanic or Latino/a Ethnicity

Line	Patients by Race	Hispanic or Latino/a (a)	Non-Hispanic or Latino/a (b)	Unreported/Refused to Report Ethnicity (c)	Total (d) (Sum Columns a+b+c)
1	Asian				
2a	Native Hawaiian				
2b	Other Pacific Islander				
2	Total Native Hawaiian/Other Pacific Islander (Sum Lines 2a + 2b)				
3	Black/African American				
4	American Indian/Alaska Native				
5	White				
6	More than one race				
7	Unreported/Refused to report race				
8	**Total Patients** (Sum of Lines 1 + 2 + 3 to 7)				

Line	Patients Best Served in a Language Other than English	Number (a)
12	Patients Best Served in a Language Other than English	

Line	Patients by Sexual Orientation	Number (a)
13	Lesbian or Gay	
14	Heterosexual (or straight)	
15	Bisexual	
16	Something else	
17	Don't know	
18	Chose not to disclose	
18a	Unknown	
19	**Total Patients** (Sum of Lines 13 to 18a)	

Line	Patients by Gender Identity	Number (a)
20	Male	
21	Female	
22	Transgender Man/Transgender Male	
23	Transgender Woman/Transgender Female	
24	Other	
25	Chose not to disclose	
25a	Unknown	
26	**Total Patients** (Sum of Lines 20 to 25a)	

Table 4: Selected Patient Characteristics

Reporting Period: January 1, 2020, through December 31, 2020

Line	Income as Percent of Poverty Guideline	Number of Patients (a)
1	100% and below	
2	101–150%	
3	151–200%	
4	Over 200%	
5	Unknown	
6	**TOTAL** (Sum of Lines 1–5)	

Line	Principal Third-Party Medical Insurance	0-17 years old (a)	18 and older (b)
7	**None/Uninsured**		
8a	Medicaid (Title XIX)		
8b	CHIP Medicaid		
8	**Total Medicaid** (Line 8a + 8b)		
9a	Dually Eligible (Medicare and Medicaid)		
9	**Medicare** (Inclusive of dually eligible and other Title XVIII beneficiaries)		
10a	Other Public Insurance (Non-CHIP) (specify___)		
10b	Other Public Insurance CHIP		
10	**Total Public Insurance** (Line 10a + 10b)		
11	**Private Insurance**		
12	**TOTAL** (Sum of Lines 7 + 8 + 9 +10 +11)		

Line	Managed Care Utilization	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	TOTAL (e)
13a	Capitated Member Months					
13b	Fee-for-service Member Months					
13c	**Total Member Months** (Sum of Lines 13a + 13b)					

Table 4: Selected Patient Characteristics (continued)

Reporting Period: January 1, 2020, through December 31, 2020

Line	Special Populations	Number of Patients (a)
14	Migratory (330g awardees only)	
15	Seasonal (330g awardees only)	
16	**Total Agricultural Workers or Dependents** (All health centers report this line)	
17	Homeless Shelter (330h awardees only)	
18	Transitional (330h awardees only)	
19	Doubling Up (330h awardees only)	
20	Street (330h awardees only)	
21a	Permanent Supportive Housing (330h awardees only)	
21	Other (330h awardees only)	
22	Unknown (330h awardees only)	
23	**Total Homeless** (All health centers report this line)	
24	**Total School-Based Health Center Patients** (All health centers report this line)	
25	**Total Veterans** (All health centers report this line)	
26	**Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site** (All health centers report this line)	

Table 5: Staffing and Utilization

Reporting Period: January 1, 2020, through December 31, 2020

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1	Family Physicians				
2	General Practitioners				
3	Internists				
4	Obstetrician/Gynecologists				
5	Pediatricians				
7	Other Specialty Physicians				
8	**Total Physicians** (Lines 1–7)				
9a	Nurse Practitioners				
9b	Physician Assistants				
10	Certified Nurse Midwives				
10a	**Total NPs, PAs, and CNMs** (Lines 9a–10)				
11	Nurses				
12	Other Medical Personnel				
13	Laboratory Personnel				
14	X-ray Personnel				
15	**Total Medical Care Services** (Lines 8 + 10a through 14)				
16	Dentists				
17	Dental Hygienists				
17a	Dental Therapists				
18	Other Dental Personnel				
19	**Total Dental Services** (Lines 16–18)				
20a	Psychiatrists				
20a1	Licensed Clinical Psychologists				
20a2	Licensed Clinical Social Workers				
20b	Other Licensed Mental Health Providers				
20c	Other Mental Health Staff				
20	**Total Mental Health Services** (Lines 20a–c)				
21	**Substance Use Disorder Services**				
22	**Other Professional Services** (specify___)				

Table 5: Staffing and Utilization (continued)

Reporting Period: January 1, 2020, through December 31, 2020

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
22a	Ophthalmologists				
22b	Optometrists				<cell not reported>
22c	Other Vision Care Staff		<cell not reported>	<cell not reported>	<cell not reported>
22d	**Total Vision Services** (Lines 22a–c)				
23	**Pharmacy Personnel**		<cell not reported>	<cell not reported>	<cell not reported>
24	Case Managers				<cell not reported>
25	Patient and Community Education Specialists				<cell not reported>
26	Outreach Workers		<cell not reported>	<cell not reported>	<cell not reported>
27	Transportation Staff		<cell not reported>	<cell not reported>	<cell not reported>
27a	Eligibility Assistance Workers		<cell not reported>	<cell not reported>	<cell not reported>
27b	Interpretation Staff		<cell not reported>	<cell not reported>	<cell not reported>
27c	Community Health Workers		<cell not reported>	<cell not reported>	<cell not reported>
28	Other Enabling Services (specify___)		<cell not reported>	<cell not reported>	<cell not reported>
29	**Total Enabling Services** (Lines 24–28)				
29a	**Other Programs and Services** (specify___)		<cell not reported>	<cell not reported>	<cell not reported>
29b	**Quality Improvement Staff**		<cell not reported>	<cell not reported>	<cell not reported>
30a	Management and Support Staff		<cell not reported>	<cell not reported>	<cell not reported>
30b	Fiscal and Billing Staff		<cell not reported>	<cell not reported>	<cell not reported>
30c	IT Staff		<cell not reported>	<cell not reported>	<cell not reported>
31	Facility Staff		<cell not reported>	<cell not reported>	<cell not reported>
32	Patient Support Staff		<cell not reported>	<cell not reported>	<cell not reported>
33	**Total Facility and Non-Clinical Support Staff** (Lines 30a–32)		<cell not reported>	<cell not reported>	<cell not reported>
34	**Grand Total** (Lines 15+19+20+21+22+22d+23+29+29a+29b+33)				<cell not reported>

Table 5: Selected Service Detail Addendum

Reporting Period: January 1, 2020, through December 31, 2020

Line	Personnel by Major Service Category: Mental Health Service Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
20a01	Physicians (other than Psychiatrists)				
20a02	Nurse Practitioners				
20a03	Physician Assistants				
20a04	Certified Nurse Midwives				
Line	**Personnel by Major Service Category: Substance Use Disorder Detail**	**Personnel (a1)**	**Clinic Visits (b)**	**Virtual Visits (b2)**	**Patients (c)**
21a	Physicians (other than Psychiatrists)				
21b	Nurse Practitioners (Medical)				
21c	Physician Assistants				
21d	Certified Nurse Midwives				
21e	Psychiatrists				
21f	Licensed Clinical Psychologists				
21g	Licensed Clinical Social Workers				
21h	Other Licensed Mental Health Providers				

Table 6A: Selected Diagnoses and Services Rendered

Reporting Period: January 1, 2020, through December 31, 2020

Selected Diagnoses

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
	Selected Infectious and Parasitic Diseases			
1-2	Symptomatic/Asymptomatic human immunodeficiency virus (HIV)	B20, B97.35, O98.7-, Z21		
3	Tuberculosis	A15- through A19-, O98.0-		
4	Sexually transmitted infections	A50- through A64-		
4a	Hepatitis B	B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.1-, O98.4-		
4b	Hepatitis C	B17.1-, B18.2, B19.2-		
4c	Novel coronavirus (SARS-CoV-2) disease	U07.1		
	Selected Diseases of the Respiratory System			
5	Asthma	J45-		
6	Chronic lower respiratory diseases	J40 (count only when code U07.1 **is not** present), J41- through J44-, J47-		
6a	Acute respiratory illness due to novel coronavirus (SARS-CoV-2) disease	J12.89, J20.8, J40, J22, J98.8, J80 (count only when code U07.1 **is** present)		
	Selected Other Medical Conditions			
7	Abnormal breast findings, female	C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.81, D05-, D48.6-, D49.3, N60-, N63-, R92-		
8	Abnormal cervical findings	C53-, C79.82, D06-, R87.61-, R87.629, R87.810, R87.820		
9	Diabetes mellitus	E08- through E13-, O24- (exclude O24.41-)		
10	Heart disease (selected)	I01-, I02- (exclude I02.9), I20- through I25-, I27-, I28-, I30- through I52-		
11	Hypertension	I10- through I16-, O10-, O11-		
12	Contact dermatitis and other eczema	L23- through L25-, L30- (exclude L30.1, L30.3, L30.4, L30.5), L58-		
13	Dehydration	E86-		
14	Exposure to heat or cold	T33-, T34-, T67-, T68-, T69-, W92-, W93-		
14a	Overweight and obesity	E66-, Z68- (exclude Z68.1, Z68.20 through Z68.24, Z68.51, Z68.52)		

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
	Selected Childhood Conditions (limited to ages 0 through 17)			
15	Otitis media and Eustachian tube disorders	H65- through H69-		
16	Selected perinatal/neonatal medical conditions	A33-, P19-, P22- through P29- (exclude P29.3), P35- through P96- (exclude P54-, P91.6-, P92-, P96.81), R78.81, R78.89		
17	Lack of expected normal physiological development (such as delayed milestone, failure to gain weight, failure to thrive); nutritional deficiencies in children only. Does not include sexual or mental development.	E40- through E46-, E50- through E63-, P92-, R62- (exclude R62.7), R63.3		
	Selected Mental Health Conditions, Substance Use Disorders, and Exploitations			
18	Alcohol-related disorders	F10-, G62.1, O99.31-		
19	Other substance-related disorders (excluding tobacco use disorders)	F11- through F19- (exclude F17-), G62.0, O99.32-		
19a	Tobacco use disorder	F17-, O99.33-		
20a	Depression and other mood disorders	F30- through F39-		
20b	Anxiety disorders, including post-traumatic stress disorder (PTSD)	F06.4, F40- through F42-, F43.0, F43.1-, F93.0		
20c	Attention deficit and disruptive behavior disorders	F90- through F91-		
20d	Other mental disorders, excluding drug or alcohol dependence	F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0- and F43.1-), F50- through F99- (exclude F55-, F84.2, F90-, F91-, F93.0, F98-), O99.34-, R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0		
20e	Human trafficking	T74.5- through T74.6-, T76.5- through T76.6-, Z04.81, Z04.82, Z62.813, Z91.42		
20f	Intimate partner violence	T74.11, T74.21, T74.31, Z69.11, Y07.0		

Selected Services Rendered

Line	Service Category	Applicable ICD-10-CM, CPT-4/II/PLA, or HCPCS Code	Number of Visits (a)	Number of Patients (b)
	Selected Diagnostic Tests/ Screening/Preventive Services			
21	HIV test	**CPT-4**: 86689, 86701 through 86703, 87389 through 87391, 87534 through 87539, 87806		
21a	Hepatitis B test	**CPT-4**: 86704 through 86707, 87340, 87341, 87350		
21b	Hepatitis C test	**CPT-4**: 86803, 86804, 87520 through 87522		
21c	Novel coronavirus (SARS-CoV-2) diagnostic test	**CPT-4**: 87426, 87635 **HCPCS**: U0001, U0002, U0003, U0004 **CPT PLA**: 0202U, 0223U, 0225U		
21d	Novel coronavirus (SARS-CoV-2) antibody test	**CPT-4**: 86328, 86408, 86409, 86769 **CPT PLA**: 0224U, 0226U		
21e	Pre-Exposure Prophylaxis (PrEP)-associated management of **all** PrEP patients	**CPT-4**: 99401-99404 **ICD-10**: Z11.3, Z11.4, Z20.2, Z20.6, Z51.81, Z71.51, Z71.7, Z79.899 Limit to emtricitabine/tenofovir disoproxil fumarate (FTC/TDF) or emtricitabine/tenofovir alafenamide (FTC/TAF) for PrEP		
22	Mammogram	**CPT-4**: 77065, 77066, 77067 **ICD-10**: Z12.31		
23	Pap test	**CPT-4**: 88141 through 88153, 88155, 88164 through 88167, 88174, 88175 **ICD-10**: Z01.41-, Z01.42, Z12.4 (exclude Z01.411 and Z01.419)		
24	Selected immunizations: hepatitis A; haemophilus influenzae B (HiB); pneumococcal, diphtheria, tetanus, pertussis (DTaP) (DTP) (DT); measles, mumps, rubella (MMR); poliovirus; varicella; hepatitis B	**CPT-4**: 90632, 90633, 90634, 90636, 90643, 90644, 90645, 90646, 90647, 90648, 90669, 90670, 90696, 90697, 90698, 90700, 90701, 90702, 90703, 90704, 90705, 90706, 90707, 90708, 90710, 90712, 90713, 90714, 90715, 90716, 90718, 90720, 90721, 90723, 90730, 90731, 90732, 90740, 90743, 90744, 90745, 90746, 90747, 90748		
24a	Seasonal flu vaccine	**CPT-4**: 90630, 90653 through 90657, 90658, 90661, 90662, 90672, 90673, 90674, 90682, 90685 through 90689, 90756		
25	Contraceptive management	**ICD-10**: Z30-		
26	Health supervision of infant or child (ages 0 through 11)	**CPT-4**: 99381 through 99383, 99391 through 99393 **ICD-10**: Z00.1-		

Line	Service Category	Applicable ICD-10-CM, CPT-4/II/PLA, or HCPCS Code	Number of Visits (a)	Number of Patients (b)
26a	Childhood lead test screening (9 to 72 months)	**ICD-10:** Z13.88 **CPT-4**: 83655		
26b	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	**CPT-4**: 99408, 99409 **HCPCS**: G0396, G0397, G0443, H0050		
26c	Smoke and tobacco use cessation counseling	**CPT-4**: 99406, 99407 **HCPCS**: S9075 **CPT-II**: 4000F, 4001F, 4004F		
26d	Comprehensive and intermediate eye exams	**CPT-4**: 92002, 92004, 92012, 92014		

Line	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)
	Selected Dental Services			
27	Emergency services	**CDT:** D0140, D9110		
28	Oral exams	**CDT:** D0120, DO145, D0150, D0160, D0170, D0171, D0180		
29	Prophylaxis—adult or child	**CDT:** D1110, D1120		
30	Sealants	**CDT:** D1351		
31	Fluoride treatment—adult or child	**CDT:** D1206, D1208 **CPT-4:** 99188		
32	Restorative services	**CDT:** D21xx through D29xx		
33	Oral surgery (extractions and other surgical procedures)	**CDT:** D7xxx		
34	Rehabilitative services (Endo, Perio, Prostho, Ortho)	**CDT:** D3xxx, D4xxx, D5xxx, D6xxx, D8xxx		

Sources of Codes

- ICD-10-CM (2020)–National Center for Health Statistics (NCHS)
- CPT (2020)–American Medical Association (AMA)
- Code on Dental Procedures and Nomenclature CDT Code (2020)–Dental Procedure Codes. American Dental Association (ADA)

Note: *"X" in a code denotes any number, including the absence of a number in that place. Dashes (-) in a code indicate that additional characters are required. ICD-10-CM codes all have at least four digits. These codes are not intended to reflect whether or not a code is billable. Instead, they are used to point out that other codes in the series are to be considered.*

Table 6B: Quality of Care Measures

Reporting Period: January 1, 2020, through December 31, 2020

0	**Prenatal Care Provided by Referral Only (Check if Yes)**	

Section A—Age Categories for Prenatal Care Patients: Demographic Characteristics of Prenatal Care Patients

Line	Age	Number of Patients (a)
1	Less than 15 years	
2	Ages 15-19	
3	Ages 20-24	
4	Ages 25-44	
5	Ages 45 and over	
6	**Total Patients (Sum of Lines 1-5)**	

Section B—Early Entry into Prenatal Care

Line	Early Entry into Prenatal Care	Patients Having First Visit with Health Center (a)	Patients Having First Visit with Another Provider (b)
7	First Trimester		
8	Second Trimester		
9	Third Trimester		

Section C—Childhood Immunization Status

Line	Childhood Immunization Status	Total Patients with 2nd Birthday (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Immunized (c)
10	MEASURE: Percentage of children 2 years of age who received age appropriate vaccines by their 2nd birthday			

Section D—Cervical and Breast Cancer Screening

Line	Cervical Cancer Screening	Total Female Patients Aged 23 through 64 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Tested (c)
11	MEASURE: Percentage of women 23–64 years of age who were screened for cervical cancer			
Line	**Breast Cancer Screening**	**Total Female Patients Aged 51 through 73 (a)**	**Number Charts Sampled or EHR Total (b)**	**Number of Patients with Mammogram (c)**
11a	MEASURE: Percentage of women 51–73 years of age who had a mammogram to screen for breast cancer			

Section E—Weight Assessment and Counseling for Nutrition and Physical Activity of Children and Adolescents

Line	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Total Patients Aged 3 through 16 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Counseling and BMI Documented (c)
12	MEASURE: Percentage of patients 3–16 years of age with a BMI percentile *and* counseling on nutrition *and* physical activity documented			

Section F—Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Line	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate (c)
13	MEASURE: Percentage of patients 18 years of age and older with (1) BMI documented and (2) follow-up plan documented if BMI is outside normal parameters			

Section G—Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Line	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Assessed for Tobacco Use *and* Provided Intervention if a Tobacco User (c)
14a	MEASURE: Percentage of patients aged 18 years of age and older who (1) were screened for tobacco use one or more times within 24 months, *and* (2) if identified to be a tobacco user received cessation counseling intervention			

Section H—Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Line	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Total Patients Aged 21 and Older at High Risk of Cardiovascular Events (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Prescribed or On Statin Therapy (c)
17a	MEASURE: Percentage of patients 21 years of age and older at high risk of cardiovascular events who were prescribed or were on statin therapy			

Section I—Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet

Line	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Total Patients Aged 18 and Older with IVD Diagnosis or AMI, CABG, or PCI Procedure (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Documentation of Aspirin or Other Antiplatelet Therapy (c)
18	MEASURE: Percentage of patients 18 years of age and older with a diagnosis of IVD or AMI, CABG, or PCI procedure with aspirin or another antiplatelet			

Section J—Colorectal Cancer Screening

Line	Colorectal Cancer Screening	Total Patients Aged 50 through 74 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Appropriate Screening for Colorectal Cancer(c)
19	MEASURE: Percentage of patients 50 through 74 years of age who had appropriate screening for colorectal cancer			

Section K—HIV Measures

Line	HIV Linkage to Care	Total Patients First Diagnosed with HIV (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Seen Within 30 Days of First Diagnosis of HIV (c)
20	MEASURE: Percentage of patients whose first-ever HIV diagnosis was made by health center staff between December 1 of the prior year and November 30 of the measurement year and who were seen for follow-up treatment within 30 days of that first-ever diagnosis			
Line	**HIV Screening**	**Total Patients Aged 15 through 65 (a)**	**Number Charts Sampled or EHR Total (b)**	**Number of Patients Tested for HIV (c)**
20a	MEASURE: Percentage of patients 15 through 65 years of age who were tested for HIV when within age range			

Section L—Depression Measures

Line	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Total Patients Aged 12 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Screened for Depression and Follow-Up Plan Documented as Appropriate (c)
21	MEASURE: Percentage of patients 12 years of age and older who were (1) screened for depression with a standardized tool *and,* if screening was positive, (2) had a follow-up plan documented			
Line	**Depression Remission at Twelve Months**	**Total Patients Aged 12 and Older with Major Depression or Dysthymia (a)**	**Number Charts Sampled or EHR Total (b)**	**Number of Patients who Reached Remission (c)**
21a	MEASURE: Percentage of patients 12 years of age and older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event			

Section M—Dental Sealants for Children between 6–9 Years

Line	Dental Sealants for Children between 6–9 Years	Total Patients Aged 6 through 9 at Moderate to High Risk for Caries (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Sealants to First Molars (c)
22	MEASURE: Percentage of children 6 through 9 years of age at moderate to high risk of caries who received a sealant on a first permanent molar			

Table 7: Health Outcomes and Disparities

Reporting Period: January 1, 2020, through December 31, 2020

Section A: Deliveries and Birth Weight

Line	Description	Patients (a)
0	HIV-Positive Pregnant Patients	
2	Deliveries Performed by Health Center's Providers	

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: <1500 grams (1b)	Live Births: 1500–2499 grams (1c)	Live Births: ≥2500 grams (1d)
	Hispanic or Latino/a				
1a	Asian				
1b1	Native Hawaiian				
1b2	Other Pacific Islander				
1c	Black/African American				
1d	American Indian/Alaska Native				
1e	White				
1f	More than One Race				
1g	Unreported/Refused to Report Race				
	Subtotal Hispanic or Latino/a				
	Non-Hispanic or Latino/a				
2a	Asian				
2b1	Native Hawaiian				
2b2	Other Pacific Islander				
2c	Black/African American				
2d	American Indian/Alaska Native				
2e	White				
2f	More than One Race				
2g	Unreported/Refused to Report Race				
	Subtotal Non-Hispanic or Latino/a				
	Unreported/Refused to Report Race & Ethnicity				
h	Unreported/Refused to Report Race and Ethnicity				
i	**Total**				

Section B: Controlling High Blood Pressure

Line	Race and Ethnicity	Total Patients 18 through 84 Years of Age with Hypertension (2a)	Number Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)
	Hispanic or Latino/a			
1a	Asian			
1b1	Native Hawaiian			
1b2	Other Pacific Islander			
1c	Black/African American			
1d	American Indian/Alaska Native			
1e	White			
1f	More than One Race			
1g	Unreported/Refused to Report Race			
	Subtotal Hispanic or Latino/a			
	Non-Hispanic or Latino/a			
2a	Asian			
2b1	Native Hawaiian			
2b2	Other Pacific Islander			
2c	Black/African American			
2d	American Indian/Alaska Native			
2e	White			
2f	More than One Race			
2g	Unreported/Refused to Report Race			
	Subtotal Non-Hispanic or Latino/a			
	Unreported/Refused to Report Race and Ethnicity			
h	Unreported/Refused to Report Race and Ethnicity			
i	**Total**			

Section C: Diabetes: Hemoglobin A1c Poor Control

Line	Race and Ethnicity	Total Patients 18 through 74 Years of Age with Diabetes (3a)	Number Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)
	Hispanic or Latino/a			
1a	Asian			
1b1	Native Hawaiian			
1b2	Other Pacific Islander			
1c	Black/African American			
1d	American Indian/Alaska Native			
1e	White			
1f	More than One Race			
1g	Unreported/Refused to Report Race			
	Subtotal Hispanic or Latino/a			
	Non-Hispanic or Latino/a			
2a	Asian			
2b1	Native Hawaiian			
2b2	Other Pacific Islander			
2c	Black/African American			
2d	American Indian/Alaska Native			
2e	White			
2f	More than One Race			
2g	Unreported/Refused to Report Race			
	Subtotal Non-Hispanic or Latino/a			
	Unreported/Refused to Report Race and Ethnicity			
h	Unreported/Refused to Report Race and Ethnicity			
i	**Total**			

Table 8A: Financial Costs

Reporting Period: January 1, 2020, through December 31, 2020

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
	Financial Costs of Medical Care			
1	Medical Staff			
2	Lab and X-ray			
3	Medical/Other Direct			
4	**Total Medical Care Services** (Sum of Lines 1 through 3)			
	Financial Costs of Other Clinical Services			
5	Dental			
6	Mental Health			
7	Substance Use Disorder			
8a	Pharmacy (not including pharmaceuticals)			
8b	Pharmaceuticals			
9	Other Professional (specify___)			
9a	Vision			
10	**Total Other Clinical Services** (Sum of Lines 5 through 9a)			
	Financial Costs of Enabling and Other Services			
11a	Case Management			
11b	Transportation			
11c	Outreach			
11d	Patient and Community Education			
11e	Eligibility Assistance			
11f	Interpretation Services			
11g	Other Enabling Services (specify ___)			
11h	Community Health Workers			
11	**Total Enabling Services** (Sum of Lines 11a through 11h)			
12	Other Program-Related Services (specify___)			
12a	Quality Improvement			
13	**Total Enabling and Other Services** (Sum of Lines 11, 12, and 12a)			

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
	Facility and Non-Clinical Support Services and Totals			
14	Facility			
15	Non-Clinical Support Services			
16	**Total Facility and Non-Clinical Support Services** (Sum of Lines 14 and 15)			
17	**Total Accrued Costs** (Sum of Lines 4 + 10 + 13 + 16)			
18	Value of Donated Facilities, Services, and Supplies (specify___)			
19	**Total with Donations** (Sum of Lines 17 and 18)			

Table 9D: Patient-Related Revenue

Reporting Period: January 1, 2020, through December 31, 2020

				Retroactive Settlements, Receipts, and Paybacks (c)						
Line	**Payer Category**	**Full Charges This Period (a)**	**Amount Collected This Period (b)**	**Collection of Reconciliation/ Wraparound Current Year (c1)**	**Collection of Reconciliation/ Wraparound Previous Years (c2)**	**Collection of Other Payments: P4P, Risk Pools, etc. (c3)**	**Penalty/ Payback (c4)**	**Adjustments (d)**	**Sliding Fee Discounts (e)**	**Bad Debt Write -Off (f)**
1	Medicaid Non-Managed Care									
2a	Medicaid Managed Care (capitated)									
2b	Medicaid Managed Care (fee-for-service)									
3	**Total Medicaid** (Sum of Lines 1 + 2a + 2b)									
4	Medicare Non-Managed Care									
5a	Medicare Managed Care (capitated)									
5b	Medicare Managed Care (fee-for-service)									
6	**Total Medicare** (Sum of Lines 4 + 5a + 5b)									
7	Other Public, including Non-Medicaid CHIP, Non-Managed Care									
8a	Other Public, including Non-Medicaid CHIP, Managed Care (capitated)									
8b	Other Public, including Non-Medicaid CHIP, Managed Care (fee-for-service)									
8c	Other Public, including COVID-19 Uninsured Program									
9	**Total Other Public** (Sum of Lines 7 + 8a + 8b + 8c)									

				Retroactive Settlements, Receipts, and Paybacks (c)						
Line	**Payer Category**	**Full Charges This Period (a)**	**Amount Collected This Period (b)**	**Collection of Reconciliation/ Wraparound Current Year (c1)**	**Collection of Reconciliation/ Wraparound Previous Years (c2)**	**Collection of Other Payments: P4P, Risk Pools, etc. (c3)**	**Penalty/ Payback (c4)**	**Adjustments (d)**	**Sliding Fee Discounts (e)**	**Bad Debt Write -Off (f)**
10	Private Non-Managed Care									
11a	Private Managed Care (capitated)									
11b	Private Managed Care (fee-for-service)									
12	**Total Private** (Sum of Lines 10 + 11a + 11b)									
13	**Self-Pay**									
14	**TOTAL** (Sum of Lines 3 + 6 + 9 + 12 + 13)									

Table 9E: Other Revenues

Reporting Period: January 1, 2020, through December 31, 2020

Line	Source	Amount (a)
	BPHC Grants (Enter Amount Drawn Down—Consistent with PMS 272)	
1a	Migrant Health Center	
1b	Community Health Center	
1c	Health Care for the Homeless	
1e	Public Housing Primary Care	
1g	**Total Health Center** (Sum of Lines 1a through 1e)	
1k	Capital Development Grants, including School-Based Health Center Capital Grants	
1l	Coronavirus Preparedness and Response Supplemental Appropriations Act (H8C)	
1m	Coronavirus Aid, Relief, and Economic Security Act (CARES) (H8D)	
1n	Expanding Capacity for Coronavirus Testing (ECT) (H8E and LAL ECT)	
1o	Health and Economic Recovery Omnibus Emergency Solutions Act (HEROES)/ Health, Economic Assistance, Liability Protection and Schools Act (HEALS)	
1p	Other COVID-19-Related Funding from BPHC (specify_______)	
1q	**Total COVID-19 Supplemental** (Sum of Lines 1l through 1p)	
1	**Total BPHC Grants** (Sum of Lines 1g + 1k + 1q)	
	Other Federal Grants	
2	Ryan White Part C HIV Early Intervention	
3	Other Federal Grants (specify _______)	
3a	Medicare and Medicaid EHR Incentive Payments for Eligible Providers	
3b	Provider Relief Fund (specify _______)	
5	**Total Other Federal Grants** (Sum of Lines 2 through 3b)	
	Non-Federal Grants or Contracts	
6	State Government Grants and Contracts (specify_______)	
6a	State/Local Indigent Care Programs (specify_______)	
7	Local Government Grants and Contracts (specify_______)	
8	Foundation/Private Grants and Contracts (specify_______)	
9	**Total Non-Federal Grants and Contracts** (Sum of Lines 6 + 6a + 7 + 8)	
10	Other Revenue (non-patient related revenue not reported elsewhere) (specify _______)	
11	**Total Revenue** (Sum of Lines 1 + 5 + 9 + 10)	

Appendix D: Health Center Health Information Technology (HIT) Capabilities

Instructions

The HIT Capabilities Form includes a series of questions on HIT capabilities, including EHR interoperability and eligibility for CMS Promoting Interoperability programs. The HIT Form must be completed and submitted as part of the UDS submission. The form includes questions about the health center's implementation of an EHR, certification of systems, and how widely adopted the system is throughout the health center and its providers.

Questions

The following questions appear in the EHBs. Complete them before you file the UDS Report. Instructions for the HIT questions are on-screen in the EHBs as you complete the form. Respond to each question based on your health center status *as of December 31*.

1. Does your center currently have an electronic health record (EHR) system installed and in use?
    a. Yes, installed at all sites and used by all providers
    b. Yes, but only installed at some sites or used by some providers
    c. No

If the health center installed it, indicate if it was in use by December 31 by indicating:

a. **Installed at all sites and used by all providers:** For the purposes of this response, "providers" mean all medical providers, including physicians, nurse practitioners, physician assistants, and certified nurse midwives. Although some or all of the dental, mental health, or other providers may also be using the system, as may medical support staff, this is not required to choose response (a). For the purposes of this response, "all sites" means all permanent sites where medical providers serve health center medical patients. It does not include administrative-only locations, hospitals or nursing homes, mobile vans, or sites used on a seasonal or temporary basis. You may check this option if a few newly hired, untrained employees are the only ones not using the system.
b. **Installed at some sites or used by some providers:** Select option (b) if one or more permanent sites did not have the EHR installed or in use (even if this is planned), or if one or more medical providers (as defined on this page under [a]) do not yet use the system. When determining if all providers have access to the system, the health center should also consider part-time and locum providers who serve clinic patients. Do not select this option if the only medical providers who did not have access were those who were newly hired and still being trained on the system.
c. **Select "no" if no EHR** was in use on December 31, even if you had the system installed and training had started.

This question seeks to determine whether the health center installed an EHR by December 31 and, if so, which product was in use, how broad system access was, and what features were available and in use. Do not include PMS or other billing systems, even though they can often produce much of the UDS data. If the health center purchased an EHR but has not yet put it into use, answer "no."

If a system is in use (i.e., if [a] or [b] has been selected), indicate that it has been certified by the Office of the National Coordinator—Authorized Testing and Certification Bodies.

1a. Is your system certified by the Office of the National Coordinator for Health IT (ONC) Health IT Certification Program?

a. Yes

b. No

Health centers are to indicate the vendor, product name, version number, and ONC-certified health IT product list number. (More information is available at https://chpl.healthit.gov/#/search.) If you have more than one EHR (if, for example, you acquired another practice with its own EHR), report the EHR that will be the successor system or the EHR used for capturing primary medical care.

1a1. Vendor

1a2. Product Name

1a3. Version Number

1a4. ONC-certified Health IT Product List Number

1b. Did you switch to your current EHR from a previous system this year?

a. Yes

b. No

If "yes, but only at some sites or for some providers" is selected, a box expands for health centers to identify how many sites have the EHR in use and how many (medical) providers are using it. Please enter the number of sites (as defined under question 1) where the EHR is in use and the number of providers who use the system (at all sites). Include part-time and locum medical providers who serve clinic patients. Count a provider who has separate login identities at more than one site as just one provider.

1c. Do you use more than one EHR or data system across your organization?

a. Yes

b. No

1c1. If yes, what is the reason?

a. Second EHR/data system is used during transition to primary EHR

b. Second EHR/data system is specific to one service type (e.g., dental, behavioral health)

c. Second EHR/data system is used at specific sites with no plan to transition

d. Other (please describe ______)

1d. Is your EHR up to date with the latest software and system patches?

1e. When do you plan to update/install the latest EHR software and system patches?

2. Question removed.
3. Question removed.
4. Which of the following key providers/health care settings does your center electronically exchange clinical information with? (Select all that apply.)
   a. Hospitals/Emergency rooms
   b. Specialty clinicians
   c. Other primary care providers
   d. Labs or imaging
   e. Health information exchange (HIE)
   f. None of the above
   g. Other (please describe ______)
5. Does your center engage patients through health IT in any of the following ways? (Select all that apply.)
   a. Patient portals
   b. Kiosks
   c. Secure messaging

  d. Other (please describe _______)
  e. No, we do not engage patients using HIT

6. Question removed.
7. How do you collect data for UDS clinical reporting (Tables 6B and 7)?
   a. We use the EHR to extract automated reports
   b. We use the EHR but only to access individual patient charts
   c. We use the EHR in combination with another data analytic system
   d. We do not use the EHR
8. Question removed.
9. Question removed.
10. How does your health center utilize HIT and EHR data beyond direct patient care? (Select all that apply.)
    a. Quality improvement
    b. Population health management
    c. Program evaluation
    d. Research
    e. Other (please describe ______)
    f. We do not utilize HIT or EHR data beyond direct patient care
11. Does your health center collect data on individual patients' social risk factors, outside of the data reportable in the UDS?
    a. Yes
    b. No, but we are in planning stages to collect this information
    c. No, we are not planning to collect this information
12. Which standardized screener(s) for social risk factors, if any, do you use? (Select all that apply.)
    a. Accountable Health Communities Screening Tools
    b. Upstream Risks Screening Tool and Guide
    c. iHELLP
    d. Recommend Social and Behavioral Domains for EHRs
    e. Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)
    f. Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education (WE CARE)
    g. WellRx
    h. Health Leads Screening Toolkit
    i. Other (please describe __________)
    j. We do not use a standardized screener

12a. Please provide the total number of patients that screened positive for the following:

  a. Food insecurity ___________
  b. Housing insecurity ___________
  c. Financial strain ___________
  d. Lack of transportation/access to public transportation ___________

12b. If you do not use a standardized assessment to collect this information, please indicate why. (Select all that apply.)

a. Have not considered/unfamiliar with assessments

b. Lack of funding for addressing these unmet social needs of patients

c. Lack of training for staff to discuss these issues with patients

d. Inability to include with patient intake and clinical workflow

e. Not needed

f. Other (please describe ___________)

13. Does your center integrate a statewide Prescription Drug Monitoring Program (PDMP) database into the health information systems, such as health information exchanges, EHRs, and/or pharmacy dispensing software (PDS) to streamline provider access to controlled substance prescriptions?

a. Yes

b. No

c. Not sure

Appendix E: Other Data Elements

Instructions

Health centers are becoming increasingly diverse and comprehensive in the care and services they provide. These questions capture the changing landscape of health care centers to include expanded services and delivery systems.

Questions

Report on these data elements as part of your UDS submission. Topics include medication-assisted treatment (MAT), telehealth, and outreach and enrollment assistance. Respond to each question based on your health center status *as of December 31*.

1. Medication-Assisted Treatment (MAT) for Opioid Use Disorder
   a. How many physicians, certified nurse practitioners, physician assistants, and certified nurse midwives,[1] on-site or with whom the health center has contracts, have obtained a Drug Addiction Treatment Act of 2000 (DATA) waiver to treat opioid use disorder with medications specifically approved by the U.S. Food and Drug Administration (FDA) for that indication?
   b. How many patients received MAT for opioid use disorder from a physician, certified nurse practitioner, or physician assistant, with a DATA waiver working on behalf of the health center?

2. Did your organization use telemedicine to provide remote clinical care services?

   (The term "telehealth" includes "telemedicine" services but encompasses a broader scope of remote health care services. Telemedicine is specific to remote clinical services, whereas telehealth may include remote non-clinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services.)

   a. Yes

   2a1. Who did you use telemedicine to communicate with? (Select all that apply.)
   - a. Patients at remote locations from your organization (e.g., home telehealth, satellite locations)
   - b. Specialists outside your organization (e.g., specialists at referral centers)

   2a2. What telehealth technologies did you use? (Select all that apply.)
   - a. Real-time telehealth (e.g., live videoconferencing)
   - b. Store-and-forward telehealth (e.g., secure e-mail with photos or videos of patient examinations)
   - c. Remote patient monitoring
   - d. Mobile Health (mHealth)

[1] With the enactment of the Comprehensive Addiction and Recovery Act of 2016, PL 114-198, opioid treatment prescribing privileges have been extended beyond physicians to include certain qualifying nurse practitioners (NPs), physician assistants (PAs), and certified nurse midwives (CNMs).

2a3. What primary telemedicine services were used at your organization? (Select all that apply.)

a. Primary care

b. Oral health

c. Behavioral health: Mental health

d. Behavioral health: Substance use disorder

e. Dermatology

f. Chronic conditions

g. Disaster management

h. Consumer health education

i. Provider-to-provider consultation

j. Radiology

k. Nutrition and dietary counseling

l. Other (Please specify: _________________)

b. **No.** If you did not have telemedicine services, please comment why. (Select all that apply.)

a. Have not considered/unfamiliar with telehealth service options

b. Policy barriers (Select all that apply)

i. Lack of or limited reimbursement

ii. Credentialing, licensing, or privileging

iii. Privacy and security

iv. Other (Please specify: ___________________)

c. Inadequate broadband/ telecommunication service (Select all that apply)

i. Cost of service

ii. Lack of infrastructure

iii. Other (Please specify: ___________________)

d. Lack of funding for telehealth equipment

e. Lack of training for telehealth services

f. Not needed

g. Other (Please specify: ___________________)

3. Provide the number of all assists provided during the past year by all trained assisters (e.g., certified application counselor or equivalent) working on behalf of the health center (employees, contractors, or volunteers), regardless of the funding source that is supporting the assisters' activities. Outreach and enrollment assists are defined as customizable education sessions about affordable health insurance coverage options (one-on-one or small group) and any other assistance provided by a health center assister to facilitate enrollment.

Enter number of assists ________________

Note: *Assists do not count as visits on the UDS tables.*

4. How many patients received a FDA-approved COVID-19 vaccine during the calendar year at your organization? _______

Note: *Exclude vaccines administered to health center patients while participating in clinical trials.*

Appendix F: Workforce

Instructions

It is important to understand the current state of health center workforce training and different staffing models to better support recruitment and retention of health center professionals. This section includes a series of questions on health center workforce.

Questions

Report on these data elements as part of your UDS submission. Topics include health professional education/training (do not include continuing education units) and satisfaction surveys. Respond to each question based on your health center status *as of December 31*.

1. Does your health center provide health professional education/training that is a hands-on, practical, or clinical experience?

   a. Yes

   b. No

1a. If yes, which category best describes your health center's role in the health professional education/training process? (Select all that apply.)

   a. Sponsor[2]

   b. Training site partner[3]

   c. Other (please describe ________________)

2. Please indicate the range of health professional education/training offered at your health center and how many individuals you have trained in each category[4] within the reporting year.

	a. Pre-Graduate/Certificate	b. Post-Graduate Training
Medical		
1. Physicians		
a. Family Physicians		
b. General Practitioners		
c. Internists		
d. Obstetrician/Gynecologists		
e. Pediatricians		
f. Other Specialty Physicians		
2. Nurse Practitioners		
3. Physician Assistants		
4. Certified Nurse Midwives		
5. Registered Nurses		
6. Licensed Practical Nurses/ Vocational Nurses		
7. Medical Assistants		

[2] A sponsor hosts a comprehensive health profession education and/or training program, the implementation of which may require partnerships with other entities that deliver focused, time-limited education and/or training (e.g., a teaching health center with a family medicine residency program).
[3] A training site partner delivers focused, time-limited education and/or training to learners in support of a comprehensive curriculum hosted by another health profession education provider (e.g., month-long primary care dentistry experience for dental students).
[4] Examples of pre-gcertificate training include student clinical rotations or externships. A residency, fellowship, or practicum would be examples of post-graduate training. Include non-health-center individuals trained by your health center.

	a. Pre-Graduate/Certificate	b. Post-Graduate Training
Dental		
8. Dentists		
9. Dental Hygienists		
10. Dental Therapists		
10a. Dental Assistants		
Mental Health and Substance Use Disorder		
11. Psychiatrists		
12. Clinical Psychologists		
13. Clinical Social Workers		
14. Professional Counselors		
15. Marriage and Family Therapists		
16. Psychiatric Nurse Specialists		
17. Mental Health Nurse Practitioners		
18. Mental Health Physician Assistants		
19. Substance Use Disorder Personnel		
Vision		
20. Ophthalmologists		
21. Optometrists		
Other Professionals		
22. Chiropractors		
23. Dieticians/Nutritionists		
24. Pharmacists		
25. Other (please specify ________)		

3. Provide the number of health center staff serving as preceptors at your health center: ____
4. Provide the number of health center staff (non-preceptors) supporting ongoing health center training programs: ____
5. How often does your health center implement satisfaction surveys for providers? (Select one.)
   a. Monthly
   b. Quarterly
   c. Annually
   d. We do not currently conduct provider satisfaction surveys
   e. Other (please describe _________)

6. How often does your health center implement satisfaction surveys for general staff (report provider surveys in question 5 only)? (Select one.)
   a. Monthly
   b. Quarterly
   c. Annually
   d. We do not currently conduct staff satisfaction surveys
   e. Other (please describe _________)

Nurse Visits for UDS Reporting

Visits must include three criteria in order to be reported in the UDS:

- The service must be documented.
- The service must include a real-time (face-to-face or virtual) contact between a patient and a licensed or credentialed provider.
- The provider must be exercising independent, professional judgment in the provision of services to the patient based on their unique training and skills.

Registered nurses may occasionally provide UDS-reportable services to patients. It is important that nurse visits:

- include the three criteria,
- are independent where the patient is not seen by another more advanced skilled medical provider on the date of service,
- are not among those services that are never reportable in the UDS (regardless of provider level) – see *Services and Persons Not Reported on the UDS Report* in the UDS Manual,
- are only counted when meeting the visit definitions, even if services are provided under standing orders of another medical provider, under specific instructions from a previous visit, or under the general supervision of a physician, nurse practitioner, physician assistant, or certified nurse.

The most common visit examples that nurses might count (again assuming all visit criteria is met and the patient is not seen by another provider at the same service delivery site on the same date of service) include:

- Triage
- Home health care where the patient is evaluated

Under no circumstances can the following be counted as nurse visits:

- Medication dispensing or administration including injections (e.g., flu shots, childhood vaccinations, Methadone, Depo-Provera, Coumadin)
- Screenings, tests, or laboratory services (e.g., PPD, HbA1c, pregnancy, blood pressure, COVID-19)
- Health status checks (e.g., wound care, health histories)
- Visits where the patient is then evaluated by another more advanced provider

The reference made in the manual of "*count visits charged and code as CPT 99211*" is to simply inform that the types of services that are most apt to be counted as nurse visits are those that are charged/billed using CPT code 99211 since the code is specifically for the evaluation and management of a patient's medical care.

There are instances when the health center does not charge for nurse visits. It is recommended that the health center track the countable, reportable visits using this code with either a zero charge or a fixed fee schedule charge with a corresponding sliding fee discount, if applicable, and/or bad debt write-off, based on the health center's policies and procedures.

Note: *Patients seen by a nurse for a reportable medical visit will be included in the UDS Report tables and corresponding medical metrics even if this is their only visit for the year. This means the visit will be included in the count of total medical visits and the patient will be included in all clinical quality care measures where they meet the age, sex, and/or disease criteria.*

Virtual UDS Visits Defined

- A virtual visit is one that meets all other requirements of a UDS visit except that it is not an in-person interaction between a patient and provider. Just as with interactions in-person, not all virtual interactions are countable.
- State and Federal telehealth definitions and regulations regarding acceptable modes of care delivery, types of providers, informed consent, and location of patient are not applicable in determining virtual visits for UDS reporting.

Glossary of Terms

Below are key terms used throughout this document.

- **Asynchronous/Store and forward:** Electronic transmission of medical information, such as x-rays, sonograms, other digital images, documents, and pre-recorded audio and/or videos that are not real-time interactions.
- **Distant/Consultant/Hub site:** Location of provider.
- **Mobile Health (mHealth):** Patient technologies, like smartphone and tablet apps, that enable patients to capture personal health data independent of an interaction with a clinician.
- **Originating/Patient/Spoke site:** Location of patient.
- **Remote patient monitoring:** Electronic transmission of collected medical data, such as vital signs, pulse, and blood pressure, from patients in one location (typically the home) to health care providers in a different location.
- **Synchronous/Live audio and/or video:** Use of two-way interactive audio and/or video technology, such as video conferencing, or other HIPAA compliant video connections between a provider and patient, or telephone, that are "live" or real-time interactions.
- **Telehealth:** Use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.
- **Telemedicine:** Telemedicine is a subset of telehealth services referring to remote clinical services.
- **UDS service categories:** Medical, dental, mental health, substance use disorder, vision, other professional, and enabling services.
- **Virtual visits:** Another term for telemedicine visits.

Virtual Visit Guidance for Health Centers

Guidance for UDS reporting is provided below. The table is arranged by topic area with UDS reporting instructions in blue, followed by clarification of the reporting requirements in white.

Virtual Visits

Count patients throughout the UDS (demographics, services, clinical, and financial sections) when their visits qualify as a virtual visit, consistent with the health center's scope of project, even if the virtual visit is the first or only visit for the patient during the reporting period, and even if the visit is not billed (though almost all medical, dental, and mental health visits are normally billed). Accordingly, for patients who had virtual visits, the patient must be registered and all relevant demographic, insurance, clinical, and other data about the patients must be collected and reported.

Reporting Guidance	Note
Virtual visits within the seven (7) UDS service categories are eligible to be included as countable visits, if those services meet all other countable visit definitions.	The seven service categories include: medical, dental, mental health, substance use disorder, vision, other professional, and enabling services. Although reimbursement for items billed is not 'required' to count as a visit for UDS, health centers should consider Health Center Program rules for maximizing revenue and determining eligibility for sliding discounts. Do not count the types of services that are unreportable interactions in the UDS, such as distance monitoring of patients' vitals, prescription refills, and provider reading of lab, x-ray, or other test results. Virtual group sessions that meet the visit definitions are countable only under the mental health or substance use disorder services categories.

Provision of Care

- If the health center provider virtually provided care to a patient who is elsewhere (not physically at a health center), count the patient and the virtual visit.
- If the health center has authorized patient services by another provider (not at the health center) who provided the care to the patient at the health center through virtual visits and the health center paid for the services, count the patient and the visit as a virtual visit.
- If the health center has referred the patient's care to another provider and the health center did not pay for the service, do not count.

Reporting Guidance	Note
Virtual visits provided by the health center or by paid referral are counted.	If the originating location of the patient is at the health center and the patient received care from a non-health center provider at a distant location, the health center may bill a facility fee. However, for purposes of UDS reporting, do not count the visit unless the health center paid for the service. The provider needs access to the health center's HIT/EHR to record their activities and review the patient's record.

Modes

Only count virtual visits provided using interactive, synchronous audio and/or video telecommunication systems that permit real-time communication between a distant provider and a patient.

Reporting Guidance	Note
Despite the numerous modes of virtual visits, limitations are set to match UDS reporting definitions of visits.	**A Countable Visit** Live video and/or audio (synchronous, real time): Use of two-way interactive audio (i.e., telephone) and/or video technology, such as video connections between a provider and a patient (i.e., "face-time"). **Not a Countable Visit** Store and forward (asynchronous, not real time): Electronic transmission of medical information, such as digital images, documents, and pre-recorded videos. Remote patient monitoring: Electronic transmission of collected medical data, such as vital signs and blood pressure, from patients in one location to health care providers in a different location. Mobile Health (mHealth): Technologies, such as smartphone and tablet apps, that enable patients to capture their own health data without a clinician's assistance or interpretation. Other asynchronous technologies: Email, fax, internet/online questionnaires, prescribing, or other transmissions.

Coding

Use telehealth-specific codes with the CPT or Healthcare Common Procedure Coding System (HCPCS) codes such as G0071, G0406-G0408, G0425-G0427, G2025, modifier ".95," or Place of Service code "02" or"50" to identify virtual visits.

Reporting Guidance	Note
Codes must be used to demonstrate services provided to patients via interactive audio and/or video telecommunication systems.	Use only eligible CPT or HCPCS codes. Although third-party payers may not recognize or pay for virtual visits, they must be coded and charged. Charges are generally comparable to clinic visit charges. Do not count services as virtual visits if they are not coded as such. Telehealth services coded with a "GQ" (used for asynchronous, or store and forward technologies) modifier cannot be counted as a visit. Do not count consultations (such as CPT 99241-99245) in the UDS as virtual visits.

Multiple Visits

On any given day, count one and only one visit per patient per service category, regardless of the number of visits, including virtual visits. The only exception is if there are two different providers at two different locations providing care on that same day.

Reporting Guidance	Note
Limitations to count visits are applied for multiple patient visits (in-person and virtual or multiple virtual) on the same day by the same service category or provider type.	When a patient is seen by a provider in-person at the health center and separately by a distant (virtual) provider of the same service category on the same day, count each as a visit (one clinic visit and one virtual visit) if the service with the distant provider is paid for by the health center or performed by a health center provider. When a patient is with staff from the health center who is supporting the service and the patient receives services from a distant provider, count this as one virtual visit, and ***only*** if the health center paid for or provided the care virtually.

Virtual Visit Updates during COVID-19

The recent public health emergency due to the Coronavirus has accelerated interest in and the use of virtual care. Important considerations for virtual visits as of 2020 are outlined below:

- With an increase in virtual visits, there may be a decrease in clinic visits resulting in an impact of reported clinical quality measures. Please refer to CMS guidance and the telehealth guidance on reporting clinical quality measures as they relate to virtual visits.
- The Coronavirus Preparedness and Response Supplemental Appropriations Act waives certain Medicare telehealth payment requirements during the Public Health Emergency to allow beneficiaries in all areas of the country to receive telehealth services. Under the waiver, limitations on where Medicare patients are eligible for telehealth will be removed during the emergency. In particular, patients outside of rural areas, and patients in their homes will be eligible for telehealth services.

Telehealth Resources for Health Centers

Telehealth can be an important tool for improving access to quality health care, especially for underserved and medically vulnerable populations. Here are some resources for health centers interested in offering or expanding telehealth services:

- Health Information Technology, Evaluation, and Quality Center (HITEQ): a HRSA-funded National Cooperative Agreement.

- Telehealth Resource Centers: 12 HRSA-supported regional and two national centers (including the Center for Connected Health Policy) provide expert and customizable technical assistance, advice on telehealth technology and state specific regulations and policies such Medicaid or private payers as well as Medicare.

- Centers for Medicare and Medicaid Services Telehealth: provides Medicare telehealth services definitions.

- Medicare Telehealth Payment Analyzer: checks if an address is eligible for Medicare telehealth originating site payment.

- State Medicaid & CHIP Telehealth Toolkit: a resource to aggregate telehealth information and highlights questions that health centers may ask themselves when establishing new telehealth policy.

- List of Medicare Telehealth Codes: provides a list of services payable under the Medicare Physician Fee Schedule when furnished via telehealth.

UDS: UNIFORM DATA SYSTEM

Mental Health and Substance Use Disorder Services Detail Addendum Guidance

Purpose

The purpose of the addendum of Table 5 – *Selected Service* Detail is to fully capture integrated primary care and behavioral health treatment services provided in health centers. Reporting on an expanded group of health care providers who address mental health and substance use disorders better reflects the comprehensive, integrated model of care provided in health centers.

Specifically, the addendum captures information on:

- Mental health (MH) services provided by medical providers.
- Substance use disorder (SUD) services provided by medical and mental health providers.

Together, the addendum and services/visits reported in the main part of Table 5 provide an unduplicated representation of mental health and substance use disorder services across all provider types.

The patients and visits reported in the Selected Service Detail addendum involve a subset of activity already reported in the medical and/or mental health visits of the main part of Table 5.

- ✓ MH services provided in medical visits by medical providers (reported in the addendum, Lines 20a01 through 20a04) are a subset of *medical visits and patients* (main part of Table 5, Lines 1 through 10a and Line 15). They are **not** a subset of MH visits and patients.

- ✓ SUD services provided in medical visits by medical providers (reported in the addendum, Lines 21a through 21d) are a subset of *medical visits and patients* (main part of Table 5, Lines 1 through 10a and Line 15). They are **not** a subset of SUD visits and patients.

- ✓ SUD services provided in mental health visits by mental health providers (reported in the addendum, Lines 21e through 21h) are a *subset* of *mental health visits and patients* (main part of Table 5, Lines 20a through 20b and Line 20). They are **not** a subset of SUD visits and patients.

Some medical visits (clinic or virtual) may involve both MH and SUD treatment and will be reported in both addendum sections.

Data in the addendum are reported only on the Universal table, not the Grant Report tables.

Addendum Instructions

The Addendum to Table 5 – *Selected Service Detail* is divided into two service categories: mental health and substance use disorder detail. For each service category, report the number of:

- Providers (not FTE) by type who provided mental health and/or substance use disorder treatment in Column a1. The provider can be counted once in each service category if they provide both services.
  - ✓ For MH Service Detail, count MH treatment provided by Physicians (other than psychiatrists), Nurse Practitioners, Physician Assistants, or Certified Nurse Midwives.
  - ✓ For SUD Detail, count SUD treatment provided by Psychiatrists, other Physicians, Nurse Practitioners, Physician Assistants, Clinical Nurse Midwives, Licensed Clinical Psychologists, and Licensed Clinical Social Workers, or Other Licensed Mental Health Providers including Psychiatric Nurse Practitioners.
  - ✓ Contract providers paid by the visit are not reported in the FTE columns in the main portion of Table 5, but they will be reported in the *Selected Service Detail* section. It is possible to report, for example, zero providers on a line in the main section of Table 5, but one or more in the corresponding line of the Selected Service Detail.
- Visits that patients had for these services by provider type. Report in-person clinic visits in Column b and virtual visits in Column b2.
  - ✓ Report visits that include treatment for MH on the addendum Lines 20a01 through 20a04 and treatment for SUD services on the addendum Lines 21a through 21h.
  - ✓ Use ICD-10 diagnostic codes associated with the visit to document/count the delivery of MH services by medical providers, and SUD services by medical and mental health providers.
    - Include at minimum ICD-10 diagnosis codes specified on Table 6A, lines 18-19a for SUD treatment made by medical and MH providers, and diagnosis codes specified on lines 20a-20d for MH treatment made by medical providers.
  - ✓ Exclude visits that only provide the following MH or SUD services:
    - Screening
    - Medication delivery or refill
    - Patient education
    - Referral
    - Case management
  - ✓ MH and SUD treatment services should be reported even if there is no associated billing or reimbursement for the provision of these services.
  - ✓ See the Virtual Visit Reporting Guidance for specific requirements for reporting virtual visits.
- Patients seen for these services by provider type in Column c.

Example Scenarios

Scenarios are arranged below by topic area with guidance for UDS reporting of mental health and substance use disorder activity on the main part of Table 5 and the selected services addendum of Table 5.

Integrated Visits

When a medical provider delivers mental health treatment (in whole or in part) as part of a medical visit, count the visit on the appropriate line by provider type in the main part of Table 5 (on lines 1-10a) and on the appropriate line in the *Selected Service Detail* addendum (20a01-20a04).

When a medical or mental health provider provides substance use disorder treatment, count the visit on the appropriate line by provider type in the main part of Table 5 (on lines 1-10a or 20a-20b) and the appropriate line in the *Selected Service Detail* addendum (21a-21h).

Situation	Note
A family physician who sees a patient for an annual check-up, and during that visit the provider also treats the patient for depression and opioid use disorder (OUD).	The visit will be reported in three different places on Table 5: ✓ Report the visit provided by the family physician and the physician's full-time equivalent (FTE) in the main part of Table 5 on Line 1, and include the patient in the total on Line 15. ✓ Report the depression treatment provided by the physician (personnel, visit, and patient) in the MH *Selected Service Detail* addendum, Line 20a01. ✓ Report the treatment provided for OUD (personnel, visit, and patient) in the SUD *Selected Service Detail* addendum, Line 21a.
A licensed clinical psychologist sees a patient for depression complicated by an alcohol-related disorder.	The visit is reported in two different places on Table 5: ✓ Report the treatment services visit and the clinical psychologist FTE in the main part of Table 5 on Line 20a1, and the patient in the total on Line 20. ✓ Report the alcohol-related treatment provided by the clinical psychologist (personnel, visit, & patient) in the SUD *Selected Service Detail* addendum, Line 21f.

Visits Related to Medication

Count services as visits only when they meet all the UDS visit criteria (refer to page 19 or the UDS Manual). Never count medication administration, dispensing, prescription refills, or referrals as a visit.

Situation	Note
A nurse practitioner (NP) evaluates and discusses an anti-depressant regimen by phone with the patient.	This virtual visit will be reported twice on Table 5: ✓ Report the evaluation visit and the NP FTE in the main part of Table 5 on Line 9a (Column b2), and the patient in the total on Line 15. ✓ Report the mental health treatment services provided by the NP (personnel, virtual visit, & patient) in the MH *Selected Service Detail* addendum, Line 20a02.
An internist discusses a refill of antidepressant medication with a patient.	Do not count the interaction as a visit on the main part of Table 5 or the addendum. It does not meet the criteria for a reportable visit in the UDS Report.

Clarifications

This section includes references for UDS Tables that are referred to this file that will support your understanding of the Mental Health and Substance Use Disorder Services Detail Addendum. It includes table snippets mentioned throughout the file, including specific line references?

Main part of Table 5, Medical – Describes the activity reported in the Total Medical Care Services section, Table 5, Line 15.

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1	Family Physicians				
2	General Practitioners				
3	Internists				
4	Obstetrician/Gynecologists				
5	Pediatricians				
7	Other Specialty Physicians				
8	**Total Physicians** (Lines 1–7)				
9a	Nurse Practitioners				
9b	Physician Assistants				
10	Certified Nurse Midwives				
10a	**Total NPs, Pas, and CNMs** (Lines 9a–10)				
15	**Total Medical Care Services** (Lines 8 + 10a through 14)				

Main part of Table 5, Mental Health – Describes the activity reported in the Total Mental Health Services section, Table 5, Line 20.

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
20a	Psychiatrists				
20a1	Licensed Clinical Psychologists				
20a2	Licensed Clinical Social Workers				
20b	Other Licensed Mental Health Providers				
20	**Total Mental Health Services** (Lines 20a–c)				

Main part of Table 5, Substance Use Disorder – Describes the activity reported in the Substance Use Disorder Services section, Table 5, Line 21.

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
21	**Substance Use Disorder Services**				

Addendum, Mental Health Service Detail – Describes the activity reported in the Mental Health Service Detail section, Table 5 Selected Service Detail Addendum, Lines 20a01-20a04.

Line	Personnel by Major Service Category: Mental Health Service Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
20a01	Physicians (other than Psychiatrists)				
20a02	Nurse Practitioners				
20a03	Physician Assistants				
20a04	Certified Nurse Midwives				

Addendum, Substance Use Disorder Detail – Describes the activity reported in the Substance Use Disorder Detail section, Table 5 Selected Service Detail Addendum, Lines 21a-21h.

Line	Personnel by Major Service Category: Substance Use Disorder Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
21a	Physicians (other than Psychiatrists)				
21b	Nurse Practitioners (Medical)				
21c	Physician Assistants				
21b	Certified Nurse Midwives				
21e	Psychiatrists				
21f	Licensed Clinical Psychologists				
21g	Licensed Clinical Social Workers				
21h	Other Licensed Mental Health Providers				

Table 6A, Selected Mental Health Diagnosis – Describes the activity reported in the Selected Mental Health Conditions, Substance Use Disorders, and Exploitations section, Table 6A Selected Diagnoses and Services Rendered, Lines 20a-20d.

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
	Selected Mental Health Conditions, Substance Use Disorders, and Exploitations			
20a	Depression and other mood disorders	F30- through F39-		
20b	Anxiety disorders, including post-traumatic stress disorder (PTSD)	F06.4, F40- through F42-, F43.0, F43.1-, F93.0		
20c	Attention deficit and disruptive behavior disorders	F90- through F91-		
20d	Other mental disorders, excluding drug or alcohol dependence	F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0- and F43.1-), F50- through F99- (exclude F55-, F84.2, F90-, F91-, F93.0, F98-), O99.34-, R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0		

Table 6A, Selected Substance Use Diagnosis – Describes the activity reported in the Selected Mental Health Conditions, Substance Use Disorders, and Exploitations section, Table 6A Selected Diagnoses and Services Rendered, Lines 18-19a.

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
	Selected Mental Health Conditions, Substance Use Disorders, and Exploitations			
18	Alcohol-related disorders	F10-, G62.1, O99.31-		
19	Other substance-related disorders (excluding tobacco use disorders)	F11- through F19- (exclude F17-), G62.0, O99.32-		
19a	Tobacco use disorder	F17-, O99.33-		

Table 6A: Selected Diagnoses and Services Rendered

** Indicates change from 2019*

Line	Diagnosis/Service	2019 Codes	2020 Codes
	Selected Infectious and Parasitic Diseases		
1-2	Symptomatic/Asymptomatic human immunodeficiency virus (HIV)	B20, B97.35, O98.7-, Z21	B20, B97.35, O98.7-, Z21
3	Tuberculosis	A15- through A19-, O98.0-	A15- through A19-, O98.0-
4	Sexually transmitted infections	A50- through A64- (exclude A63.0)	A50- through A64-
4a	Hepatitis B	B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, O98.4-	B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.1-, O98.4-
4b	Hepatitis C	B17.10, B17.11, B18.2, B19.20, B19.21	B17.1-, B18.2, B19.2-
4c	Novel coronavirus (SARS-CoV-2) disease		U07.1
	Selected Diseases of the Respiratory System		
5	Asthma	J45-	J45-
6	Chronic lower respiratory diseases	J40- through J44-, J47	J40 (count only when code U07.1 **is not** present), J41- through J44-, J47-
6a	Acute respiratory illness due to novel coronavirus (SARS-CoV-2) disease		J12.89, J20.8, J40, J22, J98.8, J80 (count only when code U07.1 **is** present)
	Selected Other Medical Conditions		
7	Abnormal breast findings, female	C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.81, D05-, D48.6-, D49.3, N60-, N63-, R92-	C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.81, D05-, D48.6-, D49.3, N60-, N63-, R92-
8	Abnormal cervical finding	C53-, C79.82, D06-, R87.61-, R87.629, R87.810, R87.820	C53-, C79.82, D06-, R87.61-, R87.629, R87.810, R87.820
9	Diabetes mellitus	E08- through E13-, O24- (exclude O24.41-)	E08- through E13-, O24- (exclude O24.41-)

Line	Diagnosis/Service	2019 Codes	2020 Codes
10	Heart disease (selected)	I01-, I02- (exclude I02.9), I20- through I25-, I27-, I28-, I30- through I52-	I01-, I02- (exclude I02.9), I20- through I25-, I27-, I28-, I30- through I52-
11	Hypertension	I10- through I16-, O10-, O11-	I10- through I16-, O10-, O11-
12	Contact dermatitis and other eczema	L23- through L25-, L30- (exclude L30.1, L30.3, L30.4, L30.5), L58-	L23- through L25-, L30- (exclude L30.1, L30.3, L30.4, L30.5), L58-
13	Dehydration	E86-	E86-
14	Exposure to heat or cold	T33-, T34-, T67-, T68-, T69-, W92-, W93-	T33-, T34-, T67-, T68-, T69-, W92-, W93-
14a	Overweight and obesity	E66-, Z68- (exclude Z68.1, Z68.20 through Z68.24, Z68.51, Z68.52)	E66-, Z68- (exclude Z68.1, Z68.20 through Z68.24, Z68.51, Z68.52)
	Selected Childhood Conditions (limited to ages 0 through 17)		
15	Otitis media and Eustachian tube disorders	H65- through H69-	H65- through H69-
16	Selected perinatal/neonatal medical conditions	A33-, P19-, P22- through P29- (exclude P29.3), P35- through P96- (exclude P54-, P91.6-, P92-, P96.81), R78.81, R78.89	A33-, P19-, P22- through P29- (exclude P29.3), P35- through P96- (exclude P54-, P91.6-, P92-, P96.81), R78.81, R78.89
17	Lack of expected normal physiological development (such as delayed milestone, failure to gain weight, failure to thrive); nutritional deficiencies in children only. Does not include sexual or mental development.	E40- through E46-, E50- through E63-, P92-, R62- (exclude R62.7), R63.3	E40- through E46-, E50- through E63-, P92-, R62- (exclude R62.7), R63.3
	Selected Mental Health Conditions, Substance Use Disorders, and Exploitations		
18	Alcohol-related disorders	F10-, G62.1, O99.31-	F10-, G62.1, O99.31-
19	Other substance-related disorders (excluding tobacco use disorders)	F11- through F19- (exclude F17-), G62.0, O99.32-	F11- through F19- (exclude F17-), G62.0, O99.32-
19a	Tobacco use disorder	F17-, O99.33-	F17-, O99.33-

Line	Diagnosis/Service	2019 Codes	2020 Codes
20a	Depression and other mood disorders	F30- through F39-	F30- through F39-
20b	Anxiety disorders including post-traumatic stress disorder (PTSD)	F06.4, F40- through F42-, F43.0, F43.1-, F93.0	F06.4, F40- through F42-, F43.0, F43.1-, F93.0
20c	Attention deficit and disruptive behavior disorders	F90- through F91-	F90- through F91-
20d	Other mental disorders, excluding drug or alcohol dependence	F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0- and F43.1-), F50- through F99- (exclude F55-, F84.2, F90-, F91-, F93.0, F98-), O99.34-, R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0	F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0- and F43.1-), F50- through F99- (exclude F55-, F84.2, F90-, F91-, F93.0, F98-), O99.34-, R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0
20e	Human trafficking		T74.5- through T74.6-, T76.5- through T76.6-, Z04.81, Z04.82, Z62.813, Z91.42
20f	Intimate partner violence		T74.11, T74.21, T74.31, Z69.11, Y07.0
	Selected Diagnostic Tests/Screening/Preventive Services		
21	HIV test	**CPT-4:** 86689, 86701 through 86703, 87389 through 87391, 87534 through 87539, 87806	**CPT-4:** 86689, 86701 through 86703, 87389 through 87391, 87534 through 87539, 87806
21a	Hepatitis B test	**CPT-4:** 86704 through 86707, 87340, 87341, 87350	**CPT-4:** 86704 through 86707, 87340, 87341, 87350
21b	Hepatitis C test	**CPT-4:** 86803, 86804, 87520 through 87522	**CPT-4:** 86803, 86804, 87520 through 87522
21c	Novel coronavirus (SARS-CoV-2) diagnostic test		**CPT-4:** 87426, 87635 **HCPCS:** U0001, U0002, U0003, U0004 **CPT PLA:** 0202U, 0223U, 0225U
21d	Novel coronavirus (SARS-CoV-2) antibody test		**CPT-4:** 86328, 86408, 86409, 86769 **CPT PLA:** 0224U, 0226U

Line	Diagnosis/Service	2019 Codes	2020 Codes
21e	Pre-Exposure Prophylaxis (PrEP)-associated management of **all** PrEP patients		**CPT-4:** 99401-99404 **ICD-10:** Z11.3, Z11.4, Z20.2, Z20.6, Z51.81, Z71.51, Z71.7, Z79.899 Limit to emtricitabine/tenofovir disoproxil fumarate (FTC/TDF) or emtricitabine/tenofovir alafenamide (FTC/TAF) for PrEP
22	Mammogram	**CPT-4:** 77065, 77066, 77067 OR **ICD-10:** Z12.31	**CPT-4:** 77065, 77066, 77067 **ICD-10:** Z12.31
23	Pap test	**CPT-4:** 88141 through 88153, 88155, 88164 through 88167, 88174, 88175 **ICD-10:** Z01.41-, Z01.42, Z12.4 (exclude Z01.411, and Z01.419)	**CPT-4:** 88141 through 88153, 88155, 88164 through 88167, 88174, 88175 **ICD-10:** Z01.41-, Z01.42, Z12.4 (exclude Z01.411, and Z01.419)
24	Selected immunizations: hepatitis A; haemophilus influenzae B (HiB); pneumococcal, diphtheria, tetanus, pertussis (DTaP) (DTP) (DT); measles, mumps, rubella (MMR); poliovirus; varicella; hepatitis B	**CPT-4:** 90632, 90633, 90634, 90636, 90643, 90644, 90645, 90646, 90647, 90648, 90669, 90670, 90696, 90697, 90698, 90700, 90701, 90702, 90703, 90704, 90705, 90706, 90707, 90708, 90710, 90712, 90713, 90714, 90715, 90716, 90718, 90720, 90721, 90723, 90730, 90731, 90732, 90740, 90743, 90744, 90745, 90746, 90747, 90748	**CPT-4:** 90632, 90633, 90634, 90636, 90643, 90644, 90645, 90646, 90647, 90648, 90669, 90670, 90696, 90697, 90698, 90700, 90701, 90702, 90703, 90704, 90705, 90706, 90707, 90708, 90710, 90712, 90713, 90714, 90715, 90716, 90718, 90720, 90721, 90723, 90730, 90731, 90732, 90740, 90743, 90744, 90745, 90746, 90747, 90748
24a	Seasonal flu vaccine	**CPT-4:** 90630, 90653 through 90657, 90658, 90661, 90662, 90672, 90673, 90674, 90682, 90685 through 90689, 90749, 90756	**CPT-4:** 90630, 90653 through 90657, 90658, 90661, 90662, 90672, 90673, 90674, 90682, 90685 through 90689, 90756
25	Contraceptive management	**ICD-10:** Z30-	**ICD-10:** Z30-
26	Health supervision of infant or child (ages 0 through 11)	**CPT-4:** 99381 through 99383, 99391 through 99393 **ICD-10:** Z00.1-	**CPT-4:** 99381 through 99383, 99391 through 99393 **ICD-10:** Z00.1-

Line	Diagnosis/Service	2019 Codes	2020 Codes
26a	Childhood lead test screening (9 to 72 months)	**ICD-10:** Z13.88 **CPT-4:** 83655	**ICD-10:** Z13.88 **CPT-4:** 83655
26b	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	**CPT-4:** 99408, 99409 **HCPCS:** G0396, G0397, G0443, H0050	**CPT-4:** 99408, 99409 **HCPCS:** G0396, G0397, G0443, H0050
26c	Smoke and tobacco use cessation counseling	**CPT-4:** 99406, 99407 OR **HCPCS:** S9075 OR **CPT-II:** 4000F, 4001F, 4004F	**CPT-4:** 99406, 99407 **HCPCS:** S9075 **CPT-II:** 4000F, 4001F, 4004F
26d	Comprehensive and intermediate eye exams	**CPT-4:** 92002, 92004, 92012, 92014	**CPT-4:** 92002, 92004, 92012, 92014
	Selected Dental Services		
27	Emergency services	**ADA:** D0140, D9110	**CDT:** D0140, D9110
28	Oral exams	**ADA:** D0120, DO145, D0150, D0160, D0170, D0171, D0180	**CDT:** D0120, DO145, D0150, D0160, D0170, D0171, D0180
29	Prophylaxis—adult or child	**ADA:** D1110, D1120	**CDT:** D1110, D1120
30	Sealants	**ADA:** D1351	**CDT:** D1351
31	Fluoride treatment—adult or child	**ADA:** D1206, D1208 **CPT-4:** 99188	**CDT:** D1206, D1208 **CPT-4:** 99188
32	Restorative services	**ADA:** D21xx through D29xx	**CDT:** D21xx through D29xx
33	Oral surgery (extractions and other surgical procedures)	**ADA**: D7xxx	**CDT**: D7xxx
34	Rehabilitative services (Endo, Perio, Prostho, Ortho)	ADA: D3xxx, D4xxx, D5xxx, D6xxx, D8xxx	**CDT:** D3xxx, D4xxx, D5xxx, D6xxx, D8xxx

** Indicates change from 2019*

Table	Line/ Section	Measurement Name	eCQM Code	Brief Measure Description	Denominator (Universe)	Numerator	Exclusions/Exceptions	2019 National Average	Major Changes 2019 to 2020	Major Diff. UDS to eCQM
6B	7-9	Early Entry into Prenatal Care	no eCQM	Percentage of prenatal care patients who entered prenatal care during their first trimester	Patients seen for prenatal care during the year	Patients beginning prenatal care at the health center or with a referral provider, or with the another prenatal care provider, during their first trimester	None	73.81%	None	None
6B	10	Childhood Immunization Status	CMS117v8	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three or four H influenza type B (HiB); three Hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one Hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	Children who turn 2 years of age during the measurement period and who had a medical visit during the measurement period	Children who have evidence showing they received recommended vaccines, had documented history of the illness, had a seropositive test result, or had an allergic reaction to the vaccine by their second birthday	Patients who were in hospice care during the measurement period	39.75%	Numerator: Updated with addition of 4 dose HiB vaccine (does depends on the manufacturer of the vaccine)	None
6B	11	Cervical Cancer Screening	CMS124v8	Percentage of women 21*–64 years of age who were screened for cervical cancer using either of the following criteria: •Women age 21*–64 who had cervical cytology performed every 3 years •Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years Note: *Use 23 as the initial age to include in assessment.	Women 23 through 64 years of age with a medical visit during the measurement period	Women with one or more screenings for cervical cancer. Appropriate screenings are defined by any one of the following criteria: •Cervical cytology performed during the measurement period or the 2 years prior to the measurement period for women who are at least 21 years old at the time of the test. •Cervical cytology/HPV co-testing performed during the measurement period or the 4 years prior to the measurement period for women who are at least 30 years old at the time of the test.	•Women who had a hysterectomy with no residual cervix or a congenital absence of cervix •Women who were in hospice care during the measurement period	56.53%	None	None

Table	Line/ Section	Measurement Name	eCQM Code	Brief Measure Description	Denominator (Universe)	Numerator	Exclusions/Exceptions	2019 National Average	Major Changes 2019 to 2020	Major Diff. UDS to eCQM
6B	11a	Breast Cancer Screening	CMS125v8	Percentage of women 50*–74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period Note: *Use 51 as the initial age to include in assessment.	Women 51 through 73 years of age with a medical visit during the measurement period Note: Use 51 as the initial age to include in assessment.	Women with one or more mammograms during the 27 months prior to the end of the measurement period	•Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy •Patients who were in hospice care during the measurement period •Patients aged 66 or older who were living long-term in an institution for more than 90 days during the measurement period •Patients aged 66 and older with advanced illness and frailty	N/A	New	None
6B	12	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	CMS155v8	Percentage of patients 3–17* years of age who had an outpatient medical visit and who had evidence of height, weight, and body mass index (BMI) percentile documentation and who had documentation of counseling for nutrition and who had documentation of counseling for physical activity during the measurement period Note: *Use age 3 through 16 at the start of the measurement year as the initial age to include in assessment.	Patients 3 through 16 years of age with at least one outpatient medical visit during the measurement period	Children and adolescents who have had: • Their BMI percentile (not just BMI or height and weight) recorded during the measurement period and • Counseling for nutrition during the measurement period and • Counseling for physical activity during the measurement period	•Patients who have a diagnosis of pregnancy during the measurement period •Patients who were in hospice care during the measurement period	71.21%	None	• eCQM denominator is limited to outpatient visits with a primary care physician or OB /GYN. UDS includes children seen by NPs and PAs • Numerator BMI, nutrition, and activity are reported separately in the eCQM, but combined in the UDS

Table	Line/ Section	Measurement Name	eCQM Code	Brief Measure Description	Denominator (Universe)	Numerator	Exclusions/Exceptions	2019 National Average	Major Changes 2019 to 2020	Major Diff. UDS to eCQM
6B	13	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	CMS69 v8	Percentage of patients aged 18 years and older with BMI documented during the most recent visit or within the previous 12 months to that visit and, when the BMI is outside of normal parameters, a follow-up plan is documented during the visit or during the previous 12 months of that visit	Patients 18 years of age or older on the date of the visit with at least one medical visit during the measurement period	Patients with: •a documented BMI (not just height and weight) during their most recent visit in the measurement period or during the previous 12 months of that visit, and •when the BMI is outside of normal parameters, a follow-up plan is documented during the visit or during the previous 12 months of the current visit Note: Include in the numerator patients within normal parameters who had their BMI documented and those with a follow-up plan if BMI is outside normal parameters.	•Patients who are pregnant during the measurement period •Patients receiving palliative care during or prior to the visit •Patients who refuse measurement of height and/or weight •Patients with a documented medical reason (see Specification Guidance) •Patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status	72.43%	None	None
6B	14a	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS138v8	Percentage of patients aged 18 and older who were screened for tobacco use one or more times within 24 months and who received cessation counseling intervention if defined as a tobacco user	Patients aged 18 years and older seen for at least two medical visits in the measurement period or at least one preventive medical visit during the measurement period.	• Patients who were screened for tobacco use at least once within 24 months before the end of the measurement period and • Who received tobacco cessation intervention if identified as a tobacco user	Documentation of medical reason(s) for not screening for tobacco use or for not providing tobacco cessation intervention (e.g., limited life expectancy, other medical reason)	87.17%	None	Three separate rates are reported in the eCQM, but combined in the UDS

Table	Line/ Section	Measurement Name	eCQM Code	Brief Measure Description	Denominator (Universe)	Numerator	Exclusions/Exceptions	2019 National Average	Major Changes 2019 to 2020	Major Diff. UDS to eCQM
6B	17a	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	[CMS347v3]()	Percentage of the following patients at high risk of cardiovascular events aged 21 years and older who were prescribed or were on statin therapy during the measurement period: • Patients 21 years of age or older who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD), or • Patients 21 years of age or older who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level greater than or equal to 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia, or • Patients 40 through 75 years of age with a diagnosis of diabetes with a fasting or direct LDL-C level of 70–189 mg/dL	• Patients 21 years of age and older who have an active diagnosis of ASCVD or ever had a fasting or direct laboratory result of LDL-C greater than or equal to 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia, or patients 40 through 75 years of age with Type 1 or Type 2 diabetes and with an LDL-C result of 70–189 mg/dL recorded as the highest fasting or direct laboratory test result in the measurement year or the 2 years prior; with a medical visit during the measurement period	• Patients who are actively using or who received an order (prescription) for statin therapy at any point during the measurement period	•Patients who have a diagnosis of pregnancy •Patients who are breastfeeding •Patients who have a diagnosis of rhabdomyolysis •Patients with adverse effect, allergy, or intolerance to statin medication •Patients who are receiving palliative care •Patients with active liver disease or hepatic disease or insufficiency •Patients with end-stage renal disease (ESRD) •Patients 40 through 75 years of age with diabetes whose most recent fasting or direct LDL-C laboratory test result was less than 70 mg/dL and who are not taking statin therapy	69.94%	None	None
6B	18	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	[CMS164v7]()	Percentage of patients aged 18 years of age and older who were diagnosed with acute myocardial infarction (AMI), or who had a coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCIs) in the 12 months prior to the measurement period, or who had an active diagnosis of IVD during the measurement period, and who had documentation of use of aspirin or another antiplatelet during the measurement period	Patients 18 years of age and older with a medical visit during the measurement period who had an AMI, CABG, or PCI during the 12 months prior to the measurement year or who had a diagnosis of IVD overlapping the measurement period	Patients who had an active medication of aspirin or another antiplatelet during the measurement period	•Patients who had documentation of use of anticoagulant medications overlapping the measurement period •Patients who were in hospice care during the measurement period	80.78%	None	None Note: This measure is no longer e-specified. Use CMS164v7 specifications for UDS reporting

Table	Line/ Section	Measurement Name	eCQM Code	Brief Measure Description	Denominator (Universe)	Numerator	Exclusions/Exceptions	2019 National Average	Major Changes 2019 to 2020	Major Diff. UDS to eCQM
6B	19	Colorectal Cancer Screening	CMS130v8	Percentage of adults 50–75 years of age who had appropriate screening for colorectal cancer	Patients 50 through 74 years of age with a medical visit during the measurement period	Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria: •Fecal occult blood test (FOBT) during the measurement period •Fecal immunochemical test (FIT)-deoxyribonucleic acid (DNA) during the measurement period or the 2 years prior to the measurement period •Flexible sigmoidoscopy during the measurement period or the 4 years prior to the measurement period •Computerized tomography (CT) colonography during the measurement period or the 4 years prior to the measurement period •Colonoscopy during the measurement period or the 9 years prior to the measurement period	•Patients with a diagnosis of colorectal cancer or a history of total colectomy •Patients who were in hospice care during the measurement period •Patients aged 66 or older who were living long-term in an institution for more than 90 days during the measurement period •Patients aged 66 and older with advanced illness and frailty	45.56%	Two exclusions added for patients aged 66 and older living in long-term institutions or with advances illness or frailty	None
6B	20	HIV Linkage to Care	no eCQM	Percentage of patients newly diagnosed with HIV who were seen for follow-up treatment within 30 days of diagnosis	Patients first diagnosed with HIV by the health center between December 1 of the prior year through November 30 of the current measurement year and who had at least one medical visit during the measurement period or prior year	Newly diagnosed HIV patients that received treatment within 30 days of diagnosis. Include patients who were newly diagnosed by your health center providers and: •had a medical visit with your health center provider who initiates treatment for HIV, or •had a visit with a referral resource who initiates treatment for HIV.	Patients already having diagnosis of HIV prior to measurement period	87.21%	None	None

Table	Line/ Section	Measurement Name	eCQM Code	Brief Measure Description	Denominator (Universe)	Numerator	Exclusions/Exceptions	2019 National Average	Major Changes 2019 to 2020	Major Diff. UDS to eCQM
6B	20a	HIV Screening	CMS349v2	Percentage of patients aged 15–65 at the start of the measurement period who were between 15–65 years old when tested for HIV	Patients aged 15 through 65 years of age at the start of the measurement period and with at least one outpatient medical visit during the measurement period	Patients with documentation of an HIV test performed on or after their 15th birthday and before their 66th birthday	Patients diagnosed with HIV prior to the start of the measurement period	N/A	New	None
6B	21	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	CMS2v9	Percentage of patients aged 12 years and older screened for depression on the date of the visit or 14 days prior to the visit using an age-appropriate standardized depression screening tool and, if positive, had a follow-up plan documented on the date of the visit	Patients aged 12 years and older with at least one medical visit during the measurement period	Patients who: •were screened for depression on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized tool and, •if screened positive for depression, had a follow-up plan documented on the date of the visit. Note: Include in the numerator patients with a negative screening and those with a positive screening who had a follow-up plan documented.	•Patients with an active diagnosis for depression or a diagnosis of bipolar disorder •Patients: -Who refuse to participate -Who are in urgent or emergent situations where time is of the essence and to delay treatment would jeopardize the patient's health status -Whose cognitive or functional capacity or motivation to improve may impact the accuracy of results of standardized assessment tools	71.61%	Numerator: Added option to screen for depression up to 14 days prior to visit and follow-up plan documented on date of the visit	None
6B	21a	Depression Remission at Twelve Months	CMS159v8	Percentage of patients aged 12 years and older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event	Patients aged 12 years and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 or PHQ-9 modified for teens score greater than 9 during the index event between 11/01/2018 through 10/31/2019 and at least one medical visit during the measurement period	Patients who achieved remission at 12 months as demonstrated by a 12 month (+/- 60 days) PHQ-9 or PHQ-9M score of less than 5 Note: Patients may be screened using PHQ-9 and PHQ-9M up to 7 days prior to the office visit, including the day of the visit.	•Patients with a diagnosis of bipolar disorder, personality disorder, schizophrenia, psychotic disorder, or pervasive developmental disorder •Patients: -Who died -Who received hospice or palliative care services -Who were permanent nursing home residents	N/A	New	None

Table	Line/ Section	Measurement Name	eCQM Code	Brief Measure Description	Denominator (Universe)	Numerator	Exclusions/Exceptions	2019 National Average	Major Changes 2019 to 2020	Major Diff. UDS to eCQM
6B	22	Dental Sealants for Children between 6–9 Years	CMS277v0	Percentage of children, age 6–9 years, at moderate to high risk for caries who received a sealant on a first permanent molar during the measurement period	Children 6 through 9 years of age with an oral assessment or comprehensive or periodic oral evaluation dental visit who are at moderate to high risk for caries in the measurement period	Children who received a sealant on a permanent first molar tooth during the measurement period	Children for whom all first permanent molars are non-sealable (i.e., molars are either decayed, filled, currently sealed, or un-erupted/missing)	56.80%	None	Note: Although measure title is age 6 through 9 years, draft e-CQM reflects age 5 through 9 years — Health centers should continue to use age 6 through 9 years, as measure steward intended
7	Section A	Low Birth Weight	no eCQM	Percentage of babies of health center prenatal care patients born whose birth weight was below normal (less than 2,500 grams)	Babies born during measurement period to prenatal care patients	Babies born with a birth weight below normal (under 2,500 grams)	Still-births or miscarriages	8.05%	None	None

Table	Line/ Section	Measurement Name	eCQM Code	Brief Measure Description	Denominator (Universe)	Numerator	Exclusions/Exceptions	2019 National Average	Major Changes 2019 to 2020	Major Diff. UDS to eCQM
7	Section B	Controlling High Blood Pressure	CMS165v8	Percentage of patients 18–85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure (BP) was adequately controlled (less than 140/90 mmHg) during the measurement period	Patients 18 through 84 years of age who had a diagnosis of essential hypertension overlapping the measurement period with a medical visit during the measurement period	Patients whose most recent blood pressure is adequately controlled (systolic blood pressure less than 140 mmHg and diastolic blood pressure less than 90 mmHg) during the measurement period	•Patients with evidence of ESRD, dialysis, or renal transplant before or during the measurement period •Patients with a diagnosis of pregnancy during the measurement period •Patients who were in hospice care during the measurement period •Patients aged 66 or older who were living long-term in an institution for more than 90 days during the measurement period •Patients aged 66 and older with advanced illness and frailty	64.62%	•Denominator no longer has limit of diagnosis within first 6 months or prior to the measurement period •Two exclusions added for patients aged 66 and older living in long-term institutions or with advances illness or frailty	Note: Although measure CQL was not updated in 2020 to remove the limit of 6 months, health centers should adjust denominator to account for patients diagnosis overlapping the measurement year, as measure steward intended
7	Section C	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9 percent)	CMS122v8	Percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c (HbA1c) greater than 9.0 percent during the measurement period	Patients 18 through 74 years of age with diabetes with a medical visit during the measurement period	Patients whose most recent HbA1c level performed during the measurement year was greater than 9.0 percent or patients who had no test conducted during the measurement period	•Patients who were in hospice care during the measurement period •Patients aged 66 or older who were living long-term in an institution for more than 90 days during the measurement period •Patients aged 66 and older with advanced illness and frailty	31.95%	Two exclusions added for patients aged 66 and older living in long-term institutions or with advances illness or frailty	None

Telehealth Impact on 2020 Uniform Data System (UDS) Clinical Measure Reporting

Purpose:

- The table is intended to help health centers determine how services to patients provided via telehealth should be considered for the three measure components.
- This guidance applies only to UDS clinical measure denominator, numerator, and exclusion reporting on Tables 6B and 7.
- This crosswalk applies the Centers for Medicare & Medicaid Services (CMS) guidance on telehealth visits to electronic clinical quality measure (eCQM) reporting standards.
- This is not intended to provide guidance on federal and state regulations or restrictions on the use of telehealth.

Requirement:

- Clinical care provided to health center patients is reported in the UDS.
- Health centers are to identify the number of patients meeting each measure's criteria in three components:
  - Denominator: Patients who fit the detailed criteria described for inclusion in the specific measure to be evaluated.
  - Numerator: Patients (included in the denominator) that meet the measurement standard for the specified measure.
  - Exclusions/Exceptions: Patients who should not be included in the denominator.

Table Notes:

- Each of the UDS clinical measures are included as separate rows, with their corresponding CMS eCQM number.
- Some examples (not all inclusive) of visit types are included.
- Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes used to identify eligible patient visits used for identification of a patient for the denominator need to be identified by reviewing the eCQM criteria and codes directly.
- Exclusions are generally able to be determined through characteristics outside of a visit.
- Verification of already performed/completed services does not require a visit.

Column Considerations:

Denominator:

- This column is limited to defining whether patients whose only visit(s) during the year are provided via telehealth are to be included.

Numerator:

- This column considers activity of all patients included in the denominator, which may include in-person and/or telehealth visits.
- Verification of completed services can be done outside of a visit.
- For example, a mammogram cannot be completed via telehealth. However, if the patient had a mammogram performed during the measurement period (or identified timeframe) and documentation is included in the patient record, the patient record could be considered compliant for the Breast Cancer Screening measure.
- To meet the measurement standard, review the associated eCQM guidance. Some require the service to be performed by, paid for, or approved by the health center provider, while

others permit service completion by any provider as long as the service is in the specified timeframe, meets the measure requirements, and is documented in the patient record.

Resources:

- Calendar Year 2020 UDS Manual
- CMS Telehealth Guidance
- UDS Support Line

Telehealth Impacts on 2020 UDS Clinical Measures

Note: Items highlighted in pink are intended to draw attention to measure components that do not permit services via telehealth or by external providers.

Clinical Measure Name, eCQM Code, UDS Table, and UDS Section	Illustrative Examples of Types of Visits	Include patients with telehealth only visits on UDS Tables 6B and 7, Column A (Denominator)?	Can service, test, or procedure be done by telehealth to meet UDS Tables 6B and 7, Columns C or F (Numerator), requirements?	Do documented services performed by external providers (not paid for or performed by the health center) count in UDS Tables 6B and 7, Columns C or F (Numerator)?
Early Entry into Prenatal Care, no eCQM, Table 6B, Lines 7-9	•OB/GYN routine check up •Physical with primary care provider (PCP)	No. Prenatal patients are defined based on a comprehensive in-person prenatal physical exam.	Yes. Trimester of entry may be identified in this way.	Yes
Childhood Immunization Status, CMS117v8, Table 6B, Line 10	•Well-child visits for newborns •Acute pain or illness	Yes	No. Administration of immunizations are not acceptable in this way. These services cannot be conducted via telehealth.	Yes
Cervical Cancer Screening, CMS124v8, Table 6B, Line 11	•Physical with PCP •OB/GYN routine check up •Acute pain or illness •Signs or symptoms of conditions	Yes	No. Cervical cytology/HPV testing are not acceptable in this way. These services cannot be conducted via telehealth.	Yes
Breast Cancer Screening, CMS125v8, Table 6B, Line 11a	•Physical with PCP •OB/GYN routine check up •Acute pain or illness •Signs or symptoms of conditions	Yes	No. Mammograms are not acceptable in this way. These services cannot be conducted via telehealth.	Yes
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents, CMS155v8, Table 6B, Line 12	•Well-child visits •Sport or school activity physical •Acute pain or illness	Yes	No. Height and weight are not acceptable in this way.	No. Height and weight are to be performed or paid for by health center staff.
			Yes. Counseling for physical activity and nutrition are acceptable in this way.	No. Counseling for physical activity and nutrition are to be performed or paid for by health center staff.
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan, CMS69v8, Table 6B, Line 13	•Physical with PCP •Acute pain or illness •Signs or symptoms of conditions	No. This screening measure requires therapy, treatment, or assessment that cannot be conducted via telehealth.	No. Height and weight are not acceptable in this way.	No. Height and weight are to be performed or paid for by health center staff.
			Yes. Follow-up plan is acceptable in this way.	No. Follow-up plan is to be performed or paid for by health center staff.

Clinical Measure Name, eCQM Code, UDS Table, and UDS Section	**Illustrative Examples of Types of Visits**	**Include patients with telehealth only visits on UDS Tables 6B and 7, Column A (Denominator)?**	**Can service, test, or procedure be done by telehealth to meet UDS Tables 6B and 7, Columns C or F (Numerator), requirements?**	**Do documented services performed by external providers (not paid for or performed by the health center) count in UDS Tables 6B and 7, Columns C or F (Numerator)?**
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention, CMS138v8, Table 6B, Line 14a	•Physical with PCP •OB/GYN routine check up •Acute pain or illness •Signs or symptoms of use	Yes	Yes. Screening for tobacco use and cessation intervention are acceptable in this way.	No. Screening for tobacco use is to be performed or paid for by health center staff. Yes. Cessation intervention may be referred out.
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease, CMS347v3, Table 6B, Line 17a	•Physical with PCP or specialist •Acute pain or illness •Care for chronic condition	Yes	Yes. Prescription or an order for statin therapy is acceptable in this way.	Yes
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet, CMS164v7, Table 6B, Line 18	•Physical with PCP or specialist •Acute pain or illness •Care for chronic condition	Yes	Yes. An order for medication (of aspirin or antiplatelet) is acceptable in this way.	Yes
Colorectal Cancer Screening, CMS130v8, Table 6B, Line 19	•Physical with PCP •OB/GYN routine check up •Acute pain or illness •Signs or symptoms of conditions	Yes	No. Procedures (Flex Sig and Colonoscopy) and diagnostic studies (CT colography) are not acceptable in this way. These services cannot be conducted via telehealth.	Yes
			Yes. An FOBT or FIT-DNA that is mailed and processed by a lab are acceptable.	Yes
HIV Linkage to Care, no eCQM, Table 6B, Line 20	•Physical with PCP or specialist •OB/GYN routine check up •Acute pain or illness •Care for chronic condition	Yes	Yes. At the discretion of the healthcare and prescribing provider, the medical visit may be conducted and HIV treatment are acceptable in this way.	Yes

Clinical Measure Name, eCQM Code, UDS Table, and UDS Section	Illustrative Examples of Types of Visits	Include patients with telehealth only visits on UDS Tables 6B and 7, Column A (Denominator)?	Can service, test, or procedure be done by telehealth to meet UDS Tables 6B and 7, Columns C or F (Numerator), requirements?	Do documented services performed by external providers (not paid for or performed by the health center) count in UDS Tables 6B and 7, Columns C or F (Numerator)?
HIV Screening, CMS349v2, Table 6B, Line 20a	•Physical with PCP •OB/GYN routine check up •Acute pain or illness •Signs or symptoms of conditions	Yes	No. Patient attestation or self-report of HIV results is not acceptable in this way. Yes. HIV self-tests may be acceptable; the provider must receive documentation of the lab test result.	Yes
Preventive Care and Screening: Screening for Depression and Follow-Up Plan, CMS2v9, Table 6B, Line 21	•Physical with PCP •OB/GYN routine check up •Acute pain or illness •Signs or symptoms of conditions	Yes	Yes. Screening for depression and follow-up plan are acceptable in this way.	No. Screening for depression and development of follow-up plan are to be performed or paid for by health center staff. Yes. Follow-up plan may include a referral to another provider.
Depression Remission at Twelve Months, CMS159v8, Table 6B, Line 21a	•Physical with PCP or specialist •Acute pain or illness •Care for chronic condition	Yes	Yes. Identification of remission achieved is acceptable in this way.	Yes
Dental Sealants for Children between 6–9 Years, CMS277v0, Table 6B, Line 22	•Routine exam with dentist •Acute pain or illness •Signs or symptoms of risk factors	Yes	No. Application of sealants is not acceptable in this way. These services cannot be conducted via telehealth.	Yes
Low Birth Weight, no eCQM, Table 7, Section A	•Postnatal care visit •OB/GYN routine check up •Physical with PCP	Yes	Yes. Birth weights may be identified in this way.	Yes
Controlling High Blood Pressure, CMS165v8, Table 7, Section B	•Physical with PCP or specialist •Acute pain or illness •Care for chronic condition	Yes	No. Patient self-report blood pressure is not acceptable in this way. Yes. Blood pressure through remote monitoring device only is acceptable in this way.	Yes. Blood pressure taken at a qualified encounter is to be performed, paid for, or approved by a health center provider or provider delegate or done by a remote monitoring device.

Telehealth Impacts on 2020 UDS Clinical Measures

Clinical Measure Name, eCQM Code, UDS Table, and UDS Section	**Illustrative Examples of Types of Visits**	**Include patients with telehealth only visits on UDS Tables 6B and 7, Column A (Denominator)?**	**Can service, test, or procedure be done by telehealth to meet UDS Tables 6B and 7, Columns C or F (Numerator), requirements?**	**Do documented services performed by external providers (not paid for or performed by the health center) count in UDS Tables 6B and 7, Columns C or F (Numerator)?**
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9 percent), CMS122v8, Table 7, Section C	•Physical with PCP or specialist •Acute pain or illness •Care for chronic condition	Yes	No. HbA1c lab test is not acceptable in this way. These services cannot be conducted via telehealth.	Yes. HbA1c is to be performed, paid for, or approved by a health center provider or provider delegate.

Note: Items highlighted in pink are intended to draw attention to measure components that do not permit services via telehealth or by external providers.

UDS Novel Coronavirus Disease (COVID-19) Reporting

The guidance below provides responses to questions regarding UDS reporting impacted by COVID-19. For additional information on other COVID-19-related reporting considerations, such as temporary sites, health center staffing (e.g., volunteers), and funding and revenue, please refer to HRSA's COVID-19 Frequently Asked Questions (FAQs).

Visits and Patients

If health centers increased virtual visit capabilities during the COVID-19 pandemic, how are these visits and patients reported on the UDS?

- Report virtual visits on Table 5 in Column b2 (Virtual Visits, shown below). These visits **must** meet the criteria for a UDS visit (documented contact between a provider and a patient in which the provider exercises independent, professional judgement in the provision of in-scope services to the patient at an approved location). Additionally, virtual visits must be coded as such in the health center's health information technology or electronic health record system.

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1	Family Physicians				
2	General Practitioners				
3	Internists				
*	**Excerpt from Table 5**				

- Count patients throughout the UDS (demographics, services, clinical, and financial sections) when their visits qualify as a virtual visit, even if the visit is the first or only visit for the patient during the reporting period. For further guidance, refer to the UDS Virtual Visit resource guide.
- A UDS countable virtual visit must use live (synchronous, real-time) video connection between a provider and a patient (e.g., "FaceTime") and/or two-way interactive audio technology (e.g., telephone). For the purpose of UDS reporting, store-and-forward (asynchronous, not real-time) or the electronic transmission of medical information, such as digital images, documents, and pre-recorded videos is **not** a countable UDS virtual visit.
- Virtual check-ins, used to determine whether an established patient requires a visit, and e-visits, which are portal communications with established patients, would **not** count for UDS reporting purposes.

Should individuals who receive a COVID-19 test or screening during the reporting year be reported on the UDS?

- If an individual is screened or tested (i.e., a specimen is collected or a series of questions asked to assess condition) for COVID-19 and there is no treatment or examination that are typical with evaluation and management services (i.e., assessment of health status, examination, medical decision making) provided by the health center during the reporting year then this individual and encounter are not counted **anywhere** in the UDS (see also page 22 of the 2020 UDS Manual for services and persons not reported).
    - The Centers for Medicare & Medicaid Services' (CMS) Evaluation and Management Services Guide is a useful resource for learning about the general principles of evaluation and management documentation, including the level and complexity of the service provided. Note: Practitioner to practitioner consultation services are not countable as a UDS visit.
- If, during the reporting year, the health center provides an individual with additional services (either before or after a non-reportable UDS service) that meet the visit criteria mentioned above (see also page 19 of the 2020 UDS Manual), that individual may be considered a patient for UDS reporting. Their visit and the associated care would be reported on the UDS Report.
- A test or screening alone does not count as a UDS visit.

Staffing

On Table 5, should possible staffing changes experienced by health centers be reported (e.g., staff furloughed, laid off, and/or out on Family and Medical Leave Act (FMLA))?

- Health centers should calculate and report any amount of staff full-time equivalent (FTE) on Table 5 that the health center is paying for or incurring costs for during the reporting year, even if the employee is not working (e.g., seeing patients) in that time.
- If a health center staff person was laid off or furloughed during the reporting year, any portion of the year where they were not employed by the health center or not being paid by the health center, should be not be included in the FTE reported on Table 5.
- If a health center staff person was out of work under FMLA during the reporting year, any portion of the year when a staff person was not working **and** not compensated should not be included in the FTE reported on Table 5.
- If a health center employed new staff during the reporting year and the staff provided in-scope activities, then their FTE should be calculated and reported on Table 5 based on the time worked and compensated during the year (see also page 46 of the 2020 UDS Manual for Table 5 FTE reporting instructions).
- If volunteer staff provided in-scope services at a health center during the reporting year, then this volunteer time should be calculated and reported as FTE on Table 5 (see also page 158 of the 2020 UDS Manual for reporting instructions on services provided by volunteer providers).

COVID-19 Tests and Diagnoses

Were new lines added to Table 6A to capture data on COVID-19 testing and diagnosis?

- Yes. Four new lines were added: Line 4c (Novel coronavirus (SARS-CoV-2) disease), Line 6a (Acute respiratory illness due to novel coronavirus (SARS-CoV-2) disease), Line 21c (Novel coronavirus (SARS-CoV-2) diagnostic test), and Line 21d (Novel coronavirus (SARS-CoV-2) antibody test).

Table 6A, Line 6a (Acute respiratory illness due to novel coronavirus (SARS-CoV-2) disease) includes a note that states, "count only when code U07.1 is present". To be counted on Line 6a, does ICD code U07.1 (COVID-19) need to be included in the same visit as the acute respiratory illness diagnosis-coded visit?

- The COVID-19 diagnosis code, U07.1, needs to be associated **with** the acute respiratory illness visit for it to mean that the service visit for acute respiratory illness was due to the novel coronavirus.

Health centers are not always able to collect Current Procedural Terminology (CPT) codes for COVID-19 testing. Can lab codes, rather than the CPT codes listed in the manual, be used to report COVID-19 testing on Table 6A?

- If a lab code (e.g., Logical Observation Identifiers Names and Codes (LOINC) code) is specifically capturing the intended test and reflects that it is administered/completed (not just referred), then that code could be used. A test can be counted if it is: 1) performed by the health center, 2) paid for by the health center, but not performed by the health center, or 3) whose results are returned to the health center provider to evaluate and provide results to the patient, but not performed by the health center or paid for by the health center.

Will health centers need to report on patients who received COVID-19 vaccines, if developed in 2020?

- If a Food and Drug Administration-approved COVID-19 vaccine becomes available during the calendar year, health centers will report the count of patients who received the vaccine on the UDS Other Data Elements Form, Appendix E.
- The count will **not** include vaccines administered to health center patients while participating in clinical trials.

Clinical Quality Reporting

New health center protocols and workflows have changed the provision of care in response to COVID-19; and procedures, documentation, and follow up will be affected. How will UDS clinical quality measure performance be considered for 2020 UDS, especially if compliance rates suffer?

- BPHC recognizes the essential work (providing testing and care for those directly affected by the virus) being performed by health centers during the COVID-19 pandemic, while implementing steps to continue to provide routine, preventive, and chronic disease care to patients.
- There are steps that health centers can take to meet compliance with UDS clinical measure reporting. While some care must happen in person to meet the measurement standard, some care can be provided virtually. Please refer to the Telehealth Impacts on Clinical Quality Measures handout to see how virtual visits impact specific measure criteria.
- Document as much information in your systems as possible. Additionally, during the 2020 UDS data reporting and review period, health centers should document the impacts in UDS table validation comment fields prior to submission and work with their UDS Reviewer post-submission to help explain any changes resulting from the pandemic. For example, if a dental practice closed for three months and then reopened at limited capacity, provide that level of detail.

Can patient-reported vitals (e.g., blood pressure readings, height, and/or weight) obtained during a virtual visit count as meeting the measurement standard of certain UDS-reported clinical quality measures that require these? Can other services, tests, or procedures required to meet the measurement standard be done via telehealth?

- For some clinical measures that require these vitals, self-attestation is not accepted. Each electronic clinical quality measure (eCQM) is defined by the specified measure steward and the UDS Report aligns with their instruction.
- The measure stewards and CMS have provided guidance and decisions for inclusion (or removal) of telehealth (virtual) in the evaluation of each component (denominator, exclusion, numerator) of the eCQM. Please refer to the Telehealth Impacts on Clinical Quality Measures handout for specific guidance on each UDS-reported clinical measure.

On the Table 7, Controlling High Blood Pressure measure, what is the guidance on remote patient monitoring as it relates to virtual visits? How does remote patient monitoring differ from patient self-report?

- Only blood pressure readings performed by a clinician or care team member by a remote monitoring device are acceptable to meet the Controlling High Blood Pressure measurement standard, as specified by the measure steward (CMS165v8).

- The device must capture and store the reading taken by the patient from a device which is observed by the clinician or member of the care team, and recorded in the patient's chart at the health center. This is not the same as a patient providing this information to the provider (e.g.,verbally or by entering the result into a patient portal), which would not meet the measurement standard.

Revenue

Where should health centers report COVID-19-related revenue on the UDS Report?

- For 2020 UDS reporting, several lines were added to the revenue tables (Tables 9D and 9E) for COVID-19 reporting. Additions include:
  - Table 9D, Line 8c ("Other Public, including COVID-19 Uninsured Program") to reflect charges, collections, and adjustments associated with testing and treatment of uninsured patients with suspected or diagnosed COVID-19.
  - Table 9E, Lines 1l through 1p: COVID-19 Supplemental Funding to reflect the grant amounts drawn down from BPHC activity codes H8C, H8D, ECT, or HEROES/HEALS, or other COVID-19-related funding from BPHC.
    - Note: HEROES and HEALS funding are still pending, and will be reported here only if legislation passes.
  - Table 9E, Line 3b: Provider Relief Fund to reflect funds received through the U.S. Department of Health and Human Services (HHS) to provide relief to eligible providers for health care-related expenses or lost revenue attributable to coronavirus.

UDS: UNIFORM DATA SYSTEM

Background on Codes for UDS Clinical Measure Reporting

The UDS Manual does not include ICD-10-CM and CPT code references. This is because:

1. Electronic clinical quality measures (eCQMs) use data from electronic health records (EHR) and/or health information technology systems to measure health care quality. As the UDS continues to move toward alignment with national measure reporting, health centers should be utilizing the codes referenced in the eCQM specifications directly. Codes and corresponding eCQM guidance can be found through links at: https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ecqms?field_year_value=2

2. Prior years of the UDS Manual only included codes that may help, but was never intended to be a comprehensive list of codes.

3. Removing the codes reduces duplication and potential errors in codes listed.

HIV Linkage to Care

The HIV Linkage to Care (Table 6B, Line 20) measure does not have an associated eCQM. that although the UDS Manual may not be all-inclusive of codes, it is helpful to continue to provide the codes from previous manuals as reference. Below are associated ICD-10-CM and CPT codes that may help with 2020 reporting.

HIV Linkage to Care

The following codes will be useful in identifying the universe:

• ICD-10 = B20, B97.35, Z21

Note, however, that there are no ICD-10-CM or CPT codes to identify newly diagnosed HIV patients. To identify newly diagnosed HIV patients, you can either modify your HIT/EHR to record this information or keep track of the patients who are identified in a separate system. When a diagnosis is documented in the HIT/EHR the “date diagnosed” is time stamped and may be used for reporting.

Pre-Exposure Prophylaxis (PrEP)

Table 6A, Line 21e captures data on patients prescribed combinations of emtricitabine (FTC) and tenofovir disoproxil fumarate (TDF) or tenofovir alafenamide (TAF) during the reporting year for PrEP. The ICD-10-CM coding system does not have a direct coding scheme for PrEP counseling and initiation. The following ICD, CPT, and HCPCS codes could be utilized by health centers to help identify patient visits that may include counseling on or initiation of PrEP or that may be associated with currently prescribed PrEP, based on risk for HIV exposure. Please note, this is not an exhaustive list and these codes only serve as a recommendation to help health centers identify reportable PrEP management.

- Possible ICD-10 codes: Z11.3, Z11.4, Z20.2, Z20.6, Z51.81, Z71.51, Z71.7, Z79.899
- Possible CPT codes: 99401 through 99404
- Possible RxNORM codes: 1721603, 1747692, 276237, 322248, 495430

Note, however, that there are no ICD-10-CM or CPT codes to identify patients receiving PrEP management.

Table	Brief Description	Checks
	Costs: Table 8A	
5 & 8A	FTEs and cost in sync	◆ Ideally there should be a worksheet reconciling the FTE distributions on Table 5 with the personnel cost distributions on Table 8A. Cost with no FTEs may be explained by paid referred care contracts for lab, x-ray, and other services. ◆ Significant differences in the CY-PY are compared. Personnel cost is usually 65-70% of total cost so this could be an important cost reporting issue. Check for differences and correct or provide clear explanations. Unreasonably low or high costs per FTE may be an indication of a possible mismatch of cost and FTEs. This may also be explained by donated staff where there are FTEs on the service line but the cost is reported on the donated line.
5 & 8A	Other Programs and Services FTEs and cost	◆ The specify text box on both tables should be the same. The other category includes items and programs not classifiable elsewhere and those not exclusively tied to FQHC patients. Includes: WIC, pass-through cost, space leased to others, staff contracted to others, retail pharmacy, adult day health care, research, etc. ◆ Receipts related to other costs are reported on table 9E on the appropriate line. For example, pass-through receipts are reported on table 9E line 6 and are offset by an equal amount of cost on the other line of table 8A.
8A & 9E	Donation descriptions	◆ Donated drugs (table 8A) are to be valued at 340b prices and described in the specify box. Drugs donated by the pharmaceutical company directly to the patient are not reported. ◆ Other donations (non-monetary on table 8A and monetary on table 9E) should be described in the specify boxes. ◆ In-kind donation income is reported on table 8A, not on table 9E.
8A, 9D, 9E	Pharmacy size	◆ Reporting no pharmacy or pharmaceutical cost is unusual and should be explained. Medications administered by clinicians in-house are to be reported on the pharmaceutical line and not in medical. ◆ Report dispensing cost from community-based 340b pharmacies on the pharmacy line 8a. Contract pharmacies take their fees from sales receipts before reimbursing the FQHC which causes some to omit dispensing cost and some to understate drug replenishment cost. ◆ Review pharmacy cost which is greater than drug cost. Nationally pharmacy cost is 64% of drug cost. ◆ Pharmacy revenue data (see Table 9D) are to be reported in the same manner as all other service revenue data but this is often a problem because of limitations of the data provided by the 340b contract pharmacies. Work with contract pharmacies to ensure you get the pharmacy, drug, and dispensing fees costs separately; and that charges are reported as of the date of service and collections are reported by payer. This is important in centers where the pharmacy cost is significant.
8A	Allocation methods	◆ There are multiple ways of which overhead may be allocated. Preparers should use the simplest method which produces a reasonably accurate and comparable result to a more complex method. Cost centers with no overhead allocation will be questioned. ◆ Allocating known direct costs first is preferable. For example, all the facility cost of a dental only site would be charged directly to dental. ◆ Doing an allocation of facility cost second and administration cost third is also preferable. ◆ A lesser overhead charge should be considered for large purchased service items. ◆ If the proportion of overhead cost to direct cost is the same for each line, it indicates that a one-step method was used. Given that managing personnel consumes most of the overhead, using square feet of space as the sole allocation basis will generally not produce an accurate allocation of overhead. Using total direct cost, FTEs or personnel cost is a preferable one step basis.
8A	Overhead outliers	◆ Overhead cost to total cost rates of 8% for facility and 25% for non-clinical support (administration) are stable national averages over time. There is little deviation from the mean. Outliers will be questioned to check for misclassifications of cost. Significant change in rates from the prior year should be explained. ◆ Large pharmacy programs will drive overhead rates down.
All	Subrecipients and contractors	◆ Health centers should identify the existence of subrecipient and large contractor arrangements and explain how those arrangements are reported on the UDS. ◆ Subrecipients are to report a complete set of UDS tables which are consolidated with the FQHC data. Contractors report the services delivered and the amount paid by the FQHC.
Table	**Brief Description**	**Checks**
	Patient-Related Revenue:	**Table 9D**
4 & 9D	Adjustments (retros, receipts, paybacks, etc.)	◆ Report retros in columns (c1, c2, and c3) and add to column (b) and subtract out of column (d) – do the opposite for (c4) paybacks made with check. ◆ No Medicaid adjustments may mean the health center is improperly recognizing charges at the FQHC rate rather than the normal fee value. This is more likely in states where Medicaid or its MCOs pay the centers their FQHC rate rather than a market rate. The absence of wraps or settlements for managed care plans should be explained. ◆ Sliding fee adjustments are reviewed for reasonableness. Usually the change from the PY is consistent with change in self-pay charges. Indigent care fund revenue data will affect sliding fee adjustments. ◆ Bad debt reported on the UDS is currently limited to self pay. The self pay bad-debt reported is either the amount directly written-off from patient accounts or the amount of change in the allowance account attributable to self pay.
4 & 9D	Insurance vs. Payer	◆ The payers on table 4 and 9d are usually the same with a few exceptions. Table 4 classifies patients by medical insurance and table 9D classifies revenue data by the payer from which the revenue is expected or received. ◆ Other Public should be consistent with table 4 except that other public categorical grants such as Title X and BCCCP are not insurance and the patients are usually classified as uninsured on table 4.
4 & 9D	Managed care enrollment data consistency	◆ MCOs who don't provide enrollment data are not considered managed care for UDS reporting on both tables 4 and 9D. ◆ Outlier PMPM capitation and charges PMPY amounts will be questioned as will any significant change from the PY. ◆ Unusually low capitation amounts may be due to case management being mistakenly reported as managed care; and high amounts could be due to missing enrollment data or unusually high risk coverage (e.g., HIV or prenatal). Amounts may be lower or higher but should be explainable. ◆ The absence of wraps or settlements should be explained. There will be no wraps if MCOs are paying PPS rather than market rates. Wraps and settlements are to be allocated on the three lines within each payer and in columns c1 and c2.
5 & 9D	Charge ratios	◆ Charges per patient, charges per visit, and charge to cost ratio outliers may be questioned. Large pharmacy operations may explain high ratios and low productivity may explain low ratios.

9D	Pharmacy revenue	◆ Contract and in-house pharmacy revenue is reported on table 9D. ◆ Pharmacy data are to be reported on table 9D in the same manner as other services are reported. Charges are to be recorded in a uniform amount - generally the retail or UCR price - for each drug for each payer by date of service; collections are to be reported by payer upon receipt along with any corresponding adjustments. See Appendix B of the UDS Manual. ◆ Pharmacy revenue data can be a problem because of limitations of the data provided by the 340b pharmacies. Work with contract pharmacies to ensure you get the pharmacy, drug, and dispensing fees costs separately; and that charges, collections, and adjustments are reported by payer. This may be questioned, particularly in centers where the pharmacy cost is significant, as is the case when the costs exceed $1M or more or the cost is proportionately much greater than the national average of 11% of total cost.
9D	Insufficient pharmacy data	◆ When pharmacy data are reported by contractors on a cash basis and when receipts by payer are unknown, report the receipts on table 9D, line 13 column B and offset those receipts with an equal amount of charges in column A. This should be corrected for future reporting.
9D	Medicare G Codes or other capitated or negotiated rates	◆ Charges are to be reported at the normal fee value across all payers. Charges are not to be reported at negotiated or discounted rates. ◆ Medicare requires the G codes and CPT codes to be included on Medicare claims. The G codes should be eliminated from the charges reported on the UDS. Most practice management systems have corrected for this, and if not a manual adjustment is needed.
9D	Performance incentives	◆ Many managed care plans and many other insurers pay a performance bonus of some sort. This is to be reported in Column b and column c3; and not on Table 9E.
9D	Charge reclassification	◆ Charges less collections less adjustments = change in A/R. Nationally A/R increased in an amount equal to 0.31 months of charges. The change in A/R is usually consistent with the change in charges - when charges increase A/R increases. Large changes in A/R are questioned. ◆ Check that a large increase isn't the result of adjustment entries being reversed. Large A/R decreases may be an error if retros are included in column b, but were not taken out of column d. ◆ Charges are to be reclassified to secondary and subsequent payers when appropriate. Failure to do this will usually cause the change in Medicare and Private payer A/R to increase and self-pay to decrease.
9D	Patient and charge mix by payer	◆ The patient payer mix and charge payer mix are usually comparable with some difference expected. National Medicaid plus Medicare charge mix (65%) is seven points higher than the patient mix (58%). ◆ A large obstetrics practice or a large pharmacy operation can cause the charge mix to be greater than the patient mix. ◆ The failure to exclude Medicare G codes from charges will overstate the Medicare payer mix. Reporting charges at negotiated or discounted rates will undermine the validity and usefulness of the charge mix data.
Table	**Brief Description**	**Checks**
	Other Revenue: Table 9E	
8A & 9E	Income	◆ Table 9E only includes cash receipts related to income. ◆ Loan proceeds are not reported because they are not income. Insurance proceeds are not reported if the loss was taken as an asset reduction. In-kind donations received are not cash receipts and are not reported on 9E but in-kind donations consumed are reported on table 8A.
9D & 9E	Patient service receipts	◆ Incentive and performance payments are to be reported on table 9D except for CMS EHR incentive receipts. ◆ Retail pharmacy receipts are reported on table 9E. ◆ Categorical grant receipts which are tied to patient services are reported on table 9D; those grants not tied directly to specific patient services and which reimburse for expenses are reported on table 9E.
9D & 9E	Indigent care	◆ Indigent care should be reported consistently in states and localities. ◆ Indigent program receipts are reported on table 9E. The charges and patient receipts are to be reported on table 9D and offset by sliding fee discounts.
9E	Receipts by source	◆ Receipts are reported by the source from whom they were received and not where they originated (RW A = local government or non-profit; RW B = state and RW C = federal). ◆The specify boxes should identify dollars by source when amounts are material and when more than one source is included..
9E	Surplus or loss	◆ Surplus or Loss = Tables 9D+9E receipts less table 8A cost before donations. ◆ Large surplus or loss for CY & PY are questioned. Check if the amount is consistent with audited net income. ◆ Check if some receipts or costs are excluded, particularly pharmacy income or cost. ◆ A possible reason for changes from year to year may be timing of grant or wrap receipts showing large deficit one year and surplus the next.
9E	Large change from prior year	◆ Review prior year reporting for comparability to check that items are not omitted. If omitted, confirm no dollars were received in the current year for that program.
9E	Other receipts	◆ No other receipts, line 11, are questioned. Nationally other receipts = 4% of total 9D+9E receipts.

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

Acronyms used:

	A/R	Accounts receivable
	BCCCP	Breast and Cervical Cancer Control Program
	CY	Current or calendar year
	FQHC	Federally qualified health center
	FTE	Full-time equivalent
	HIV	Human immunodeficiency virus
	MCO	Managed care organization
	PMPM	Per member per month
	PMPY	Per member per year
	PPS	Prospective payment system
	PY	Prior year
	RW	Ryan White
	UCR	Usual, customary, and reasonable
	WIC	Women, infants, and children

FACT SHEET

UDS: Uniform Data System

UDS Training Resources Available for Beginner Users

The following resources and trainings are recommended to assist beginner users of UDS reports and data. There are several other resources available to assist you in UDS reporting. Please visit the UDS Training Website or HRSA's Health Center Data & Reporting page to view all available resources.

GENERAL RESOURCES

- Interested in attending an annual state-based training? Visit our training website to find a session.
- Looking for written guidance on the annual Uniform Data System (UDS) reporting requirements for all health centers in the Health Center Program? Access the 2020 UDS Reporting Instructions.
- Need clarification on key terms used for UDS table reporting, changes from the prior year, helpful hints for completing UDS tables, or cross table considerations? Check out Quick Fact Sheets, available for each table.
- Interested in expert input through email or phone on UDS content, definitions, or use of UDS data? Contact the UDS Support Line at 1-866-837-4357 or udshelp330@bphcdata.net (available 8:30 - 5:00 PM EST Monday - Friday).
- Not sure which support line to call with your question? Check out our Support Center Information guide to contact the right center.
- Looking for guidance on COVID-19 UDS reporting requirements? Visit the COVID-19 Frequently Asked Questions (FAQs) website.
- Looking to learn more about reporting visits in the UDS? View our Reporting Visits in the UDS webinar.

BEGINNER CLINICAL RESOURCES

- Looking for guidance on Tables 6A, 6B, and 7 reporting? Check out our 2020 Clinical Tables webinar series.
- Interested in learning about the clinical services provided by and performance of health center programs? Take our Online Training Module 3 - Clinical Services and Performance.
- Want to view eCQM measure specifications? Access the USHIK website here.
- Looking for detailed information on Table 6B and Table 7's Clinical Measures, including changes from the prior year and reporting tips? Review the Clinical Measures Handout.

FACT SHEET

UDS: Uniform Data System

UDS Training Resources Available for Beginner Users **Continued**

BEGINNER FINANCIAL REPORTING RESOURCES

- Looking for guidance on Tables 8A, 9D, and 9E reporting? Check out our 2020 Financial Tables webinar series.
- Interested in learning about the operational costs and revenues of health center programs? Take our Online Training Module 4 - Operational Costs and Revenues.
- Looking for common issues in the reporting of UDS financial tables? View our Financial Tables Handout.
- Interested in learning more about reporting donations on the UDS? View our Donations Handout for guidance.

BEGINNER ADMINISTRATIVE RESOURCES

- Interested in learning tips and tricks for successful data collection and submission process? Take our Online Training Module 5 - Submission Success.
- Looking to learn more about the EHBs? Watch the EHB demo.

FACT SHEET

UDS: Uniform Data System

UDS Training Resources Available for Advanced Users

The following resources and trainings are recommended to assist people experienced with the UDS Report and data. In addition to those listed below, there are several other resources available to assist you in UDS reporting. Please visit the UDS Training Website or HRSA's Health Center Data & Reporting page to view all available resources.

GENERAL RESOURCES

- Interested in approved changes for 2020 UDS reporting due on February 15, 2021? View the 2020 UDS Reporting Changes webinar.
- Looking for written guidance on the annual Uniform Data System (UDS) reporting requirements for health centers in the Health Center Program? Access the 2020 UDS Reporting Instructions.
- Need clarification on key terms used for UDS table reporting, changes from the prior year, helpful hints for completing UDS tables, and cross table considerations? Check out Quick Fact Sheets available for each table.
- Interested in expert input through email or phone on UDS content, definitions, or use of UDS data? Contact the UDS Support Line at 1-866-837-4357 or udshelp330@bphcdata.net (available 8:30 - 5:00 PM EST Monday - Friday).
- Not sure which support line to call with your question? Check out our Support Center Information guide to contact the right center.
- Want to log into the Preliminary Reporting Environment (before Jan. 1)? Access it via the EHB system here.
- Want to log into the EHBs? Access the system here.
- Looking for guidance on COVID-19 UDS reporting requirements? Visit the COVID-19 Frequently Asked Questions (FAQs) website.

ADVANCED VISIT RESOURCES

- Need clarification on reporting nurse visits? Check out the Nurse Visits for UDS Reporting handout.
- Looking guidance on reporting virtual visits? Check out the Virtual Visits handout.
- Interested in learning more about reporting visits on the Table 5 Selected Service Detail Addendum? Check out the Mental Health and Substance Use Disorder Services Detail Addendum Guidance handout.

FACT SHEET

UDS: Uniform Data System

UDS Training Resources Available for Advanced Users **Continued**

ADVANCED CLINICAL RESOURCES

- Need guidance on Tables 6A, 6B, and 7 reporting? Check out our 2020 Clinical Tables webinar series.
- Looking for detailed information on Table 6B and Table 7's Clinical Measures, including changes from the prior year and reporting tips? Review the Clinical Measures handout.
- Looking for detailed code changes on Table 6A from the prior year? View the Table 6A Code Changes handout.
- Looking for relevant ICD and CPT codes to identify patients for the non-eCQM associated HIV and PrEP measures? View Helpful codes for HIV and PrEP.
- Interested in learning more about telehealth impacts on clincial quality measures? Review the Telehealth Impact on 2020 UDS crosswalk for more details.

ADVANCED FINANCIAL RESOURCES

- Need guidance on Tables 8A, 9D, and 9E reporting? Check out our 2020 Financial Tables webinar series.
- Looking for common issues in the reporting of UDS financial tables? View our Financial Tables handout.
- Interested in learning more about reporting donations on the UDS? View our Donations handout for guidance.

ADVANCED ADMINISTRATIVE RESOURCES

- Looking to improve your submission process? View the Strategies for Successful Reporting webinar.
- Wondering how to complete your UDS Report more efficiently and accurately? Watch these short videos to learn how to resolve edits and practice reporting using the PRE.
- Looking for an explanation of the calculation formulae used for statistics present in standard UDS reports available through the EHBs? View the Formula Reference Guide and UDS CY 2019 Performance Indicators by State.
- Interested in a snapshot of overall health center program performance for the year? View the At-a-glance worksheets for program statistics.
- Interested in viewing health center services areas? Access the UDS Mapper.

Bureau of Primary Health Care (BPHC)

Uniform Data System (UDS) Submissions in the HRSA Electronic Handbooks (EHBs)

User Guide for Health Center Program Grantees and Look-Alikes

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

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This user guide is designed to provide quick help for Health Center Program grantees and look-alikes. It covers accessing UDS Reports in the HRSA Electronic Handbooks (EHBs), preparing and submitting UDS Reports, revising and resubmitting UDS Reports, and accessing reports and data related to your UDS Report.

How to Find Your UDS Reports in the HRSA EHBs (Grantees)

Whether you're preparing your initial filing, resubmitting a previously-filed report, or coming to the HRSA EHBs to find reports based on data collected through UDS, your first step is to navigate to your UDS reports (the current one or any you've submitted through the HRSA EHBs in previous years). There are several ways to do this, but the following steps will work in all cases.

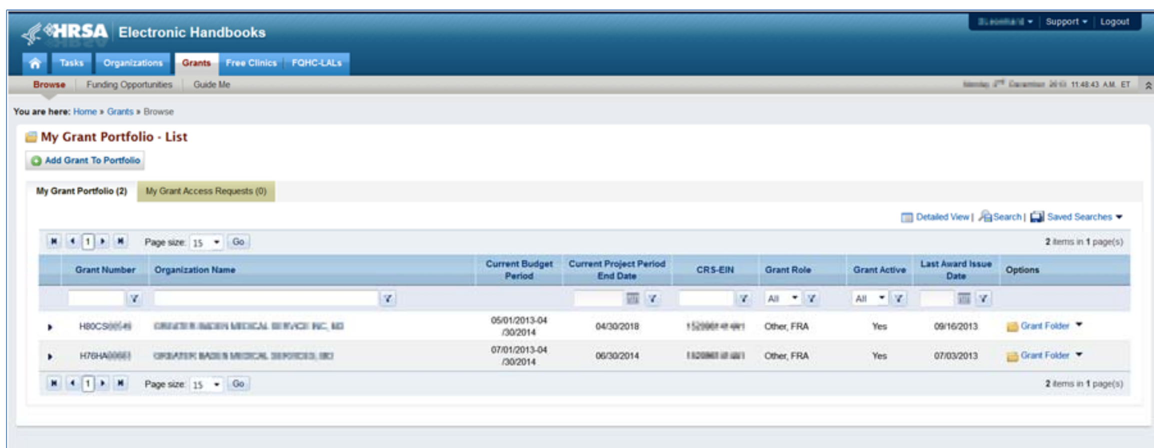
1. Log in to the HRSA EHBs.

2. In the Top Navigation panel (Figure 1), click the **Grants** tab.

Figure 1: Grants Tab in Top Navigation Panel

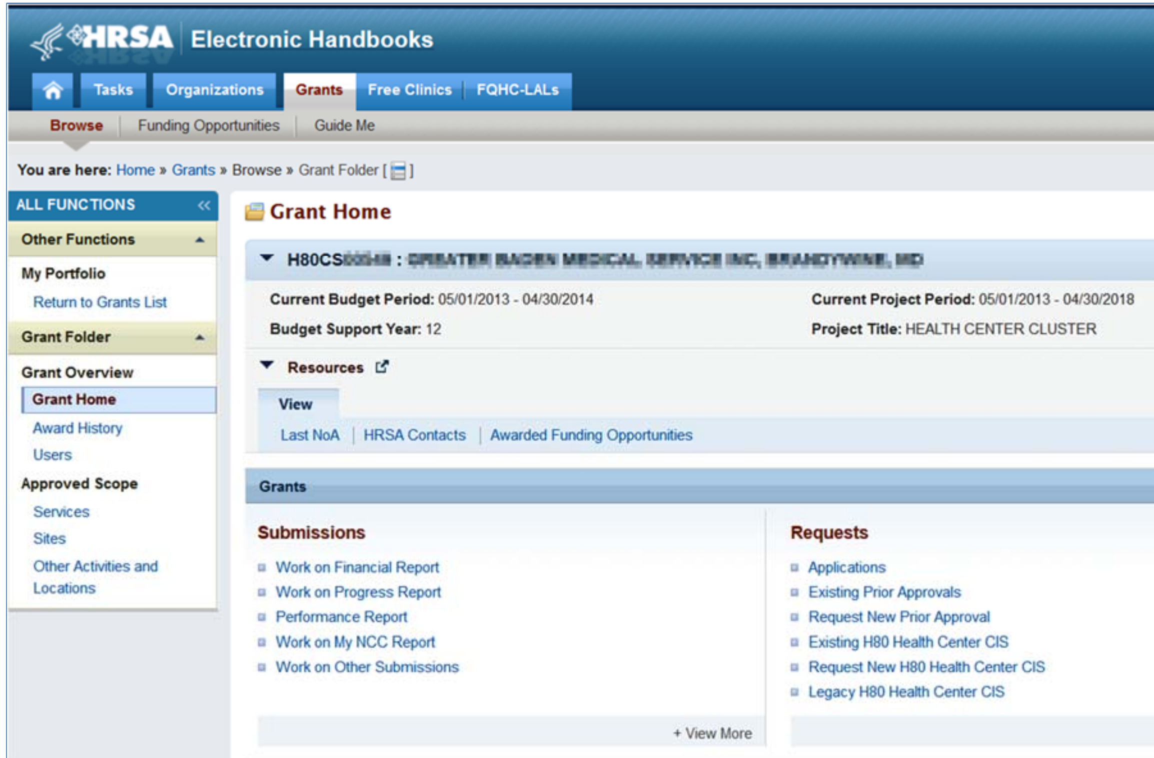
3. The My Grant Portfolio – List page opens (Figure 2), displaying your grants in a list. Find the Health Center Cluster grant (grant number begins with "H80") and click **Grant Folder**.

Figure 2: My Grant Portfolio – List Page



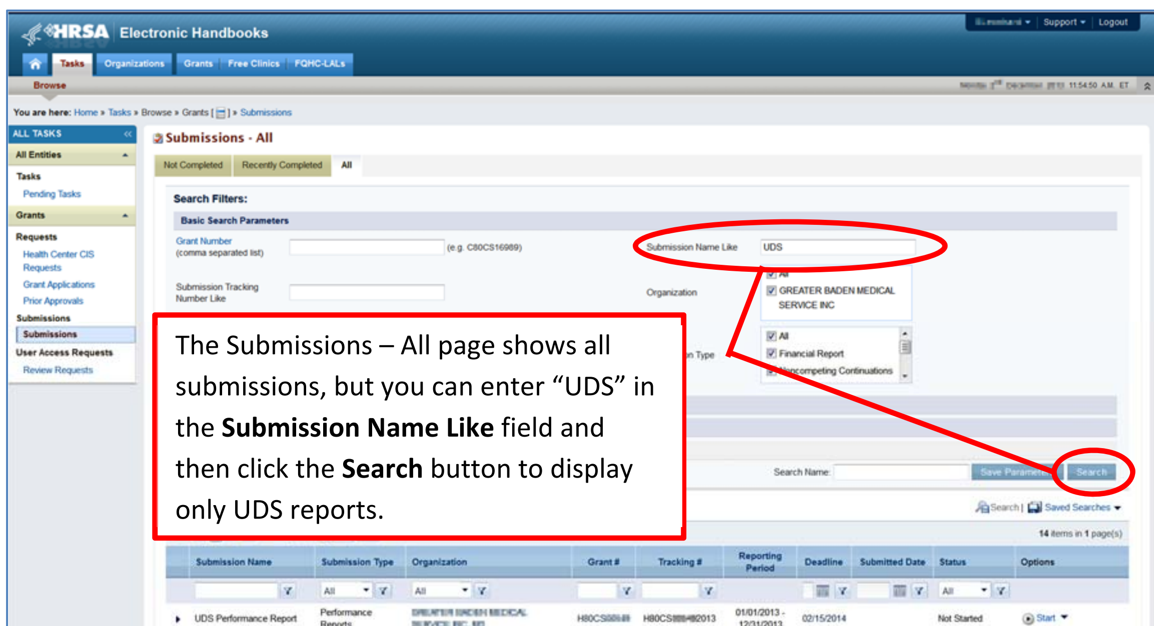
4. The folder for the grant opens to the Grant Home page (Figure 3). In the Grants section of the page, under Submissions, click **Performance Report**.

Figure 3: Grant Home Page



5. The Submissions – All page opens (Figure 4), displaying all performance reports related to the grant.

Figure 4: Submissions – All Page



6. To display only UDS reports, you can enter search parameters under **Search Filters** at the top of the page. For example, you can enter “UDS” in the **Submission Name Like** field, and then click **Search**. The list will display only UDS reports (Figure 5).

Figure 5: Submissions – All Page Showing Only UDS Reports

If you’ve come here to find your current UDS Report, note that it’ll be the one with “Start” or “Edit” in the Options column (last column on the right). The remaining listings (the ones with “Performance Report” in the Options column) are reports you submitted in previous reporting periods.

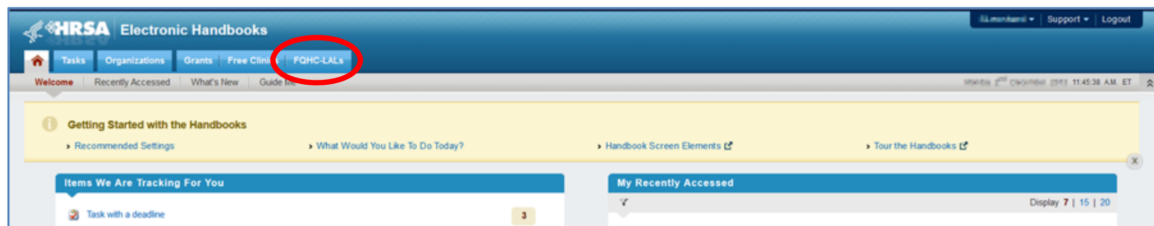
How to Find Your UDS Reports in the HRSA EHBs (Look-Alikes)

Whether you're preparing your initial filing, resubmitting a previously-filed report, or coming to the HRSA EHBs to find reports based on data collected through UDS, your first step is to navigate to your UDS reports (the current one or any you've submitted in previous years). There are several ways to do this, but the following steps will work in all cases.

1. Log in to the HRSA EHBs.

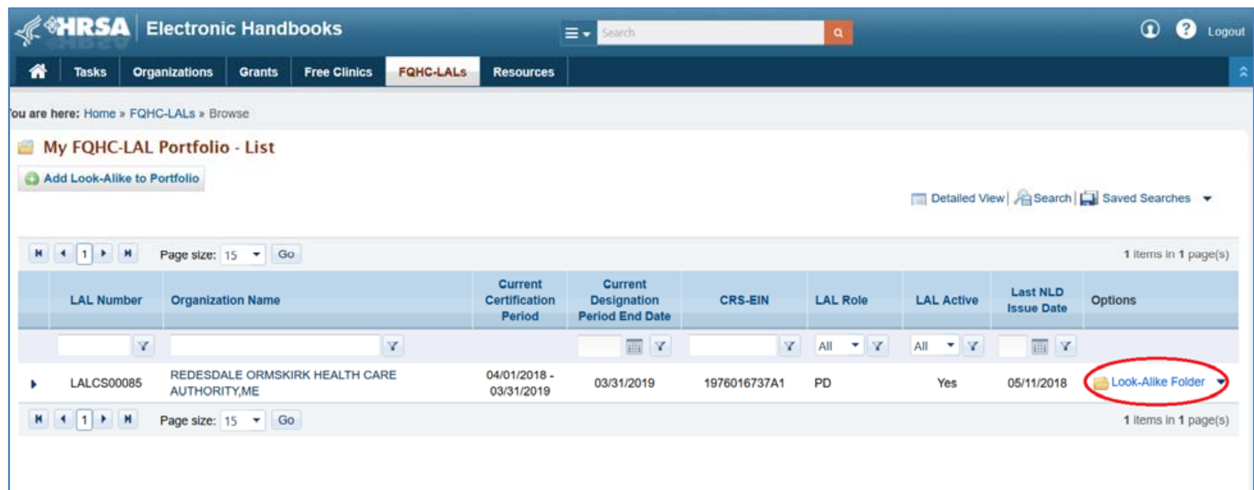
2. In the Top Navigation panel (Figure 6), click the **FQHC-LALs** tab.

Figure 6: FQHC-LALs Tab in Top Navigation Panel



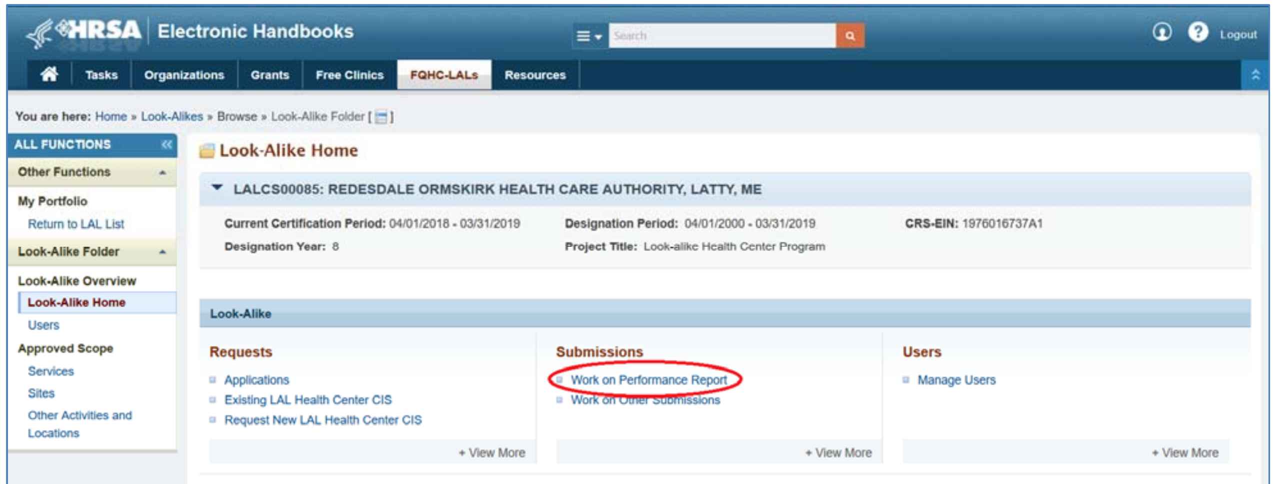
3. The My FQHC-LAL Portfolio – List page opens (Figure 7), displaying information related to any active LAL portfolios. To access the Look-Alike Home page, click the **Look-Alike Folder** link in the Options column

Figure 7: My FQHC-LAL Portfolio List Page



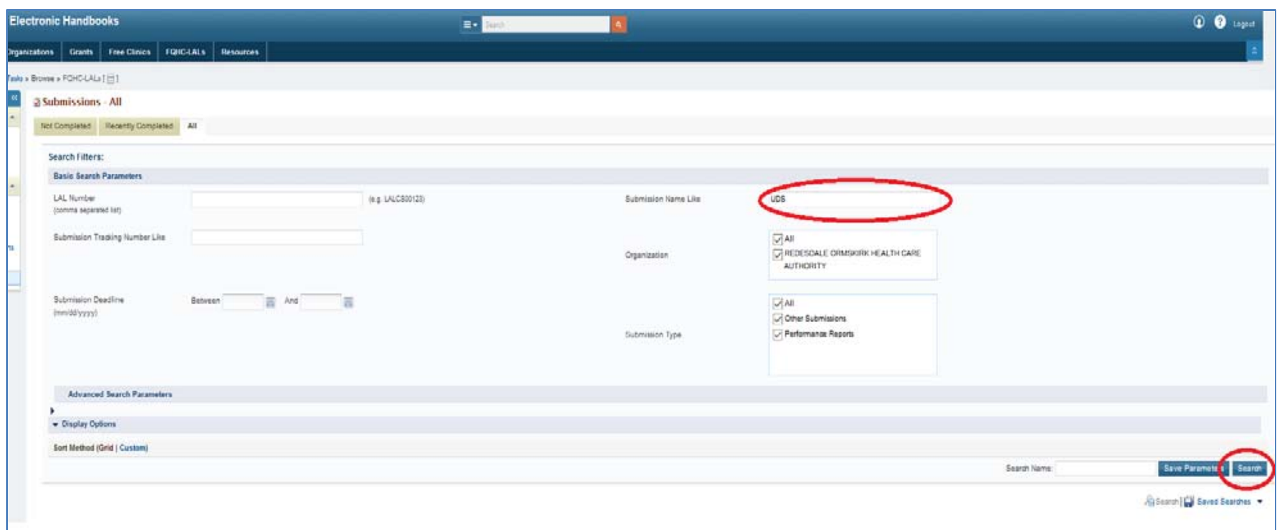
4. From the Look-Alike Home page (Figure 8), click the **Work on Performance Report** link in the Submissions section.

Figure 8: Look-Alike Home Page



5. The Submissions – All page opens, displaying all performance reports related to the LAL. To display only UDS reports, you can enter search parameters under **Search Filters** at the top of the page. For example, you can enter "UDS" in the **Submission Name Like** field, and then click **Search** (Figure 9).

Figure 9: Submissions – All Page



6. The list will display only UDS reports (Figure 10).

Figure 10: Submission – All Page Showing Only UDS Reports

Submissions - All

Not Completed | Recently Completed | All

Detailed View | Search | Saved Searches

Page size: 15 Go — 8 items in 1 page(s)

Submitted	Submission Name	Submission Type	Organization	LAL #	Tracking #	Reporting Period	Submitted Date	Status	Options
Submitted On: In more than 30 Days ago (7)									
156 Days Ago	FQHC Look-Alike Annual UDS Report	Performance Reports	REDESDALE ORMSKIRK HEALTH CARE AUTHORITY, ME	LALCS00003	LALCS000032017	01/01/2017 - 12/31/2017	03/26/2018	Submitted	Performance Reports
546 Days Ago	FQHC Look-Alike Annual UDS Report	Performance Reports	REDESDALE ORMSKIRK HEALTH CARE AUTHORITY, ME	LALCS00003	LALCS000032016	01/01/2016 - 12/31/2016	03/01/2017	Submitted	Performance Reports
887 Days Ago	FQHC Look-Alike Annual UDS Report	Performance Reports	REDESDALE ORMSKIRK HEALTH CARE AUTHORITY, ME	LALCS00003	LALCS000032015	01/01/2015 - 12/31/2015	03/25/2016	Submitted	Performance Reports
1251 Days Ago	FQHC Look-Alike Annual UDS Report	Performance Reports	REDESDALE ORMSKIRK HEALTH CARE AUTHORITY, ME	LALCS00003	LALCS000032014	01/01/2014 - 12/31/2014	03/27/2015	Submitted	Performance Reports
1590 Days Ago	FQHC Look-Alike Annual UDS Report	Performance Reports	REDESDALE ORMSKIRK HEALTH CARE AUTHORITY, ME	LALCS00003	LALCS000032013	01/01/2013-12/31/2013	04/22/2014	Submitted	Performance Reports
1967 Days Ago	FQHC Look-Alike Annual UDS Report	Performance Reports	REDESDALE ORMSKIRK HEALTH CARE AUTHORITY, ME	LALCS00003	LALCS000032012	01/01/2012-12/31/2012	04/10/2013	Submitted	Performance Reports
2352 Days Ago	FQHC Look-Alike Annual UDS Report	Performance Reports	REDESDALE ORMSKIRK HEALTH CARE AUTHORITY, ME	LALCS00003	LALCS000032011	01/01/2011-12/31/2011	03/21/2012	Submitted	Performance Reports
Submitted On: In more than 30 Days (1)									
170 Days	FQHC Look-Alike Annual UDS Report	Performance Reports	REDESDALE ORMSKIRK HEALTH CARE AUTHORITY, ME	LALCS00003	LALCS000032018	01/01/2018 - 12/31/2018		Not Started	Start

Page size: 15 Go — 8 items in 1 page(s)

Preparing and Submitting a UDS Report (Grantees and Look-Alikes)

Preparing and submitting your UDS is a matter of entering the data, running the required audit checks, and then submitting your report. On-line resources are available if you need help you with this.

1. Users new to the EHBs or UDS should view the *Web-Based Uniform Data System (UDS) Overview* presentation at https://grants3.hrsa.gov/2010/WebTrainingInternal/Interface/CBT/UDS%20TA/UDS_TA_Slides.htm. This presentation covers the whole process, from logging in to submitting your UDS.

2. For help with completing and submitting your report, see *Completing and Submitting Your UDS Report - Overview for Section 330 Grantees and Look-Alikes*, an article in the Electronic Handbooks Help and Knowledge Base, at https://help.hrsa.gov/display/public/EHBSKBFG/Completing+and+Submitting+Your+UDS+Report+-+Overview+for+Health+Center+Program+Grantees+and+Look-Alikes.

3. If you still have questions, see the UDS-related Frequently Asked Questions (FAQ) at https://help.hrsa.gov/display/public/EHBSKBFG/UDS+FAQs.

Since this material is readily available and quite comprehensive, we won't reproduce any of its content here.

Revising and Resubmitting a UDS Report (Grantees and Look-Alikes)

If your reviewer returns your UDS Report to you with a request for corrections or changes, you'll receive notification, usually by email. The email may contain the date the report is due back. It will contain a list of issues which will require action from you. Take the following steps:

1. **Open Your UDS Report.** Follow the steps given under "How to Find Your UDS Reports" above to find your UDS reports. Click **Edit** to open the report for changes.

2. **Review the Reviewer's Comments.** The comments may be included in an email sent to you or using the EHBs system through the "Change Request Email" link (accessed from the Status Overview page). The reviewer will let you know what items need revision.

3. **Run the Data Audit Report.** Run the data audit report to get the most recent list of edits since some edits may have been reprogrammed or added since submission or need to be corrected as indicated by the reviewer. For help with running the Data Audit Report, see https://help.hrsa.gov/display/public/EHBSKBFG/Executing+the+Data+Audit+Report+and+Clearing+an+Edit.

4. **Address the Reviewer's Findings.** Carefully review each problem identified by the reviewer. Correct the data or provide an explanation. Changes you make to the data entered into one table may make it necessary to change data entered into another.

5. **Run the Data Audit Report Again.** Validation rules apply as they did when you first prepared the report. You must run the Data Audit report to check for errors or exceptions. Just as when you first submitted your UDS, it must be free of errors, and exceptions must be explained.

6. **Resubmit the Report**, as detailed in the following paragraphs.

   The **Continue** button appears at the bottom of the Data Audit Report page as soon as the Data Audit Report is complete. Click the **Continue** button to open the Review page. (You can also access the Review page by clicking **Review** on the Left Navigation panel.)

   From the Review page, you may review any section of the report. You may also print the report.

   When you're ready to proceed with submission, click the **Continue** button at the bottom of the Review page to open the UDS Certification page (the "Submit" page).

   - If your report is ready to be submitted, you can also open the UDS Certification page by clicking **Submit** in the Left Navigation panel.

   - If clicking **Submit** in the Left Navigation panel opens the Status Overview page, your report is not ready to be submitted. See the note at the top of the Status Overview page.

Follow the directions under UDS Certification ("I Agree" is not case-sensitive), and then click the **Submit Report** button.

On submission of the report, you'll receive a confirmation email. The reviewer will be notified by the EHB system when your report has been resubmitted.

How to Find Reports Based on UDS Data ("Standard UDS Reports") (Grantees)

Each year, HRSA issues a series of reports based on data collected through UDS. The reports are listed and described in this section. You can access them through your UDS report. To do this, follow the steps given under "How to Find Your UDS Reports in the HRSA EHBs" to find your UDS reports. Then:

1. Choose a Reporting Period. For the UDS report submitted for that Reporting Period, click **Performance Reports** (Figure 11).

Figure 11: Performance Reports Link on Submissions – All Page

2. The page that will open after clicking Performance Reports link on the Submission – All

   2.1. For reports submitted before the 2018 reporting period, the page that will open after clicking the Performance Reports link on the Submission – All page will be titled Review (Figure 12). Use the Access reports and data related to your UDS submission link to open a report. The UDS Report page will open (Figure 13). Use the View link to open a report.

Figure 12: Review Page

Figure 13: UDS Report Page

UDS Report

H80CS000082016/V4: CHARTERS TELECOM HEALTH SERVICE CORPORATION, East Bloomfield, PA — Due Date: 2/15/2017 11:59 PM

REPORTS

Report Name	Description	Action
UDS Data File in XML	Submitted Raw UDS Data File in XML format.	Download / Email
UDS Health Center, State, National Summary Report	The Summary Report is a 'dashboard' report intended to describe each health center in a statistical manner. Calculations of key measures are derived from their own organization's current reporting on the UDS. The measures are broken out into two main categories: 1) Demographic and Clinical Data (Patients, Visits, Staffing and Clinical Information) and 2) Fiscal Information (Costs and Revenues) and provide an overall picture of the health center's performance in each of these areas. Formula Guide: UDS Summary Report	View
UDS National and State Rollups	The Rollup Reports compile annual data reported by Health Center Program (HCP) health centers. Summary HCP data are provided for patient demographics, socioeconomic characteristics, staffing, patient diagnoses and services rendered, quality of care, health outcomes and disparities, financial costs, and revenues. The UDS Standard Rollup Reports provide the values and measures for universal and grant specific data at the National and State level. Formula Guide: UDS Rollup Report	View

2.2. For UDS Reports submitted in 2018 and later reporting period, will open in a separate Review and Report list page. The page lists all the Reports on top of the page and Tables on the second half of the page (Figure 14). Click View link adjacent to each of the reports to access the reports.

Figure 14: Review and Report List Page

Review and Report List Page

Reports

Report Name	Description	Action
UDS Data File in XML	Submitted Raw UDS Data File in XML format.	Download / Email
UDS Health Center, State, National Summary Report	The Summary Report is a 'dashboard' report intended to describe each health center in a statistical manner. Calculations of key measures are derived from their own organization's current reporting on the UDS. The measures are broken out into two main categories: 1) Demographic and Clinical Data (Patients, Visits, Staffing and Clinical Information) and 2) Fiscal Information (Costs and Revenues) and provide an overall picture of the health center's performance in each of these areas. Formula Guide: UDS Summary Report	View
UDS National and State Rollups	The Rollup Reports compile annual data reported by Health Center Program (HCP) health centers. Summary HCP data are provided for patient demographics, socioeconomic characteristics, staffing, patient diagnoses and services rendered, quality of care, health outcomes and disparities, financial costs, and revenues. The UDS Standard Rollup Reports provide the values and measures for universal and grant specific data at the National and State level. Formula Guide: UDS Rollup Report	View
UDS Health Center Trend Report	The Health Center Trend Report, introduced in 2008, reports on the key performance measures. The report compares the health center's performance for these measures with national and state averages over a 3 year period. The measures describe health center performance in three categories: Access, Quality of Care/Health Outcomes, and Financial Cost/Viability and provide an overall picture of the health center's performance in each of these areas. Formula Guide: UDS Health Center Trend Report	View
UDS Health Center Performance Comparison Report	The Health Center Performance Comparison Report for individual health centers provides calculations of key measures at different levels, i.e., Health Center, State, National, Urban, Rural, National Percentiles (25th, 50th, and 75th. The report categories are Quality of Care/Health Outcomes, Costs per Patient, and Costs per Visit.	View

UDS Data file in XML

Provides the submitted raw UDS data file in XML format. The file can be downloaded and/or emailed. This will be available to the Health Center after they have submitted their UDS report at least once to HRSA for review.

UDS Summary Report

Provides the summary and analysis on the health center's current UDS data using measures across various Tables of the UDS report. The Preliminary version of this report will only have the Health Center view available. Once all the reports for the current reporting cycle have been processed, the final version of this report will be available which will have Health Center, State and National views.

UDS National and State Rollups

This report compiles annual data reported by Health Center Program (HCP) Health Centers. Summary HCP data are provided for patient demographics, socioeconomic characteristics, staffing, patient diagnoses and services rendered quality of care, health outcomes and disparities, financial costs, and revenues. This will be available after all the reports for the current reporting cycle have been processed.

UDS Health Center Trend Report

This report compares the health center's performance for 16 key performance measures (in three categories: Access, Quality of Care/Health Outcomes, and Financial Cost/Viability) with national and state averages over a 3 year period. This will be available after all the reports for the current reporting cycle have been processed.

UDS Health Center Performance Comparison Report

Provides the summary and analysis on the health center's latest UDS data giving details at Health Center, State, National, Urban and Rural level with trend comparisons and percentiles. This will be available after all the reports for the current reporting cycle have been processed.

How to Find Reports Based on UDS Data (“Standard UDS Reports”) (Look-Alikes)

Each year, HRSA issues a series of reports based on data collected through UDS. The reports are listed and described in this section. You can access them through your UDS report. To do this, follow the steps given under “How to Find Your UDS Reports in the HRSA EHBs” to find your UDS reports. Then:

1. Choose a Reporting Period. For the UDS report submitted for that Reporting Period, click **Performance Reports** (Figure 15).

Figure 15: Performance Report Link on Submissions – All Page

Page size: 15 Go — 8 items in 1 page(s)

Submitted	Submission Name	Submission Type	Organization	LAL #	Tracking #	Reporting Period	Submitted Date	Status	Options
Submitted On: In more than 30 Days ago (7)									
156 Days Ago	FQHC Look-Alike Annual UDS Report	Performance Reports	REDESDALE ORMSKIRK HEALTH CARE AUTHORITY, ME	LALCS00003	LALCS000032017	01/01/2017 - 12/31/2017	03/26/2018	Submitted	Performance Reports
546 Days Ago	FQHC Look-Alike Annual UDS Report	Performance Reports	REDESDALE ORMSKIRK HEALTH CARE AUTHORITY, ME	LALCS00003	LALCS000032016	01/01/2016 - 12/31/2016	03/01/2017	Submitted	Performance Reports
887 Days Ago	FQHC Look-Alike Annual UDS Report	Performance Reports	REDESDALE ORMSKIRK HEALTH CARE AUTHORITY, ME	LALCS00003	LALCS000032015	01/01/2015 - 12/31/2015	03/25/2016	Submitted	Performance Reports
1251 Days Ago	FQHC Look-Alike Annual UDS Report	Performance Reports	REDESDALE ORMSKIRK HEALTH CARE AUTHORITY, ME	LALCS00003	LALCS000032014	01/01/2014 - 12/31/2014	03/27/2015	Submitted	Performance Reports
1590 Days Ago	FQHC Look-Alike Annual UDS Report	Performance Reports	REDESDALE ORMSKIRK HEALTH CARE AUTHORITY, ME	LALCS00003	LALCS000032013	01/01/2013-12 /31/2013	04/22/2014	Submitted	Performance Reports
1967 Days Ago	FQHC Look-Alike Annual UDS Report	Performance Reports	REDESDALE ORMSKIRK HEALTH CARE AUTHORITY, ME	LALCS00003	LALCS000032012	01/01/2012-12 /31/2012	04/10/2013	Submitted	Performance Reports
2352 Days Ago	FQHC Look-Alike Annual UDS Report	Performance Reports	REDESDALE ORMSKIRK HEALTH CARE AUTHORITY, ME	LALCS00003	LALCS000032011	01/01/2011-12 /31/2011	03/21/2012	Submitted	Performance Reports
Submitted On: In more than 30 Days (1)									
170 Days	FQHC Look-Alike Annual UDS Report	Performance Reports	REDESDALE ORMSKIRK HEALTH CARE AUTHORITY, ME	LALCS00003	LALCS000032018	01/01/2018 - 12/31/2018		Not Started	Start

Page size: 15 Go — 8 items in 1 page(s)

2. The page that will open after clicking Performance Reports link on the Submission – All
   2.1. For reports submitted prior to 2018 reporting period, page titled Review (Figure 16) will open. Use the Access reports and data related to your UDS submission link to open a report. The UDS Report page will open (Figure 17). Use the View link to open a report.

Figure 16: "Access Reports" Link in UDS Report (Look-Alikes)

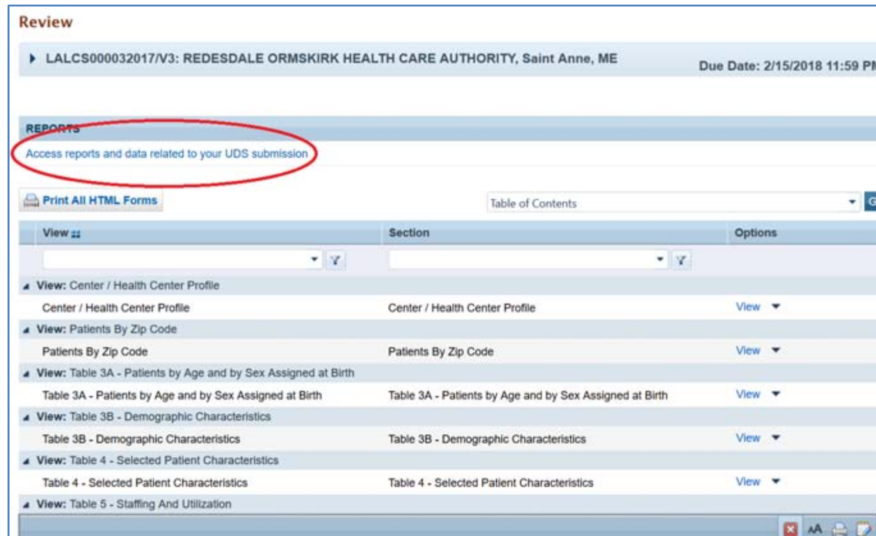


Figure 17: UDS Report Page

UDS Report

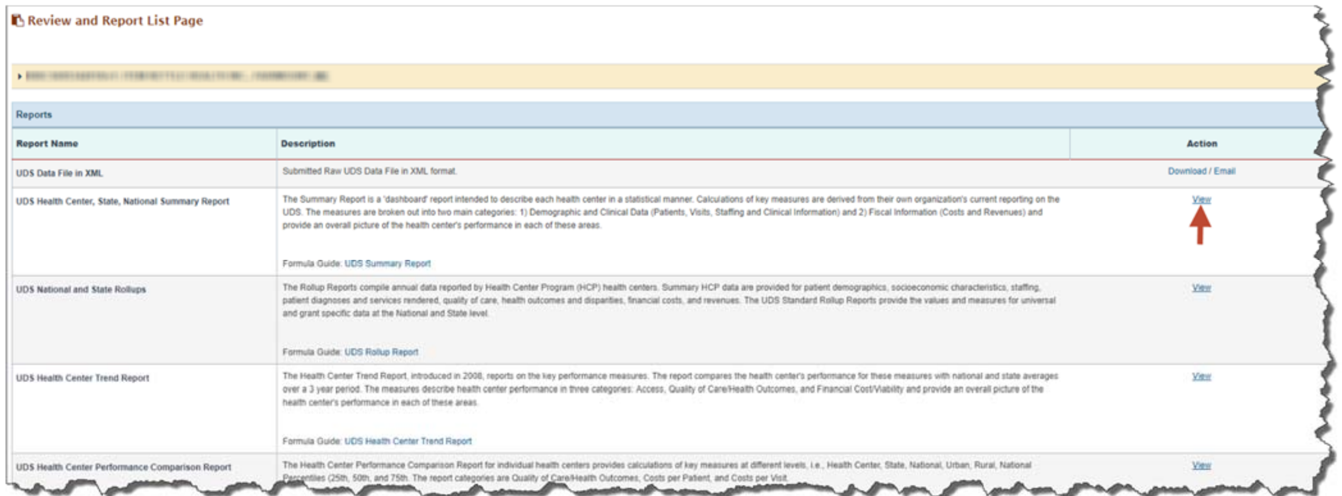
LALCS00003016/V3: REDESDALE ORMSKIRK HEALTH CARE AUTHORITY, North Augusta, ME — Due Date: 2/15/2017 11:59 PM

REPORTS

Report Name	Description	Action
UDS Health Center, State, National Summary Report	The Summary Report is a 'dashboard' report intended to describe each health center in a statistical manner. Calculations of key measures are derived from their own organization's current reporting on the UDS. The measures are broken out into two main categories: 1) Demographic and Clinical Data (Patients, Visits, Staffing and Clinical Information) and 2) Fiscal Information (Costs and Revenues) and provide an overall picture of the health center's performance in each of these areas. Formula Guide: UDS Summary Report	View
UDS National and State Rollups	The Rollup Reports compile annual data reported by Health Center Program (HCP) health centers. Summary HCP data are provided for patient demographics, socioeconomic characteristics, staffing, patient diagnoses and services rendered, quality of care, health outcomes and disparities, financial costs, and revenues. The UDS Standard Rollup Reports provide the values and measures for universal and grant specific data at the National and State level. Formula Guide: UDS Rollup Report	View

2.2. For UDS Reports submitted in 2018 and later reporting period, will open in a separate Review and Report list page. The page lists all the Reports on top of the page and Tables on the second half of the page (Figure 18). Click View link adjacent to each of the reports to access the reports.

Figure 18: Review and Report List Page



Review and Report List Page

Reports

Report Name	Description	Action
UDS Data File in XML	Submitted Raw UDS Data File in XML format.	Download / Email
UDS Health Center, State, National Summary Report	The Summary Report is a 'dashboard' report intended to describe each health center in a statistical manner. Calculations of key measures are derived from their own organization's current reporting on the UDS. The measures are broken out into two main categories: 1) Demographic and Clinical Data (Patients, Visits, Staffing and Clinical Information) and 2) Fiscal Information (Costs and Revenues) and provide an overall picture of the health center's performance in each of these areas. Formula Guide: UDS Summary Report	View
UDS National and State Rollups	The Rollup Reports compile annual data reported by Health Center Program (HCP) health centers. Summary HCP data are provided for patient demographics, socioeconomic characteristics, staffing, patient diagnoses and services rendered, quality of care, health outcomes and disparities, financial costs, and revenues. The UDS Standard Rollup Reports provide the values and measures for universal and grant specific data at the National and State level. Formula Guide: UDS Rollup Report	View
UDS Health Center Trend Report	The Health Center Trend Report, introduced in 2008, reports on the key performance measures. The report compares the health center's performance for these measures with national and state averages over a 3 year period. The measures describe health center performance in three categories: Access, Quality of Care/Health Outcomes, and Financial Cost/Viability and provide an overall picture of the health center's performance in each of these areas. Formula Guide: UDS Health Center Trend Report	View
UDS Health Center Performance Comparison Report	The Health Center Performance Comparison Report for individual health centers provides calculations of key measures at different levels, i.e., Health Center, State, National, Urban, Rural, National Percentiles (25th, 50th, and 75th. The report categories are Quality of Care/Health Outcomes, Costs per Patient, and Costs per Visit.	View

UDS National Rollups

This report compiles annual data reported by FQHC-LALs. Summary data are provided for patient demographics, socioeconomic characteristics, staffing, patient diagnoses and services rendered quality of care, health outcomes and disparities, financial costs, and revenues. This will be available after all the reports for the current reporting cycle have been processed.

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

For Help and Support

The following resources are available to you for help and support.

EHBs Account and User Access Questions

HRSA Call Center

http://www.hrsa.gov/about/contact/ehbhelp.aspx or 877-464-4772 (877-Go4-HRSA)

Monday through Friday (except federal holidays) 8 AM to 8 PM (ET)

UDS Content Questions

Your Reviewer or the UDS Help Desk

udshelp330@bphcdata.net or 866-837-4357 (866-UDS-HELP)

UDS Electronic Reporting Questions

BPHC Help Desk

http://www.hrsa.gov/about/contact/bphc.aspx or 877-974-2742 (877-974-BPHC)

Monday through Friday (except federal holidays) 8:30 AM to 5:30 PM (ET)

Software Requirements and Section 508 Compliance Statement

Software Requirements

The developed functionality will be compatible with the browser(s) recommended within the Browser Requirements section of the HRSA EHBs portal. The information can be found at

https://grants3.hrsa.gov/2010/WebEPSExternal/Interface/common/BrowserSettings.aspx

Section 508 Compliance Statement

Section 508 compliance testing was done to ensure that the UDS is in compliance with requirements that users with disabilities have equivalent access to the system developed.

Supported Document Types

The following document types are supported in the HRSA EHBs:

.DOC or .DOCX - Microsoft Word

.RTF - Rich Text Format

.TXT - Text

.WPD - Word Perfect Document

.PDF - Adobe Portable Document Format

.XLS or .XLSX - Microsoft Excel

UDS Submission Checklist

Use this checklist as a reference to ensure a complete, accurate, and on-time UDS submission. It is common for multiple people to contribute to reporting. The lead preparer should organize the team, the report and review activities, and the submission process early.

	Activity	Notes
☐	Plan ahead. Try to have a complete UDS Report available for internal review at least 2 days before submission.	Your UDS Report is due by February 15. Give yourself sufficient time to review the report for completeness and reasonableness.
☐	Review comments and questions that your Reviewer sent last year.	Avoid making the same errors in the report year after year. Reviewing the letter will help to identify common mistakes to avoid.
☐	Pull your health center's prior year UDS Report from the Electronic Handbooks (EHB).	Be sure to get the final report that includes all corrections, not the initial submission.
☐	Compare key metrics across years. Investigate large increases or decreases for accuracy. At minimum, review: • Tables 3A, 3B, 4, and ZIP: Patient demographic, income, and insurance shifts, and special population counts, • Tables 5, 6A, and 8A: Patient, visits, and costs by service category, • Tables 6B and 7: Universe and compliance for each measure, and • Tables 8A, 9D, and 9E: Ratio of total costs to total cash revenues.	Unless your health center has experienced a substantial change in the service delivery model (new services, change in number or type of providers, or change in number of patients served), year-to-year changes are generally minor. *Note: If your program has experienced a significant change in activity, it is advisable to provide a brief explanation in the report comments.*
☐	Check answers to flagged edits for adequacy.	Edits help to identify potential issues with your data prior to submission and must be addressed through data changes (where appropriate) or through meaningful explanations. Explanations such as, "Looking into it," "This is what the data say," or "Verified with our EHR vendor" are not acceptable. *Note: If your program activity is not in line with state and/or national averages, explain the program's impact and variance from the comparison in the edit comment(s).*

❒	Check that all tables are marked as complete.	All tables must be marked as complete. Tables that are complete are shown with a green check mark.
❒	Mark the report as complete and accurate and submit.	The health center staff person with submission rights in the EHB is responsible for reviewing and approving the UDS Report before submission.

Patient Profile Indicators	National Benchmarks (ACS 2014-2018, etc.)	2019 UDS Nation	AK	AL	AR	AS
% Uninsured	8.9%	22.74%	21.37%	45.36%	18.64%	0.00%
% Medicaid/ CHIP/Other Public	20.1%	48.52%	35.81%	28.08%	37.57%	100.00%
% Low income (at or below <200% FPG)	30.0%	91.06%	82.30%	96.36%	86.43%	100.00%
% Racial and/or ethnic minority	38.9%	62.99%	57.95%	60.53%	39.37%	98.96%
% Hispanic or Latino	17.8%	36.84%	5.73%	11.43%	14.95%	0.00%
% Best served in another language	4.4%	24.66%	4.00%	8.58%	11.72%	12.61%
% Experiencing homelessness	0.17%	4.89%	2.36%	3.42%	2.29%	0.00%
% Agricultural	0.20%	3.46%	0.10%	3.71%	0.70%	0.00%
% Served at a Health Center Located In or Immediately Accessible to Public Housing		17.31%	10.66%	19.95%	13.74%	0.00%
% School-based		2.97%	0.10%	1.83%	5.93%	0.00%
% Veterans	7.1%	1.34%	5.12%	1.06%	1.75%	0.00%
Quality of Care Indicators	**National Benchmarks (HP 2020, CDC, etc.)**	**2019 UDS Nation**	**AK**	**AL**	**AR**	**AS**
% total patients receiving medical services		83.89%	85.36%	89.49%	91.98%	95.90%
% total patients receiving dental services		22.50%	32.92%	16.54%	12.52%	29.87%
Average medical visits/medical patient (excl.nurses)		3.14	2.93	2.97	3.19	1.48
% Medical Visits that Include MH Treatment		10.64%	8.99%	10.55%	18.94%	0.00%
% Medical Visits that Include SUD Treatment		4.29%	7.75%	2.29%	4.58%	0.00%
% Mental Health Visits that Include SUD Treatment		1.75%	3.18%	0.34%	0.58%	0.00%
% Early access to prenatal care	84.8%*	73.81%	78.47%	63.91%	70.87%	58.05%
% Low birth weight	7.8%*	8.05%	5.31%	9.47%	12.72%	7.83%
% Childhood immunizations		39.75%	37.51%	22.73%	35.17%	54.29%
% Weight assessment and counseling for children and adolescents		71.21%	30.68%	63.74%	75.48%	35.71%
% Adult weight screening and follow-up		72.43%	43.07%	73.49%	87.65%	51.43%
% Tobacco use screening and cessation services		87.17%	81.90%	82.73%	95.19%	50.00%
% Depression screening and follow-up		71.61%	73.24%	64.96%	70.72%	41.43%
% Cervical cancer screening	93.0%*	56.53%	45.14%	35.67%	41.08%	47.14%
% Colorectal cancer screening	70.5%*	45.56%	34.93%	29.75%	41.60%	2.86%
% HIV linkage to care		87.21%	100.00%	88.79%	95.87%	
% Statin Therapy Received		69.94%	67.88%	75.27%	72.83%	44.29%
% Controlled hypertension	61.2%*	64.62%	53.82%	51.95%	59.92%	48.57%
% Uncontrolled diabetes	16.2%*	31.95%	30.30%	42.60%	31.98%	55.71%
% Dental sealants	28.1%*	56.80%	57.25%	41.65%	45.47%	58.57%

*indicates this is a Healthy People 2020 goal, not a current rate.

Service Delivery Indicators		2019 UDS Nation	AK	AL	AR	AS
% growth in total patients		5.13%	2.11%	3.88%	7.29%	26.87%
Non-clinical/facility/service support FTEs as % of total FTEs		35.17%	37.18%	36.08%	33.42%	45.59%
Medical cost per medical patient		$ 647.11	$ 1,546.75	$478.43	$576.78	$193.40
Medical cost per medical visit		$ 206.86	$ 532.40	$160.94	$181.31	$130.49
Dental cost per dental patient		$ 552.97	$ 925.54	$306.76	$586.33	$ 58.99
Dental cost per dental visit		$ 214.91	$ 349.24	$151.93	$240.87	$ 49.29
330 Grant Funds per Patient		$ 165.23	$ 662.33	$ 236.71	$ 222.15	$ 221.98
Net Collection Rate		0.97	0.89	0.95	1.04	1.00

*indicates this is a Healthy People 2020 goal, not a current rate.

Patient Profile Indicators	National Benchmarks (ACS 2014-2018, etc.)	2019 UDS Nation	AZ	CA	CO	CT
% Uninsured	8.9%	22.74%	16.70%	19.08%	23.90%	16.62%
% Medicaid/ CHIP/Other Public	20.1%	48.52%	46.51%	65.43%	52.69%	60.58%
% Low income (at or below <200% FPG)	30.0%	91.06%	87.72%	94.92%	91.62%	91.63%
% Racial and/or ethnic minority	38.9%	62.99%	64.01%	78.81%	66.16%	76.98%
% Hispanic or Latino	17.8%	36.84%	50.68%	61.83%	53.21%	51.45%
% Best served in another language	4.4%	24.66%	26.48%	35.52%	28.55%	25.88%
% Experiencing homelessness	0.17%	4.89%	4.58%	6.81%	4.76%	3.51%
% Agricultural	0.20%	3.46%	1.48%	9.96%	2.12%	0.38%
% Served at a Health Center Located In or Immediately Accessible to Public Housing		17.31%	23.71%	5.54%	6.53%	29.52%
% School-based		2.97%	1.10%	2.33%	3.86%	6.40%
% Veterans	7.1%	1.34%	2.12%	0.71%	1.52%	0.74%
Quality of Care Indicators	**National Benchmarks (HP 2020, CDC, etc.)**	**2019 UDS Nation**	**AZ**	**CA**	**CO**	**CT**
% total patients receiving medical services		83.89%	92.50%	84.82%	91.52%	83.28%
% total patients receiving dental services		22.50%	15.24%	24.88%	23.53%	27.36%
Average medical visits/medical patient (excl.nurses)		3.14	3.02	3.62	3.11	3.27
% Medical Visits that Include MH Treatment		10.64%	8.25%	7.63%	10.89%	9.66%
% Medical Visits that Include SUD Treatment		4.29%	3.70%	3.00%	4.16%	5.76%
% Mental Health Visits that Include SUD Treatment		1.75%	1.23%	1.18%	1.28%	9.46%
% Early access to prenatal care	84.8%*	73.81%	73.09%	77.71%	76.99%	76.84%
% Low birth weight	7.8%*	8.05%	6.04%	6.80%	9.15%	9.11%
% Childhood immunizations		39.75%	38.95%	39.24%	40.48%	63.09%
% Weight assessment and counseling for children and adolescents		71.21%	77.77%	67.62%	71.81%	79.87%
% Adult weight screening and follow-up		72.43%	70.55%	72.09%	62.81%	75.80%
% Tobacco use screening and cessation services		87.17%	88.34%	87.38%	88.72%	90.83%
% Depression screening and follow-up		71.61%	80.58%	67.94%	70.04%	71.22%
% Cervical cancer screening	93.0%*	56.53%	52.04%	60.40%	57.94%	57.91%
% Colorectal cancer screening	70.5%*	45.56%	43.33%	46.24%	39.53%	51.94%
% HIV linkage to care		87.21%	80.90%	88.19%	92.65%	100.00%
% Statin Therapy Received		69.94%	70.63%	66.11%	73.03%	76.55%
% Controlled hypertension	61.2%*	64.62%	63.22%	66.23%	68.14%	66.24%
% Uncontrolled diabetes	16.2%*	31.95%	31.87%	34.38%	32.92%	29.73%
% Dental sealants	28.1%*	56.80%	66.43%	57.85%	56.67%	65.63%

*indicates this is a Healthy People 2020 goal, not a current rate.

Service Delivery Indicators		2019 UDS Nation	AZ	CA	CO	CT
% growth in total patients		5.13%	20.65%	7.16%	2.67%	0.82%
Non-clinical/facility/service support FTEs as % of total FTEs		35.17%	34.90%	35.26%	30.99%	33.72%
Medical cost per medical patient		$ 647.11	$642.21	$ 813.77	$ 618.14	$ 694.66
Medical cost per medical visit		$ 206.86	$213.15	$ 225.82	$ 199.08	$ 213.05
Dental cost per dental patient		$ 552.97	$593.05	$ 686.30	$ 575.52	$ 472.06
Dental cost per dental visit		$ 214.91	$268.73	$ 221.42	$ 231.40	$ 188.35
330 Grant Funds per Patient		$ 165.23	$ 115.99	$ 125.50	$ 164.12	$ 158.81
Net Collection Rate		0.97	1.01	0.98	0.96	0.95

*indicates this is a Healthy People 2020 goal, not a current rate.

Patient Profile Indicators	National Benchmarks (ACS 2014-2018, etc.)	2019 UDS Nation	DC	DE	FL	FM
% Uninsured	8.9%	22.74%	18.52%	32.03%	36.16%	70.45%
% Medicaid/ CHIP/Other Public	20.1%	48.52%	63.08%	35.63%	37.56%	5.70%
% Low income (at or below <200% FPG)	30.0%	91.06%	88.72%	96.92%	91.88%	99.60%
% Racial and/or ethnic minority	38.9%	62.99%	94.47%	77.31%	68.27%	99.86%
% Hispanic or Latino	17.8%	36.84%	35.12%	42.62%	40.71%	0.00%
% Best served in another language	4.4%	24.66%	33.75%	39.14%	25.93%	99.58%
% Experiencing homelessness	0.17%	4.89%	6.11%	1.73%	5.67%	0.00%
% Agricultural	0.20%	3.46%	0.05%	2.12%	3.07%	0.00%
% Served at a Health Center Located In or Immediately Accessible to Public Housing		17.31%	9.90%	9.04%	18.04%	0.00%
% School-based		2.97%	0.95%	0.88%	4.36%	0.00%
% Veterans	7.1%	1.34%	0.70%	1.17%	0.73%	0.00%
Quality of Care Indicators	**National Benchmarks (HP 2020, CDC, etc.)**	**2019 UDS Nation**	**DC**	**DE**	**FL**	**FM**
% total patients receiving medical services		83.89%	94.57%	89.50%	80.32%	94.66%
% total patients receiving dental services		22.50%	23.22%	19.43%	23.71%	7.70%
Average medical visits/medical patient (excl.nurses)		3.14	3.08	2.74	2.87	2.40
% Medical Visits that Include MH Treatment		10.64%	4.78%	9.90%	10.43%	0.15%
% Medical Visits that Include SUD Treatment		4.29%	1.90%	5.28%	3.50%	0.01%
% Mental Health Visits that Include SUD Treatment		1.75%	2.09%	0.84%	1.20%	0.00%
% Early access to prenatal care	84.8%*	73.81%	60.96%	52.90%	60.21%	35.56%
% Low birth weight	7.8%*	8.05%	8.12%	9.26%	8.98%	6.54%
% Childhood immunizations		39.75%	53.57%	39.49%	39.66%	53.76%
% Weight assessment and counseling for children and adolescents		71.21%	80.38%	75.85%	83.74%	74.63%
% Adult weight screening and follow-up		72.43%	56.86%	77.21%	84.91%	58.91%
% Tobacco use screening and cessation services		87.17%	83.05%	90.44%	89.29%	53.55%
% Depression screening and follow-up		71.61%	71.52%	79.86%	79.43%	48.40%
% Cervical cancer screening	93.0%*	56.53%	65.00%	73.29%	61.02%	28.87%
% Colorectal cancer screening	70.5%*	45.56%	48.32%	64.78%	47.11%	2.58%
% HIV linkage to care		87.21%	90.00%	100.00%	86.86%	
% Statin Therapy Received		69.94%	73.28%	69.97%	71.22%	71.81%
% Controlled hypertension	61.2%*	64.62%	63.65%	60.55%	63.77%	56.34%
% Uncontrolled diabetes	16.2%*	31.95%	32.74%	37.05%	33.53%	58.82%
% Dental sealants	28.1%*	56.80%	34.44%	33.00%	61.55%	28.68%

*indicates this is a Healthy People 2020 goal, not a current rate.

Service Delivery Indicators		**2019 UDS Nation**	**DC**	**DE**	**FL**	**FM**
% growth in total patients		5.13%	3.29%	-0.52%	5.61%	-4.86%
Non-clinical/facility/service support FTEs as % of total FTEs		35.17%	32.49%	36.12%	36.23%	29.71%
Medical cost per medical patient		$ 647.11	$ 717.37	$503.67	$480.04	$ 82.81
Medical cost per medical visit		$ 206.86	$ 233.10	$183.82	$168.32	$ 34.44
Dental cost per dental patient		$ 552.97	$ 434.61	$670.74	$420.65	$ 140.58
Dental cost per dental visit		$ 214.91	$ 199.38	$277.64	$173.88	$ 93.23
330 Grant Funds per Patient		$ 165.23	$ 140.97	$ 302.15	$ 153.45	$ 121.15
Net Collection Rate		0.97	1.02	0.93	0.90	0.94

Patient Profile Indicators	National Benchmarks (ACS 2014-2018, etc.)	2019 UDS Nation	GA	GU	HI	IA
% Uninsured	8.9%	22.74%	35.39%	14.38%	12.77%	22.70%
% Medicaid/ CHIP/Other Public	20.1%	48.52%	26.93%	80.10%	54.71%	47.13%
% Low income (at or below <200% FPG)	30.0%	91.06%	90.82%	99.11%	85.28%	92.65%
% Racial and/or ethnic minority	38.9%	62.99%	65.45%	99.25%	80.09%	46.91%
% Hispanic or Latino	17.8%	36.84%	15.07%	0.00%	10.36%	23.91%
% Best served in another language	4.4%	24.66%	12.13%	55.00%	15.17%	21.73%
% Experiencing homelessness	0.17%	4.89%	3.61%	0.68%	5.10%	4.64%
% Agricultural	0.20%	3.46%	3.88%	0.02%	0.78%	0.75%
% Served at a Health Center Located In or Immediately Accessible to Public Housing		17.31%	5.00%	0.00%	9.95%	18.21%
% School-based		2.97%	4.23%	0.00%	1.06%	0.29%
% Veterans	7.1%	1.34%	1.17%	0.29%	2.07%	1.61%
Quality of Care Indicators	**National Benchmarks (HP 2020, CDC, etc.)**	**2019 UDS Nation**	**GA**	**GU**	**HI**	**IA**
% total patients receiving medical services		83.89%	90.96%	100.00%	80.03%	73.26%
% total patients receiving dental services		22.50%	11.22%	0.00%	30.47%	37.20%
Average medical visits/medical patient (excl.nurses)		3.14	2.79	1.53	3.47	3.06
% Medical Visits that Include MH Treatment		10.64%	13.05%	2.12%	8.30%	12.39%
% Medical Visits that Include SUD Treatment		4.29%	4.28%	1.38%	4.04%	5.07%
% Mental Health Visits that Include SUD Treatment		1.75%	0.53%	0.00%	3.23%	1.76%
% Early access to prenatal care	84.8%*	73.81%	63.97%	22.17%	68.86%	72.81%
% Low birth weight	7.8%*	8.05%	13.30%	12.93%	8.60%	8.18%
% Childhood immunizations		39.75%	29.44%	30.00%	40.42%	45.48%
% Weight assessment and counseling for children and adolescents		71.21%	71.73%	27.14%	73.23%	79.89%
% Adult weight screening and follow-up		72.43%	81.54%	52.86%	72.66%	82.55%
% Tobacco use screening and cessation services		87.17%	84.71%	62.86%	85.71%	91.55%
% Depression screening and follow-up		71.61%	82.78%	77.14%	74.19%	78.46%
% Cervical cancer screening	93.0%*	56.53%	48.84%	47.14%	54.19%	61.57%
% Colorectal cancer screening	70.5%*	45.56%	36.79%	58.57%	42.31%	52.42%
% HIV linkage to care		87.21%	79.01%		34.62%	100.00%
% Statin Therapy Received		69.94%	69.51%	88.57%	68.71%	77.58%
% Controlled hypertension	61.2%*	64.62%	60.43%	52.86%	63.05%	74.25%
% Uncontrolled diabetes	16.2%*	31.95%	34.03%	54.29%	34.89%	27.42%
% Dental sealants	28.1%*	56.80%	42.91%		57.68%	65.64%

*indicates this is a Healthy People 2020 goal, not a current rate.

Service Delivery Indicators		**2019 UDS Nation**	**GA**	**GU**	**HI**	**IA**
% growth in total patients		5.13%	6.86%	-2.37%	1.29%	4.29%
Non-clinical/facility/service support FTEs as % of total FTEs		35.17%	33.39%	38.72%	34.45%	32.63%
Medical cost per medical patient		$ 647.11	$ 463.11	$ 447.17	$ 919.22	$ 645.39
Medical cost per medical visit		$ 206.86	$ 166.46	$ 291.67	$ 264.66	$ 210.64
Dental cost per dental patient		$ 552.97	$ 417.37		$ 632.56	$ 431.53
Dental cost per dental visit		$ 214.91	$ 188.61		$ 264.53	$ 198.12
330 Grant Funds per Patient		$ 165.23	$ 214.53	$ 208.42	$ 201.26	$ 176.33
Net Collection Rate		0.97	0.91	0.98	1.00	1.00

*indicates this is a Healthy People 2020 goal, not a current rate.

Patient Profile Indicators	National Benchmarks (ACS 2014-2018, etc.)	2019 UDS Nation	ID	IL	IN	KS
% Uninsured	8.9%	22.74%	31.86%	21.36%	17.63%	31.13%
% Medicaid/ CHIP/Other Public	20.1%	48.52%	25.37%	56.03%	54.39%	31.02%
% Low income (at or below <200% FPG)	30.0%	91.06%	87.34%	94.87%	92.10%	90.16%
% Racial and/or ethnic minority	38.9%	62.99%	32.44%	74.14%	53.35%	40.89%
% Hispanic or Latino	17.8%	36.84%	25.43%	37.71%	19.83%	25.30%
% Best served in another language	4.4%	24.66%	11.60%	23.91%	15.23%	15.46%
% Experiencing homelessness	0.17%	4.89%	2.90%	3.34%	2.05%	2.06%
% Agricultural	0.20%	3.46%	5.66%	0.71%	0.38%	1.63%
% Served at a Health Center Located In or Immediately Accessible to Public Housing		17.31%	0.72%	10.65%	5.64%	0.57%
% School-based		2.97%	0.38%	2.72%	2.96	10.07%
% Veterans	7.1%	1.34%	3.66%	0.97%	0.89%	2.31%

Quality of Care Indicators	National Benchmarks (HP 2020, CDC, etc.)	2019 UDS Nation	ID	IL	IN	KS
% total patients receiving medical services		83.89%	82.73%	89.90%	90.39%	75.61%
% total patients receiving dental services		22.50%	21.31%	13.32%	12.09%	30.94%
Average medical visits/medical patient (excl.nurses)		3.14	3.20	2.96	2.96	2.74
% Medical Visits that Include MH Treatment		10.64%	18.33%	10.61%	13.33%	13.31%
% Medical Visits that Include SUD Treatment		4.29%	6.74%	4.08%	4.20%	3.48%
% Mental Health Visits that Include SUD Treatment		1.75%	3.36%	1.31%	2.16%	1.08%
% Early access to prenatal care	84.8%*	73.81%	76.86%	77.78%	68.47%	63.82%
% Low birth weight	7.8%*	8.05%	7.31%	8.52%	7.67%	6.74%
% Childhood immunizations		39.75%	39.63%	34.80%	32.55%	44.79%
% Weight assessment and counseling for children and adolescents		71.21%	65.52%	78.89%	75.21%	69.88%
% Adult weight screening and follow-up		72.43%	72.29%	77.40%	73.96%	64.68%
% Tobacco use screening and cessation services		87.17%	86.72%	89.21%	88.10%	83.83%
% Depression screening and follow-up		71.61%	70.24%	77.86%	68.45%	72.34%
% Cervical cancer screening	93.0%*	56.53%	53.28%	62.71%	52.53%	48.68%
% Colorectal cancer screening	70.5%*	45.56%	46.56%	45.58%	41.44%	35.53%
% HIV linkage to care		87.21%	86.36%	94.85%	83.87%	100.00%
% Statin Therapy Received		69.94%	71.52%	70.26%	74.32%	76.49%
% Controlled hypertension	61.2%*	64.62%	65.26%	64.19%	61.84%	64.41%
% Uncontrolled diabetes	16.2%*	31.95%	27.92%	32.89%	31.62%	28.65%
% Dental sealants	28.1%*	56.80%	46.30%	57.74%	59.55%	47.44%

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Service Delivery Indicators		2019 UDS Nation	ID	IL	IN	KS
% growth in total patients		5.13%	2.24%	2.05%	11.84%	15.95%
Non-clinical/facility/service support FTEs as % of total FTEs		35.17%	36.38%	33.79%	30.69%	36.64%
Medical cost per medical patient		$ 647.11	$ 721.23	$534.83	$553.00	$ 483.41
Medical cost per medical visit		$ 206.86	$ 225.14	$180.83	$188.07	$ 177.16
Dental cost per dental patient		$ 552.97	$ 621.71	$382.61	$532.29	$ 434.06
Dental cost per dental visit		$ 214.91	$ 239.65	$180.55	$244.97	$ 205.80
330 Grant Funds per Patient		$ 165.23	$ 240.82	$ 146.89	$ 135.13	$ 171.42
Net Collection Rate		0.97	0.93	1.00	0.99	0.91

*indicates this is a Healthy People 2020 goal, not a current rate.

Patient Profile Indicators	National Benchmarks (ACS 2014-2018, etc.)	2019 UDS Nation	KY	LA	MA	MD
% Uninsured	8.9%	22.74%	14.48%	17.26%	13.13%	20.43%
% Medicaid/ CHIP/Other Public	20.1%	48.52%	43.25%	58.64%	47.93%	46.29%
% Low income (at or below <200% FPG)	30.0%	91.06%	81.40%	93.22%	83.92%	88.18%
% Racial and/or ethnic minority	38.9%	62.99%	20.50%	67.08%	66.48%	67.26%
% Hispanic or Latino	17.8%	36.84%	7.63%	8.88%	36.01%	22.06%
% Best served in another language	4.4%	24.66%	7.80%	6.84%	40.59%	17.52%
% Experiencing homelessness	0.17%	4.89%	3.51%	5.66%	4.57%	4.17%
% Agricultural	0.20%	3.46%	0.51%	0.52%	1.00%	0.42%
% Served at a Health Center Located In or Immediately Accessible to Public Housing		17.31%	9.42%	21.89%	50.21%	4.08%
% School-based		2.97%	8.29%	7.52%	1.83%	3.07%
% Veterans	7.1%	1.34%	1.95%	0.86%	1.29%	1.46%
Quality of Care Indicators	**National Benchmarks (HP 2020, CDC, etc.)**	**2019 UDS Nation**	**KY**	**LA**	**MA**	**MD**
% total patients receiving medical services		83.89%	88.77%	78.25%	85.18%	87.50%
% total patients receiving dental services		22.50%	16.15%	20.58%	23.40%	16.83%
Average medical visits/medical patient (excl.nurses)		3.14	3.44	2.72	3.42	2.98
% Medical Visits that Include MH Treatment		10.64%	14.94%	11.56%	12.60%	9.29%
% Medical Visits that Include SUD Treatment		4.29%	4.03%	4.09%	6.30%	5.37%
% Mental Health Visits that Include SUD Treatment		1.75%	0.79%	2.60%	3.11%	1.75%
% Early access to prenatal care	84.8%*	73.81%	74.77%	74.09%	82.57%	74.24%
% Low birth weight	7.8%*	8.05%	8.51%	12.43%	7.36%	8.56%
% Childhood immunizations		39.75%	37.57%	35.05%	53.14%	44.47%
% Weight assessment and counseling for children and adolescents		71.21%	80.72%	73.07%	62.20%	63.49%
% Adult weight screening and follow-up		72.43%	80.16%	83.39%	60.18%	64.86%
% Tobacco use screening and cessation services		87.17%	90.61%	88.04%	86.94%	87.09%
% Depression screening and follow-up		71.61%	74.83%	80.38%	59.67%	77.91%
% Cervical cancer screening	93.0%*	56.53%	57.14%	58.50%	64.30%	54.68%
% Colorectal cancer screening	70.5%*	45.56%	46.04%	43.31%	58.28%	45.59%
% HIV linkage to care		87.21%	96.43%	88.64%	88.84%	77.46%
% Statin Therapy Received		69.94%	76.53%	76.48%	70.11%	74.79%
% Controlled hypertension	61.2%*	64.62%	70.35%	58.42%	65.20%	63.11%
% Uncontrolled diabetes	16.2%*	31.95%	28.04%	33.07%	26.75%	34.57%
% Dental sealants	28.1%*	56.80%	79.41%	61.05%	56.11%	62.91%

*indicates this is a Healthy People 2020 goal, not a current rate.

Service Delivery Indicators		**2019 UDS Nation**	**KY**	**LA**	**MA**	**MD**
% growth in total patients		5.13%	8.49%	3.85%	2.40%	1.72%
Non-clinical/facility/service support FTEs as % of total FTEs		35.17%	33.79%	33.73%	32.19%	35.76%
Medical cost per medical patient		$ 647.11	$ 531.74	$ 552.15	$ 794.14	$ 647.35
Medical cost per medical visit		$ 206.86	$ 155.44	$ 202.83	$ 232.01	$ 217.05
Dental cost per dental patient		$ 552.97	$ 375.73	$ 479.67	$ 567.94	$ 515.28
Dental cost per dental visit		$ 214.91	$ 185.52	$ 247.57	$ 186.42	$ 203.15
330 Grant Funds per Patient		$ 165.23	$ 146.88	$ 219.19	$ 161.50	$ 160.35
Net Collection Rate		0.97	1.00	0.94	0.94	0.96

*indicates this is a Healthy People 2020 goal, not a current rate.

Patient Profile Indicators	National Benchmarks (ACS 2014-2018, etc.)	2019 UDS Nation	ME	MH	MI	MN
% Uninsured	8.9%	22.74%	14.73%	100.00%	14.51%	30.33%
% Medicaid/ CHIP/Other Public	20.1%	48.52%	23.95%	0.00%	51.82%	44.59%
% Low income (at or below <200% FPG)	30.0%	91.06%	69.76%	100.00%	89.64%	91.30%
% Racial and/or ethnic minority	38.9%	62.99%	8.21%	100.00%	46.38%	68.38%
% Hispanic or Latino	17.8%	36.84%	2.08%	0.00%	14.40%	28.59%
% Best served in another language	4.4%	24.66%	3.36%	100.00%	10.39%	30.50%
% Experiencing homelessness	0.17%	4.89%	3.54%	0.00%	5.41%	4.41%
% Agricultural	0.20%	3.46%	1.11%	0.00%	1.94%	1.18%
% Served at a Health Center Located In or Immediately Accessible to Public Housing		17.31%	4.98%	0.00%	54.39%	17.72%
% School-based		2.97%	0.57%	0.00%	3.63%	2.67%
% Veterans	7.1%	1.34%	5.68%	0.00%	1.96%	1.54%
Quality of Care Indicators	**National Benchmarks (HP 2020, CDC, etc.)**	**2019 UDS Nation**	**ME**	**MH**	**MI**	**MN**
% total patients receiving medical services		83.89%	82.92%	76.32%	76.35%	70.19%
% total patients receiving dental services		22.50%	23.22%	18.37%	31.36%	35.45%
Average medical visits/medical patient (excl.nurses)		3.14	3.34	3.20	3.11	2.94
% Medical Visits that Include MH Treatment		10.64%	12.05%	0.03%	14.63%	11.24%
% Medical Visits that Include SUD Treatment		4.29%	6.20%	0.00%	6.65%	4.95%
% Mental Health Visits that Include SUD Treatment		1.75%	4.64%	0.14%	2.17%	1.89%
% Early access to prenatal care	84.8%*	73.81%	87.13%	30.17%	70.30%	78.22%
% Low birth weight	7.8%*	8.05%	11.11%	13.77%	8.63%	7.47%
% Childhood immunizations		39.75%	42.73%	0.00%	34.07%	43.26%
% Weight assessment and counseling for children and adolescents		71.21%	56.17%	24.29%	65.85%	67.92%
% Adult weight screening and follow-up		72.43%	63.78%	15.71%	69.84%	63.27%
% Tobacco use screening and cessation services		87.17%	92.12%	40.00%	83.55%	88.96%
% Depression screening and follow-up		71.61%	62.34%	51.43%	62.63%	57.22%
% Cervical cancer screening	93.0%*	56.53%	58.77%	15.71%	58.16%	55.20%
% Colorectal cancer screening	70.5%*	45.56%	61.22%	8.57%	47.97%	45.03%
% HIV linkage to care		87.21%	100.00%		84.38%	88.89%
% Statin Therapy Received		69.94%	67.37%	94.44%	74.28%	60.26%
% Controlled hypertension	61.2%*	64.62%	70.29%	48.57%	64.99%	62.06%
% Uncontrolled diabetes	16.2%*	31.95%	17.72%	40.00%	31.11%	30.96%
% Dental sealants	28.1%*	56.80%	51.07%	35.71%	56.76%	52.99%

*indicates this is a Healthy People 2020 goal, not a current rate.

Service Delivery Indicators		2019 UDS Nation	ME	MH	MI	MN
% growth in total patients		5.13%	2.52%	0.96%	1.09%	-1.01%
Non-clinical/facility/service support FTEs as % of total FTEs		35.17%	40.69%	22.98%	36.49%	31.82%
Medical cost per medical patient		$ 647.11	$699.63	$183.88	$ 647.96	$ 699.12
Medical cost per medical visit		$ 206.86	$209.52	$ 57.55	$ 208.48	$ 237.73
Dental cost per dental patient		$ 552.97	$551.08	$ 84.29	$ 504.30	$ 664.55
Dental cost per dental visit		$ 214.91	$216.89	$ 49.00	$ 204.42	$ 271.72
330 Grant Funds per Patient		$ 165.23	$ 234.62	$ 67.50	$ 183.87	$ 234.23
Net Collection Rate		0.97	0.97	0.31	0.99	0.96

*indicates this is a Healthy People 2020 goal, not a current rate.

Patient Profile Indicators	National Benchmarks (ACS 2014-2018, etc.)	2019 UDS Nation	MO	MP	MS	MT
% Uninsured	8.9%	22.74%	25.39%	31.75%	35.08%	20.26%
% Medicaid/ CHIP/Other Public	20.1%	48.52%	44.17%	35.09%	28.16%	35.80%
% Low income (at or below <200% FPG)	30.0%	91.06%	94.18%	100.00%	91.97%	77.49%
% Racial and/or ethnic minority	38.9%	62.99%	36.91%	96.20%	68.58%	18.54%
% Hispanic or Latino	17.8%	36.84%	9.14%	0.07%	6.31%	6.68%
% Best served in another language	4.4%	24.66%	6.64%	15.90%	4.14%	2.54%
% Experiencing homelessness	0.17%	4.89%	3.30%	0.00%	4.25%	4.80%
% Agricultural	0.20%	3.46%	0.22%	0.00%	0.21%	3.14%
% Served at a Health Center Located In or Immediately Accessible to Public Housing		17.31%	15.96%	0.00%	37.15%	6.01%
% School-based		2.97%	2.66%	0.00%	7.88%	1.45%
% Veterans	7.1%	1.34%	1.68%	0.27%	1.02%	4.52%
Quality of Care Indicators	**National Benchmarks (HP 2020, CDC, etc.)**	**2019 UDS Nation**	**MO**	**MP**	**MS**	**MT**
% total patients receiving medical services		83.89%	61.12%	100.00%	88.80%	79.59%
% total patients receiving dental services		22.50%	41.53%	0.00%	15.61%	27.92%
Average medical visits/medical patient (excl.nurses)		3.14	2.75	2.37	2.76	2.98
% Medical Visits that Include MH Treatment		10.64%	15.13%	5.65%	10.38%	20.69%
% Medical Visits that Include SUD Treatment		4.29%	6.14%	0.45%	2.15%	7.47%
% Mental Health Visits that Include SUD Treatment		1.75%	3.51%	0.00%	0.37%	2.10%
% Early access to prenatal care	84.8%*	73.81%	70.99%	64.44%	63.75%	80.60%
% Low birth weight	7.8%*	8.05%	9.67%	8.57%	12.43%	9.35%
% Childhood immunizations		39.75%	24.84%	70.73%	44.42%	27.85%
% Weight assessment and counseling for children and adolescents		71.21%	70.43%	22.86%	73.75%	57.08%
% Adult weight screening and follow-up		72.43%	83.20%	35.71%	80.95%	65.84%
% Tobacco use screening and cessation services		87.17%	87.90%	74.29%	84.44%	85.62%
% Depression screening and follow-up		71.61%	80.77%	53.49%	74.38%	67.64%
% Cervical cancer screening	93.0%*	56.53%	53.25%	14.19%	44.88%	53.82%
% Colorectal cancer screening	70.5%*	45.56%	40.34%	7.29%	36.63%	46.06%
% HIV linkage to care		87.21%	88.89%		95.00%	81.82%
% Statin Therapy Received		69.94%	75.40%	52.61%	67.90%	67.88%
% Controlled hypertension	61.2%*	64.62%	63.54%	40.73%	56.62%	64.59%
% Uncontrolled diabetes	16.2%*	31.95%	29.54%	46.74%	33.17%	25.94%
% Dental sealants	28.1%*	56.80%	51.99%		38.83%	56.58%

*indicates this is a Healthy People 2020 goal, not a current rate.

Service Delivery Indicators		2019 UDS Nation	MO	MP	MS	MT
% growth in total patients		5.13%	3.06%	13.80%	3.21%	5.49%
Non-clinical/facility/service support FTEs as % of total FTEs		35.17%	33.33%	53.94%	37.70%	35.04%
Medical cost per medical patient		$ 647.11	$576.18	$477.23	$ 446.54	$ 697.47
Medical cost per medical visit		$ 206.86	$210.22	$201.01	$ 175.17	$ 234.68
Dental cost per dental patient		$ 552.97	$553.37		$ 349.40	$ 570.89
Dental cost per dental visit		$ 214.91	$251.35		$ 173.73	$ 227.66
330 Grant Funds per Patient		$ 165.23	$ 184.62	$ 754.81	$ 246.30	$ 367.49
Net Collection Rate		0.97	0.99	0.41	0.89	0.93

*indicates this is a Healthy People 2020 goal, not a current rate.

Patient Profile Indicators	National Benchmarks (ACS 2014-2018, etc.)	2019 UDS Nation	NC	ND	NE	NH
% Uninsured	8.9%	22.74%	43.36%	30.75%	46.67%	14.22%
% Medicaid/ CHIP/Other Public	20.1%	48.52%	24.16%	25.94%	26.81%	31.84%
% Low income (at or below <200% FPG)	30.0%	91.06%	89.52%	81.59%	93.51%	72.41%
% Racial and/or ethnic minority	38.9%	62.99%	63.37%	34.43%	65.74%	19.69%
% Hispanic or Latino	17.8%	36.84%	30.31%	6.38%	45.93%	10.96%
% Best served in another language	4.4%	24.66%	22.31%	14.80%	28.87%	14.06%
% Experiencing homelessness	0.17%	4.89%	2.99%	5.02%	7.51%	7.42%
% Agricultural	0.20%	3.46%	5.82%	0.75%	1.09%	0.49%
% Served at a Health Center Located In or Immediately Accessible to Public Housing		17.31%	24.53%	0.00%	3.45%	0.00%
% School-based		2.97%	1.31%	0.00%	4.73%	0.00%
% Veterans	7.1%	1.34%	1.42%	2.44%	0.78%	2.98%
Quality of Care Indicators	**National Benchmarks (HP 2020, CDC, etc.)**	**2019 UDS Nation**	**NC**	**ND**	**NE**	**NH**
% total patients receiving medical services		83.89%	80.94%	65.42%	82.36%	91.65%
% total patients receiving dental services		22.50%	18.48%	40.95%	25.55%	11.75%
Average medical visits/medical patient (excl.nurses)		3.14	2.89	2.74	2.57	3.34
% Medical Visits that Include MH Treatment		10.64%	11.19%	16.07%	13.13%	14.08%
% Medical Visits that Include SUD Treatment		4.29%	5.58%	7.93%	6.52%	8.57%
% Mental Health Visits that Include SUD Treatment		1.75%	1.69%	0.20%	1.65%	2.23%
% Early access to prenatal care	84.8%*	73.81%	70.37%	78.01%	78.98%	79.55%
% Low birth weight	7.8%*	8.05%	9.43%	7.69%	9.01%	9.05%
% Childhood immunizations		39.75%	47.74%	52.16%	61.37%	53.93%
% Weight assessment and counseling for children and adolescents		71.21%	70.61%	49.10%	89.37%	74.27%
% Adult weight screening and follow-up		72.43%	73.67%	55.77%	80.00%	63.55%
% Tobacco use screening and cessation services		87.17%	85.28%	80.32%	91.93%	92.58%
% Depression screening and follow-up		71.61%	69.96%	84.17%	90.31%	66.85%
% Cervical cancer screening	93.0%*	56.53%	52.81%	48.05%	55.37%	65.12%
% Colorectal cancer screening	70.5%*	45.56%	46.47%	46.09%	44.30%	60.09%
% HIV linkage to care		87.21%	91.16%	77.78%	100.00%	88.89%
% Statin Therapy Received		69.94%	72.97%	77.89%	82.95%	61.62%
% Controlled hypertension	61.2%*	64.62%	61.20%	64.80%	66.01%	72.08%
% Uncontrolled diabetes	16.2%*	31.95%	28.66%	25.79%	26.84%	22.94%
% Dental sealants	28.1%*	56.80%	49.97%	52.58%	77.04%	66.14%

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Service Delivery Indicators		2019 UDS Nation	NC	ND	NE	NH
% growth in total patients		5.13%	6.93%	0.47%	13.88%	-0.12%
Non-clinical/facility/service support FTEs as % of total FTEs		35.17%	34.36%	35.40%	29.28%	37.07%
Medical cost per medical patient		$ 647.11	$ 511.61	$ 781.08	$ 487.25	$ 769.53
Medical cost per medical visit		$ 206.86	$ 177.41	$ 284.76	$ 190.75	$ 230.34
Dental cost per dental patient		$ 552.97	$ 525.70	$ 442.74	$ 486.04	$ 613.87
Dental cost per dental visit		$ 214.91	$ 209.30	$ 194.30	$ 212.58	$ 251.58
330 Grant Funds per Patient		$ 165.23	$ 228.19	$ 277.57	$ 192.91	$ 276.09
Net Collection Rate		0.97	0.97	1.04	0.97	1.01

*indicates this is a Healthy People 2020 goal, not a current rate.

Patient Profile Indicators	National Benchmarks (ACS 2014-2018, etc.)	2019 UDS Nation	NJ	NM	NV	NY
% Uninsured	8.9%	22.74%	30.62%	24.22%	28.80%	14.85%
% Medicaid/ CHIP/Other Public	20.1%	48.52%	51.57%	41.35%	41.93%	55.00%
% Low income (at or below <200% FPG)	30.0%	91.06%	93.85%	89.43%	88.34%	90.10%
% Racial and/or ethnic minority	38.9%	62.99%	77.24%	76.27%	69.50%	70.95%
% Hispanic or Latino	17.8%	36.84%	48.28%	65.65%	49.91%	37.38%
% Best served in another language	4.4%	24.66%	38.74%	18.90%	23.80%	29.10%
% Experiencing homelessness	0.17%	4.89%	4.95%	5.19%	7.33%	4.15%
% Agricultural	0.20%	3.46%	2.46%	6.22%	2.79%	1.03%
% Served at a Health Center Located In or Immediately Accessible to Public Housing		17.31%	16.11%	0.08%	0.62%	28.23%
% School-based		2.97%	2.00%	5.96%	1.37%	3.74%
% Veterans	7.1%	1.34%	0.80%	2.28%	0.59%	0.89%
Quality of Care Indicators	**National Benchmarks (HP 2020, CDC, etc.)**	**2019 UDS Nation**	**NJ**	**NM**	**NV**	**NY**
% total patients receiving medical services		83.89%	85.78%	76.41%	87.22%	82.54%
% total patients receiving dental services		22.50%	25.19%	24.84%	10.56%	22.47%
Average medical visits/medical patient (excl.nurses)		3.14	2.85	3.16	2.48	3.38
% Medical Visits that Include MH Treatment		10.64%	5.60%	17.17%	27.36%	8.91%
% Medical Visits that Include SUD Treatment		4.29%	2.39%	9.13%	2.14%	4.15%
% Mental Health Visits that Include SUD Treatment		1.75%	1.50%	9.25%	1.10%	1.94%
% Early access to prenatal care	84.8%*	73.81%	71.78%	69.40%	71.04%	81.27%
% Low birth weight	7.8%*	8.05%	7.03%	8.44%	5.22%	7.77%
% Childhood immunizations		39.75%	51.03%	38.83%	24.02%	44.32%
% Weight assessment and counseling for children and adolescents		71.21%	75.51%	81.20%	78.15%	72.28%
% Adult weight screening and follow-up		72.43%	76.61%	76.98%	77.58%	69.57%
% Tobacco use screening and cessation services		87.17%	90.02%	90.78%	76.19%	86.97%
% Depression screening and follow-up		71.61%	75.58%	78.77%	70.29%	72.45%
% Cervical cancer screening	93.0%*	56.53%	62.41%	52.52%	38.37%	60.60%
% Colorectal cancer screening	70.5%*	45.56%	45.25%	46.58%	34.70%	49.64%
% HIV linkage to care		87.21%	96.11%	84.62%	49.25%	87.90%
% Statin Therapy Received		69.94%	62.10%	70.83%	69.93%	65.73%
% Controlled hypertension	61.2%*	64.62%	62.73%	70.91%	67.70%	67.19%
% Uncontrolled diabetes	16.2%*	31.95%	33.39%	28.11%	36.22%	27.19%
% Dental sealants	28.1%*	56.80%	49.25%	58.63%	53.53%	52.45%

*indicates this is a Healthy People 2020 goal, not a current rate.

Service Delivery Indicators		2019 UDS Nation	NJ	NM	NV	NY
% growth in total patients		5.13%	6.55%	-0.05%	8.34%	-0.97%
Non-clinical/facility/service support FTEs as % of total FTEs		35.17%	40.39%	34.49%	32.40%	37.40%
Medical cost per medical patient		$ 647.11	$ 477.18	$586.65	$ 627.19	$ 820.17
Medical cost per medical visit		$ 206.86	$ 167.73	$187.98	$ 255.78	$ 243.20
Dental cost per dental patient		$ 552.97	$ 409.68	$694.29	$ 523.92	$ 532.12
Dental cost per dental visit		$ 214.91	$ 164.37	$227.57	$ 189.70	$ 202.41
330 Grant Funds per Patient		$ 165.23	$ 143.05	$ 230.22	$ 201.64	$ 122.14
Net Collection Rate		0.97	0.88	0.91	1.01	0.93

*indicates this is a Healthy People 2020 goal, not a current rate.

Patient Profile Indicators	National Benchmarks (ACS 2014-2018, etc.)	2019 UDS Nation	OH	OK	OR	PA
% Uninsured	8.9%	22.74%	15.08%	30.99%	18.14%	15.21%
% Medicaid/ CHIP/Other Public	20.1%	48.52%	51.80%	32.34%	56.60%	49.32%
% Low income (at or below <200% FPG)	30.0%	91.06%	90.97%	94.19%	89.37%	86.87%
% Racial and/or ethnic minority	38.9%	62.99%	39.08%	47.08%	40.07%	54.48%
% Hispanic or Latino	17.8%	36.84%	9.04%	29.03%	28.43%	20.41%
% Best served in another language	4.4%	24.66%	7.76%	18.75%	21.94%	15.44%
% Experiencing homelessness	0.17%	4.89%	3.82%	2.38%	8.31%	3.74%
% Agricultural	0.20%	3.46%	0.60%	0.38%	3.61%	1.07%
% Served at a Health Center Located In or Immediately Accessible to Public Housing		17.31%	14.18%	6.38%	29.36%	16.26%
% School-based		2.97%	3.99%	0.58%	7.82%	1.43%
% Veterans	7.1%	1.34%	1.89%	1.87%	2.52%	1.53%
Quality of Care Indicators	**National Benchmarks (HP 2020, CDC, etc.)**	**2019 UDS Nation**	**OH**	**OK**	**OR**	**PA**
% total patients receiving medical services		83.89%	78.08%	89.24%	75.87%	80.13%
% total patients receiving dental services		22.50%	24.17%	11.80%	30.12%	25.60%
Average medical visits/medical patient (excl.nurses)		3.14	2.93	2.90	2.90	2.75
% Medical Visits that Include MH Treatment		10.64%	14.59%	12.05%	19.11%	9.38%
% Medical Visits that Include SUD Treatment		4.29%	9.34%	4.24%	7.98%	4.10%
% Mental Health Visits that Include SUD Treatment		1.75%	4.88%	1.15%	2.59%	1.51%
% Early access to prenatal care	84.8%*	73.81%	70.36%	79.10%	77.15%	77.50%
% Low birth weight	7.8%*	8.05%	7.96%	8.92%	6.10%	8.97%
% Childhood immunizations		39.75%	34.09%	43.31%	31.60%	40.15%
% Weight assessment and counseling for children and adolescents		71.21%	70.01%	67.37%	59.51%	60.00%
% Adult weight screening and follow-up		72.43%	74.99%	66.03%	53.84%	65.21%
% Tobacco use screening and cessation services		87.17%	86.84%	76.68%	83.92%	87.04%
% Depression screening and follow-up		71.61%	77.18%	68.34%	67.57%	71.98%
% Cervical cancer screening	93.0%*	56.53%	52.84%	43.54%	54.60%	51.04%
% Colorectal cancer screening	70.5%*	45.56%	45.42%	29.28%	48.73%	45.77%
% HIV linkage to care		87.21%	67.59%	66.67%	82.73%	77.30%
% Statin Therapy Received		69.94%	73.55%	70.93%	61.54%	72.80%
% Controlled hypertension	61.2%*	64.62%	66.82%	59.46%	69.33%	65.19%
% Uncontrolled diabetes	16.2%*	31.95%	30.43%	39.80%	28.11%	31.27%
% Dental sealants	28.1%*	56.80%	74.71%	62.16%	48.18%	45.21%

*indicates this is a Healthy People 2020 goal, not a current rate.

Service Delivery Indicators		2019 UDS Nation	OH	OK	OR	PA
% growth in total patients		5.13%	9.77%	10.39%	3.21%	2.35%
Non-clinical/facility/service support FTEs as % of total FTEs		35.17%	31.48%	34.82%	34.40%	39.05%
Medical cost per medical patient		$ 647.11	$ 540.56	$ 518.07	$ 1,036.29	$ 547.55
Medical cost per medical visit		$ 206.86	$ 184.40	$ 178.85	$ 364.90	$ 198.94
Dental cost per dental patient		$ 552.97	$ 449.49	$ 677.82	$ 693.63	$ 443.61
Dental cost per dental visit		$ 214.91	$ 207.63	$ 289.22	$ 270.31	$ 181.26
330 Grant Funds per Patient		$ 165.23	$ 185.89	$ 221.16	$ 235.60	$ 154.62
Net Collection Rate		0.97	0.92	0.93	1.04	0.94

*indicates this is a Healthy People 2020 goal, not a current rate.

Patient Profile Indicators	National Benchmarks (ACS 2014-2018, etc.)	2019 UDS Nation	PR	PW	RI	SC
% Uninsured	8.9%	22.74%	13.45%	92.85%	11.80%	26.43%
% Medicaid/ CHIP/Other Public	20.1%	48.52%	62.32%	0.00%	53.49%	33.16%
% Low income (at or below <200% FPG)	30.0%	91.06%	97.02%	94.44%	90.58%	89.99%
% Racial and/or ethnic minority	38.9%	62.99%	99.41%	98.23%	56.98%	65.58%
% Hispanic or Latino	17.8%	36.84%	99.14%	0.00%	41.17%	14.18%
% Best served in another language	4.4%	24.66%	99.29%	98.19%	23.45%	10.85%
% Experiencing homelessness	0.17%	4.89%	2.54%	0.00%	3.13%	3.60%
% Agricultural	0.20%	3.46%	1.95%	0.00%	0.62%	2.20%
% Served at a Health Center Located In or Immediately Accessible to Public Housing		17.31%	23.87%	0.00%	31.66%	13.58%
% School-based		2.97%	0.46%	0.00%	0.99%	1.61%
% Veterans	7.1%	1.34%	0.40%	0.00%	1.17%	1.56%

Quality of Care Indicators	National Benchmarks (HP 2020, CDC, etc.)	2019 UDS Nation	PR	PW	RI	SC
% total patients receiving medical services		83.89%	93.47%	79.11%	79.33%	93.71%
% total patients receiving dental services		22.50%	12.48%	25.37%	34.87%	10.73%
Average medical visits/medical patient (excl.nurses)		3.14	3.44	2.43	3.35	3.10
% Medical Visits that Include MH Treatment		10.64%	2.52%	0.00%	11.94%	13.39%
% Medical Visits that Include SUD Treatment		4.29%	0.99%	0.00%	3.47%	4.98%
% Mental Health Visits that Include SUD Treatment		1.75%	0.74%	0.00%	2.55%	1.53%
% Early access to prenatal care	84.8%*	73.81%	87.35%	36.72%	83.76%	70.87%
% Low birth weight	7.8%*	8.05%	9.26%	12.68%	8.84%	10.93%
% Childhood immunizations		39.75%	23.20%	71.94%	61.95%	31.40%
% Weight assessment and counseling for children and adolescents		71.21%	77.05%	99.27%	84.80%	70.06%
% Adult weight screening and follow-up		72.43%	83.79%	14.29%	90.54%	71.41%
% Tobacco use screening and cessation services		87.17%	89.16%	0.02%	94.02%	83.41%
% Depression screening and follow-up		71.61%	71.15%	0.16%	82.75%	69.34%
% Cervical cancer screening	93.0%*	56.53%	55.33%	44.90%	65.84%	50.73%
% Colorectal cancer screening	70.5%*	45.56%	55.53%	0.00%	55.26%	46.53%
% HIV linkage to care		87.21%	96.55%		92.31%	94.90%
% Statin Therapy Received		69.94%	71.41%	13.35%	75.28%	78.23%
% Controlled hypertension	61.2%*	64.62%	69.66%	52.28%	72.37%	62.23%
% Uncontrolled diabetes	16.2%*	31.95%	38.27%	3.32%	22.44%	32.48%
% Dental sealants	28.1%*	56.80%	60.46%	21.46%	58.78%	42.62%

*indicates this is a Healthy People 2020 goal, not a current rate.

Service Delivery Indicators		2019 UDS Nation	PR	PW	RI	SC
% growth in total patients		5.13%	8.37%	-2.34%	7.55%	6.48%
Non-clinical/facility/service support FTEs as % of total FTEs		35.17%	37.76%	37.86%	33.80%	38.32%
Medical cost per medical patient		$ 647.11	$ 479.07	$ 187.33	$ 751.83	$ 604.74
Medical cost per medical visit		$ 206.86	$ 139.41	$ 77.03	$ 224.51	$ 195.05
Dental cost per dental patient		$ 552.97	$ 257.79	$ 95.05	$ 496.29	$ 494.32
Dental cost per dental visit		$ 214.91	$ 138.78	$ 53.74	$ 191.80	$ 212.45
330 Grant Funds per Patient		$ 165.23	$ 250.20	$ 74.70	$ 147.15	$ 192.90
Net Collection Rate		0.97	0.92	0.53	0.98	1.01

*indicates this is a Healthy People 2020 goal, not a current rate.

Patient Profile Indicators	National Benchmarks (ACS 2014-2018, etc.)	2019 UDS Nation	SD	TN	TX	UT
% Uninsured	8.9%	22.74%	19.16%	32.55%	41.02%	49.10%
% Medicaid/ CHIP/Other Public	20.1%	48.52%	24.02%	32.97%	32.37%	17.49%
% Low income (at or below <200% FPG)	30.0%	91.06%	70.32%	93.09%	91.59%	93.38%
% Racial and/or ethnic minority	38.9%	62.99%	31.95%	42.10%	76.14%	60.97%
% Hispanic or Latino	17.8%	36.84%	10.60%	12.66%	58.66%	49.13%
% Best served in another language	4.4%	24.66%	9.63%	10.59%	30.93%	37.12%
% Experiencing homelessness	0.17%	4.89%	2.46%	5.79%	5.10%	4.29%
% Agricultural	0.20%	3.46%	0.34%	1.59%	1.11%	3.69%
% Served at a Health Center Located In or Immediately Accessible to Public Housing		17.31%	0.00%	15.46%	21.13%	0.00%
% School-based		2.97%	4.52%	0.55%	0.87%	6.98%
% Veterans	7.1%	1.34%	2.65%	1.48%	0.88%	0.92%
Quality of Care Indicators	**National Benchmarks (HP 2020, CDC, etc.)**	**2019 UDS Nation**	**SD**	**TN**	**TX**	**UT**
% total patients receiving medical services		83.89%	88.23%	89.16%	89.85%	87.63%
% total patients receiving dental services		22.50%	17.88%	8.76%	15.21%	16.63%
Average medical visits/medical patient (excl.nurses)		3.14	2.68	2.78	3.01	2.72
% Medical Visits that Include MH Treatment		10.64%	7.87%	10.42%	9.41%	13.82%
% Medical Visits that Include SUD Treatment		4.29%	2.21%	5.26%	2.21%	4.41%
% Mental Health Visits that Include SUD Treatment		1.75%	0.27%	1.43%	0.54%	0.88%
% Early access to prenatal care	84.8%*	73.81%	65.12%	67.13%	68.81%	76.48%
% Low birth weight	7.8%*	8.05%	7.07%	8.85%	8.18%	6.69%
% Childhood immunizations		39.75%	52.80%	32.34%	38.23%	36.40%
% Weight assessment and counseling for children and adolescents		71.21%	38.86%	83.42%	73.85%	44.36%
% Adult weight screening and follow-up		72.43%	56.43%	79.22%	79.23%	52.30%
% Tobacco use screening and cessation services		87.17%	82.07%	88.06%	88.93%	79.87%
% Depression screening and follow-up		71.61%	53.96%	81.34%	73.63%	57.43%
% Cervical cancer screening	93.0%*	56.53%	56.60%	48.23%	58.15%	49.45%
% Colorectal cancer screening	70.5%*	45.56%	50.97%	39.25%	38.64%	30.58%
% HIV linkage to care		87.21%	100.00%	92.11%	90.84%	72.73%
% Statin Therapy Received		69.94%	66.53%	74.32%	71.47%	68.34%
% Controlled hypertension	61.2%*	64.62%	65.06%	61.85%	61.99%	61.86%
% Uncontrolled diabetes	16.2%*	31.95%	38.57%	30.63%	35.74%	33.91%
% Dental sealants	28.1%*	56.80%	64.62%	66.71%	54.14%	39.65%

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Service Delivery Indicators		2019 UDS Nation	SD	TN	TX	UT
% growth in total patients		5.13%	17.09%	2.80%	8.35%	0.19%
Non-clinical/facility/service support FTEs as % of total FTEs		35.17%	38.64%	33.98%	37.05%	30.94%
Medical cost per medical patient		$ 647.11	$ 536.60	$ 468.34	$ 562.47	$ 486.04
Medical cost per medical visit		$ 206.86	$ 203.15	$ 169.27	$ 186.77	$ 178.86
Dental cost per dental patient		$ 552.97	$ 681.07	$ 499.40	$ 531.38	$ 792.90
Dental cost per dental visit		$ 214.91	$ 288.92	$ 231.08	$ 208.64	$ 292.73
330 Grant Funds per Patient		$ 165.23	$ 231.48	$ 194.63	$ 167.70	$ 248.00
Net Collection Rate		0.97	0.90	0.97	0.95	0.94

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Patient Profile Indicators	National Benchmarks (ACS 2014-2018, etc.)	2019 UDS Nation	VA	VI	VT	WA
% Uninsured	8.9%	22.74%	24.28%	19.62%	9.51%	16.65%
% Medicaid/ CHIP/Other Public	20.1%	48.52%	33.16%	58.33%	26.11%	56.76%
% Low income (at or below <200% FPG)	30.0%	91.06%	90.12%	97.84%	73.85%	88.16%
% Racial and/or ethnic minority	38.9%	62.99%	52.92%	94.88%	6.59%	55.19%
% Hispanic or Latino	17.8%	36.84%	19.68%	15.56%	1.58%	35.20%
% Best served in another language	4.4%	24.66%	17.37%	6.90%	3.54%	26.17%
% Experiencing homelessness	0.17%	4.89%	2.91%	0.99%	1.26%	10.38%
% Agricultural	0.20%	3.46%	2.09%	0.04%	0.45%	10.49%
% Served at a Health Center Located In or Immediately Accessible to Public Housing		17.31%	0.70%	80.32%	22.90%	50.41%
% School-based		2.97%	0.90%	0.71%	0.15%	0.99%
% Veterans	7.1%	1.34%	2.37%	1.46%	3.48%	2.21%

Quality of Care Indicators	National Benchmarks (HP 2020, CDC, etc.)	2019 UDS Nation	VA	VI	VT	WA
% total patients receiving medical services		83.89%	86.67%	81.81%	86.09%	75.92%
% total patients receiving dental services		22.50%	20.31%	34.04%	21.08%	37.06%
Average medical visits/medical patient (excl.nurses)		3.14	2.91	2.78	3.30	2.94
% Medical Visits that Include MH Treatment		10.64%	14.71%	4.90%	15.32%	14.00%
% Medical Visits that Include SUD Treatment		4.29%	5.76%	0.66%	5.58%	6.61%
% Mental Health Visits that Include SUD Treatment		1.75%	1.06%	0.60%	2.36%	0.66%
% Early access to prenatal care	84.8%*	73.81%	59.88%	61.81%	85.76%	82.49%
% Low birth weight	7.8%*	8.05%	7.35%	7.23%	7.18%	6.01%
% Childhood immunizations		39.75%	44.68%	11.25%	49.06%	49.23%
% Weight assessment and counseling for children and adolescents		71.21%	71.76%	53.82%	47.40%	66.93%
% Adult weight screening and follow-up		72.43%	69.18%	70.00%	51.87%	67.16%
% Tobacco use screening and cessation services		87.17%	89.71%	88.92%	80.51%	88.42%
% Depression screening and follow-up		71.61%	67.07%	76.76%	52.20%	63.86%
% Cervical cancer screening	93.0%*	56.53%	50.28%	63.25%	47.91%	52.42%
% Colorectal cancer screening	70.5%*	45.56%	45.60%	30.37%	55.97%	46.84%
% HIV linkage to care		87.21%	68.89%	100.00%	81.82%	75.89%
% Statin Therapy Received		69.94%	70.69%	49.71%	63.93%	66.30%
% Controlled hypertension	61.2%*	64.62%	62.79%	48.05%	67.29%	70.39%
% Uncontrolled diabetes	16.2%*	31.95%	27.93%	33.17%	21.84%	28.68%
% Dental sealants	28.1%*	56.80%	51.72%	28.40%	59.31%	57.35%

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Service Delivery Indicators		**2019 UDS Nation**	**VA**	**VI**	**VT**	**WA**
% growth in total patients		5.13%	6.53%	8.86%	2.99%	4.46%
Non-clinical/facility/service support FTEs as % of total FTEs		35.17%	36.41%	50.92%	34.35%	34.51%
Medical cost per medical patient		$ 647.11	$ 527.54	$ 992.48	$ 687.58	$ 687.22
Medical cost per medical visit		$ 206.86	$ 181.26	$ 357.28	$ 208.26	$ 234.05
Dental cost per dental patient		$ 552.97	$ 569.29	$ 524.71	$ 685.68	$ 603.70
Dental cost per dental visit		$ 214.91	$ 245.28	$ 233.89	$ 275.75	$ 222.53
330 Grant Funds per Patient		$ 165.23	$ 232.85	$ 192.29	$ 130.04	$ 109.45
Net Collection Rate		0.97	0.95	0.76	1.01	1.09

*indicates this is a Healthy People 2020 goal, not a current rate.

Patient Profile Indicators	National Benchmarks (ACS 2014-2018, etc.)	2019 UDS Nation	WI	WV	WY
% Uninsured	8.9%	22.74%	18.52%	8.34%	27.54%
% Medicaid/ CHIP/Other Public	20.1%	48.52%	57.26%	35.35%	17.21%
% Low income (at or below <200% FPG)	30.0%	91.06%	92.07%	81.03%	83.85%
% Racial and/or ethnic minority	38.9%	62.99%	49.48%	7.43%	22.46%
% Hispanic or Latino	17.8%	36.84%	26.61%	2.20%	13.01%
% Best served in another language	4.4%	24.66%	18.96%	1.64%	3.18%
% Experiencing homelessness	0.17%	4.89%	2.32%	2.49%	7.54%
% Agricultural	0.20%	3.46%	0.43%	0.22%	0.38%
% Served at a Health Center Located In or Immediately Accessible to Public Housing		17.31%	3.89%	7.03%	0.00%
% School-based		2.97%	1.42%	10.52%	0.45%
% Veterans	7.1%	1.34%	1.16%	2.31%	3.76%
Quality of Care Indicators	**National Benchmarks (HP 2020, CDC, etc.)**	**2019 UDS Nation**	**WI**	**WV**	**WY**
% total patients receiving medical services		83.89%	49.36%	92.43%	93.22%
% total patients receiving dental services		22.50%	56.68%	9.94%	7.50%
Average medical visits/medical patient (excl.nurses)		3.14	3.04	3.26	2.76
% Medical Visits that Include MH Treatment		10.64%	8.16%	14.96%	18.71%
% Medical Visits that Include SUD Treatment		4.29%	4.36%	5.95%	5.57%
% Mental Health Visits that Include SUD Treatment		1.75%	3.30%	1.90%	0.85%
% Early access to prenatal care	84.8%*	73.81%	75.09%	81.38%	57.83%
% Low birth weight	7.8%*	8.05%	7.32%	11.12%	11.25%
% Childhood immunizations		39.75%	47.47%	30.83%	37.17%
% Weight assessment and counseling for children and adolescents		71.21%	64.95%	59.93%	29.49%
% Adult weight screening and follow-up		72.43%	62.18%	65.05%	46.08%
% Tobacco use screening and cessation services		87.17%	87.86%	80.24%	76.28%
% Depression screening and follow-up		71.61%	68.10%	65.39%	68.44%
% Cervical cancer screening	93.0%*	56.53%	59.09%	53.47%	32.08%
% Colorectal cancer screening	70.5%*	45.56%	50.84%	53.32%	33.07%
% HIV linkage to care		87.21%	93.10%	77.78%	20.00%
% Statin Therapy Received		69.94%	70.77%	73.91%	66.71%
% Controlled hypertension	61.2%*	64.62%	64.07%	68.04%	55.10%
% Uncontrolled diabetes	16.2%*	31.95%	31.41%	29.65%	39.34%
% Dental sealants	28.1%*	56.80%	65.28%	55.04%	52.63%

*indicates this is a Healthy People 2020 goal, not a current rate.

Service Delivery Indicators		2019 UDS Nation	WI	WV	WY
% growth in total patients		5.13%	-0.27%	2.61%	11.81%
Non-clinical/facility/service support FTEs as % of total FTEs		35.17%	37.53%	35.34%	32.89%
Medical cost per medical patient		$ 647.11	$698.69	$ 559.35	$600.53
Medical cost per medical visit		$ 206.86	$229.60	$ 171.61	$217.26
Dental cost per dental patient		$ 552.97	$661.31	$ 459.30	$909.72
Dental cost per dental visit		$ 214.91	$256.13	$ 196.01	$354.76
330 Grant Funds per Patient		$ 165.23	$ 157.20	$ 151.19	$ 270.80
Net Collection Rate		0.97	1.13	0.95	0.92

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Health Center Name	City	State	Tracking Number	BHCMIS ID	Funding Streams
1ST CHOICE HEALTHCARE, INC.	CORNING	AR	H80CS005372019	063720	CHC
A+ FAMILY HEALTHCARE, LLC	BROWNSVILLE	KY	H80CS337932019	04E01371	CHC, HCH
AAA COMPREHENSIVE HEALTHCARE, INC	N HOLLYWOOD	CA	H80CS289822019	09E01211	CHC
AARON E. HENRY COMMUNITY HEALTH SERVICES CENTER, INC.	CLARKSDALE	MS	H80CS004802019	046150	CHC
ACCESS COMMUNITY HEALTH CENTERS, INC.	MADISON	WI	H80CS002802019	0515200	CHC
ACCESS COMMUNITY HEALTH NETWORK	CHICAGO	IL	H80CS008342019	051750	CHC, PHPC
ACCESS FAMILY HEALTH SERVICES, INC.	SMITHVILLE	MS	H80CS006332019	046860	CHC
ACCESS HEALTH LOUISIANA	LULING	LA	H80CS008672019	0613350	CHC
ACHIEVABLE FOUNDATION THE	CULVER CITY	CA	H80CS266112019	09E00422	CHC
ADAMS COUNTY HEALTH CENTER INC	COUNCIL	ID	H80CS083292019	101840	CHC
ADAPT, INC	ROSEBURG	OR	H80CS241012019	10E00467	CHC, HCH
ADELANTE HEALTHCARE, INC.	PHOENIX	AZ	H80CS001402019	093030	CHC, MHC
ADVOCATES FOR A HEALTHY COMMUNITY	SPRINGFIELD	MO	H80CS002752019	077200	CHC
AFFINIA HEALTHCARE	SAINT LOUIS	MO	H80CS004152019	071190	CHC, HCH, PHPC
AFFINITY HEALTH CENTER	ROCK HILL	SC	H80CS289722019	04E00154	CHC
AGAPE COMMUNITY HEALTH CENTER, INC.	JACKSONVILLE	FL	H80CS294562019	04E01228	CHC
AIDS ACTION COALITION OF HUNTSVILLE	HUNTSVILLE	AL	H80CS336422019	04E01318	CHC
AJO COMMUNITY HEALTH CENTER	AJO	AZ	H80CS007532019	092650	CHC
ALABAMA REGIONAL MEDICAL SERVICES	BIRMINGHAM	AL	H80CS000202019	041960	CHC, HCH, PHPC
ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY	OAKLAND	CA	H80CS000472019	090870	HCH
ALBANY AREA PRIMARY HEALTH CARE, INC.	ALBANY	GA	H80CS007632019	044150	CHC
ALBUQUERQUE HEALTH CARE FOR THE HOMELESS	ALBUQUERQUE	NM	H80CS000362019	061440	HCH
ALCONA CITIZENS FOR HEALTH, INC.	LINCOLN	MI	H80CS006792019	051980	CHC
ALETHEIA HOUSE, INC.	BIRMINGHAM	AL	H80CS307112019	04E01241	HCH
ALEUTIAN PRIBILOF ISLAND ASSOCIATIONS	ANCHORAGE	AK	H80CS011292019	106170	CHC

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ALIVIO MEDICAL CENTER	CHICAGO	IL	H80CS001162019	056620	CHC
ALL CARE HEALTH CENTER	COUNCIL BLFS	IA	H80CS005702019	074650	CHC
ALL FOR HEALTH, HEALTH FOR ALL	GLENDALE	CA	H80CS128512019	09E00008	CHC
ALL-INCLUSIVE COMMUNITY HEALTH CENTER	BURBANK	CA	H80CS266122019	09E00123	CHC
ALLIANCE MEDICAL CENTER, INC.	HEALDSBURG	CA	H80CS002492019	092080	CHC
ALTA MED HEALTH SERVICES CORPORATION	COMMERCE	CA	H80CS001422019	093110	CHC, PHPC
ALTAPOINTE HEALTH SYSTEMS, INC.	MOBILE	AL	H80CS336432019	04E01304	CHC
ALTURA CENTERS FOR HEALTH	TULARE	CA	H80CS003382019	095340	CHC, MHC
AMERICAN INDIAN HEALTH & SERVICES	SANTA BARBARA	CA	H80CS289832019	09E01200	CHC
AMERICAN SAMOA GOVERNMENT DEPT OF HEALTH	PAGO PAGO	AS	H80CS024702019	099040	CHC
AMISTAD COMMUNITY HEALTH CENTER INCORPORATED	CORP CHRISTI	TX	H80CS087782019	0627970	CHC
AMITE COUNTY MEDICAL SERVICES, INC.	LIBERTY	MS	H80CS006092019	045780	CHC
AMMONOOSUC COMMUNITY HEALTH SRVS, INC.	LITTLETON	NH	H80CS005542019	010980	CHC
AMPLA HEALTH	YUBA CITY	CA	H80CS007652019	090850	CHC, MHC
ANCHORAGE NEIGHBORHOOD HEALTH CENTER	ANCHORAGE	AK	H80CS001462019	100020	CHC, HCH
ANDERSON VALLEY HEALTH CENTER, INC	BOONVILLE	CA	H80CS226822019	09E00102	CHC, MHC
ANSON REGIONAL MEDICAL SERVICES	WADESBORO	NC	H80CS004862019	044230	CHC
ANTHONY L. JORDAN HEALTH CORPORATION	ROCHESTER	NY	H80CS215822019	022070	CHC, PHPC
APICHA COMMUNITY HEALTH CENTER	NEW YORK	NY	H80CS290162019	02E01173	CHC
APLA HEALTH & WELLNESS	LOS ANGELES	CA	H80CS266142019	09E01052	CHC
APPALACHIAN DISTRICT HEALTH DEPARTMENT	SPARTA	NC	H80CS289702019	04E01177	CHC
APPALACHIAN MOUNTAIN COMMUNITY HEALTH CENTERS.	ASHEVILLE	NC	H80CS283482019	04E01135	CHC, HCH
ARCARE	AUGUSTA	AR	H80CS002072019	060940	CHC, MHC, PHPC
ARKANSAS VERDIGRIS VALLEY HEALTH CENTERS, INC.	PORTER	OK	H80CS128872019	06E00035	CHC
ARROYO VISTA FAMILY HEALTH FOUNDATION	LOS ANGELES	CA	H80CS003742019	093160	CHC

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ASHER COMMUNITY HEALTH CENTER	FOSSIL	OR	H80CS042062019	102400	CHC
ASIAN AMERICAN HEALTH COALITION DBA HOPE CLINIC	HOUSTON	TX	H80CS241532019	06E00130	CHC
ASIAN AMERICANS FOR COMMUNITY INVOLVEMENT OF SANTA CLARA, INC, THE	SAN JOSE	CA	H80CS266152019	09E01091	CHC
ASIAN AND PACIFIC ISLANDER WELLNESS CENTER, INC.	SAN FRANCISCO	CA	H80CS289782019	09E01174	CHC, HCH
ASIAN HEALTH SERVICES, INC.	OAKLAND	CA	H80CS007732019	091030	CHC
ASIAN HUMAN SERVICES FAMILY HEALTH CENTER, INC.	CHICAGO	IL	H80CS023272019	0518270	CHC
ASIAN PACIFIC HEALTH CARE VENTURE	LOS ANGELES	CA	H80CS007872019	091040	CHC
ASIAN SERVICES IN ACTION, INC	AKRON	OH	H80CS265742019	05E00131	CHC
ATASCOSA HEALTH CENTER, INC.	PLEASANTON	TX	H80CS004052019	062390	CHC
ATCHISON COMMUNITY HEALTH CLINIC	ATCHISON	KS	H80CS289602019	07E01216	CHC
ATHENS NEIGHBORHOOD HEALTH CENTER	ATHENS	GA	H80CS241292019	04E00480	CHC, PHPC
ATLANTICARE HEALTH SERVICES	EGG HBR TWP	NJ	H80CS008582019	027710	CHC, HCH
AUDUBON AREA COMMUNITY CARE CLINIC, INC.	OWENSBORO	KY	H80CS307142019	04E01244	HCH
AUNT MARTHA'S HEALTH & WELLNESS, INC.	OLYMPIA FLDS	IL	H80CS006852019	059720	CHC, HCH
AVENAL COMMUNITY HEALTH CENTER	AVENAL	CA	H80CS087392019	0911950	CHC, MHC
AXESSPOINTE COMMUNITY HEALTH CENTER, INC.	AKRON	OH	H80CS001172019	057270	CHC
AXIS COMMUNITY HEALTH	PLEASANTON	CA	H80CS128492019	09E00007	CHC
B-K HEALTH CENTER, INC., D/B/A NEPA COMMUNITY HEALTH CARE	HALLSTEAD	PA	H80CS004202019	030480	CHC
BAKERSVILLE COMMUNITY MEDICAL CLINIC, INC.	BAKERSVILLE	NC	H80CS241412019	04E00134	CHC, MHC
BALDWIN FAMILY HEALTH CARE, INC.	BALDWIN	MI	H80CS001082019	050210	CHC
BALTIMORE MEDICAL SYSTEM, INC.	BALTIMORE	MD	H80CS008002019	033180	CHC
BANDON COMMUNITY HEALTH CENTER	BANDON	OR	H80CS266022019	10E00136	CHC, HCH
BANYAN COMMUNITY HEALTH CENTER, INC.	MIAMI	FL	H80CS283442019	04E00479	CHC
BAPTIST COMMUNITY HEALTH SERVICES, INC.	NEW ORLEANS	LA	H80CS336532019	06E01275	CHC
BARCELONETA PRIMARY HEALTH SERVICES, INC	BARCELONETA	PR	H80CS004742019	021870	CHC, HCH

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BARRIO COMPREHENSIVE FAMILY HEALTH CARE CENTER, INC.	SAN ANTONIO	TX	H80CS006722019	062360	CHC, PHPC
BARTZ-ALTADONNA COMMUNITY HEALTH CENTER	LANCASTER	CA	H80CS226862019	09E00107	CHC, HCH
BATON ROUGE PRIMARY CARE COLLABORATIVE, INC.	BATON ROUGE	LA	H80CS025852019	0618420	CHC, HCH
BATTENKILL VALLEY HEALTH CENTER, INC.	ARLINGTON	VT	H80CS266412019	01E01057	CHC
BAY MILLS INDIAN COMMUNITY	BRIMLEY	MI	H80CS066642019	0530870	CHC
BAYOU LA BATRE AREA HEALTH DEVELOPMENT BOARD, INC.	BAYOU LABATRE	AL	H80CS000982019	044700	CHC
BEACON CHRISTIAN COMMUNITY HEALTH CENTER	STATEN ISLAND	NY	H80CS128662019	02E00028	CHC
BEAR LAKE COMMUNITY HEALTH CENTER, INC.	GARDEN CITY	UT	H80CS007232019	0811150	CHC
BEAUFORT-JASPER COMPREHENSIVE HLTH. SERVICES, INC.	RIDGELAND	SC	H80CS006992019	041190	CHC, MHC
BEDFORD STUYVESANT FAMILY HEALTH CENTER, INC.	BROOKLYN	NY	H80CS005102019	022120	CHC
BEE BUSY WELLNESS CENTER	HOUSTON	TX	H80CS265862019	06E00140	CHC, HCH
BEHAVIORAL HEALTH SERVICES INC	HAWTHORNE	CA	H80CS290482019	09E01219	CHC
BELINGTON COMMUNITY MEDICAL SERVICES ASSOCIATION, INC	BELINGTON	WV	H80CS128782019	03E00052	CHC
BELOVED COMMUNITY FAMILY WELLNESS CENTER	CHICAGO	IL	H80CS082582019	0535370	CHC
BEN ARCHER HEALTH CENTER	HATCH	NM	H80CS006032019	060370	CHC, MHC
BENEVOLENCE INDUSTRIES INCORPORATED	LOS ANGELES	CA	H80CS266162019	09E01093	CHC
BENEWAH MEDICAL CENTER	PLUMMER	ID	H80CS005442019	101530	CHC
BERKS COMMUNITY HEALTH CENTER	READING	PA	H80CS241462019	03E00493	CHC, PHPC
BERTIE COUNTY RURAL HEALTH ASSOCIATION	WINDSOR	NC	H80CS003552019	049190	CHC
BETANCES HEALTH CENTER	NEW YORK	NY	H80CS002352019	021200	CHC
BETHEL FAMILY CLINIC	BETHEL	AK	H80CS011382019	101470	CHC
BETTY JEAN KERR - PEOPLE'S HEALTH CENTERS	SAINT LOUIS	MO	H80CS001332019	072100	CHC
BIG SANDY HEALTH CARE, INC.	PRESTONSBURG	KY	H80CS006192019	040670	CHC
BIG SPRINGS MEDICAL ASSOCIATION DBA MISSOURI HIGHLAND HEALTH CARE	ELLINGTON	MO	H80CS007032019	070430	CHC
BIGHORN VALLEY HEALTH CENTER	HARDIN	MT	H80CS241022019	08E00468	CHC

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BLACKSTONE VALLEY COMMUNITY HEALTH CARE INC.	PAWTUCKET	RI	H80CS001542019	011990	CHC
BLAND COUNTY MEDICAL CLINIC, INC.	BASTIAN	VA	H80CS003312019	032650	CHC
BLUE RIDGE COMMUNITY HEALTH SERVICES, INC.	HENDERSONVLLE	NC	H80CS006502019	040940	CHC, MHC
BLUE RIDGE MEDICAL CENTER, INC.	ARRINGTON	VA	H80CS001752019	034050	CHC
BLUESTEM HEALTH	LINCOLN	NE	H80CS002362019	078170	CHC
BLUESTONE HEALTH ASSOCIATION, INC.	PRINCETON	WV	H80CS004502019	031250	CHC
BOARD OF TRUSTEES OF SOUTHER ILLINOIS UNIVERSITY	SPRINGFIELD	IL	H80CS240982019	05E00466	CHC
BOND COMMUNITY HEALTH CENTER INC	TALLAHASSEE	FL	H80CS289572019	048050	CHC
BORINQUEN HEALTH CARE CENTER, INC.	MIAMI	FL	H80CS006182019	040310	CHC
BORREGO COMMUNITY HEALTH FOUNDATION	BORREGO SPGS	CA	H80CS002872019	099010	CHC, MHC
BOSTON HEALTH CARE FOR THE HOMELESS, INC.	BOSTON	MA	H80CS000062019	011210	HCH
BOSTON MOUNTAIN RURAL HEALTH CENTER, INC	MARSHALL	AR	H80CS006412019	063730	CHC
BOUNDARY REGIONAL COMMUNITY HEALTH CENTER	BONNERS FERRY	ID	H80CS003022019	106300	CHC, MHC
BRAZOS VALLEY COMMUNITY ACTION AGENCY, INC.	COLLEGE STA	TX	H80CS002992019	0612230	CHC
BREAD FOR THE CITY, INC.	WASHINGTON	DC	H80CS290022019	03E00144	CHC
BRISTOL BAY AREA HEALTH CORPORATION	DILLINGHAM	AK	H80CS011332019	106200	CHC
BRISTOL BAY BOROUGH	NAKNEK	AK	H80CS011342019	106230	CHC
BROAD TOP AREA MEDICAL CENTER, INC.	BROAD TOP	PA	H80CS003302019	030220	CHC
BROCKTON NEIGHBORHOOD HEALTH CENTER, INC.	BROCKTON	MA	H80CS005602019	010700	CHC
BRONX COMMUNITY HEALTH NETWORK, INC.	BRONX	NY	H80CS006262019	024270	CHC
BRONXCARE HEALTH INTEGRATED SERVICES SYSTEM INC.	BRONX	NY	H80CS006252019	024260	CHC
BROOKLYN PLAZA MEDICAL CENTER, INC.	BROOKLYN	NY	H80CS004102019	021980	CHC, PHPC
BROWARD COMMUNITY AND FAMILY HEALTH CENTERS, INC.	HOLLYWOOD	FL	H80CS005962019	0415310	CHC
BROWNSVILLE COMMUNITY DEVELOPMENT CORP.	BROOKLYN	NY	H80CS005892019	021960	CHC
BROWNSVILLE COMMUNITY HEALTH CENTER	BROWNSVILLE	TX	H80CS007172019	061510	CHC, MHC

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BUCKSPORT REGIONAL HEALTH CENTER	BUCKSPORT	ME	H80CS005912019	010340	CHC
BULLHOOK COMMUNITY HEALTH CENTER, INC	HAVRE	MT	H80CS082192019	0818560	CHC
BUTLER COUNTY COMMUNITY HEALTH CONSORTIUM, INC DBA PRIMARY HEALTH SOLUTIONS	HAMILTON	OH	H80CS087532019	0534830	CHC
BUTTE-SILVER BOW PRI. HLTH. C. CLN.	BUTTE	MT	H80CS007992019	083270	CHC, HCH
C A S S E DENTAL HEALTH INSTITUTE	MANSFIELD	LA	H80CS265792019	06E01083	CHC
CABARRUS ROWAN COMMUNITY HEALTH CENTERS, INC	CONCORD	NC	H80CS066522019	0445230	CHC, MHC
CABIN CREEK HEALTH CENTER, INC.	DAWES	WV	H80CS002942019	031820	CHC
CABUN RURAL HEALTH SERVICES, INC.	HAMPTON	AR	H80CS003422019	062140	CHC
CACTUS HEALTH CENTERS	SANDERSON	TX	H80CS014262019	0614120	CHC
CAHABA MEDICAL CARE FOUNDATION	CENTREVILLE	AL	H80CS241772019	04E00519	CHC
CAMARENA HEALTH	MADERA	CA	H80CS001432019	093210	CHC, MHC
CAMCARE HEALTH CORPORATION	CAMDEN	NJ	H80CS001722019	021280	CHC
CAMDEN-ON-GAULEY MEDICAL CENTER, INC.	CAMDEN ON GLY	WV	H80CS000782019	033100	CHC
CAMILLUS HEALTH CONCERN, INC.	MIAMI	FL	H80CS000262019	042400	HCH
CAMINO HEALTH CENTER	SAN JUAN CAPO	CA	H80CS241952019	09E00520	CHC
CAMUY HEALTH SERVICES, INC.	CAMUY	PR	H80CS004892019	020910	CHC
CANYONLANDS COMMUNITY HEALTH CARE	PAGE	AZ	H80CS004482019	091300	CHC
CAPITOL CITY FAMILY HEALTH CENTER, INC., DBA CARE SOUTH	BATON ROUGE	LA	H80CS005042019	067570	CHC
CAPSTONE RURAL HEALTH CENTER	PARRISH	AL	H80CS082362019	0448530	CHC
CARBON MEDICAL SERVICE ASSOCIATION, INC.	EAST CARBON	UT	H80CS005182019	083440	CHC
CARE ALLIANCE	CLEVELAND	OH	H80CS000292019	051820	HCH, PHPC
CARE FOR THE HOMELESS	NEW YORK	NY	H80CS000072019	020020	HCH
CARE NET OF LANCASTER	LANCASTER	SC	H80CS265972019	04E01063	CHC
CARE RESOURCE COMMUNITY HEALTH CENTERS, INC.	MIAMI	FL	H80CS128642019	04E00012	CHC
CARECONNECT HEALTH, INC	RICHLAND	GA	H80CS003932019	043340	CHC

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CARES COMMUNITY HEALTH	SACRAMENTO	CA	H80CS283642019	09E01155	CHC
CARESOUTH CAROLINA, INC.	HARTSVILLE	SC	H80CS006542019	045230	CHC
CARESTL HEALTH	SAINT LOUIS	MO	H80CS007492019	070370	CHC
CARING HANDS HEALTHCARE CENTERS, INC.	MCALESTER	OK	H80CS128772019	06E00036	CHC
CARING HEALTH CENTER	SPRINGFIELD	MA	H80CS005852019	010840	CHC
CAROLINA FAMILY HEALTH CENTERS, INC.	WILSON	NC	H80CS007282019	046450	CHC, MHC
CAROLINA HEALTH CENTERS, INC.	GREENWOOD	SC	H80CS007852019	042780	CHC, MHC
CASS COUNTY HEALTH DEPARTMENT	VIRGINIA	IL	H80CS087772019	0537670	CHC
CASSOPOLIS FAMILY CLINIC NETWORK	CASSOPOLIS	MI	H80CS087522019	056900	CHC
CASTANER GENERAL HOSPITAL	CASTANER	PR	H80CS003542019	020660	CHC, MHC
CASWELL FAMILY MEDICAL CENTER	YANCEYVILLE	NC	H80CS004782019	044920	CHC
CATAHOULA PARISH HOSPITAL DISTRICT # 2	SICILY ISLAND	LA	H80CS002062019	062480	CHC
CEDAR RIVERSIDE PEOPLES CENTER	MINNEAPOLIS	MN	H80CS008592019	0516700	CHC
CENTER FOR FAMILY AND CHILD ENRICHMENT, INC., THE	MIAMI GARDENS	FL	H80CS265892019	04E01089	CHC
CENTER FOR FAMILY HEALTH	JACKSON	MI	H80CS007722019	057030	CHC
CENTER FOR FAMILY HEALTH & EDUCATION, INC.	PANORAMA CITY	CA	H80CS289842019	09E01195	CHC
CENTER FOR PANASIAN COMMUNITY SERVICES INC	ATLANTA	GA	H80CS265912019	04E01070	CHC
CENTER STREET COMMUNITY HEALTH CENTER	MARION	OH	H80CS105842019	05E00058	CHC
CENTERPLACE HEALTH, INC.	SARASOTA	FL	H80CS318922019	04E01302	CHC
CENTERVILLE CLINICS INC	FREDERICKTOWN	PA	H80CS007052019	031700	CHC
CENTRAL CITY COMMUNITY HEALTH CENTER, INC.	ANAHEIM	CA	H80CS106082019	09E00066	CHC, MHC
CENTRAL CITY CONCERN	PORTLAND	OR	H80CS002342019	107660	HCH
CENTRAL COUNTIES HEALTH CENTERS, INC.	SPRINGFIELD	IL	H80CS005332019	059700	CHC, HCH
CENTRAL FLORIDA FAMILY HEALTH CENTER, INC.	SANFORD	FL	H80CS001782019	041720	CHC
CENTRAL FLORIDA HEALTH CARE, INC.	WINTER HAVEN	FL	H80CS004232019	040210	CHC, MHC

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CENTRAL MISSISSIPPI CIVIC IMPROVEMENT ASSOCIATION, INC.	JACKSON	MS	H80CS000842019	040750	CHC, HCH
CENTRAL MISSISSIPPI HEALTH SERVICES, INC.	JACKSON	MS	H80CS008602019	046080	CHC
CENTRAL NEIGHBORHOOD HEALTH FOUNDATION	LOS ANGELES	CA	H80CS289852019	09E01214	CHC
CENTRAL NORTH ALABAMA HEALTH	HUNTSVILLE	AL	H80CS001052019	048190	CHC
CENTRAL OKLAHOMA FAMILY MEDICAL CENTER	KONAWA	OK	H80CS007572019	063930	CHC
CENTRAL VIRGINIA HEALTH SERVICES	NEW CANTON	VA	H80CS004792019	030700	CHC
CENTRO DE SALUD DE LA COMUNIDAD SAN YSIDRO, INC	SAN YSIDRO	CA	H80CS107482019	091080	CHC, PHPC
CENTRO DE SALUD DE LARES, INC.	LARES	PR	H80CS003532019	022090	CHC
CENTRO DE SALUD FAMILIAR (PALMIERI)	ARROYO	PR	H80CS003252019	020150	CHC, PHPC
CENTRO DE SALUD FAMILIAR LA FE	EL PASO	TX	H80CS001282019	061230	CHC, MHC, PHPC
CENTRO DE SERVICIOS PRIMARIOS DE SALUD INC	FLORIDA	PR	H80CS001622019	021400	CHC
CENTRO SAN VICENTE	EL PASO	TX	H80CS006372019	066580	CHC, HCH
CHAMBERS COUNTY PUBLIC HOSPITAL DISTRICT #1	ANAHUAC	TX	H80CS087882019	0621770	CHC
CHANGE, INC.	WEIRTON	WV	H80CS082382019	0321030	CHC
CHARLES B. WANG COMMUNITY HEALTH CENTER, INC.	NEW YORK	NY	H80CS003582019	021390	CHC
CHARLES DREW HEALTH CENTER, INC	OMAHA	NE	H80CS004382019	072110	CHC, HCH, PHPC
CHARLES RIVER COMMUNITY HEALTH, INC.	BRIGHTON	MA	H80CS003782019	011890	CHC
CHARLOTTE COMMUNITY HEALTH CLINIC, INC	CHARLOTTE	NC	H80CS283452019	04E01140	CHC, HCH
CHARTER OAK HEALTH CENTER, INC.	HARTFORD	CT	H80CS001532019	011830	CHC, HCH, PHPC
CHASE BREXTON HEALTH SERVICES, INC	BALTIMORE	MD	H80CS007342019	036640	CHC
CHATTANOOGA-HAMILTON COUNTY HEALTH DEPARTMENT	CHATTANOOGA	TN	H80CS000232019	042030	HCH
CHEROKEE HEALTH SYSTEMS	KNOXVILLE	TN	H80CS003092019	0413090	CHC, HCH, MHC, PHPC
CHERRY STREET SERVICES, INC.	GRAND RAPIDS	MI	H80CS007702019	052030	CHC, HCH, MHC
CHESPENN HEALTH SERVICES	CHESTER	PA	H80CS007382019	033930	CHC
CHESTNUT HEALTH SYSTEMS	BLOOMINGTON	IL	H80CS241302019	05E00481	CHC

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CHEYENNE HEALTH AND WELLNESS CENTER	CHEYENNE	WY	H80CS041962019	0814640	CHC
CHICAGO FAMILY HEALTH CENTER, INC.	CHICAGO	IL	H80CS005142019	051050	CHC
CHILDREN'S CLINIC SERVING CHILDREN & THEIR FAMILIES	LONG BEACH	CA	H80CS002642019	098820	CHC
CHILDREN'S HOSP. & RESEARCH CTR. OF OAKLAND	OAKLAND	CA	H80CS000522019	091850	HCH
CHINATOWN SERVICE CENTER	LOS ANGELES	CA	H80CS087352019	0928870	CHC
CHIRICAHUA COMMUNITY HEALTH CENTERS	DOUGLAS	AZ	H80CS006962019	092870	CHC, MHC, PHPC
CHOPTANK COMMUNITY HEALTH SYSTEM, INC.	DENTON	MD	H80CS001762019	032750	CHC, MHC
CHOTA COMMUNITY HEALTH SERVICES	VONORE	TN	H80CS064612019	0442510	CHC
CHRIST COMMUNITY HEALTH SERVICES AUGUSTA	AUGUSTA	GA	H80CS241722019	04E00516	CHC, PHPC
CHRIST COMMUNITY HEALTH SERVICES, INC.	MEMPHIS	TN	H80CS008812019	0417140	CHC, HCH
CHRIST HEALTH CENTER, INC.	BIRMINGHAM	AL	H80CS265882019	04E01095	CHC
CHRISTIAN COMMUNITY HEALTH CENTER	CHICAGO	IL	H80CS005942019	0512480	CHC
CHRISTIAN COMMUNITY HEALTH SERVICES	CINCINNATI	OH	H80CS256822019	05E01026	CHC
CHRISTOPHER GREATER AREA RURAL HEALTH PLANNING CORPORATION	CHRISTOPHER	IL	H80CS007262019	052130	CHC
CHUUK STATE DEPARTMENT OF HEALTH SERVICES	CHUUK	FM	H80CS307202019	11E01249	CHC
CINCINNATI HEALTH NETWORK, INC.	CINCINNATI	OH	H80CS001892019	051570	HCH
CINCINNATI, CITY OF	CINCINNATI	OH	H80CS256832019	05E00167	CHC
CIRCLE HEALTH SERVICES	CLEVELAND	OH	H80CS241112019	05E00475	CHC
CIRCLE THE CITY	PHOENIX	AZ	H80CS283652019	09E01133	HCH
CITIZENS OF LAKE COUNTY FOR HEALTH	TIPTONVILLE	TN	H80CS003332019	045420	CHC
CITRUS HEALTH NETWORK, INC.	HIALEAH	FL	H80CS042142019	0438180	CHC, HCH
CITY OF FREDERICK	FREDERICK	MD	H80CS290072019	03E01218	CHC, HCH
CITY OF MANCHESTER NEW HAMPSHIRE	MANCHESTER	NH	H80CS000022019	010130	HCH
CITY OF NEWARK	NEWARK	NJ	H80CS000092019	020710	CHC, HCH, PHPC
CITY OF SIOUX FALLS HEALTH DEPARTMENT	SIOUX FALLS	SD	H80CS002192019	081450	CHC, HCH

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CITY OF SPRINGFIELD, MASSACHUSETTS	SPRINGFIELD	MA	H80CS000012019	010120	HCH
CLACKAMAS COUNTY HEALTH CENTERS DIVISION	OREGON CITY	OR	H80CS005472019	101310	CHC, MHC
CLAIBORNE COUNTY FAMILY HEALTH CENTER	PORT GIBSON	MS	H80CS004822019	048420	CHC
CLAY BATTELLE HEALTH SERVICES ASSOC.	BLACKSVILLE	WV	H80CS006162019	030800	CHC
CLINCH RIVER HEALTH SERVICES, INC.	DUNGANNON	VA	H80CS004492019	031230	CHC
CLINICA CAMPESINA FAMILY HEALTH SVCS	LAFAYETTE	CO	H80CS006902019	081650	CHC
CLINICA DE SALUD DEL VALLE DE SALINAS	SALINAS	CA	H80CS002322019	091050	CHC, HCH, MHC
CLINICA MONSENOR OSCAR A. ROMERO	LOS ANGELES	CA	H80CS008442019	099410	CHC
CLINICA SIERRA VISTA	BAKERSFIELD	CA	H80CS005402019	090390	CHC, HCH, MHC
CLINICAS DE SALUD DEL PUEBLO, INC.	BRAWLEY	CA	H80CS007332019	090250	CHC, HCH, MHC
CLINICAS DEL CAMINO REAL, INC.	VENTURA	CA	H80CS005502019	093650	CHC, MHC
COAL COUNTRY COMMUNITY HEALTH CENTER	BEULAH	ND	H80CS094692019	08E00054	CHC
COASTAL BEND AIDS FOUNDATION, INC.	CORP CHRISTI	TX	H80CS289762019	06E01188	CHC
COASTAL COMMUNITY HEALTH SERVICES, INC.	BRUNSWICK	GA	H80CS265922019	04E01082	CHC
COASTAL FAMILY HEALTH CENTER, INC.	BILOXI	MS	H80CS001882019	042430	CHC, HCH
COASTAL HEALTH & WELLNESS	TEXAS CITY	TX	H80CS003442019	061610	CHC
COASTAL HEALTH ALLIANCE	POINT REYES STATION	CA	H80CS003392019	095400	CHC
CODMAN SQUARE HEALTH CENTER	DORCHESTR CTR	MA	H80CS112992019	01E00090	CHC
COLLIER HEALTH SERVICES	IMMOKALEE	FL	H80CS007352019	041700	CHC, MHC
COLORADO COALITION FOR THE HOMELESS	DENVER	CO	H80CS000402019	080620	HCH, PHPC
COLUMBIA BASIN HEALTH ASSOCIATION	OTHELLO	WA	H80CS001472019	100460	CHC, MHC
COLUMBIA RIVER COMMUNITY HEALTH SERVICES	BOARDMAN	OR	H80CS042072019	107200	CHC, MHC
COLUMBIA VALLEY COMMUNITY HEALTH	WENATCHEE	WA	H80CS005742019	100570	CHC, MHC
COLUMBUS NEIGHBORHOOD HEALTH CENTER	COLUMBUS	OH	H80CS001182019	058470	CHC, HCH, PHPC
COLVILLE CONFEDERATED TRIBES	INCHELIUM	WA	H80CS014412019	107940	CHC

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COMANCHE COUNTY HOSPITAL AUTHORITY	LAWTON	OK	H80CS087792019	0627960	CHC
COMM HLTH CNTR OF FRANKLIN COUNTY, INC.	GREENFIELD	MA	H80CS008062019	013260	CHC
COMMON GROUND HEALTH CLINIC	NEW ORLEANS	LA	H80CS265802019	06E01048	CHC
COMMUNICARE HEALTH CENTERS, INC.	DAVIS	CA	H80CS082162019	0928880	CHC, MHC
COMMUNITY ACTION AGENCY OF COLUMBIANA	LISBON	OH	H80CS001972019	056820	CHC
COMMUNITY ACTION COMMITTEE OF PIKE COUNTY	PIKETON	OH	H80CS003992019	052900	CHC
COMMUNITY ACTION CORPORATION OF SOUTH TEXAS	ALICE	TX	H80CS023232019	0614350	CHC
COMMUNITY ACTION OF LARAMIE COUNTY, INC.	CHEYENNE	WY	H80CS000422019	084620	HCH
COMMUNITY ACTION PARTNERSHIP OF NATRONA COUNTY	CASPER	WY	H80CS023302019	083970	HCH
COMMUNITY ACTION PARTNERSHIP OF WESTERN NEBRASKA	GERING	NE	H80CS003292019	073080	CHC, MHC
COMMUNITY AND RURAL HEALTH SERVICES	FREMONT	OH	H80CS006612019	050960	CHC, MHC
COMMUNITY CARE OF WEST VIRGINIA	ROCK CAVE	WV	H80CS000802019	034210	CHC
COMMUNITY CLINIC OF MAUI, INC	WAILUKU	HI	H80CS007222019	096040	CHC
COMMUNITY CLINIC, INC.	SILVER SPRING	MD	H80CS105912019	03E00060	CHC
COMMUNITY COUNCIL OF IDAHO, INC.	CALDWELL	ID	H80CS042012019	1011880	CHC, MHC
COMMUNITY HEALTH & EMERGENCY SVCS., INC.	CAIRO	IL	H80CS006802019	050030	CHC
COMMUNITY HEALTH & SOCIAL SERVICES CENTER, INC.	DETROIT	MI	H80CS007242019	056770	CHC
COMMUNITY HEALTH & WELLNESS CENTER OF GREATER TORRINGTON	TORRINGTON	CT	H80CS128432019	01E00009	CHC
COMMUNITY HEALTH & WELLNESS PARTNERS OF LOGAN COUNTY	WEST LIBERTY	OH	H80CS265752019	05E01097	CHC
COMMUNITY HEALTH ALLIANCE	RENO	NV	H80CS005392019	092280	CHC, HCH
COMMUNITY HEALTH ALLIANCE OF PASADENA	PASADENA	CA	H80CS042202019	0910140	CHC, HCH
COMMUNITY HEALTH AND DENTAL CARE	POTTSTOWN	PA	H80CS241472019	03E00494	CHC
COMMUNITY HEALTH ASSOCIATION OF SPOKANE	SPOKANE	WA	H80CS003192019	102570	CHC, HCH
COMMUNITY HEALTH CARE	TACOMA	WA	H80CS004812019	100450	CHC
COMMUNITY HEALTH CARE CENTER, INCORPORATED	GREAT FALLS	MT	H80CS325212019	08E01322	CHC

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COMMUNITY HEALTH CARE SYSTEMS, INC.	WRIGHTSVILLE	GA	H80CS005072019	045180	CHC
COMMUNITY HEALTH CARE, INC.	BRIDGETON	NJ	H80CS001642019	021270	CHC, MHC
COMMUNITY HEALTH CARE, INC.	DAVENPORT	IA	H80CS006702019	071170	CHC, HCH
COMMUNITY HEALTH CENTER IN COWLEY COUNTY, INC	WINFIELD	KS	H80CS283722019	07E01149	CHC
COMMUNITY HEALTH CENTER OF BLACK HILLS, INC.	RAPID CITY	SD	H80CS002162019	081890	CHC, HCH
COMMUNITY HEALTH CENTER OF BUFFALO, INC.	BUFFALO	NY	H80CS001572019	024690	CHC, HCH, PHPC
COMMUNITY HEALTH CENTER OF CAPE COD, INC.	MASHPEE	MA	H80CS082432019	0114410	CHC
COMMUNITY HEALTH CENTER OF CENTRAL WYOMING	CASPER	WY	H80CS005642019	086120	CHC
COMMUNITY HEALTH CENTER OF FORT DODGE, INC	FORT DODGE	IA	H80CS066672019	0715040	CHC
COMMUNITY HEALTH CENTER OF LUBBOCK	LUBBOCK	TX	H80CS007662019	062910	CHC, HCH, MHC, PHPC
COMMUNITY HEALTH CENTER OF NORTHEAST OKLAHOMA, INC.	JAY	OK	H80CS265852019	06E01060	CHC
COMMUNITY HEALTH CENTER OF RICHMOND, INC.	STATEN ISLAND	NY	H80CS166392019	02E00091	CHC
COMMUNITY HEALTH CENTER OF SNOHOMISH COUNTY	EVERETT	WA	H80CS007462019	102280	CHC, HCH
COMMUNITY HEALTH CENTER OF SOUTHEAST KANSAS INC	PITTSBURG	KS	H80CS008412019	077570	CHC
COMMUNITY HEALTH CENTER, INC.	MIDDLETOWN	CT	H80CS003262019	012080	CHC, HCH
COMMUNITY HEALTH CENTERS OF BENTON AND LINN COUNTIES	CORVALLIS	OR	H80CS025922019	1010810	CHC, MHC
COMMUNITY HEALTH CENTERS OF BURLINGTON, INC.	BURLINGTON	VT	H80CS003112019	010150	CHC, HCH
COMMUNITY HEALTH CENTERS OF GREATER DAYTON	DAYTON	OH	H80CS128822019	05E00029	CHC
COMMUNITY HEALTH CENTERS OF PINELLAS, INC.	SAINT PETERSBURG	FL	H80CS004632019	049070	CHC
COMMUNITY HEALTH CENTERS OF S. CENTRAL TEXAS, INC.	GONZALES	TX	H80CS001252019	060810	CHC
COMMUNITY HEALTH CENTERS OF SOUTHEASTERN IOWA, INC.	W BURLINGTON	IA	H80CS002722019	077310	CHC
COMMUNITY HEALTH CENTERS OF SOUTHERN IOWA, INC.	LEON	IA	H80CS042002019	0712430	CHC
COMMUNITY HEALTH CENTERS OF THE RUTLAND REGION, INC	BOMOSEEN	VT	H80CS066592019	0112230	CHC
COMMUNITY HEALTH CENTERS OF WESTERN KENTUCKY	GREENVILLE	KY	H80CS005622019	048070	CHC
COMMUNITY HEALTH CENTERS, INC.	MIDVALE	UT	H80CS002202019	080220	CHC, MHC

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COMMUNITY HEALTH CENTERS, INC.	MIDWEST CITY	OK	H80CS003202019	060530	CHC, HCH
COMMUNITY HEALTH CENTERS, INC.	WINTER GARDEN	FL	H80CS008092019	041660	CHC, MHC
COMMUNITY HEALTH CLINIC, INC.	NEW KENSINGTN	PA	H80CS128802019	03E00037	CHC
COMMUNITY HEALTH CONNECTION, INC.	TULSA	OK	H80CS064462019	0621080	CHC
COMMUNITY HEALTH CONNECTIONS, INC.	FITCHBURG	MA	H80CS002572019	013900	CHC, HCH, PHPC
COMMUNITY HEALTH CTR OF CENTRAL MISSOURI	LINN	MO	H80CS087482019	0718730	CHC
COMMUNITY HEALTH DEVELOPMENT, INC.	UVALDE	TX	H80CS001302019	063910	CHC, MHC
COMMUNITY HEALTH FOUNDATION OF PUERTO RICO INC.	BAYAMON	PR	H80CS336622019	02E01268	CHC
COMMUNITY HEALTH IMPROVEMENT	DECATUR	IL	H80CS006812019	053150	CHC
COMMUNITY HEALTH INITIATIVES INC.	BROOKLYN	NY	H80CS284452019	02E01157	PHPC
COMMUNITY HEALTH NET	ERIE	PA	H80CS005232019	034230	CHC, HCH
COMMUNITY HEALTH OF CENTRAL WASHINGTON	YAKIMA	WA	H80CS087742019	1014910	CHC, MHC
COMMUNITY HEALTH OF EAST TENNESSEE	JACKSBORO	TN	H80CS003042019	041330	CHC
COMMUNITY HEALTH OF SOUTH FLORIDA, INC.	CUTLER BAY	FL	H80CS008212019	040320	CHC, HCH, MHC
COMMUNITY HEALTH PARTNERS, INC.	LIVINGSTON	MT	H80CS007362019	084990	CHC, MHC
COMMUNITY HEALTH PARTNERSHIP OF ILLINOIS	CHICAGO	IL	H80CS007482019	050060	CHC, MHC
COMMUNITY HEALTH PROGRAMS, INC.	GT BARRINGTON	MA	H80CS002372019	013840	CHC
COMMUNITY HEALTH PROJECT, INC.	NEW YORK	NY	H80CS290172019	02E01163	CHC, HCH
COMMUNITY HEALTH SERVICE AGENCY, INC.	GREENVILLE	TX	H80CS006752019	060820	CHC
COMMUNITY HEALTH SERVICES OF THE LAMOILLE VALLEY	MORRISVILLE	VT	H80CS106112019	01E00069	CHC
COMMUNITY HEALTH SERVICES, INC	HARTFORD	CT	H80CS006122019	011260	CHC
COMMUNITY HEALTH SERVICES, INC.	MOORHEAD	MN	H80CS006602019	050320	MHC
COMMUNITY HEALTH SYSTEMS, INC.	MORENO VALLEY	CA	H80CS002222019	093660	CHC
COMMUNITY HEALTH SYSTEMS, INC.	BECKLEY	WV	H80CS003452019	030790	CHC
COMMUNITY HEALTH SYSTEMS, INC.	BELOIT	WI	H80CS006762019	059030	CHC

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COMMUNITY HEALTHCARE NETWORK, INC.	NEW YORK	NY	H80CS005972019	021630	CHC
COMMUNITY HEALTHNET, INC.	GARY	IN	H80CS066652019	058660	CHC
COMMUNITY HLTH CNTRS/CENTRAL COASTS	NIPOMO	CA	H80CS006212019	090710	CHC, HCH, MHC, PHPC
COMMUNITY MEDICAL CENTERS, INC.	STOCKTON	CA	H80CS001382019	090780	CHC, HCH, MHC
COMMUNITY MEDICAL WELLNESS CENTERS USA	LONG BEACH	CA	H80CS289862019	09E01191	CHC
COMMUNITY MEDICINE FOUNDATION	ROCK HILL	SC	H80CS007502019	042600	CHC, PHPC
COMMUNITY MENTAL HEALTHCARE INC	DOVER	OH	H80CS283492019	05E01138	CHC
COMMUNITY OF HOPE	WASHINGTON	DC	H80CS066722019	0318420	CHC
COMMUNITY TREATMENT, INC.	FESTUS	MO	H80CS241052019	07E00470	CHC
COMPASS COMMUNITY HEALTH	PORTSMOUTH	OH	H80CS290202019	05E01175	CHC
COMPASS HEALTH, INC.	CLINTON	MO	H80CS265632019	07E01084	CHC
COMPLETE CARE COMMUNITY HEALTH CENTER, INC.	LOS ANGELES	CA	H80CS289872019	09E01183	CHC
COMPREHENSIVE COMMUNITY ACTION, INC	CRANSTON	RI	H80CS066662019	0112210	CHC
COMPREHENSIVE COMMUNITY HEALTH CENTERS, INC	GLENDALE	CA	H80CS106072019	09E00065	CHC
CONCILIO DE SALUD INTEGRAL DE LOIZA, INC	LOIZA	PR	H80CS003232019	020670	CHC, PHPC
CONNECTICUT INSTITUTE FOR COMMUNITIES, INC.	DANBURY	CT	H80CS166402019	01E00010	CHC
CONTRA COSTA COUNTY HEALTH SERVICES DEPT	MARTINEZ	CA	H80CS000502019	091120	HCH
COOK AREA HEALTH SERVICES, INC.	COOK	MN	H80CS007062019	052710	CHC
COOS COUNTY FAMILY HEALTH SERVICES, INC.	BERLIN	NH	H80CS005082019	010850	CHC
COPPERTOWER FAMILY MEDICAL CENTER INC	CLOVERDALE	CA	H80CS266082019	09E01046	CHC
CORNELL SCOTT HILL HEALTH CORPORATION	NEW HAVEN	CT	H80CS003122019	010070	CHC, HCH, PHPC
CORNERSTONE CARE	GREENSBORO	PA	H80CS004012019	033090	CHC
CORNERSTONE FAMILY HEALTHCARE	CORNWALL	NY	H80CS004692019	020620	CHC, HCH, PHPC
CORPORACION DE SERVICIOS DE SALUD Y MEDICINA AVANZADA	CIDRA	PR	H80CS003792019	020730	CHC, MHC
CORPORACION DE SERVICOS MEDICOS PRIMARIOS Y PREVENCION DE HATILLO	HATILLO	PR	H80CS003342019	021260	CHC, MHC, PHPC

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CORPORACION SANOS	CAGUAS	PR	H80CS226872019	02E00103	CHC, HCH, PHPC
COSTA SALUD COMMUNITY HEALTH CENTERS INC	RINCON	PR	H80CS003562019	021030	CHC
COUNCIL OF ATHABASCAN TRIBAL GOVERNMENT	FORT YUKON	AK	H80CS011312019	106220	CHC
COUNTRY DOCTOR COMMUNITY CLINIC	SEATTLE	WA	H80CS006472019	102520	CHC
COUNTY OF INGHAM, HEALTH DEPARTMENT	LANSING	MI	H80CS000302019	051830	CHC, HCH
COUNTY OF LAKE, DBA LAKE COUNTY HEALTH DEPARTMENT AND COMMUNITY HEALTH CENTER	WAUKEGAN	IL	H80CS001192019	058870	CHC
COUNTY OF LEWIS & CLARK	HELENA	MT	H80CS005152019	083930	CHC, HCH
COUNTY OF SACRAMENTO DOH & HUMAN SERVICES	SACRAMENTO	CA	H80CS000452019	090800	HCH
COUNTY OF SOLANO	FAIRFIELD	CA	H80CS042182019	0921350	CHC, HCH
COVENANT COMMUNITY CARE INC.	DETROIT	MI	H80CS087382019	0537520	CHC, HCH
COVENANT HOUSE (UNDER 21)	NEW YORK	NY	H80CS000132019	021770	HCH
COVENANT HOUSE, INC.	PHILADELPHIA	PA	H80CS000712019	032220	CHC
COVERED BRIDGE HEALTHCARE OF ST. JOSEPH COUNTY, INC.	CENTREVILLE	MI	H80CS294572019	05E01226	CHC, HCH
COWLITZ FAMILY HEALTH CENTER	LONGVIEW	WA	H80CS005422019	102480	CHC, HCH
CRAVEN COUNTY GOVERNMENT	NEW BERN	NC	H80CS283462019	04E01146	CHC
CREEK VALLEY HEALTH CLINIC	COLORADO CITY	AZ	H80CS336382019	09E01367	CHC
CRESCENT COMMUNITY HEALTH CENTER	DUBUQUE	IA	H80CS087652019	0719270	CHC
CROSS ROAD HEALTH MINISTRIES, INC.	GLENNALLEN	AK	H80CS014442019	107860	CHC
CROSS TIMBERS HEALTH CLINIC, INC.	DE LEON	TX	H80CS001242019	060710	CHC, MHC
CROSS TRAILS MEDICAL CENTER	CPE GIRARDEAU	MO	H80CS002112019	074020	CHC
CRUSADERS CENTRAL CLINIC ASSOCIATION	ROCKFORD	IL	H80CS001132019	052760	CHC, HCH
CUMBERLAND FAMILY MEDICAL CENTER	BURKESVILLE	KY	H80CS082182019	0452070	CHC
CURTIS V. COOPER PRIMARY HEALTH CENTER INC.	SAVANNAH	GA	H80CS000822019	040490	CHC, PHPC
DAILY PLANET	RICHMOND	VA	H80CS000182019	031720	HCH, PHPC
DALLAS COUNTY HOSPITAL DISTRICT	DALLAS	TX	H80CS000392019	069730	HCH

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DAMIAN FAMILY CARE CENTERS, INC.	JAMAICA	NY	H80CS017652019	028480	CHC, HCH
DAVID RAINES COMUNITY HEALTH CENTER, INC.	SHREVEPORT	LA	H80CS007202019	061920	CHC
DAVIS STREET COMMUNITY CENTER INC	SAN LEANDRO	CA	H80CS289792019	09E01189	CHC
DAYSPRING FAMILY HEALTH CENTER, INC.	JELLICO	TN	H80CS007162019	042160	CHC
DAYTON HEALTH CENTER DBA FIVE RIVERS HEALTH CENTERS	DAYTON	OH	H80CS265762019	05E01100	CHC, HCH
DE BACA FAMILY PRACTICE CLINIC, INC.	FORT SUMNER	NM	H80CS008612019	067560	CHC
DELAWARE VALLEY COMMUNITY HEALTH, INC	PHILADELPHIA	PA	H80CS008332019	032900	CHC
DELTA HEALTH CENTER, INC.	MOUND BAYOU	MS	H80CS000852019	040780	CHC
DENVER HEALTH & HOSPITAL AUTHORITY	DENVER	CO	H80CS002182019	080060	CHC
DESERT AIDS PROJECT INC.	PALM SPRINGS	CA	H80CS289882019	09E01207	CHC
DETROIT CENTRAL CITY COMMUNITY MENTAL HEALTH INC.	DETROIT	MI	H80CS265712019	05E00210	CHC, HCH, PHPC
DETROIT COMMUNITY HEALTH CONNECTION, INC.	DETROIT	MI	H80CS003982019	052070	CHC
DETROIT HEALTH CARE FOR THE HOMELESS	DETROIT	MI	H80CS000332019	051880	CHC, HCH
DFD RUSSELL MEDICAL CENTER	LEEDS	ME	H80CS006422019	013280	CHC
DIRNE HEALTH CENTERS, INC.	COEUR D ALENE	ID	H80CS023312019	108170	CHC, HCH
DIVERSITY HEALTH CENTER, INC	LUDOWICI	GA	H80CS087802019	0452920	CHC
DOLORES COUNTY HEALTH ASSOCIATION	DOVE CREEK	CO	H80CS004642019	080100	CHC
DOTHOUSE HEALTH, INC.	DORCHESTER	MA	H80CS113002019	01E00089	CHC
DOUGLAS COUNTY PUBLIC HEALTH SERVICES GROUP, INC.	AVA	MO	H80CS004572019	074400	CHC
DOWNRIVER COMMUNITY SERVICES, INC.	ALGONAC	MI	H80CS004972019	052200	CHC, HCH
DR. ARENIA C. MALLORY COMMUNITY HEALTH CENTER, INC.	LEXINGTON	MS	H80CS005802019	047980	CHC
DUFFY HEALTH CENTER, INC.	HYANNIS	MA	H80CS002712019	011720	HCH
E.A. HAWSE HEALTH CENTER, INC.	BAKER	WV	H80CS005632019	033130	CHC
EAST ARKANSAS FAMILY HEALTH CENTER, INC.	WEST MEMPHIS	AR	H80CS001232019	060140	CHC
EAST BAY COMMUNITY ACTION PROGRAM	NEWPORT	RI	H80CS023292019	015160	CHC

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EAST BOSTON NEIGHBORHOOD HEALTH CENTER	BOSTON	MA	H80CS000582019	010720	CHC
EAST CENTRAL MISSISSIPPI HEALTH CARE, INC	SEBASTOPOL	MS	H80CS004312019	042720	CHC
EAST CENTRAL MISSOURI BEHAVIORAL HEALTH SVCS INC	MEXICO	MO	H80CS265602019	07E00214	CHC
EAST CENTRAL OKLAHOMA FAMILY HEALTH CENTER INC	WETUMKA	OK	H80CS105832019	06E00057	CHC
EAST GEORGIA HEALTHCARE CENTER, INC.	SWAINSBORO	GA	H80CS005122019	049010	CHC, MHC
EAST HARLEM COUNCIL FOR HUMAN SERVICES, INC.	NEW YORK	NY	H80CS000602019	020390	CHC
EAST HILL FAMILY MEDICAL, INC.	AUBURN	NY	H80CS241632019	02E00509	CHC
EAST JORDAN FAMILY HEALTH CENTER	EAST JORDAN	MI	H80CS195332019	051680	CHC
EAST LIBERTY FAMILY HEALTH CARE CENTER	PITTSBURGH	PA	H80CS006642019	030750	CHC, PHPC
EAST TENNESSEE STATE UNIVERSITY	JOHNSON CITY	TN	H80CS008402019	0413490	CHC, HCH, MHC
EAST TEXAS BORDER HEALTH CLINIC	MARSHALL	TX	H80CS087812019	0627930	CHC
EAST TEXAS COMMUNITY HEALTH SERVICE	NACOGDOCHES	TX	H80CS007932019	061260	CHC
EAST VALLEY COMMUNITY HEALTH CENTER INC	WEST COVINA	CA	H80CS002862019	099000	CHC
EAST-CENTRAL DISTRICT HEALTH DEPARTMENT	COLUMBUS	NE	H80CS008622019	078030	CHC
EASTERN ALEUTIAN TRIBES, INC	ANCHORAGE	AK	H80CS007402019	102900	CHC
EASTERN IOWA HEALTH CENTER	CEDAR RAPIDS	IA	H80CS082262019	0718570	CHC, HCH
EASTERN KENTUCKY UNIVERSITY	RICHMOND	KY	H80CS004442019	0420550	CHC, HCH, MHC
EASTERN SHORE RURAL HEALTH SYSTEM, INC.	ONANCOCK	VA	H80CS007912019	030720	CHC, MHC
EASTPORT HEALTH CARE, INC.	EASTPORT	ME	H80CS006302019	010570	CHC
EAU CLAIRE COOPERATIVE HEALTH CENTER, INC.	COLUMBIA	SC	H80CS007302019	043270	CHC, HCH, MHC
ECHO COMMUNITY HEALTH CARE	EVANSVILLE	IN	H80CS001992019	058490	CHC, HCH
EDWARD M. KENNEDY COMMUNITY HEALTH CENTER, INC.	WORCESTER	MA	H80CS004652019	010830	CHC, PHPC
EISNER PEDIATRIC & FAMILY MEDICAL CENTER	LOS ANGELES	CA	H80CS042232019	0921340	CHC
EL CENTRO DE CORAZON	HOUSTON	TX	H80CS024522019	0614370	CHC
EL CENTRO DEL BARRIO, INC.	SAN ANTONIO	TX	H80CS007582019	063250	CHC, HCH

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EL CENTRO FAMILY HEALTH	ESPANOLA	NM	H80CS006052019	060330	CHC, HCH
EL DORADO COUNTY COMMUNITY HEALTH CENTER	PLACERVILLE	CA	H80CS066712019	0923660	CHC
EL PROYECTO DEL BARRIO, INC.	ARLETA	CA	H80CS066472019	091620	CHC
EL RIO SANTA CRUZ NEIGHBORHOOD HEALTH CENTER	TUCSON	AZ	H80CS002302019	090160	CHC, HCH
ELAINE ELLIS CENTER OF HEALTH	WASHINGTON	DC	H80CS226792019	03E00099	CHC, PHPC
ELICA HEALTH CENTERS	W SACRAMENTO	CA	H80CS241132019	09E00477	CHC, HCH
ELLIS COUNTY COALITION FOR HEALTH OPTIONS	WAXAHACHIE	TX	H80CS128742019	06E00043	CHC
EMPOWER U, INCORPORATED	MIAMI	FL	H80CS265902019	04E00220	CHC
ENTERPRISE VALLEY MEDICAL CLINIC, INC.	ENTERPRISE	UT	H80CS006442019	082480	CHC
ERIE FAMILY HEALTH CENTER, INC.	CHICAGO	IL	H80CS001152019	053210	CHC
ERIE, COUNTY OF	SANDUSKY	OH	H80CS283502019	05E01136	CHC
ERLANGER MEDICAL CENTER	CHATTANOOGA	TN	H80CS000912019	041260	CHC
ESCAMBIA COMMUNITY CLINICS, INC.	PENSACOLA	FL	H80CS087552019	0452890	CHC, HCH
ESPERANZA HEALTH CENTER	PHILADELPHIA	PA	H80CS066442019	0318390	CHC
ESPERANZA HEALTH CENTERS	CHICAGO	IL	H80CS241032019	05E00469	CHC
EXCELTH INC.	NEW ORLEANS	LA	H80CS001292019	062870	CHC
EZRAS CHOILIM HEALTH CENTER INC.	MONROE	NY	H80CS241382019	02E00487	CHC
FAIR HAVEN COMMUNITY HEALTH CLINIC, INC.	NEW HAVEN	CT	H80CS007412019	010060	CHC
FAIRFAX MEDICAL FACILITIES, INC	FAIRFAX	OK	H80CS064562019	0622470	CHC
FAIRFIELD COMMUNITY HEALTH CENTER	LANCASTER	OH	H80CS195952019	05E00032	CHC
FAIRVIEW COMMUNITY HEALTH CENTER	BOWLING GREEN	KY	H80CS008562019	0421240	CHC
FAMILY AND MEDICAL COUNSELING SERVICE, INC.	WASHINGTON	DC	H80CS241752019	03E00227	CHC
FAMILY CARE HEALTH CENTERS	SAINT LOUIS	MO	H80CS004922019	071700	CHC
FAMILY CENTERS INC.	GREENWICH	CT	H80CS289992019	01E00228	PHPC
FAMILY CHRISTIAN HEALTH CENTER	HARVEY	IL	H80CS008792019	059300	CHC

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FAMILY FIRST HEALTH CORPORATION	YORK	PA	H80CS005292019	031160	CHC
FAMILY HEALTH CARE CENTERS OF GREATER LOS ANGELES, INC.	BELL GARDENS	CA	H80CS128582019	09E00005	CHC
FAMILY HEALTH CARE CLINIC, INC.	PEARL	MS	H80CS004872019	042440	CHC
FAMILY HEALTH CARE OF NORTHWEST OHIO, INC.	VAN WERT	OH	H80CS290212019	05E01176	CHC
FAMILY HEALTH CENTER OF BOONE COUNTY	COLUMBIA	MO	H80CS005732019	075300	CHC
FAMILY HEALTH CENTER OF CLARK COUNTY, INC	JEFFERSONVLLE	IN	H80CS087822019	0537610	CHC
FAMILY HEALTH CENTER OF MARSHFIELD, INC.	MARSHFIELD	WI	H80CS007922019	050840	CHC
FAMILY HEALTH CENTER OF SOUTHERN OKLAHOMA	TISHOMINGO	OK	H80CS024542019	0614360	CHC
FAMILY HEALTH CENTER OF WORCESTER, INC.	WORCESTER	MA	H80CS004522019	010800	CHC, HCH
FAMILY HEALTH CENTER, INC.	LOUISVILLE	KY	H80CS001022019	046840	CHC, HCH
FAMILY HEALTH CENTER, INC.	KALAMAZOO	MI	H80CS003362019	056230	CHC, HCH
FAMILY HEALTH CENTER, INC.	LAUREL	MS	H80CS005382019	040570	CHC
FAMILY HEALTH CENTERS	OKANOGAN	WA	H80CS004092019	101770	CHC, MHC
FAMILY HEALTH CENTERS OF BALTIMORE, INC.	BROOKLYN	MD	H80CS004362019	031270	CHC
FAMILY HEALTH CENTERS OF SAN DIEGO, INC.	SAN DIEGO	CA	H80CS002242019	093120	CHC, HCH, PHPC
FAMILY HEALTH CENTERS OF SW FLORIDA, INC.	FORT MYERS	FL	H80CS001852019	041680	CHC, HCH, MHC
FAMILY HEALTH CENTERS, INC.	ORANGEBURG	SC	H80CS000902019	041180	CHC
FAMILY HEALTH NETWORK OF CENTRAL NEW YORK, INC.	CORTLAND	NY	H80CS000652019	021240	CHC
FAMILY HEALTH SERVICES CORPORATION	TWIN FALLS	ID	H80CS004252019	101650	CHC, MHC
FAMILY HEALTH SERVICES OF DARKE COUNTY	GREENVILLE	OH	H80CS004192019	050640	CHC
FAMILY HEALTH SERVICES OF ERIE COUNTY	SANDUSKY	OH	H80CS283512019	05E01148	CHC
FAMILY HEALTHCARE CENTER	FARGO	ND	H80CS003172019	083670	CHC, HCH
FAMILY HEALTHCARE NETWORK	VISALIA	CA	H80CS007862019	093640	CHC, MHC
FAMILY MEDICAL CENTER OF MICHIGAN, INC.	CARLETON	MI	H80CS003902019	052910	CHC, MHC
FAMILY MEDICINE RESIDENCY OF IDAHO, INC.	BOISE	ID	H80CS266012019	10E00721	CHC, MHC

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FENWAY COMMUNITY HEALTH CENTER, INC.	BOSTON	MA	H80CS003032019	010600	CHC
FETTER HEALTH CARE NETWORK INC.	CHARLESTON	SC	H80CS090882019	041110	CHC, HCH, MHC
FINGER LAKES MIGRANT HEALTH CARE PROJECT	PENN YAN	NY	H80CS008492019	028210	CHC, MHC
FIRST CARE CLINIC, INC	HAYS	KS	H80CS128912019	07E00017	CHC
FIRST CHOICE COMMUNITY HEALTH CENTERS	MAMERS	NC	H80CS001002019	045200	CHC
FIRST CHOICE COMMUNITY HEALTHCARE, INC.	ALBUQUERQUE	NM	H80CS002022019	060240	CHC
FIRST CHOICE HEALTH CENTERS, INC.	EAST HARTFORD	CT	H80CS002622019	013370	CHC
FIRST CHOICE PRIMARY CARE, INC	MACON	GA	H80CS082422019	0452110	CHC, HCH
FIRST NATIONS COMMUNITY HEALTHSOURCE	ALBUQUERQUE	NM	H80CS082292019	0627300	CHC, HCH
FIRST PERSON CARE CLINIC	LAS VEGAS	NV	H80CS312402019	09E01227	CHC
FIRSTMED HEALTH AND WELLNESS CENTER	LAS VEGAS	NV	H80CS265132019	09E00231	CHC
FISH RIVER RURAL HEALTH	EAGLE LAKE	ME	H80CS003962019	010530	CHC
FIVE-TOWN HEALTH ALLIANCE, INC.	BRISTOL	VT	H80CS266422019	01E01088	CHC
FLATHEAD CITY - COUNTY HEALTH DEPT	KALISPELL	MT	H80CS128472019	08E00023	CHC
FLINT HILLS COMMUNITY HEALTH CENTER, INC.	EMPORIA	KS	H80CS284232019	074540	CHC
FLORIDA COMMUNITY HEALTH CENTER INC	WEST PALM BEACH	FL	H80CS007982019	040370	CHC, MHC
FLORIDA DEPARTMENT OF HEALTH UNION COUNTY HEALTH DEPARTMENT	TALLAHASSEE	FL	H80CS241732019	04E00464	CHC
FLORIDA DOH, WALTON COUNTY HEALTH DEPT	DEFUNIAK SPGS	FL	H80CS241282019	04E00465	CHC
FOOTHILLS COMMUNITY HEALTH CARE	CLEMSON	SC	H80CS241572019	04E00503	CHC
FORDLAND CLINIC	FORDLAND	MO	H80CS289652019	07E01164	CHC
FORT BEND FAMILY HEALTH CENTER, INC.	RICHMOND	TX	H80CS002632019	066540	CHC
FOUNDCARE INC.	WEST PALM BCH	FL	H80CS266262019	04E01069	CHC
FOUR CORNERS PRIMARY CARE CENTER	NORCROSS	GA	H80CS257082019	04E01034	CHC, HCH
FRANKLIN PRIMARY HEALTH CENTER, INC.	MOBILE	AL	H80CS000992019	044710	CHC, HCH, MHC, PHPC
FREDERIKSTED HEALTH CARE INC.	ST CROIX	VI	H80CS003722019	025320	CHC

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FREE CLINIC OF THE NEW RIVER VALLEY INC	CHRISTIANSBRG	VA	H80CS265162019	03E01039	CHC
FRIEND FAMILY HEALTH CENTER, INC.	CHICAGO	IL	H80CS001202019	059110	CHC
FRIENDS OF FAMILY HEALTH CENTER	LA HABRA	CA	H80CS241962019	09E00521	CHC
FRONTERA HEALTHCARE NETWORK	EDEN	TX	H80CS082252019	0627190	CHC
G. A. CARMICHAEL FAMILY HEALTH CENTER, INC.	CANTON	MS	H80CS004842019	040760	CHC
GARDNER FAMILY HEALTH NETWORK, INC.	SAN JOSE	CA	H80CS003592019	090210	CHC, HCH
GASTON FAMILY HEALTH SERVICES, INC.	GASTONIA	NC	H80CS002932019	045630	CHC
GATEWAY COMMUNITY HEALTH CENTER, INC	LAREDO	TX	H80CS007792019	061750	CHC
GATEWAY COMMUNITY HEALTH CENTERS, INC.	GATESVILLE	NC	H80CS268932019	04E01116	CHC, MHC
GENERATIONS FAMILY HEALTH CENTER, INC.	WILLIMANTIC	CT	H80CS001552019	010220	CHC, HCH
GENESEE HEALTH SYSTEM	FLINT	MI	H80CS257092019	05E01033	HCH, PHPC
GENESIS COMMUNITY HEALTH, INC.	BOYNTON BEACH	FL	H80CS241072019	04E00471	CHC, HCH
GENESIS HEALTHCARE, INC	COLUMBIA	SC	H80CS289732019	04E01160	CHC
GEORGIA DEPT. OF COMMUNITY HEALTH	ATLANTA	GA	H80CS003222019	048270	MHC
GEORGIA HIGHLANDS MEDICAL SERVICES, INC.	CUMMING	GA	H80CS004702019	047430	CHC
GEORGIA MOUNTAINS HEALTH SERVICES, INC.	MORGANTON	GA	H80CS000932019	042110	CHC
GERALD L. IGNACE INDIAN HEALTH CENTER, INC.	MILWAUKEE	WI	H80CS290262019	05E01167	CHC
GIFFORD HEALTH CARE, INC.	RANDOLPH	VT	H80CS267982019	01E01113	CHC
GIRDWOOD HEALTH CLINIC	GIRDWOOD	AK	H80CS289972019	10E01196	CHC
GLACIER COMMUNITY HEALTH CENTER, INC.	CUT BANK	MT	H80CS014512019	0811480	CHC
GLENDALE AREA MEDICAL ASSOCIATION, INC.	COALPORT	PA	H80CS004132019	032430	CHC
GLENNS FERRY HEALTH CLINIC, INC.	GLENNS FERRY	ID	H80CS004732019	101610	CHC, MHC
GOLDEN VALLEY HEALTH CENTER	MERCED	CA	H80CS007422019	090470	CHC, HCH, MHC
GOOD SAMARITAN HEALTH & WELLNESS CENTER, INC.	JASPER	GA	H80CS283472019	04E01150	CHC
GOOD SAMARITAN HEALTH CENTER OF COBB, INC.	MARIETTA	GA	H80CS265932019	04E01055	CHC

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GOOD SHEPHERD COMMUNITY CLINIC, INC.	ARDMORE	OK	H80CS336612019	06E01357	CHC
GOSHEN MEDICAL CENTER, INC.	FAISON	NC	H80CS001812019	045800	CHC, HCH, MHC
GRACE COMMUNITY HEALTH CENTER, INC. D/B/A GRACE HEALTH	GRAY	KY	H80CS099592019	04E00055	CHC
GRACE HEALTH, INC.	BATTLE CREEK	MI	H80CS005862019	056430	CHC, HCH
GRACEMED HEALTH CLINIC, INC	WICHITA	KS	H80CS087722019	073430	CHC, HCH
GREAT LAKES BAY HEALTH CENTERS	SAGINAW	MI	H80CS006892019	050360	CHC, MHC
GREAT MINES HEALTH CENTER	POTOSI	MO	H80CS066702019	078000	CHC
GREAT SALT PLAINS HEALTH CENTER, INC.	CHEROKEE	OK	H80CS087442019	0627800	CHC
GREATER BADEN MEDICAL SERVICE INC	BRANDYWINE	MD	H80CS005492019	033770	CHC, MHC
GREATER ELGIN FAMILY CARE CENTER	ELGIN	IL	H80CS002882019	0515160	CHC
GREATER LAWRENCE FAMILY HEALTH CENTER, INC	LAWRENCE	MA	H80CS003142019	012160	CHC, HCH
GREATER MERIDIAN HEALTH CLINIC, INC.	MERIDIAN	MS	H80CS004392019	042070	CHC
GREATER NEW BEDFORD COMMUNITY HEALTH CTR	NEW BEDFORD	MA	H80CS005112019	011930	CHC, HCH
GREATER PHILADELPHIA HEALTH ACTION, INC.	PHILADELPHIA	PA	H80CS007082019	033200	CHC
GREATER PRINCE WILLIAM COMMUNITY HEALTH CENTER	WOODBRIDGE	VA	H80CS128712019	03E00049	CHC, HCH
GREATER SEACOAST COMMUNITY HEALTH	SOMERSWORTH	NH	H80CS042102019	019980	CHC, HCH
GREATER SIOUX COMMUNITY HEALTH CENTER	SIOUX CENTER	IA	H80CS241712019	07E00515	CHC
GREEN RIVER MEDICAL CENTER	GREEN RIVER	UT	H80CS004622019	082490	CHC
GREENE COUNTY HEALTH CARE INCORPORATED	SNOW HILL	NC	H80CS000882019	041020	CHC, MHC
GREENVILLE RANCHERIA	RED BLUFF	CA	H80CS266072019	09E01065	CHC, MHC
GUAM DEPARTMENT OF PUBLIC HEALTH	HAGATNA	GU	H80CS024682019	093530	CHC
GULF COAST HEALTH CENTER, INC.	PORT ARTHUR	TX	H80CS004082019	061730	CHC
H I V/ A I D S ALLIANCE FOR REGION TWO INC	BATON ROUGE	LA	H80CS289622019	06E01178	CHC
HACKLEY COMMUNITY CARE CENTER, INC.	MUSKEGON	MI	H80CS006842019	051020	CHC
HAMAKUA HEALTH CENTER	HONOKAA	HI	H80CS004512019	092160	CHC

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HAMDARD CENTER FOR HEALTH & HUMAN SERVICES NFP	ADDISON	IL	H80CS265652019	05E01076	CHC
HAMILTON COMMUNITY HEALTH NETWORK, INC.	FLINT	MI	H80CS004352019	053300	CHC, HCH
HAMILTON HEALTH CENTER, INC.	HARRISBURG	PA	H80CS006592019	030290	CHC
HANA COMMUNITY HEALTH CENTER, INC.	HANA	HI	H80CS002902019	098550	CHC
HARBOR COMMUNITY CLINIC	SAN PEDRO	CA	H80CS283662019	09E01151	CHC
HARBOR HEALTH SERVICES	MATTAPAN	MA	H80CS007432019	010170	CHC
HARBOR HOMES, INC	NASHUA	NH	H80CS128672019	01E00025	HCH
HARDEMAN COUNTY COMMUNITY HEALTH CENTER	BOLIVAR	TN	H80CS005302019	045190	CHC
HARDIN COUNTY REGIONAL HEALTH CENTER	SAVANNAH	TN	H80CS001802019	046560	CHC
HARMONY HEALTH MEDICAL CLINIC AND FAMILY RESOURCE CENTER	MARYSVILLE	CA	H80CS289802019	09E01201	CHC
HARRINGTON FAMILY HEALTH CENTER	HARRINGTON	ME	H80CS008022019	013250	CHC
HARRIS COUNTY HOSPITAL DISTRICT	HOUSTON	TX	H80CS000382019	061600	HCH
HARRISONBURG COMMUNITY HEALTH CENTER, INC.	HARRISONBURG	VA	H80CS105922019	03E00061	CHC
HARVARD STREET NEIGHBORHOOD HEALTH CENTER INC	DORCHESTER	MA	H80CS290092019	01E01168	CHC
HEALING HANDS MINISTRIES, INC	DALLAS	TX	H80CS307192019	06E01229	CHC
HEALTH ACCESS FOR ALL INC.	LOS ANGELES	CA	H80CS337942019	09E01300	CHC
HEALTH ACCESS NETWORK, INC.	LINCOLN	ME	H80CS024502019	015110	CHC
HEALTH CARE CENTER FOR THE HOMELESS, INC.	ORLANDO	FL	H80CS002402019	0413580	CHC, HCH
HEALTH CARE COALITION OF LAFAYETTE COUNTY	LEXINGTON	MO	H80CS265612019	07E00251	CHC
HEALTH CARE DISTRICT OF PALM BEACH COUNTY	WEST PALM BEACH	FL	H80CS256842019	04E00551	CHC, HCH, MHC
HEALTH CARE FOR THE HOMELESS	BALTIMORE	MD	H80CS000172019	031690	HCH
HEALTH CARE PARTNERS OF SOUTH CAROLINA, INC.	CONWAY	SC	H80CS004112019	047000	CHC
HEALTH CENTER OF SOUTHEAST TEXAS	CLEVELAND	TX	H80CS087702019	0627760	CHC
HEALTH EDUCATION, ASSESSMENT AND LEADERSHIP, INC.	ATLANTA	GA	H80CS265942019	04E01061	CHC
HEALTH FIRST FAMILY CARE CENTER, INC.	FRANKLIN	NH	H80CS002952019	014060	CHC

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HEALTH HELP, INC.	MCKEE	KY	H80CS004592019	044820	CHC
HEALTH MINISTRIES CLINIC, INC.	NEWTON	KS	H80CS241692019	07E00513	CHC
HEALTH OPPORTUNITIES FOR THE PEOPLE OF EAST TEXAS, INC.	CENTER	TX	H80CS128502019	06E00045	CHC
HEALTH PARTNERS OF WESTERN OHIO	LIMA	OH	H80CS042122019	0516380	CHC, MHC
HEALTH PARTNERSHIP CLINIC, INC.	OLATHE	KS	H80CS241082019	07E00472	CHC, HCH
HEALTH SERVICES OF NORTH TEXAS, INC.	DENTON	TX	H80CS241972019	06E00522	CHC
HEALTH SERVICES, INC.	MONTGOMERY	AL	H80CS007952019	040130	CHC
HEALTH WEST, INC.	POCATELLO	ID	H80CS003212019	100180	CHC, MHC
HEALTH, TENNESSEE DEPT OF	NASHVILLE	TN	H80CS289742019	04E01224	CHC
HEALTHCARE CHOICES NY, INC.	BROOKLYN	NY	H80CS226802019	02E00100	CHC, HCH
HEALTHCARE FOR THE HOMELESS--HOUSTON	HOUSTON	TX	H80CS003002019	0612210	HCH
HEALTHCORE CLINIC INC	WICHITA	KS	H80CS128542019	07E00016	CHC
HEALTHFIRST BLUEGRASS INC.	LEXINGTON	KY	H80CS282022019	04E01125	CHC, HCH
HEALTHFIRST FAMILY CARE CENTER, INC.	FALL RIVER	MA	H80CS042152019	012120	CHC
HEALTHLINC, INC.	VALPARAISO	IN	H80CS066622019	0530920	CHC
HEALTHNET, INC.	INDIANAPOLIS	IN	H80CS001142019	053200	CHC, HCH
HEALTHPOINT	RENTON	WA	H80CS003602019	101300	CHC
HEALTHPOINT FAMILY CARE	COVINGTON	KY	H80CS004222019	044090	CHC
HEALTHREACH COMMUNITY HEALTH CENTERS	WATERVILLE	ME	H80CS007972019	010460	CHC
HEALTHSOURCE OF OHIO, INC.	MILFORD	OH	H80CS002012019	050990	CHC
HEALTHY CONNECTIONS, INC.	MENA	AR	H80CS002792019	0612200	CHC
HEART CITY HEALTH CENTER, INC.	ELKHART	IN	H80CS082212019	0526110	CHC
HEART OF FLORIDA HEALTH CENTER, INC	OCALA	FL	H80CS128592019	04E00013	CHC
HEART OF KANSAS FAMILY HEALTH CARE, INC.	GREAT BEND	KS	H80CS008252019	076340	CHC
HEART OF OHIO FAMILY HEALTH CENTERS	COLUMBUS	OH	H80CS078972019	0518310	CHC

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HEART OF TEXAS COMMUNITY HEALTH CENTER, INC.	WACO	TX	H80CS007192019	068160	CHC, HCH, PHPC
HEARTLAND HEALTH CENTER, INC.	GRAND ISLAND	NE	H80CS265622019	07E01086	CHC
HEARTLAND HEALTH OUTREACH, INC.	CHICAGO	IL	H80CS001112019	051900	HCH
HEARTLAND HEALTH SERVICES	PEORIA	IL	H80CS024572019	0518330	CHC
HEARTLAND INTERNATIONAL HEALTH CENTER	CHICAGO	IL	H80CS002152019	0512780	CHC
HEARTLAND MEDICAL CLINIC, INC.	LAWRENCE	KS	H80CS241702019	07E00514	CHC
HENDERSON CO. RURAL HEALTH CENTER, INC.	OQUAWKA	IL	H80CS001922019	052140	CHC
HENNEPIN CO COMMUNITY HEALTH DEPARTMENT	MINNEAPOLIS	MN	H80CS000282019	051810	HCH
HENNEPIN COUNTY, DEPARTMENT OF PRIMARY CARE	MINNEAPOLIS	MN	H80CS067032019	050080	CHC
HENRY J AUSTIN HEALTH CENTER INC	TRENTON	NJ	H80CS005312019	020070	CHC, HCH
HERALD CHRISTIAN HEALTH CENTER	SAN GABRIEL	CA	H80CS266182019	09E01051	CHC
HERITAGE HEALTH AND HOUSING, INC.	NEW YORK	NY	H80CS112852019	020130	CHC
HI-DESERT MEMORIAL HEALTH CARE DISTRICT	JOSHUA TREE	CA	H80CS266102019	09E01096	CHC
HIDALGO MEDICAL SERVICES	LORDSBURG	NM	H80CS007442019	067230	CHC
HIGH COUNTRY COMMUNITY HEALTH	BOONE	NC	H80CS241422019	04E00489	CHC, MHC
HIGH PLAINS COMMUNITY HEALTH CENTER	LAMAR	CO	H80CS002142019	084100	CHC, MHC
HIGHLAND HEALTH PROVIDERS CORPORATION	HILLSBORO	OH	H80CS336572019	05E01236	CHC
HIGHLAND MEDICAL CENTER, INC.	MONTEREY	VA	H80CS016862019	038580	CHC
HILL COUNTRY COMMUNITY CLINIC	ROUND MOUNTAIN	CA	H80CS042262019	0920440	CHC
HILLTOWN COMMUNITY HEALTH CENTER, INC.	WORTHINGTON	MA	H80CS006012019	010330	CHC
HO'OLA LAHUI HAWAI'I	LIHUE	HI	H80CS008522019	091290	CHC
HOLYOKE HEALTH CENTER, INC.	HOLYOKE	MA	H80CS008032019	010030	CHC
HOPE CHRISTIAN HEALTH CENTER CORP	N LAS VEGAS	NV	H80CS289672019	09E01169	CHC
HOPE FAMILY HEALTH SERVICES	WESTMORELAND	TN	H80CS241092019	04E00473	CHC
HOPEHEALTH, INC.	FLORENCE	SC	H80CS082402019	0452150	CHC

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HOPEWELL HEALTH CENTERS, INC.	CHILLICOTHE	OH	H80CS001932019	052270	CHC
HORIZON HEALTH AND WELLNESS, INC.	APACHE JCT	AZ	H80CS266062019	09E01014	CHC
HORIZON HEALTH CARE, INC.	HOWARD	SD	H80CS001352019	081030	CHC
HORIZON HEALTH CENTER	JERSEY CITY	NJ	H80CS195342019	023480	CHC
HORIZON HEALTH SERVICES, INC.	IVOR	VA	H80CS003522019	032840	CHC
HOSPITAL SERVICE DISTRICT NO. 1-A OF THE PARISH OF RICHLAND	DELHI	LA	H80CS241672019	06E00261	CHC
HOUSING WORKS HEALTH SERVICES III, INC.	BROOKLYN	NY	H80CS261912019	02E01036	CHC, HCH
HOUSTON AREA COMNTY SERVICES, INC.	HOUSTON	TX	H80CS128852019	06E00044	CHC, HCH, PHPC
HOUSTON COMMUNITY HEALTH CENTERS, INC.	HOUSTON	TX	H80CS082312019	0613920	CHC
HOWARD BROWN HEALTH CENTER	CHICAGO	IL	H80CS290042019	05E01170	CHC
HPM FOUNDATION, INC.	SAN JUAN	PR	H80CS006952019	020700	CHC, PHPC
HUDSON HEADWATERS HEALTH NETWORK	QUEENSBURY	NY	H80CS001592019	021790	CHC
HUDSON RIVER HEALTH CARE, INC.	PEEKSKILL	NY	H80CS003132019	021510	CHC, HCH, MHC, PHPC
HURTT FAMILY HEALTH CLINIC	TUSTIN	CA	H80CS128752019	09E00006	CHC, HCH
HYNDMAN AREA HEALTH CENTER, INC.	HYNDMAN	PA	H80CS005322019	032440	CHC
I.M. SULZBACHER CENTER FOR THE HOMELESS	JACKSONVILLE	FL	H80CS003052019	0420630	CHC, HCH
IBERIA COMPREHENSIVE COMMUNITY HEALTH CENTER	NEW IBERIA	LA	H80CS006972019	062350	CHC
ILIULIUK FAMILY AND HEALTH SERVICES, INC.	UNALASKA	AK	H80CS011372019	102040	CHC
IMPERIAL BEACH COMMUNITY CLINIC	IMPERIAL BCH	CA	H80CS066482019	092500	CHC
INDIAN HEALTH BOARD OF MINNEAPOLIS, INC.	MINNEAPOLIS	MN	H80CS004412019	051770	CHC
INDIAN HEALTH CENTER OF SANTA CLARA VALLEY	SAN JOSE	CA	H80CS023252019	0912090	CHC
INDIAN STREAM HEALTH CENTER	COLEBROOK	NH	H80CS066552019	0112200	CHC
INDIANA HEALTH CENTERS, INC.	INDIANAPOLIS	IN	H80CS006682019	053110	CHC, HCH, MHC
INLAND BEHAVIORAL & HEALTH SERVICES, INC.	SN BERNRDNO	CA	H80CS002482019	098620	CHC
INNER CITY MUSLIM ACTION NETWORK	CHICAGO	IL	H80CS336492019	05E01299	CHC

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INNIS COMMUNITY HEALTH CENTER, INC.	INNIS	LA	H80CS008552019	0610680	CHC
INSTITUTUTE FOR POPULATION HEALTH, INC.	DETROIT	MI	H80CS336542019	05E01257	CHC
INTERCARE COMMUNITY HEALTH NETWORK	BANGOR	MI	H80CS007712019	050220	CHC, MHC
INTERIOR COMMUNITY HEALTH CENTER	FAIRBANKS	AK	H80CS007452019	102270	CHC
INTERNATIONAL COMMUNITY HEALTH SERVICES	SEATTLE	WA	H80CS004372019	102530	CHC
IRONTON LAWRENCE COUNTY CAO	IRONTON	OH	H80CS004712019	051660	CHC, HCH
ISABELLA CITIZENS FOR HEALTH, INC.	MT PLEASANT	MI	H80CS283522019	05E00271	CHC
ISLAND HEALTH INC	WEST TISBURY	MA	H80CS266382019	01E00272	CHC
ISLANDS COMMUNITY MEDICAL SERVICES, INC	VINALHAVEN	ME	H80CS066572019	010450	CHC
J.C. LEWIS PRIMARY HEALTH CARE CENTER, INC.	SAVANNAH	GA	H80CS256792019	04E01031	CHC, HCH
JANE PAULEY COMMUNITY HEALTH CENTER, INC.	INDIANAPOLIS	IN	H80CS265662019	05E01099	CHC
JEFFERSON COMMUNITY HEALTH CARE CENTERS, INC.	AVONDALE	LA	H80CS067162019	0623760	CHC
JEFFERSON COMPREHENSIVE CARE SYSTEM	PINE BLUFF	AR	H80CS007272019	060110	CHC, HCH
JEFFERSON COMPREHENSIVE HEALTH CENTER, INC.	FAYETTE	MS	H80CS005822019	048800	CHC
JEFFERSON PARISH HUMAN SERVICES AUTHORITY	METAIRIE	LA	H80CS265812019	06E01062	CHC
JERICHO ROAD MINISTRIES, INC.	BUFFALO	NY	H80CS266302019	02E01074	CHC
JESSIE TRICE COMMUNITY HEALTH SYSTEM, INC	MIAMI	FL	H80CS007322019	040330	CHC
JEWISH RENAISSANCE FOUNDATION INC., THE	PERTH AMBOY	NJ	H80CS290132019	02E00696	HCH
JEWISH RENAISSANCE MEDICAL CENTER	PERTH AMBOY	NJ	H80CS002532019	027000	CHC
JOHNSON HEALTH CENTER	MADISON HTS	VA	H80CS024452019	0310560	CHC
JOSEPH P. ADDABBO FAMILY HEALTH CENTER	ARVERNE	NY	H80CS004302019	022110	CHC
JUNIPER HEALTH, INC.	BEATTYVILLE	KY	H80CS042032019	0438280	CHC
JWCH INSTITUTE, INC.	LOS ANGELES	CA	H80CS066732019	0925360	CHC, HCH
KAGMAN COMMUNITY HEALTH CENTR E, INC	SAIPAN	MP	H80CS316242019	09E01294	CHC
KALIHI-PALAMA HEALTH CENTER	HONOLULU	HI	H80CS008142019	096010	CHC

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KANSAS CITY CARE CLINIC	KANSAS CITY	MO	H80CS289662019	07E01179	CHC
KANSAS STATE DEPT OF HEALTH AND ENVIRONMENT	TOPEKA	KS	H80CS001312019	070090	MHC
KARUK TRIBE OF CALIFORNIA	HAPPY CAMP	CA	H80CS042242019	0921240	CHC
KATAHDIN VALLEY HEALTH CENTER	PATTEN	ME	H80CS004882019	013240	CHC
KEDREN COMMUNITY HEALTH CENTER, INC.	LOS ANGELES	CA	H80CS266192019	09E00280	CHC
KENOSHA COMMUNITY HEALTH CENTER, INC.	KENOSHA	WI	H80CS006622019	057260	CHC
KENTUCKY MOUNTAIN HEALTH ALLIANCE, INC	HAZARD	KY	H80CS077722019	0450640	HCH
KENTUCKY RIVER FOOTHILLS DEVELOPMENT COUNCIL, INC.	RICHMOND	KY	H80CS044322019	0441420	HCH
KEYSTONE RURAL HEALTH CENTER	CHAMBERSBURG	PA	H80CS000762019	032700	CHC, MHC
KEYSTONE RURAL HEALTH CONSORTIA, INC.	EMPORIUM	PA	H80CS006882019	032300	CHC
KIAMICHI FAMILY MEDICAL CENTER, INC.	BROKEN BOW	OK	H80CS002672019	0611930	CHC
KINSTON COMMUNITY HEALTH CENTER, INC.	KINSTON	NC	H80CS001042019	048120	CHC, MHC
KLAMATH HEALTH PARTNERSHIP,INC.	KLAMATH FALLS	OR	H80CS002332019	102910	CHC
KNOX COUNTY HEALTH DEPARTMENT	GALESBURG	IL	H80CS241322019	05E00286	CHC
KNOX, COUNTY OF	MOUNT VERNON	OH	H80CS307162019	05E01246	CHC
KO'OLAULOA COMMUNITY HEALTH AND WELLNESS CENTER, INC.	KAHUKU	HI	H80CS066412019	0925370	CHC
KODIAK AREA NATIVE ASSOCIATION	KODIAK	AK	H80CS265992019	10E00288	CHC
KODIAK ISLAND HEALTH CARE FOUNDATION	KODIAK	AK	H80CS014452019	107930	CHC
KOKUA KALIHI VALLEY COMPREHENSIVE FAMILY SERVICES	HONOLULU	HI	H80CS007762019	093410	CHC, PHPC
KONZA PRAIRIE COMMUNITY HEALTH CENTER	JUNCTION CITY	KS	H80CS002102019	074010	CHC
KOREAN COMMUNITY SERVICES, INC.	BUENA PARK	CA	H80CS336462019	09E01237	CHC
KOREAN HEALTH, EDUCATION, INFORMATION AND RESEARCH CENTER	LOS ANGELES	CA	H80CS266202019	09E01079	CHC
KOSRAE DEPARTMENT OF HEALTH SERVICES	KOSRAE	FM	H80CS283672019	09E01131	CHC
KUUMBA COMM. HLTH & WELLNESS CENTER	ROANOKE	VA	H80CS006082019	037480	CHC
L'REFUAH MEDICAL AND REHABILITATION CENTER	BROOKLYN	NY	H80CS241642019	02E00510	CHC

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LA CASA DE BUENA SALUD, INC.	PORTALES	NM	H80CS004042019	061290	CHC
LA CASA DE SALUD, INC.	BRONX	NY	H80CS266312019	02E00291	CHC, HCH
LA CLINICA DE FAMILIA, INC.	LAS CRUCES	NM	H80CS003162019	063010	CHC, MHC
LA CLINICA DE LA RAZA INC.	OAKLAND	CA	H80CS006312019	091230	CHC
LA CLINICA DE LOS CAMPESINOS, INC. DBA FAMILY HLTH & DENT CTR	WAUTOMA	WI	H80CS007132019	050900	CHC, MHC
LA CLINICA DEL PUEBLO	WASHINGTON	DC	H80CS082442019	036820	CHC
LA CLINICA DEL PUEBLO DE RIO ARRIBA	TIRA AMARILLA	NM	H80CS004032019	060460	CHC
LA CLINICA DEL VALLE FAMILY HEALTH	MEDFORD	OR	H80CS007592019	100790	CHC, HCH, MHC, PHPC
LA CLINICA TEPEYAC INC	DENVER	CO	H80CS289982019	08E01215	CHC
LA COMUNIDAD HISPANA	KENNETT SQ	PA	H80CS241482019	03E00495	CHC, MHC
LA ESPERANZA CLINIC, INC.	SAN ANGELO	TX	H80CS002032019	066570	CHC
LA FAMILIA MEDICAL CENTER	SANTA FE	NM	H80CS006062019	063920	CHC, HCH
LA MAESTRA FAMILY CLINIC, INC.	SAN DIEGO	CA	H80CS008122019	095440	CHC, HCH, PHPC
LA RED HEALTH CENTER, INC.	GEORGETOWN	DE	H80CS066512019	0314560	CHC, HCH
LAKE SUPERIOR COMMUNITY HEALTH CENTER	DULUTH	MN	H80CS008112019	0510280	CHC
LAKESHORE COMMUNITY HEALTH CARE, INC.	SHEBOYGAN	WI	H80CS241522019	05E00499	CHC
LAKEWOOD RESOURCE AND REFERRAL CENTER, INC.	LAKEWOOD	NJ	H80CS128682019	02E00026	CHC
LAMPREY HEALTH CARE	NEWMARKET	NH	H80CS006402019	011580	CHC
LANA'I COMMUNITY HEALTH CENTER	LANAI CITY	HI	H80CS087752019	0931570	CHC
LANCASTER HEALTH CENTER	LANCASTER	PA	H80CS006862019	033620	CHC
LANE COUNTY	EUGENE	OR	H80CS014432019	107920	CHC, HCH, MHC
LAPINE COMMUNITY HEALTH CENTER	LA PINE	OR	H80CS114622019	1018560	CHC
LAS CLINICAS DEL NORTE, INC.	EL RITO	NM	H80CS006072019	060310	CHC
LATINO KIDS HEALTH	MONTEBELLO	CA	H80CS289892019	09E01180	CHC
LAWNDALE CHRISTIAN HEALTH CENTER	CHICAGO	IL	H80CS007252019	056420	CHC, HCH

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LEE COUNTY COOPERATIVE CLINIC, INC.	MARIANNA	AR	H80CS001222019	060060	CHC
LEGACY COMMUNITY HEALTH SERVICES, INC.	HOUSTON	TX	H80CS075022019	0625340	CHC
LEWIS COUNTY COMMUNITY HEALTH SERVICES, INC. D/B/A VALLEY VIEW HEALTH CENTER	CHEHALIS	WA	H80CS042052019	1011760	CHC
LEWIS COUNTY PRIMARY CARE CENTER	VANCEBURG	KY	H80CS001062019	048980	CHC
LIFECARE FAMILY HEALTH AND DENTAL CENTER, INC	CANTON	OH	H80CS066542019	0530860	CHC
LIFELONG MEDICAL CARE	BERKELEY	CA	H80CS008082019	092880	CHC, PHPC
LIFESPRING INC.	JEFFERSONVLLE	IN	H80CS283532019	05E01139	CHC, HCH
LINCOLN COMMUNITY HEALTH CENTER, INC	DURHAM	NC	H80CS004772019	040910	CHC, HCH
LINCOLN COUNTY COMMUNITY HEALTH CENTER DBA NORTHWEST COMMUNITY HEALTH CENTER	LIBBY	MT	H80CS008052019	088300	CHC
LINCOLN COUNTY HEALTH AND HUMAN SERVICES	NEWPORT	OR	H80CS066392019	1014200	CHC
LINCOLN COUNTY PRIMARY CARE CENTER	HAMLIN	WV	H80CS002542019	030850	CHC
LITTLE RIVER MEDICAL CENTER, INC.	LITTLE RIVER	SC	H80CS007002019	047060	CHC, HCH, MHC
LITTLE RIVERS HEALTH CARE, INC	BRADFORD	VT	H80CS066582019	0112220	CHC
LIVINGSTON COMMUNITY HEALTH	LIVINGSTON	CA	H80CS025882019	0919630	CHC, MHC
LONE STAR CIRCLE OF CARE	GEORGETOWN	TX	H80CS042892019	0619490	CHC
LONE STAR COMMUNITY HEALTH CENTER, INC.	CONROE	TX	H80CS024512019	0614320	CHC
LONG VALLEY HEALTH CENTER, INC.	LAYTONVILLE	CA	H80CS005242019	091650	CHC
LONGVIEW WELLNESS CENTER	LONGVIEW	TX	H80CS082172019	0627010	CHC
LORAIN COUNTY HEALTH & DENTISTRY	LORAIN	OH	H80CS128882019	05E00030	CHC, PHPC
LOS ANGELES CHRISTIAN HEALTH CENTERS	LOS ANGELES	CA	H80CS066742019	0921430	HCH, PHPC
LOS ANGELES LGBT CENTER	LOS ANGELES	CA	H80CS266212019	09E01087	CHC
LOS BARRIOS UNIDOS COMMUNITY CLINIC	DALLAS	TX	H80CS005052019	060680	CHC
LOUDOUN COMMUNITY HEALTH CENTER	LEESBURG	VA	H80CS128622019	03E00050	CHC
LOW COUNTRY HEALTH CARE SYSTEM, INC.	FAIRFAX	SC	H80CS000922019	0416080	CHC
LOWELL COMMUNITY HEALTH CENTER	LOWELL	MA	H80CS003972019	011460	CHC

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LOWER LIGHT CHRISTIAN HEALTH CENTER, INC	COLUMBUS	OH	H80CS128862019	05E00033	CHC
LUTHERAN SOCIAL SERVICES OF CENTRAL OHIO	WORTHINGTON	OH	H80CS307172019	05E01251	HCH
LYNN COMMUNITY HEALTH CENTER, INC.	LYNN	MA	H80CS006242019	011430	CHC
MA LEAGUE OF COMUNITY HEALTH CENTERS	BOSTON	MA	H80CS001522019	011450	MHC
MACOUPIN COUNTY PUBLIC HEALTH DEPARTMENT	CARLINVILLE	IL	H80CS226902019	05E00106	CHC, PHPC
MAINE MOBILE HEALTH PROGRAM INC.	AUGUSTA	ME	H80CS004432019	010040	MHC
MAINLINE HEALTH SYSTEMS, INC.	PORTLAND	AR	H80CS006382019	062730	CHC
MANCHESTER COMMUNITY HEALTH CENTER DBA AMOSKEAG HEALTH	MANCHESTER	NH	H80CS005712019	010760	CHC
MANET COMMUNITY HEALTH CENTER, INC.	NORTH QUINCY	MA	H80CS004532019	011640	CHC
MANILLAQ ASSOCIATION	KOTZEBUE	AK	H80CS011272019	100800	CHC
MANTACHIE RURAL HEALTH CARE, INC.	MANTACHIE	MS	H80CS000962019	043920	CHC
MAPLE CITY HEALTH CARE CENTER	GOSHEN	IN	H80CS241332019	05E00303	CHC
MARANA HEALTH CENTER	MARANA	AZ	H80CS002312019	090080	CHC
MARIAS HEALTHCARE SERVICES INC	SHELBY	MT	H80CS290122019	08E01199	CHC
MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT	PHOENIX	AZ	H80CS336442019	09E00911	CHC
MARILLAC CLINIC, INC.	GRAND JCT	CO	H80CS283562019	08E01132	CHC
MARILLAC COMMUNITY HEALTH CENTERS	NEW ORLEANS	LA	H80CS241982019	06E00523	CHC, PHPC
MARIN CITY HEALTH & WELLNESS CENTER	SAUSALITO	CA	H80CS226892019	09E00105	CHC, HCH, PHPC
MARIN COMMUNITY CLINIC	NOVATO	CA	H80CS003432019	095380	CHC
MARIPOSA COMMUNITY HEALTH CENTER, INC	NOGALES	AZ	H80CS007522019	090090	CHC
MARTIN LUTHER KING, JR. FAMILY CLINIC, INC.	DALLAS	TX	H80CS001272019	061010	CHC
MARTINSVILLE HENRY COUNTY COALITION FOR HEALTH AND WELLNESS	MARTINSVILLE	VA	H80CS087492019	0322430	CHC
MARY'S CENTER FOR MATERNAL & CHILD CARE INC	WASHINGTON	DC	H80CS042022019	037030	CHC
MAT-SU HEALTH SERVICES, INC.	WASILLA	AK	H80CS044352019	1012890	CHC
MATAGORDA EPISCOPAL HEALTH OUTREACH PROGRAM	BAY CITY	TX	H80CS128892019	06E00042	CHC

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MATTAPAN COMMUNITY HEALTH CENTER	BOSTON	MA	H80CS003952019	012010	CHC
MATTAWA COMMUNITY MEDICAL CLINIC	MATTAWA	WA	H80CS290302019	10E01221	CHC
MATTHEW WALKER HEALTH CENTER	NASHVILLE	TN	H80CS007102019	041420	CHC
MAURY REGIONAL HOSPITAL	COLUMBIA	TN	H80CS265982019	04E01085	CHC
MCCLOUD HEALTHCARE CLINIC, INC	MCCLOUD	CA	H80CS241122019	09E00476	CHC
MCKINNEY MEDICAL CENTER, INC.	WAYCROSS	GA	H80CS005062019	048080	CHC
MCR HEALTH, INC.	PALMETTO	FL	H80CS000972019	044310	CHC, MHC
MED CENTRO, INC.	PONCE	PR	H80CS000632019	020680	CHC, HCH, MHC, PHPC
MEDICAL RESOURCE CENTER FOR RANDOLPH COUNTY, INC	ASHEBORO	NC	H80CS087872019	0452910	CHC
MEDINA, COUNTY OF	MEDINA	OH	H80CS336582019	05E01314	CHC
MEDLINK GEORGIA, INC.	COLBERT	GA	H80CS004272019	040390	CHC
MEMPHIS HEALTH CENTER	MEMPHIS	TN	H80CS007802019	041410	CHC, HCH
MENDOCINO COAST CLINICS, INC.	FORT BRAGG	CA	H80CS008762019	0910250	CHC
MENDOCINO COMMUNITY HEALTH CLINIC, INC.	UKIAH	CA	H80CS006282019	091940	CHC, HCH, MHC
MERCY HEALTH SERVICES, INC.	FRANKLIN	TN	H80CS241492019	04E00496	CHC
MERIDIAN EDUCATION RESOURCE GROUP, INC	ATLANTA	GA	H80CS008842019	0429000	CHC
MERIDIAN HEALTH SERVICES CORP	MUNCIE	IN	H80CS265672019	05E01058	CHC
METRO COMMUNITY PROVIDER NETWORK	ENGLEWOOD	CO	H80CS002172019	080730	CHC, HCH
METROPOLITAN COMMUNITY HEALTH SERVICES, INC.	WASHINGTON	NC	H80CS008642019	0428200	CHC
METROPOLITAN FAMILY HEALTH NETWORK, INC	JERSEY CITY	NJ	H80CS075882019	0217710	CHC, HCH
MGH FAMILY HC DBA MUSKEGON FAMILY CARE	MUSKEGON	MI	H80CS008652019	0516820	CHC
MIAMI BEACH COMMUNITY HEALTH CENTER	MIAMI BEACH	FL	H80CS001822019	044130	CHC
MID-DELTA HEALTH SYSTEMS, INC.	CLARENDON	AR	H80CS171472019	062090	CHC
MID-STATE HEALTH CENTER	PLYMOUTH	NH	H80CS266402019	01E01077	CHC
MIDLAND COMMUNITY HEALTHCARE SERVICES	MIDLAND	TX	H80CS064552019	0622480	CHC

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MIDMICHIGAN HEALTH SERVICES	HOUGHTON LAKE	MI	H80CS001902019	050290	CHC
MIDTOWN COMMUNITY HEALTH CENTER	OGDEN	UT	H80CS008312019	083800	CHC, HCH
MIDTOWN HEALTH CENTER, INC.	NORFOLK	NE	H80CS105902019	07E00059	CHC
MIGRANT HEALTH CENTER, WESTERN REGION, INC	MAYAGUEZ	PR	H80CS006202019	021040	CHC, HCH, MHC
MILWAUKEE HEALTH SERVICES, INC.	MILWAUKEE	WI	H80CS008262019	052090	CHC
MINISTRY OF HEALTH AND ENVIRONMENT	EBEYE	MH	H80CS024722019	093570	CHC
MINNIE HAMILTON HEALTH CARE CENTER, INC.	GRANTSVILLE	WV	H80CS007612019	034190	CHC
MISSION AREA HEALTH ASSOCIATES DBA MISSION NEIGHBORHOOD HEALTH CENTER	SAN FRANCISCO	CA	H80CS005902019	090660	CHC
MISSION CITY COMMUNITY NETWORK, INC.	NORTH HILLS	CA	H80CS082412019	0929830	CHC
MISSION EAST DALLAS	DALLAS	TX	H80CS241542019	06E00500	CHC
MISSOULA CITY/COUNTY HEALTH DEPT/PARTNERSHIP HC	MISSOULA	MT	H80CS005282019	083430	CHC, HCH
MOBILE COUNTY HEALTH DEPARTMENT	MOBILE	AL	H80CS003182019	047080	CHC, MHC, PHPC
MOBILE MEDICAL CARE INC	BETHESDA	MD	H80CS290082019	03E00324	CHC
MOLOKAI OHANA HEALTH CARE, INC	KAUNAKAKAI	HI	H80CS024492019	0912120	CHC
MONMOUTH FAMILY HEALTH CENTER	LONG BRANCH	NJ	H80CS128552019	02E00027	CHC
MONONGAHELA VALLEY ASSOCIATION OF	FAIRMONT	WV	H80CS003832019	030820	CHC
MONROE COUNTY HEALTH CENTER	UNION	WV	H80CS003842019	030990	CHC
MONTANA MIGRANT COUNCIL, INC.	BILLINGS	MT	H80CS007042019	082160	MHC
MONTEFIORE MEDICAL CENTER	BRONX	NY	H80CS000112019	020800	HCH, PHPC
MONTEREY, COUNTY OF	SALINAS	CA	H80CS337952019	092640	CHC
MORA VALLEY COMMUNITY HEALTH SERVICES, INC.	MORA	NM	H80CS002962019	060300	CHC
MOREHOUSE COMMUNITY MEDICAL CENTERS, INC	BASTROP	LA	H80CS087642019	0627740	CHC
MORGAN COUNTY HEALTH COUNCIL, INC.	WARTBURG	TN	H80CS001832019	041290	CHC
MOROVIS COMMUNITY HEALTH CENTER, INC.	MOROVIS	PR	H80CS003822019	022230	CHC
MORRIS HEIGHTS HEALTH CENTER	BRONX	NY	H80CS004722019	021610	CHC

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MORTON COMPREHENSIVE HEALTH SERVICES	TULSA	OK	H80CS004402019	063890	CHC, HCH
MOSAIC MEDICAL	PRINEVILLE	OR	H80CS002702019	105600	CHC, MHC
MOSES LAKE COMMUNITY HEALTH CENTER	MOSES LAKE	WA	H80CS007022019	101000	CHC, MHC
MOUNT VERNON NEIGHBORHOOD HEALTH CENTER	MOUNT VERNON	NY	H80CS001612019	021500	CHC, HCH
MOUNTAIN COMPREHENSIVE CARE CENTER, INC.	PRESTONSBURG	KY	H80CS246922019	04E00527	HCH
MOUNTAIN COMPREHENSIVE HEALTH CORP.	WHITESBURG	KY	H80CS003672019	040600	CHC
MOUNTAIN FAMILY HEALTH CENTER	GLENWOOD SPGS	CO	H80CS008302019	081260	CHC
MOUNTAIN HEALTH & COMMUNITY SERVICES, INC.	CAMPO	CA	H80CS002842019	091520	CHC
MOUNTAIN PARK HEALTH CENTER	PHOENIX	AZ	H80CS001412019	093070	CHC
MOUNTAIN PEOPLE'S HEALTH COUNCILS, INC.	HUNTSVILLE	TN	H80CS004672019	041440	CHC
MOUNTAIN VALLEYS HEALTH CENTERS, INC	BIEBER	CA	H80CS002602019	091750	CHC
MOUNTAINEER COMMUNITY HEALTH CENTER INC	PAW PAW	WV	H80CS336632019	03E00927	CHC
MOUNTAINLANDS COMMUNITY HEALTH CENTER	PROVO	UT	H80CS002132019	083950	CHC, HCH
MQVN COMMUNITY DEVELOPMENT CORP	NEW ORLEANS	LA	H80CS265822019	06E01066	CHC, MHC
MT. ENTERPRISE COMMUNITY HEALTH CENTER	MT ENTERPRISE	TX	H80CS128562019	06E00046	CHC, MHC
MULTNOMAH COUNTY	PORTLAND	OR	H80CS001492019	101120	CHC, HCH
MUNICIPALITY OF SAN JUAN	SAN JUAN	PR	H80CS000082019	020690	HCH
MUNICIPALITY OF SKAGWAY	SKAGWAY	AK	H80CS082322019	1017080	CHC
MUSKINGUM VALLEY HEALTH CENTERS, INC.	ZANESVILLE	OH	H80CS087832019	0537630	CHC
MY COMMUNITY HEALTH CENTER	CANTON	OH	H80CS336592019	05E01317	CHC
MYCARE HEATLH CENTER	MOUNT CLEMENS	MI	H80CS265722019	05E01101	CHC
N. A. T. I. V. E. PROJECT, THE	SPOKANE	WA	H80CS266032019	10E01053	CHC, HCH
N.E.W. COMUNITY CLINIC	GREEN BAY	WI	H80CS000352019	056360	CHC, HCH
NATIVE AMERICAN COMMUNITY CLINIC	MINNEAPOLIS	MN	H80CS066612019	0530890	CHC
NATIVE AMERICAN COMMUNITY HEALTH CENTER, INC.	PHOENIX	AZ	H80CS128452019	09E00002	CHC

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NATIVE AMERICAN REHABILITATION ASSOCIATION OF THE NORTHWEST	PORTLAND	OR	H80CS015882019	107880	CHC, HCH
NATIVE VILLAGE OF EYAK	CORDOVA	AK	H80CS044342019	1012860	CHC
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES	RALEIGH	NC	H80CS003152019	044030	MHC
NE WASHINGTON CTY CMTY HEALTH, INC. DBA THE HEALTH CENTER	PLAINFIELD	VT	H80CS082302019	011440	CHC
NEAR NORTH HEALTH SERVICE CORPORATION	CHICAGO	IL	H80CS001942019	053280	CHC
NEIGHBORCARE HEALTH	SEATTLE	WA	H80CS008292019	100640	CHC, PHPC
NEIGHBORHOOD HEALTH	ALEXANDRIA	VA	H80CS024462019	0310600	CHC
NEIGHBORHOOD HEALTH ASSOCIATION OF TOLEDO, INC.	TOLEDO	OH	H80CS001102019	051780	CHC, HCH, PHPC
NEIGHBORHOOD HEALTH CARE INCORPORATED	CLEVELAND	OH	H80CS006652019	050920	CHC
NEIGHBORHOOD HEALTH CENTER	PORTLAND	OR	H80CS241602019	10E00506	CHC, MHC
NEIGHBORHOOD HEALTH CENTERS OF THE LEHIGH VALLEY	ALLENTOWN	PA	H80CS241582019	03E00504	CHC
NEIGHBORHOOD HEALTH CLINICS, INC.	FORT WAYNE	IN	H80CS005482019	058480	CHC
NEIGHBORHOOD HEALTH SERVICE INC	TALLAHASSEE	FL	H80CS268032019	04E00336	CHC, HCH, PHPC
NEIGHBORHOOD HEALTH SERVICES CORPORATION, INC.	PLAINFIELD	NJ	H80CS006452019	021230	CHC
NEIGHBORHOOD HEALTHCARE	ESCONDIDO	CA	H80CS002852019	093540	CHC
NEIGHBORHOOD HEALTHSOURCE	MINNEAPOLIS	MN	H80CS005162019	056750	CHC
NEIGHBORHOOD IMPROVEMENT PROJECT, INC.	AUGUSTA	GA	H80CS087512019	0438590	CHC
NEIGHBORHOOD OUTREACH ACCESS TO HEALTH	SCOTTSDALE	AZ	H80CS266042019	09E01078	CHC
NEOMED CENTER INC	GURABO	PR	H80CS006562019	022030	CHC, PHPC
NEVADA HEALTH CENTERS, INC.	CARSON CITY	NV	H80CS008182019	091570	CHC, HCH
NEW ENGLAND HOSPITAL DBA DIMOCK CHC	ROXBURY	MA	H80CS001512019	011280	CHC
NEW HANOVER CHC	WILMINGTON	NC	H80CS005722019	045240	CHC, HCH
NEW HEALTH PROGRAMS ASSOCIATION	CHEWELAH	WA	H80CS004932019	100360	CHC
NEW HORIZON FAMILY HEALTH SERVICES, INC.	GREENVILLE	SC	H80CS005782019	042610	CHC, HCH
NEW ORLEANS AIDS TASK FORCE	NEW ORLEANS	LA	H80CS265832019	06E00338	CHC

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NEW ORLEANS HEALTH DEPARTMENT	NEW ORLEANS	LA	H80CS000372019	061550	HCH
NEW RIVER HEALTH ASSOCIATION, INC.	SCARBRO	WV	H80CS000752019	032600	CHC
NEW YORK CITY HEALTH AND HOSPITALS CORPORATION	NEW YORK	NY	H80CS290182019	02E00868	CHC, PHPC
NEWARK COMMUNITY HEALTH CENTERS, INC.	NEWARK	NJ	H80CS000622019	020500	CHC
NHAN HOA COMPREHENSIVE HEALTH CARE CLINIC, INC.	GARDEN GROVE	CA	H80CS266222019	09E01092	CHC
NORTH BROWARD HOSPITAL DISTRICT	FT LAUDERDALE	FL	H80CS000192019	0412940	HCH
NORTH CENTRAL TEXAS COMMUNITY HLTH CARE	WICHITA FALLS	TX	H80CS005532019	063740	CHC, PHPC
NORTH COUNTRY FAMILY HEALTH CENTER, INC.	WATERTOWN	NY	H80CS241652019	02E00340	CHC, HCH
NORTH COUNTRY HEALTHCARE, INC.	FLAGSTAFF	AZ	H80CS006512019	092890	CHC
NORTH COUNTY HEALTH PROJECT, INC.	SAN MARCOS	CA	H80CS002282019	090720	CHC, MHC
NORTH CUSTER HOSPITAL DIS	CHALLIS	ID	H80CS290032019	10E01181	CHC
NORTH EAST MEDICAL SERVICES	SAN FRANCISCO	CA	H80CS002212019	090670	CHC
NORTH END COMMUNITY HLTH COMMITTEE, INC.	BOSTON	MA	H80CS004992019	010160	CHC, PHPC
NORTH FLORIDA MEDICAL CENTERS, INC.	TALLAHASSEE	FL	H80CS006932019	040380	CHC
NORTH GEORGIA HEALTHCARE CENTER, INC.	RINGGOLD	GA	H80CS289582019	04E00341	CHC
NORTH HUDSON COMMUNITY ACTION CORPORATION	UNION CITY	NJ	H80CS005212019	024490	CHC
NORTH MISSISSIPPI PRIMARY HEALTH CARE, INC.	ASHLAND	MS	H80CS006352019	049100	CHC
NORTH OLYMPIC HEALTHCARE NETWORK PC	PORT ANGELES	WA	H80CS283572019	10E01153	CHC
NORTH ORANGE COUNTY REGIONAL HEALTH FOUNDATION	FULLERTON	CA	H80CS336472019	09E00942	CHC
NORTH PENN COMPREHENSIVE HEALTH SERVICES, INC	WELLSBORO	PA	H80CS006822019	031220	CHC
NORTH SHORE COMMUNITY HEALTH, INC.	SALEM	MA	H80CS004942019	010860	CHC
NORTH SIDE CHRISTIAN HEALTH CENTER	PITTSBURGH	PA	H80CS128812019	03E00038	CHC, HCH, PHPC
NORTH TEXAS AREA COMMUNITY HEALTH CENTER, INC.	FORT WORTH	TX	H80CS064572019	0622450	CHC
NORTHEAST ALABAMA HEALTH SERVICES, INC.	SCOTTSBORO	AL	H80CS007602019	045710	CHC
NORTHEAST COMMUNITY CLINIC, INC	ALHAMBRA	CA	H80CS128692019	09E00004	CHC

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NORTHEAST FLORIDA HEALTH SERVICES, INC.	PIERSON	FL	H80CS025202019	0423770	CHC
NORTHEAST MISSISSIPPI HEALTH CARE, INC.	BYHALIA	MS	H80CS004322019	043060	CHC
NORTHEAST MISSOURI HEALTH COUNCIL, INC.	KIRKSVILLE	MO	H80CS007312019	070300	CHC
NORTHEAST OHIO NEIGHBORHOOD HLTH. SVCS.	CLEVELAND	OH	H80CS001912019	050580	CHC
NORTHEAST VALLEY HEALTH CORPORATION	SAN FERNANDO	CA	H80CS001392019	091000	CHC, HCH
NORTHEASTERN OKLAHOMA COMMUNITY HEALTH CENTER	HULBERT	OK	H80CS008482019	0612740	CHC
NORTHEASTERN RURAL HEALTH CLINICS, INC.	SUSANVILLE	CA	H80CS007092019	091960	CHC
NORTHERN COUNTIES HEALTH CARE, INC.	ST JOHNSBURY	VT	H80CS006322019	010640	CHC
NORTHERN NEVADA HIV OUTPATIENT PROGRAM, EDUCATION AND SERVICES	RENO	NV	H80CS266052019	09E00345	CHC, HCH
NORTHERN OSWEGO COUNTY HEALTH SERVICES, INC.	PULASKI	NY	H80CS001662019	020870	CHC
NORTHLAND HEALTH PARTNERS COMMUNITY HEALTH CENTER	TURTLE LAKE	ND	H80CS008472019	0810710	CHC
NORTHSHORE HEALTH CENTERS, INC.	PORTAGE	IN	H80CS024582019	0518280	CHC
NORTHWEST BUFFALO COMMUNITY HEALTH CARE CENTER, INC.	BUFFALO	NY	H80CS001712019	020010	CHC, HCH
NORTHWEST COLORADO VISITING NURSE ASSOCIATION, INC.	CRAIG	CO	H80CS106102019	08E00068	CHC
NORTHWEST COMMUNITY HEALTH CARE	PASCOAG	RI	H80CS003082019	010480	CHC
NORTHWEST HEALTH SERVICES, INC.	SAINT JOSEPH	MO	H80CS006712019	072130	CHC, HCH
NORTHWEST HUMAN SERVICES, INC	SALEM	OR	H80CS001482019	100760	CHC, HCH
NORTHWEST MICHIGAN HEALTH SERVICES, INC.	TRAVERSE CITY	MI	H80CS006692019	050390	CHC, MHC
NORTON SOUND HEALTH CORPORATION	NOME	AK	H80CS011302019	100070	CHC
NORWALK COMMUNITY HEALTH CENTER, INC.	NORWALK	CT	H80CS128442019	01E00011	CHC, HCH, PHPC
NUESTRA CLINICA DEL VALLE, INC.	PHARR	TX	H80CS002092019	060750	CHC, MHC
OAK ORCHARD COMMUNITY HEALTH CENTER, INC.	BROCKPORT	NY	H80CS001702019	020180	CHC, MHC
OAKHURST MEDICAL CENTERS, INC.	STONE MOUNTAIN	GA	H80CS001792019	046900	CHC
OAKLAND INTEGRATED HEALTHCARE NETWORK	PONTIAC	MI	H80CS283542019	05E01147	CHC, HCH
OCEAN HEALTH INITIATIVES, INC.	LAKEWOOD	NJ	H80CS066562019	0216220	CHC

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OCOEE REGIONAL HEALTH CORPORATION	BENTON	TN	H80CS007622019	041230	CHC
OCRACOKE HEALTH CENTER INC	OCRACOKE	NC	H80CS265962019	04E00350	CHC, MHC
ODYSSEY HOUSE LOUISIANA, INC.	NEW ORLEANS	LA	H80CS283622019	06E01137	CHC, HCH
OHIO HILLS HEALTH SERVICES	BARNESVILLE	OH	H80CS008162019	050560	CHC
OHIO NORTH EAST HEALTH SYSTEMS, INC.	YOUNGSTOWN	OH	H80CS001962019	056440	CHC
OHIO STATE UNIVERSITY, THE	COLUMBUS	OH	H80CS336602019	05E01269	CHC
OLATHE COMMUNITY CLINIC, INC.	OLATHE	CO	H80CS241762019	08E00518	CHC, MHC
OLE HEALTH	NAPA	CA	H80CS042192019	092420	CHC, MHC
OMNI FAMILY HEALTH	BAKERSFIELD	CA	H80CS006152019	091600	CHC, MHC
ONE COMMUNITY HEALTH LA CLINICA DEL CARINO FAMILY HEALTH	HOOD RIVER	OR	H80CS004262019	102080	CHC, MHC
ONE WORLD COMMUNITY HEALTH CENTERS	OMAHA	NE	H80CS007372019	076290	CHC
OPEN CITIES HEALTH CENTER	SAINT PAUL	MN	H80CS001122019	052730	CHC
OPEN DOOR COMMUNITY HEALTH CENTERS	ARCATA	CA	H80CS002252019	091540	CHC, HCH
OPEN DOOR FAMILY MEDICAL CENTER, INC.	OSSINING	NY	H80CS001602019	021520	CHC
OPEN DOOR HEALTH CENTER	MANKATO	MN	H80CS128842019	05E00022	CHC
OPEN DOOR HEALTH SERVICES, INC.	MUNCIE	IN	H80CS003402019	0510700	CHC
OPERATION SAMAHAN, INC.	NATIONAL CITY	CA	H80CS266232019	09E00352	CHC, HCH, MHC, PHPC
OPPORTUNITIES INDUSTRIALIZATION CENTER, INC.	ROCKY MOUNT	NC	H80CS241622019	04E00508	CHC, HCH, PHPC
OPPORTUNITY DEVELOPMENT ASSOCIATION, ODA PRIMARY CARE HEALTH CENTER	BROOKLYN	NY	H80CS000642019	021210	CHC
OPTIMUS HEALTH CARE, INC.	BRIDGEPORT	CT	H80CS003772019	011270	CHC, HCH
OREGON HEALTH AND SCIENCE UNIVERSITY	PORTLAND	OR	H80CS241612019	10E00507	CHC
OSBORN FAMILY HEALTH CENTER, INC., THE	CAMDEN	NJ	H80CS336552019	02E01282	CHC
OUT-PATIENT MEDICAL CENTER	NATCHITOCHES	LA	H80CS005132019	060190	CHC
OUTER CAPE HEALTH SERVICES, INC.	WELLFLEET	MA	H80CS004682019	011190	CHC
OUTREACH COMMUNITY HEALTH CENTERS, INC.	MILWAUKEE	WI	H80CS000342019	051920	CHC, HCH

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OUTREACH HEALTH SERVICES, INC.	SHUBUTA	MS	H80CS007752019	048870	CHC
OUTSIDE IN	PORTLAND	OR	H80CS002432019	106290	CHC, HCH
OWENSVILLE PRIMARY CARE INC DBA BAY COMMUNITY HEALTH	WEST RIVER	MD	H80CS266332019	03E01049	CHC
OZARK TRI-COUNTY HEALTH CARE CONSORTIUM DBA ACCESS FAMILY CARE	NEOSHO	MO	H80CS006732019	074490	CHC
OZARKS RESOURCE GROUP	HERMITAGE	MO	H80CS241372019	07E00486	CHC
PACKARD HEALTH, INC.	ANN ARBOR	MI	H80CS290112019	05E01203	CHC, HCH
PAIUTE INDIAN TRIBE OF UTAH, THE	CEDAR CITY	UT	H80CS265152019	08E01040	CHC
PALMETTO HEALTH COUNCIL, INC.	ATLANTA	GA	H80CS004602019	045260	CHC
PANCARE OF FLORIDA, INC. D.B.A. CHC-BAY COUNTY	PANAMA CITY	FL	H80CS064522019	0442450	CHC, MHC
PANHANDLE COUNSELING AND HEALTH CENTER, INC.	GUYMON	OK	H80CS289712019	06E01205	CHC
PARK DUVALLE COMMUNITY HEALTH CENTER, INC.	LOUISVILLE	KY	H80CS000832019	040650	CHC
PARKWEST HEALTH SYSTEMS, INC.	BALTIMORE	MD	H80CS000672019	030130	CHC
PARTNERSHIP COMMUNITY HEALTH CENTER, INC.	MENASHA	WI	H80CS041972019	0526690	CHC, HCH
PASADENA HEALTH CENTER	PASADENA	TX	H80CS064492019	0622440	CHC
PATERSON COMMUNITY HEALTH CENTER, INC.	PATERSON	NJ	H80CS001632019	021300	CHC
PATILLAS COMMUNITY GOVERNING BOARD	PATILLAS	PR	H80CS007472019	020890	CHC, MHC, PHPC
PCC COMMUNITY WELLNESS CENTER	OAK PARK	IL	H80CS002762019	057440	CHC
PEACH TREE HEALTHCARE	MARYSVILLE	CA	H80CS066292019	097180	CHC
PEAK VISTA COMMUNITY HEALTH CENTERS	COLORADO SPGS	CO	H80CS002122019	081460	CHC, HCH
PENDLETON COMMUNITY CARE	FRANKLIN	WV	H80CS003372019	031040	CHC
PENINSULA COMMUNITY HEALTH SERVICES	BREMERTON	WA	H80CS006772019	101540	CHC
PENINSULA COMMUNITY HEALTH SERVICES OF ALASKA, INC.	SOLDOTNA	AK	H80CS011392019	107170	CHC
PENINSULA INSTITUTE FOR COMMUNITY HEALTH	NEWPORT NEWS	VA	H80CS000732019	032240	CHC, HCH
PENNYROYAL HEALTHCARE SERVICE INC.	HOPKINSVILLE	KY	H80CS265952019	04E01090	CHC
PENOBSCOT COMMUNITY HEALTH CENTER, INC.	BANGOR	ME	H80CS042912019	014580	CHC

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PEOPLE'S COMMUNITY CLINIC	AUSTIN	TX	H80CS241502019	06E00497	CHC
PEOPLE'S COMMUNITY HEALTH CLINIC, INC.	WATERLOO	IA	H80CS008152019	071410	CHC, HCH
PERRY COUNTY MEDICAL CENTER, INC.	LINDEN	TN	H80CS003462019	041370	CHC
PERSON FAMILY MEDICAL CENTER, INC.	ROXBORO	NC	H80CS004832019	046800	CHC
PETALUMA HEALTH CENTER, INC.	PETALUMA	CA	H80CS005872019	097880	CHC
PHILADELPHIA FIGHT	PHILADELPHIA	PA	H80CS266342019	03E01047	CHC
PHILADELPHIA, CITY OF	PHILADELPHIA	PA	H80CS290242019	03E00360	CHC
PIEDMONT ACCESS TO HEALTH SERVICES (PATHS)	DANVILLE	VA	H80CS039722019	0315250	CHC
PIEDMONT HEALTH SERVICES, INC.	CARRBORO	NC	H80CS000862019	040890	CHC, HCH
PILLARS COMMUNITY HEALTH	LA GRANGE	IL	H80CS241312019	05E00482	CHC, HCH
PINELLAS COUNTY BOARD OF COUNTY COMMISSIONERS	CLEARWATER	FL	H80CS000242019	042040	HCH
PINES HEALTH SERVICES	CARIBOU	ME	H80CS087692019	0115570	CHC
PLAN DE SALUD DEL VALLE, INC.	FORT LUPTON	CO	H80CS008012019	080130	CHC, MHC
PLAQUEMINES PARISH HOSPITAL SERVICE DISTRICT NUMBER ONE	PORT SULPHUR	LA	H80CS336392019	06E01370	CHC
POHNPEI COMMUNITY HEALTH CENTER	POHNPEI	FM	H80CS043022019	091920	CHC
POMONA COMMUNITY HEALTH CENTER DBA PARKTREE CHC	POMONA	CA	H80CS266242019	09E01080	CHC
PORTER STARKE SERVICES INC	VALPARAISO	IN	H80CS290052019	05E01186	CHC, HCH
PORTLAND COMMUNITY HEALTH CENTER	PORTLAND	ME	H80CS256802019	01E01028	CHC, HCH
PORTSMOUTH COMMUNITY HEALTH CENTER, INC	PORTSMOUTH	VA	H80CS007292019	034100	CHC, HCH, PHPC
POWELL HEALTH CARE COALITION	POWELL	WY	H80CS283582019	08E01156	CHC
PRAIRIESTAR HEALTH CENTER, INC.	HUTCHINSON	KS	H80CS082392019	0717410	CHC
PREFERRED FAMILY HEALTHCARE INC	KIRKSVILLE	MO	H80CS265122019	07E01041	CHC, PHPC
PREMIER COMMUNITY HEALTHCARE GROUP, INC.	DADE CITY	FL	H80CS001012019	045500	CHC, MHC
PRESBYTERIAN MEDICAL SERVICES	SANTA FE	NM	H80CS002052019	063450	CHC, HCH, PHPC
PRESIDIO COUNTY HEALTH SERVICES, INC.	MARFA	TX	H80CS082352019	0627260	CHC, MHC

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PRESTON-TAYLOR COMMUNITY HEALTH CENTERS, INC.	GRAFTON	WV	H80CS006172019	030890	CHC
PRIMARY CARE HEALTH SERVICES, INC	PITTSBURGH	PA	H80CS007142019	030440	CHC, HCH, PHPC
PRIMARY CARE MEDICAL SERVICES OF POINCIANA, INC.	KISSIMMEE	FL	H80CS307492019	04E01256	CHC
PRIMARY CARE OF SOUTHWEST GEORGIA, INC	BLAKELY	GA	H80CS064542019	0443690	CHC
PRIMARY CARE PROVIDERS FOR A HEALTHY FELICIANA	CLINTON	LA	H80CS064592019	0618980	CHC
PRIMARY CONNECTION HEALTH CARE, INC.	WAUSAU	WI	H80CS005172019	057250	CHC
PRIMARY HEALTH CARE CENTER OF DADE, INC	LA FAYETTE	GA	H80CS006492019	044790	CHC
PRIMARY HEALTH CARE, INC.	URBANDALE	IA	H80CS007152019	070550	CHC, HCH
PRIMARY HEALTH NETWORK	SHARON	PA	H80CS006632019	034060	CHC
PRIMARY HEALTH SERVICES CENTER	MONROE	LA	H80CS007542019	068480	CHC, HCH, PHPC
PRIMECARE COMMUNITY HEALTH,INC.	CHICAGO	IL	H80CS003412019	0510220	CHC
PRIORITY HEALTH CARE	MARRERO	LA	H80CS289632019	06E01198	CHC
PROGRESSIVE COMMUNITY HEALTH CENTERS, INC.	MILWAUKEE	WI	H80CS007512019	0511020	CHC
PROJECT H.O.M.E.	PHILADELPHIA	PA	H80CS266352019	03E01107	HCH
PROJECT H.O.P.E., INCORPORATED	CAMDEN	NJ	H80CS090322019	02E00053	HCH
PROJECT HEALTH, INC.	SUMTERVILLE	FL	H80CS004122019	040250	CHC, HCH, MHC
PROJECT RENEWAL, INC.	NEW YORK	NY	H80CS003062019	024580	HCH
PROJECT VIDA HEALTH CENTER	EL PASO	TX	H80CS042872019	067960	CHC, HCH
PROMISE HEALTHCARE NFP	CHAMPAIGN	IL	H80CS298342019	05E01230	CHC
PROTEUS EMPLOYMENT OPPORTUNITIES, INC.	DES MOINES	IA	H80CS003352019	070530	MHC
PRYMED MEDICAL CARE, INC.	CIALES	PR	H80CS007122019	021250	CHC
PUBLIC HEALTH MANAGEMENT CORPORATION	PHILADELPHIA	PA	H80CS000162019	031670	HCH, PHPC
PUEBLO COMMUNITY HEALTH CENTER, INC.	PUEBLO	CO	H80CS006922019	080170	CHC, HCH, MHC
PUEBLO OF JEMEZ	JEMEZ PUEBLO	NM	H80CS265842019	06E01075	CHC
PUERTO RICO COMMUNITY NETWORK FOR CLINICAL RESEARCH ON AIDS	SAN JUAN	PR	H80CS336402019	02E01369	CHC

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PURDUE UNIVERSITY	W LAFAYETTE	IN	H80CS128462019	05E00015	CHC
PUSHMATAHA FAMILY MEDICAL CENTER, INC.	CLAYTON	OK	H80CS064532019	0622460	CHC
QUALITY COMMUNITY HEALTH CARE, INC.	PHILADELPHIA	PA	H80CS006872019	033780	CHC
QUALITY OF LIFE HEALTH SERVICES, INC.	GADSDEN	AL	H80CS006582019	044120	CHC, MHC, PHPC
QUEENSCARE HEALTH CENTERS	LOS ANGELES	CA	H80CS008712019	0910240	CHC
RAINELLE MEDICAL CENTER, INC.	RAINELLE	WV	H80CS182782019	033080	CHC
RAPHAEL HEALTH CENTER	INDIANAPOLIS	IN	H80CS002662019	0514720	CHC
RAPIDES PRIMARY HEALTH CARE CENTER, INC.	ALEXANDRIA	LA	H80CS002442019	067090	CHC
RECOVERY CONSULTANTS OF ATLANTA, INCORPORATED	DECATUR	GA	H80CS289592019	04E01171	HCH
REDWOOD COAST MEDICAL SERVICES	GUALALA	CA	H80CS005752019	096030	CHC
REDWOODS RURAL HEALTH CENTER, INC.	REDWAY	CA	H80CS002512019	091700	CHC
REFUAH HEALTH CENTER	NEW SQUARE	NY	H80CS002812019	027260	CHC, PHPC
REGENCE HEALTH NETWORK, INC.	PLAINVIEW	TX	H80CS001262019	060950	CHC, HCH, MHC
REGENESIS ORGANIZATION COMMUNITY HEALTH CENTER	SPARTANBURG	SC	H80CS002982019	0421000	CHC
REGIONAL HEALTH CARE AFFILIATES, INC	PROVIDENCE	KY	H80CS171572019	04E00092	CHC
REGIONAL HEALTH CARE CLINIC, INC. DBA KATY TRAIL COMMUNITY HEALTH	SEDALIA	MO	H80CS066682019	0714960	CHC
REGIONAL MEDICAL CENTER AT LUBEC, INC.	LUBEC	ME	H80CS001502019	010380	CHC
REPUBLIC OF PALAU BUREAU OF HEALTH SERVICES	PALAU	PW	H80CS024672019	090730	CHC
RESOURCES FOR HUMAN DEVELOPMENT, INC.	PHILADELPHIA	PA	H80CS007182019	036670	PHPC
RICHFORD HEALTH CENTER, INC.	RICHFORD	VT	H80CS002612019	013970	CHC
RICHLAND MEDICAL CENTER INC	RICHLAND	MO	H80CS001322019	071670	CHC
RIGGS COMMUNITY HEALTH CENTER, INC.	LAFAYETTE	IN	H80CS005652019	057480	CHC
RINEHART CLINIC	WHEELER	OR	H80CS105932019	10E00062	CHC
RITCHIE COUNTY PRIMARY CARE ASSOC., INC.	HARRISVILLE	WV	H80CS008432019	037920	CHC
RITTER CENTER	SAN RAFAEL	CA	H80CS266092019	09E01068	HCH

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RIVER HILLS COMMUNITY HEALTH CENTER, INC.	OTTUMWA	IA	H80CS007962019	075660	CHC
RIVER VALLEY PRIMARY CARE SERVICES	RATCLIFF	AR	H80CS042882019	0612020	CHC
RIVERSIDE COUNTY HEALTH SYSTEM	RIVERSIDE	CA	H80CS289902019	09E01184	CHC
ROADS FOUNDATION INC	COMPTON	CA	H80CS289912019	09E01208	CHC
ROANE CO. FAMILY HLTH CARE, INC.	SPENCER	WV	H80CS003882019	034120	CHC
ROANOKE CHOWAN COMMUNITY HEALTH CENTER INC	AHOSKIE	NC	H80CS087372019	0448640	CHC, MHC
ROBESON HEALTH CARE CORPORATION	PEMBROKE	NC	H80CS001072019	049000	CHC
ROCHESTER PRIMARY CARE NETWORK	ROCHESTER	NY	H80CS001672019	020560	CHC
ROCKBRIDGE AREA FREE CLINIC	LEXINGTON	VA	H80CS266362019	03E00378	CHC
ROCKING HORSE CENTER	SPRINGFIELD	OH	H80CS128922019	05E00031	CHC
ROGUE COMMUNITY HEALTH	MEDFORD	OR	H80CS042042019	102970	CHC, HCH
ROSA CLARK MEDICAL CLINIC INC	SENECA	SC	H80CS307132019	04E01242	CHC
RURAL ALLIANCE FOR BETTER FAMILY HLTH	WEST PLAINS	MO	H80CS003012019	077470	CHC
RURAL HEALTH CARE, INC.	PALATKA	FL	H80CS000812019	040340	CHC, MHC
RURAL HEALTH CARE, INC.	FORT PIERRE	SD	H80CS004562019	080590	CHC
RURAL HEALTH CORP. OF NORTHEASTERN PA	WILKES-BARRE	PA	H80CS007072019	030560	CHC, HCH
RURAL HEALTH GROUP, INC.	ROANOKE RAPID	NC	H80CS008662019	046680	CHC
RURAL HEALTH MEDICAL PROGRAM, INC.	SELMA	AL	H80CS007942019	042850	CHC
RURAL HEALTH NETWORK OF MONROE COUNTY FLORIDA, INC.	MARATHON	FL	H80CS241742019	04E00517	CHC, HCH
RURAL HEALTH SERVICES CONSORTIUM, INC.	ROGERSVILLE	TN	H80CS004212019	0412790	CHC
RURAL HEALTH SERVICES, INC.	CLEARWATER	SC	H80CS006532019	045220	CHC
RURAL HEALTH, INC.	ANNA	IL	H80CS007112019	052180	CHC
RURAL MEDICAL SERVICES, INC.	NEWPORT	TN	H80CS004062019	046810	CHC, MHC
RUTGERS, THE STATE UNIVERSITY OF NEW JERSEY	NEW BRUNSWICK	NJ	H80CS267632019	02E01108	CHC
RUTGERS, THE STATE UNIVERSITY OF NEW JERSEY	NEWARK	NJ	H80CS290142019	02E01213	PHPC

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RUTHERFORD COUNTY PRIMARY CARE INC.	MURFREESBORO	TN	H80CS241562019	04E00502	CHC, PHPC
S.E. ALABAMA RURAL HEALTH ASSOCIATES	TROY	AL	H80CS003762019	048950	CHC, MHC
SAC HEALTH SYSTEM	SN BERNRDNO	CA	H80CS289922019	09E01185	CHC, HCH
SACOPEE VALLEY HEALTH CENTER	PARSONSFIELD	ME	H80CS004582019	011230	CHC
SADLER HEALTH CENTER CORPORATION	CARLISLE	PA	H80CS290252019	03E01182	CHC
SAINT HOPE FOUNDATION	HOUSTON	TX	H80CS265872019	06E01098	CHC
SAINT JAMES HEALTH INC	NEWARK	NJ	H80CS290152019	02E01165	CHC, PHPC
SALINA HEALTH EDUCATION FOUNDATION	SALINA	KS	H80CS042162019	0712470	CHC
SALUD INTEGRAL EN LA MONTANA, INC.	NARANJITO	PR	H80CS005982019	020650	CHC, MHC, PHPC
SALUD PARA LA GENTE, INC.	WATSONVILLE	CA	H80CS002262019	091160	CHC, MHC
SAMUEL DIXON FAMILY HEALTH CENTERS, INC	VALENCIA	CA	H80CS241512019	09E00498	CHC
SAMUEL U RODGERS HEALTH CENTER, INC.	KANSAS CITY	MO	H80CS007842019	070290	CHC
SAN BENITO HEALTH FOUNDATION	HOLLISTER	CA	H80CS082232019	091800	CHC, MHC
SAN BERNARDINO COUNTY PUBLIC HEALTH DEPT	SAN BERNARDINO	CA	H80CS006572019	091250	CHC
SAN DIEGO AMERICAN INDIAN HEALTH CENTER INC	SAN DIEGO	CA	H80CS289932019	09E01190	CHC
SAN DIEGO FAMILY CARE	SAN DIEGO	CA	H80CS023192019	0911100	CHC
SAN FERNANDO COMMUNITY HOSPITAL	SAN FERNANDO	CA	H80CS289942019	09E01204	CHC, HCH
SAN FRANCISCO COMMUNITY CLINIC CONSORTIUM	SAN FRANCISCO	CA	H80CS000492019	091070	HCH
SAN FRANCISCO MEDICAL CENTER OUTPATIENT IMPROVEMENT PROGRAMS, INC.	SAN FRANCISCO	CA	H80CS003812019	090530	CHC
SAN JOSE FOOTHILLS FAMILY COMMUNITY CLINIC	SAN JOSE	CA	H80CS066462019	0925350	CHC
SAN MATEO COUNTY HEALTH SERVICES AGENCY	SAN MATEO	CA	H80CS000512019	091140	HCH, MHC
SANDHILLS MEDICAL FOUNDATION, INC.	JEFFERSON	SC	H80CS005012019	045050	CHC
SANTA BARBARA COUNTY PUBLIC HEALTH DEPT	SANTA BARBARA	CA	H80CS000462019	090830	CHC, HCH
SANTA BARBARA NEIGHBORHOOD CLINICS	SANTA BARBARA	CA	H80CS266252019	09E01102	CHC
SANTA CLARA VALLEY HEALTH AND HOSPITAL SYSTEM	SAN JOSE	CA	H80CS014422019	0911810	HCH

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SANTA CRUZ COMMUNITY HEALTH CENTERS	SANTA CRUZ	CA	H80CS241142019	09E00478	CHC, HCH
SANTA CRUZ COUNTY	SANTA CRUZ	CA	H80CS000482019	090880	CHC, HCH
SANTA ROSA COMMUNITY HEALTH CENTERS	SANTA ROSA	CA	H80CS002592019	098790	CHC, HCH
SAPPHIRE COMMUNITY HEALTH, INC.	HAMILTON	MT	H80CS283592019	08E00382	CHC
SAWTOOTH MOUNTAIN CLINIC, INC	GRAND MARAIS	MN	H80CS004962019	052700	CHC
SCENIC BLUFFS HEALTH CENTER, INC.	CASHTON	WI	H80CS008242019	056730	CHC
SCHENECTADY FAMILY HEALTH SERVICES, INC.	SCHENECTADY	NY	H80CS004752019	021830	CHC
SCHOOL HEALTH CLINICS OF SANTA CLARA COUNTY	SAN JOSE	CA	H80CS008852019	0911320	CHC
SCRANTON PRIMARY HEALTH CARE CENTER, INC	SCRANTON	PA	H80CS000742019	032560	CHC
SEA-MAR COMMUNITY HEALTH CENTER	SEATTLE	WA	H80CS004452019	101020	CHC, HCH, MHC
SEATTLE INDIAN HEALTH BOARD INC	SEATTLE	WA	H80CS005522019	102550	CHC
SEATTLE-KING COUNTY PUBLIC HEALTH DEPT	SEATTLE	WA	H80CS000562019	102340	HCH
SEBASTICOOK FAMILY DOCTORS	NEWPORT	ME	H80CS024482019	015170	CHC
SELDOVIA VILLAGE TRIBE	SELDOVIA	AK	H80CS011362019	106210	CHC
SERVE THE PEOPLE, INC.	SANTA ANA	CA	H80CS266272019	09E01103	CHC
SETTLEMENT HEALTH AND MEDICAL SERVICES, INC.	NEW YORK	NY	H80CS003272019	021080	CHC
SEWARD, CITY OF	SEWARD	AK	H80CS266002019	10E00170	CHC
SHACKELFORD COUNTY COMMUNITY RESOURCE	ALBANY	TX	H80CS064602019	0622370	CHC, MHC
SHALOM HEALTH CARE CENTER, INC	INDIANAPOLIS	IN	H80CS008802019	0517410	CHC
SHARE OUR SELVES	COSTA MESA	CA	H80CS241992019	09E00524	CHC, HCH
SHASTA COMMUNITY HEALTH CENTER	REDDING	CA	H80CS008322019	092240	CHC, HCH
SHAWNEE CHRISTIAN HEALTHCARE CENTER, INC.	LOUISVILLE	KY	H80CS289612019	04E01172	CHC
SHAWNEE HEALTH SERVICE AND DEVELOPMENT CORPORATION	CARTERVILLE	IL	H80CS006672019	050040	CHC, MHC
SHENANDOAH VALLEY MEDICAL SYSTEMS, INC.	MARTINSBURG	WV	H80CS007812019	030900	CHC, MHC
SHERIDAN, COUNTY OF	HOXIE	KS	H80CS283732019	07E01134	CHC

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SHINGLETOWN MEDICAL CENTER	SHINGLETOWN	CA	H80CS014402019	0911800	CHC
SHORTGRASS COMMUNITY HEALTH CENTERS, INC	HOLLIS	OK	H80CS241442019	06E00491	CHC
SHOSHONE-BANNOCK TRIBES OF THE FORT HALL RESERVATION OF IDAHO	FORT HALL	ID	H80CS283602019	10E00387	CHC
SIERRA FAMILY MEDICAL CLINIC INC	NEVADA CITY	CA	H80CS289812019	09E01209	CHC
SIGNATURE HEALTH, INC.	WILLOUGHBY	OH	H80CS307182019	05E01247	CHC
SIHF HEALTHCARE	E SAINT LOUIS	IL	H80CS001952019	053320	CHC, HCH, MHC, PHPC
SILVER STATE HEALTH SERVICES	LAS VEGAS	NV	H80CS307212019	09E01240	CHC, HCH
SIOUXLAND COMMUNITY HEALTH CENTER	SIOUX CITY	IA	H80CS005352019	070890	CHC
SISKIYOU COMMUNITY HEALTH CENTER, INC.	GRANTS PASS	OR	H80CS003692019	100150	CHC
SIXTEENTH STREET COMMUNITY HEALTH CENTERS, INC.	MILWAUKEE	WI	H80CS005932019	053060	CHC
SONOMA VALLEY COMMUNITY HEALTH CENTER	SONOMA	CA	H80CS066492019	0925380	CHC
SOUTH BAY FAMILY HEALTHCARE CENTER	TORRANCE	CA	H80CS008772019	0910260	CHC
SOUTH BOSTON COMMUNITY HEALTH CENTER	BOSTON	MA	H80CS079282019	013600	CHC, PHPC
SOUTH CAROLINA PRIMARY HEALTH CARE ASSOCIATION	COLUMBIA	SC	H80CS041842019	0438110	MHC
SOUTH CENTRAL FAMILY HEALTH CENTER	LOS ANGELES	CA	H80CS002652019	090200	CHC
SOUTH CENTRAL MEDICAL AND RESOURCE CENTER, INC.	LINDSAY	OK	H80CS128832019	06E00034	CHC
SOUTH CENTRAL MISSOURI COMMUNITY HEALTH CENTER	ROLLA	MO	H80CS265642019	07E01094	CHC
SOUTH CENTRAL PRIMARY CARE CENTER	OCILLA	GA	H80CS008362019	047990	CHC
SOUTH COUNTY COMMUNITY HEALTH CENTER, INC.	E PALO ALTO	CA	H80CS001452019	098150	CHC
SOUTH COVE COMMUNITY HEALTH CTR, INC.	BOSTON	MA	H80CS006002019	010710	CHC
SOUTH END COMMUNITY HEALTH CENTER	BOSTON	MA	H80CS266392019	01E00392	CHC, PHPC
SOUTH PLAINS RURAL HEALTH SERVICES, INC.	LEVELLAND	TX	H80CS007212019	061220	CHC, MHC
SOUTH TEXAS RURAL HEALTH SERVICES, INC.	COTULLA	TX	H80CS003612019	062120	CHC, MHC
SOUTHBRIDGE MED. ADVISORY COUNCIL, INC.	WILMINGTON	DE	H80CS003852019	031260	CHC, HCH
SOUTHCENTRAL FOUNDATION	ANCHORAGE	AK	H80CS011282019	106180	CHC

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SOUTHEAST ALASKA REGIONAL HEALTH CONSORT	SITKA	AK	H80CS005592019	101270	CHC, HCH
SOUTHEAST COMMUNITY HEALTH SYSTEMS	GREENSBURG	LA	H80CS003702019	063710	CHC, MHC
SOUTHEAST MISSISSIPPI RURAL HEALTH, INC	HATTIESBURG	MS	H80CS006102019	045770	CHC
SOUTHEAST MISSOURI HEALTH NETWORK, INC.	NEW MADRID	MO	H80CS005572019	071370	CHC, MHC
SOUTHEAST, INC.	COLUMBUS	OH	H80CS226812019	05E00101	CHC, HCH
SOUTHERN CALIFORNIA MEDICAL CENTER, INC.	EL MONTE	CA	H80CS283682019	09E01141	CHC
SOUTHERN DOMINION HEALTH SYSTEMS, INC.	VICTORIA	VA	H80CS001732019	034180	CHC
SOUTHERN INDIANA COMMUNITY HEALTH CARE INC	PAOLI	IN	H80CS336502019	05E01276	CHC
SOUTHERN JERSEY FAMILY	HAMMONTON	NJ	H80CS003802019	020930	CHC, MHC
SOUTHERN NEVADA HEALTH DISTRICT	LAS VEGAS	NV	H80CS336412019	09E01368	CHC
SOUTHERN TIER COMMUNITY HEALTH CENTER NETWORK, INC.	OLEAN	NY	H80CS241402019	02E00488	CHC
SOUTHERN TRINITY HEALTH SERVICES	MAD RIVER	CA	H80CS044312019	097210	CHC
SOUTHLAKE COMMUNITY MENTAL HEALTH CENTER, INC.	MERRILLVILLE	IN	H80CS265682019	05E01106	CHC, HCH, PHPC
SOUTHLAND INTEGRATED SERVICES, INC.	SANTA ANA	CA	H80CS283712019	09E01142	CHC
SOUTHSIDE COMMUNITY HEALTH SERVICES	MINNEAPOLIS	MN	H80CS001982019	056960	CHC
SOUTHSIDE MEDICAL CENTER, INC.	ATLANTA	GA	H80CS005762019	040400	CHC
SOUTHSIDE UNITED HEALTH CENTER	WINSTON SALEM	NC	H80CS241432019	04E00490	CHC, HCH
SOUTHWEST COLORADO MENTAL HEALTH CENTER, INC.	DURANGO	CO	H80CS265102019	08E00393	CHC, HCH
SOUTHWEST COMMUNITY HEALTH CENTER	BRIDGEPORT	CT	H80CS006132019	010810	CHC, HCH
SOUTHWEST LOUISIANA PRIMARY HEALTH CARE CTR, INC.	OPELOUSAS	LA	H80CS005792019	062900	CHC, HCH
SOUTHWEST UTAH COMMUNITY HEALTH CENTER	ST GEORGE	UT	H80CS078902019	0818490	CHC
SOUTHWEST VIRGINIA COMMUNITY HEALTH SYSTEMS, INC.	SALTVILLE	VA	H80CS002782019	031810	CHC, MHC
SPECIAL HEALTH RESOURCES FOR TEXAS, INC.	LONGVIEW	TX	H80CS283632019	06E01145	CHC
SPECTRA HEALTH	GRAND FORKS	ND	H80CS018082019	0811510	CHC
SPECTRUM HEALTH SERVICES	PHILADELPHIA	PA	H80CS003892019	034140	CHC

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SPRING BRANCH COMMUNITY HEALTH CENTER	HOUSTON	TX	H80CS064472019	0622420	CHC
SPRINGFIELD MEDICAL CARE SYSTEMS, INC	SPRINGFIELD	VT	H80CS128732019	01E00051	CHC
SQUIRREL HILL HEALTH CENTER	PITTSBURGH	PA	H80CS066432019	0318410	CHC
ST ANTHONY MEDICAL CENTERS	LOS ANGELES	CA	H80CS283692019	09E01152	CHC
ST. CHARLES HEALTH COUNCIL, INC.	JONESVILLE	VA	H80CS006042019	030740	CHC
ST. CROIX REGIONAL FAMILY HEALTH CENTER	PRINCETON	ME	H80CS005262019	013470	CHC
ST. FRANCIS HOUSE NWA, INC	SPRINGDALE	AR	H80CS042902019	0619500	CHC
ST. GABRIEL HEALTH CLINIC, INC.	SAINT GABRIEL	LA	H80CS005512019	064760	CHC
ST. GEORGE MEDICAL CLINIC, INC.	ST GEORGE	WV	H80CS008452019	033690	CHC
ST. JAMES-SANTEE FAMILY HEALTH CENTER, INC.	MCCLELLANVLE	SC	H80CS008282019	048430	CHC
ST. JOHNS WELL CHILD & FAMILY CENTER	LOS ANGELES	CA	H80CS008732019	0910370	CHC, HCH, PHPC
ST. JOSEPH'S MERCY CARE SERVICES	ATLANTA	GA	H80CS000222019	042010	HCH
ST. JUDE NEIGHBORHOOD HEALTH CENTERS	FULLERTON	CA	H80CS266282019	09E01056	CHC
ST. LUKE'S HEALTH CARE CLINIC, INC.	LAS CRUCES	NM	H80CS289692019	06E00402	CHC, HCH, MHC
ST. THOMAS COMMUNITY HEALTH CENTER, INC.	NEW ORLEANS	LA	H80CS128632019	06E00020	CHC
ST. THOMAS EAST END MEDICAL CENTER CORPORATION	ST THOMAS	VI	H80CS003732019	025310	CHC
ST. VINCENT DE PAUL VILLAGE, INC	SAN DIEGO	CA	H80CS106062019	09E00064	HCH
START CORPORATION	HOUMA	LA	H80CS289642019	06E01206	HCH
STAYWELL HEALTH CARE, INC.	WATERBURY	CT	H80CS003502019	012410	CHC, HCH
STEDMAN-WADE HEALTH SERVICES, INC.	WADE	NC	H80CS004902019	046910	CHC
STEPHEN F AUSTIN COMMUNITY HEALTH CENTER, INC.	ALVIN	TX	H80CS112552019	06E00070	CHC
STERLING AREA HEALTH CENTER	STERLING	MI	H80CS007562019	052250	CHC
STERLING HEALTH SOLUTIONS, INC	MT STERLING	KY	H80CS241682019	04E00512	CHC, MHC
STIGLER HEALTH AND WELLNESS CENTER	STIGLER	OK	H80CS042862019	0619510	CHC
STO-ROX FAMILY HEALTH COUNCIL, INC.	MC KEES ROCKS	PA	H80CS000722019	032230	CHC

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STONY CREEK COMMUNITY HEALTH CENTER	STONY CREEK	VA	H80CS003862019	031760	CHC
SU CLINICA FAMILIAR	HARLINGEN	TX	H80CS003482019	060840	CHC, MHC
SUMMIT COMMUNITY CARE CLINIC	FRISCO	CO	H80CS283612019	08E00412	CHC
SUN LIFE FAMILY HEALTH CENTER	CASA GRANDE	AZ	H80CS004662019	090030	CHC
SUNCOAST COMMUNITY HEALTH CENTERS, INC.	RUSKIN	FL	H80CS005412019	041750	CHC, MHC
SUNRISE COMMUNITY HEALTH	EVANS	CO	H80CS008042019	080140	CHC, MHC
SUNSET COMMUNITY HEALTH CENTER	SOMERTON	AZ	H80CS043212019	090130	CHC, MHC
SUNSET PARK HEALTH COUNCIL, INC	BROOKLYN	NY	H80CS079142019	0218870	CHC, HCH
SUNSHINE COMMUNITY HEALTH CENTER, INC.	TALKEETNA	AK	H80CS005682019	102120	CHC
SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.	WILLIAMSPORT	PA	H80CS241592019	03E00505	CHC
SWLA CENTER FOR HEALTH SERVICES	LAKE CHARLES	LA	H80CS005582019	063380	CHC, PHPC
SWOPE HEALTH SERVICES	KANSAS CITY	MO	H80CS005992019	070270	CHC, HCH
SYRACUSE COMMUNITY HEALTH CENTER, INC.	SYRACUSE	NY	H80CS004342019	020160	CHC
T.H.E. CLINIC, INC.	LOS ANGELES	CA	H80CS007552019	092440	CHC
TALBERT HOUSE HEALTH CENTER	FRANKLIN	OH	H80CS265772019	05E01059	CHC
TAMPA FAMILY HEALTH CENTERS, INC.	TAMPA	FL	H80CS004072019	0412810	CHC, HCH
TANANA CHIEFS CONFERENCE	FAIRBANKS	AK	H80CS082202019	101250	CHC
TANDEM HEALTH SC	SUMTER	SC	H80CS008682019	0423590	CHC
TCA HEALTH INC.	CHICAGO	IL	H80CS001092019	051030	CHC, PHPC
TECHE ACTION BOARD INC.	FRANKLIN	LA	H80CS007672019	060180	CHC
TEJAS HEALTH CARE	LA GRANGE	TX	H80CS241552019	06E00501	CHC
TENDERCARE CLINIC, INC.	GREENSBORO	GA	H80CS007642019	0421720	CHC
TENNESSEE STATE DEPARTMENT OF HEALTH	COOKEVILLE	TN	H80CS003512019	041780	CHC
TENNESSEE STATE DEPATMENT OF HEALTH	NASHVILLE	TN	H80CS004292019	049040	CHC
TENSAS COMMUNITY HEALTH CENTER, INC.	SAINT JOSEPH	LA	H80CS064502019	0622350	CHC

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TERROS INC	PHOENIX	AZ	H80CS336452019	09E00421	CHC
TERRY REILLY HEALTH SERVICES, INC.	NAMPA	ID	H80CS006362019	100160	CHC, HCH, MHC
TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER	LUBBOCK	TX	H80CS128532019	06E00041	CHC
THE BAY CLINIC, INC.	HILO	HI	H80CS008372019	091880	CHC
THE BOARD OF TRUSTEES OF THE UNIVERSITY OF ILLINOIS	CHICAGO	IL	H80CS003242019	057580	CHC, PHPC
THE BREVARD HEALTH ALLIANCE, INC.	MELBOURNE	FL	H80CS042132019	0438230	CHC, HCH, PHPC
THE C.W. WILLIAMS COMMUNITY HEALTH CENTER, INC.	CHARLOTTE	NC	H80CS004282019	047770	CHC
THE CHAUTAUQUA CENTER	DUNKIRK	NY	H80CS241662019	02E00511	CHC
THE FAMILY HEALTH CENTERS OF GEORGIA, INC.	ATLANTA	GA	H80CS004852019	040410	CHC, PHPC
THE FLOATING HOSPITAL	LONG IS CITY	NY	H80CS002682019	025500	CHC, HCH, PHPC
THE HEALTH AND HOSPITAL CORPORATION OF MARION COUNTY	INDIANAPOLIS	IN	H80CS254362019	052360	CHC, PHPC
THE HEALTHCARE CONNECTION, INC.	CINCINNATI	OH	H80CS002002019	059880	CHC
THE HUNTER HEALTH CLINIC INCORPORATED	WICHITA	KS	H80CS006222019	070150	CHC, HCH
THE INSTITUTE FOR FAMILY HEALTH	NEW YORK	NY	H80CS007682019	023710	CHC
THE LAKES COMMUNITY HEALTH CENTER, INC.	IRON RIVER	WI	H80CS087842019	0537600	CHC
THE LOS ANGELES FREE CLINIC	LOS ANGELES	CA	H80CS241152019	09E00427	CHC
THE PROVIDENCE COMMUNITY HLTH CENTERS, INC.	PROVIDENCE	RI	H80CS000572019	010580	CHC, HCH
THE SAYRE HEALTH CENTER	PHILADELPHIA	PA	H80CS066452019	0318400	CHC
THE WALLACE MEDICAL CONCERN	PORTLAND	OR	H80CS241452019	10E00492	CHC, HCH, PHPC
THE WELLNESS PLAN MEDICAL CENTERS	DETROIT	MI	H80CS241342019	05E00483	CHC
THIRD STREET COMMUNITY CLINIC	MANSFIELD	OH	H80CS005812019	057110	CHC
THREE LOWER COUNTIES COMMUNITY SERVICES, INC.	SALISBURY	MD	H80CS007742019	033010	CHC, MHC
THUNDER BAY COMMUNITY HEALTH SERVICE, INC.	HILLMAN	MI	H80CS004022019	053160	CHC
THUNDERMIST HEALTH CENTER	WOONSOCKET	RI	H80CS004542019	011820	CHC, HCH
TIBURCIO VASQUEZ HEALTH CENTER, INC.	UNION CITY	CA	H80CS002232019	093190	CHC

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TILLAMOOK COUNTY HEALTH DEPARTMENT	TILLAMOOK	OR	H80CS005552019	102360	CHC
TOTAL HEALTH CARE, INC.	BALTIMORE	MD	H80CS000682019	030150	CHC
TRAVERSE HEALTH CLINIC AND COALITION	TRAVERSE CITY	MI	H80CS265732019	05E00433	CHC
TRAVIS COUNTY HEALTHCARE DISTRICT/CENTRAL TEXAS COMM HEALTH CENTER	AUSTIN	TX	H80CS112982019	0630790	CHC, HCH
TREASURE COAST COMMUNITY HEALTH, INC.	FELLSMERE	FL	H80CS001872019	0413190	CHC, MHC
TRENTON MEDICAL CENTER, INC. DBA PALMS MEDICAL GROUP	TRENTON	FL	H80CS006912019	042710	CHC
TRI COUNTY COMMUNITY HEALTH COUNCIL, INC	NEWTON GROVE	NC	H80CS006552019	040900	CHC, MHC
TRI-AREA COMMUNITY HEALTH	LAUREL FORK	VA	H80CS004462019	033230	CHC
TRI-CITIES COMMUNITY HEALTH	PASCO	WA	H80CS004982019	101520	CHC, MHC
TRI-CITY HEALTH CENTER	FREMONT	CA	H80CS023262019	091220	CHC
TRI-STATE COMMUNITY HEALTH CENTER	HANCOCK	MD	H80CS000692019	031600	CHC
TRI-STATE COMMUNITY HEALTH CENTER	MEMPHIS	TN	H80CS289752019	04E01161	CHC, HCH
TRI-STATE COMMUNITY HEALTHCARE CENTER	NEEDLES	CA	H80CS283702019	09E01144	CHC
TRI-TOWN ECONOMIC OPPORTUNITY COMMITTEE	JOHNSTON	RI	H80CS128792019	01E00040	CHC
TRIAD ADULT AND PEDIATRIC MEDICINE, INC.	GREENSBORO	NC	H80CS265142019	04E00754	CHC, HCH, PHPC
TRIAD HEALTH SYSTEMS, INC.	WARSAW	KY	H80CS087852019	0452880	CHC
TRIANGLE AREA NETWORK, INC.	BEAUMONT	TX	H80CS289772019	06E01197	CHC
TRINITY HEALTH, MICHIGAN D/B/A MERCY HEALTH SAINT MARY'S	GRAND RAPIDS	MI	H80CS000312019	051840	CHC, HCH
TUBA CITY REGIONAL HEALTH CARE CORPORATION	TUBA CITY	AZ	H80CS242002019	09E00436	CHC
TUG RIVER HEALTH ASSOCIATION, INC.	GARY	WV	H80CS007012019	031000	CHC
TULIP TREE HEALTH SERVICES OF GIBSON COUNTY, INC.	FORT BRANCH	IN	H80CS336512019	05E01303	CHC
TURNER HOUSE CLINIC INC.	KANSAS CITY	KS	H80CS336522019	07E01289	CHC
TYLER FAMILY CIRCLE OF CARE	TYLER	TX	H80CS261902019	06E01037	CHC
UMPQUA COMMUNITY HEALTH CENTER	ROSEBURG	OR	H80CS005672019	103100	CHC
UNCOMPAHGRE COMBINED CLINICS	NORWOOD	CO	H80CS006232019	081740	CHC

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UNICARE COMMUNITY HEALTH CENTER	ONTARIO	CA	H80CS289952019	09E01159	CHC
UNION COMMUNITY HEALTH CENTER, INC.	BRONX	NY	H80CS283552019	02E01143	CHC
UNITED CEREBRAL PALSY ASSOCIATION OF THE NORTH COUNTRY, INC.	CANTON	NY	H80CS087462019	0219440	CHC
UNITED COMMUNITY AND FAMILY SERVICES INC	NORWICH	CT	H80CS290002019	01E01212	CHC
UNITED COMMUNITY HEALTH CENTER	STORM LAKE	IA	H80CS066692019	0714880	CHC
UNITED COMMUNITY HEALTH CENTER, INC.	GREEN VALLEY	AZ	H80CS004162019	093590	CHC
UNITED FAMILY PRACTICE HEALTH CENTER, INC.	SAINT PAUL	MN	H80CS241362019	05E00485	CHC
UNITED HLTH CNTRS OF SAN JOAQUIN VALLEY, INC.	PARLIER	CA	H80CS001372019	090560	CHC, MHC
UNITED MEDICAL CENTERS	EAGLE PASS	TX	H80CS006432019	060740	CHC, MHC
UNITED METHODIST WESTERN KANSAS	GARDEN CITY	KS	H80CS008382019	074630	CHC
UNITED NEIGHBORHOOD HEALTH SERVICES, INC DBA NBHD HLTH	NASHVILLE	TN	H80CS003942019	044110	CHC, HCH, PHPC
UNITY CARE NORTHWEST	BELLINGHAM	WA	H80CS087732019	1016960	CHC
UNITY HEALTH CARE, INC.	WASHINGTON	DC	H80CS000702019	037020	CHC, HCH
UNITY HOSPITAL OF ROCHESTER	ROCHESTER	NY	H80CS112742019	023890	HCH
UNIVERSAL COMMUNITY HEALTH CENTER	LOS ANGELES	CA	H80CS307222019	09E01245	CHC
UNIVERSITY COMMUNITY HEALTH SERVICES, INC. D/B/A CONNECTUS HEALTH	NASHVILLE	TN	H80CS087672019	0450710	CHC
UNIVERSITY MUSLIM MEDICAL ASSOCIATION, INC.	LOS ANGELES	CA	H80CS106092019	09E00067	CHC
UNIVERSITY OF CALIFORNIA, IRVINE	IRVINE	CA	H80CS004612019	093080	CHC
UNIVERSITY OF COLORADO DENVER	AURORA	CO	H80CS240992019	08E00441	CHC
UNIVERSITY OF KENTUCKY RESEARCH FOUNDATION	LEXINGTON	KY	H80CS066502019	0445250	CHC
UNIVERSITY OF MINNESOTA	MINNEAPOLIS	MN	H80CS002412019	0513810	CHC
UNIVERSITY OF WYOMING	LARAMIE	WY	H80CS307232019	08E01122	CHC
UPHAMS CORNER HEALTH COMMITTEE, INC.	DORCHESTER	MA	H80CS290102019	01E01166	CHC
UPPER GREAT LAKES FAMILY HEALTH CENTER	GWINN	MI	H80CS265112019	05E00445	CHC
UPPER ROOM AIDS MINISTRY, INC. HEALTH CARE CENTER	NEW YORK	NY	H80CS172512019	02E00093	HCH

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UPPER VALLEY COMMUNITY HEALTH SERVICES, INC.	SAINT ANTHONY	ID	H80CS087562019	1017440	CHC
UPSTATE FAMILY HEALTH CENTER, INC.	UTICA	NY	H80CS336562019	02E01283	CHC
URBAN COMMUNITY ACTION PROJECTS	RIVERSIDE	CA	H80CS242012019	09E00525	HCH
URBAN HEALTH PLAN, INC.	BRONX	NY	H80CS003682019	023600	CHC
UTAH NAVAJO HEALTH SYSTEM, INC.	MONTEZUMA CREEK	UT	H80CS008202019	084980	CHC
UTAH PARTNERS FOR HEALTH	MIDVALE	UT	H80CS266442019	08E01071	CHC
VALLE DEL SOL, INC.	PHOENIX	AZ	H80CS289562019	09E00448	CHC
VALLEY COMMUNITY HEALTHCARE	N HOLLYWOOD	CA	H80CS042222019	095320	CHC
VALLEY FAMILY HEALTH CARE, INC.	PAYETTE	ID	H80CS005562019	101630	CHC, MHC
VALLEY HEALTH CARE, INC.	MILL CREEK	WV	H80CS005832019	037460	CHC
VALLEY HEALTH SYSTEMS, INC.	HUNTINGTON	WV	H80CS006142019	030880	CHC, HCH
VALLEY HEALTH TEAM, INC.	SAN JOAQUIN	CA	H80CS005252019	091100	CHC, MHC
VALLEY HEALTHCARE SYSTEM, INC.	COLUMBUS	GA	H80CS006782019	048130	CHC
VALLEY PROFESSIONALS COMMUNITY HEALTH CENTER, INC.	CLINTON	IN	H80CS087762019	0537580	CHC
VALLEY-WIDE HEALTH SYSTEMS, INC.	ALAMOSA	CO	H80CS001342019	080030	CHC, MHC
VARIETY CARE, INC.	OKLAHOMA CITY	OK	H80CS005432019	063620	CHC, MHC
VENICE FAMILY CLINIC	VENICE	CA	H80CS042172019	094890	CHC, HCH, PHPC
VENTURA COUNTY HEALTH SERVICES AGENCY	OXNARD	CA	H80CS002472019	098480	CHC, HCH
VERNON J. HARRIS EAST END CHC	RICHMOND	VA	H80CS001742019	037150	CHC
VIA CARE COMMUNITY HEALTH CENTER, INC.	LOS ANGELES	CA	H80CS266172019	09E01073	CHC
VIDA Y SALUD HEALTH SYSTEMS, INC.	CRYSTAL CITY	TX	H80CS003752019	060670	CHC, MHC
VIRGINIA GARCIA MEMORIAL HEALTH CENTER	ALOHA	OR	H80CS008172019	101230	CHC, MHC
VISITING NURSE ASSOCIATION OF CENTRAL JERSEY COMMUNITY HEALTH CENTER, INC.	ASBURY PARK	NJ	H80CS008742019	027670	CHC
VISTA COMMUNITY CLINIC	VISTA	CA	H80CS002822019	091670	CHC, MHC
VNA HEALTH CARE	AURORA	IL	H80CS039832019	0526100	CHC, HCH

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VOCATIONAL INSTRUCTIONAL PROJECT COMMUNITY SERVICES, INC.	BRONX	NY	H80CS290192019	02E01217	CHC, PHPC
WA'AB CHC/YAP STATE DEPT OF HEALTH SERVICES	YAP	FM	H80CS066532019	0925390	CHC
WABASH VALLEY HEALTH CENTER, INC.	TERRE HAUTE	IN	H80CS265692019	05E01067	CHC
WAIANAE DISTRICT COMP HLTH & HOSPITAL BOARD, INC.	WAIANAE	HI	H80CS008072019	090990	CHC
WAIKIKI HEALTH	HONOLULU	HI	H80CS000532019	092060	CHC, HCH
WAIMANALO HEALTH CENTER	WAIMANALO	HI	H80CS006462019	092290	CHC
WAKE HEALTH SERVICES, INC. D/B/A ADVANCE COMMUNITY HEALTH	RALEIGH	NC	H80CS000872019	041000	CHC, HCH
WALNUT STREET COMMUNITY HEALTH CENTER, INC.	HAGERSTOWN	MD	H80CS008572019	039840	CHC
WASATCH HOMELESS HLTH CARE/4TH ST. CLINIC	SALT LAKE CTY	UT	H80CS000432019	085060	HCH
WATERFALL CLINIC, INC	NORTH BEND	OR	H80CS087712019	1010860	CHC
WATTS HEALTHCARE CORPORATION	LOS ANGELES	CA	H80CS008502019	099480	CHC
WAYNE COMMUNITY HEALTH CENTERS, INC.	BICKNELL	UT	H80CS005192019	082240	CHC
WAYNE MEMORIAL COMMUNITY HEALTH CENTERS	HONESDALE	PA	H80CS087602019	0322290	CHC
WAYNE, COUNTY OF	DETROIT	MI	H80CS241352019	05E00484	CHC
WAYNE, COUNTY OF	RICHMOND	IN	H80CS290062019	05E01192	CHC
WELLSPACE HEALTH	SACRAMENTO	CA	H80CS128722019	09E00003	CHC, HCH
WELSH MOUNTAIN HEALTH CENTERS	NEW HOLLAND	PA	H80CS004952019	030340	CHC
WESLEY COMMUNITY CENTER INC	PHOENIX	AZ	H80CS128482019	09E00001	CHC
WEST CALDWELL HEALTH COUNCIL, INC	COLLETTSVILLE	NC	H80CS128702019	04E00024	CHC
WEST CECIL HEALTH CENTER, INC.	CONOWINGO	MD	H80CS087662019	0322280	CHC
WEST COUNTY HEALTH CENTERS, INC.	GUERNEVILLE	CA	H80CS002422019	090350	CHC, HCH
WEST HAWAII COMMUNITY HEALTH CENTER, INC	KAILUA KONA	HI	H80CS066402019	0924640	CHC
WEST OAKLAND HEALTH COUNCIL, INC.	OAKLAND	CA	H80CS003472019	090540	CHC
WEST SIDE COMMUNITY HEALTH SERVICES	SAINT PAUL	MN	H80CS007902019	053020	CHC, HCH, PHPC
WESTERN MARYLAND HEALTH CARE CORPORATION	OAKLAND	MD	H80CS066422019	0318380	CHC

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WESTERN NC COMMUNITY HEALTH SERVICES INC	ASHEVILLE	NC	H80CS087862019	0413510	CHC, HCH, PHPC
WESTERN SIERRA MEDICAL CLINIC	DOWNIEVILLE	CA	H80CS082342019	0921760	CHC
WESTERN WAYNE FAMILY HEALTH CENTERS	INKSTER	MI	H80CS066632019	0530900	CHC, HCH
WESTSIDE FAMILY HEALTH CENTER	SANTA MONICA	CA	H80CS087302019	0930080	CHC
WESTSIDE FAMILY HEALTHCARE, INC.	WILMINGTON	DE	H80CS007892019	032960	CHC, MHC
WHATLEY HEALTH SERVICES, INC	TUSCALOOSA	AL	H80CS000942019	042450	CHC, HCH
WHEELER CLINIC, INC. THE	PLAINVILLE	CT	H80CS290012019	01E01210	CHC
WHITE BIRD CLINIC	EUGENE	OR	H80CS000552019	100700	HCH
WHITESIDE COUNTY HEALTH DEPARTMENT AND WHITESIDE COUNTY COMMUNITY HEALTH CLINIC, INC.	ROCK FALLS	IL	H80CS066602019	059840	CHC
WHITMAN-WALKER CLINIC, INC.	WASHINGTON	DC	H80CS266322019	03E01064	CHC
WHITNEY M. YOUNG, JR. COMMUNITY HEALTH CENTER COMMUNITY BOARD, INC.	ALBANY	NY	H80CS004332019	020110	CHC
WHITTIER STREET HEALTH COMMITTEE, INC.	ROXBURY	MA	H80CS005362019	012070	CHC, PHPC
WILKES COUNTY OF	WILKESBORO	NC	H80CS307152019	04E01243	CHC
WILL COUNTY HEALTH DEPARTMENT/WILL COUNTY CHC	JOLIET	IL	H80CS004762019	057880	CHC
WILLIAM F. RYAN COMMUNITY HEALTH CENTER, INC.	NEW YORK	NY	H80CS000612019	020490	CHC, HCH
WILLIAMSON HEALTH AND WELLNESS CENTER	WILLIAMSON	WV	H80CS266372019	03E01054	CHC, PHPC
WILMINGTON COMMUNITY CLINIC	WILMINGTON	CA	H80CS242022019	09E00526	CHC
WINDING WATERS MEDICAL CLINIC	ENTERPRISE	OR	H80CS290232019	10E01202	CHC
WINDROSE HEALTH NETWORK, INC.	TRAFALGAR	IN	H80CS024562019	0518290	CHC
WINN COMMUNITY HEALTH CENTER, INC	WINNFIELD	LA	H80CS128572019	06E00021	CHC
WINTERS HEALTHCARE FOUNDATION	WINTERS	CA	H80CS044302019	0922930	CHC, MHC
WINTON HILLS MEDICAL & HEALTH CENTER, INC.	CINCINNATI	OH	H80CS008532019	0516210	CHC
WIRT COUNTY HEALTH SERVICES ASSOCIATION, INC.	ELIZABETH	WV	H80CS002562019	038800	CHC
WOMENCARE, INC.	SCOTT DEPOT	WV	H80CS008272019	038440	CHC
WOOD RIVER HEALTH SERVICES INC.	HOPE VALLEY	RI	H80CS000592019	012230	CHC

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WOOD, COUNTY OF	BOWLING GREEN	OH	H80CS265782019	05E01081	CHC
YAKIMA NEIGHBORHOOD HEALTH SERVICES	YAKIMA	WA	H80CS060782019	101340	CHC, HCH, MHC, PHPC
YAKIMA VALLEY FARMWORKERS CLINIC	TOPPENISH	WA	H80CS006392019	101030	CHC, MHC
YAKUTAT TLINGIT TRIBE	YAKUTAT	AK	H80CS042082019	1011870	CHC
YAVAPAI COUNTY COMMUNITY HEALTH SERVICES	PRESCOTT	AZ	H80CS008422019	099420	CHC
YEHOWA MEDICAL SERVICES	CARSON	CA	H80CS336482019	09E01231	CHC
YELLOWSTONE CITY & COUNTY HEALTH DEPARTMENT D/B/A RIVERSTONE HEALTH	BILLINGS	MT	H80CS004182019	082500	CHC, HCH
YORK COUNTY COMMUNITY ACTION CORPORATION	SANFORD	ME	H80CS041912019	019970	CHC, HCH, PHPC
YUKON KUSKOKWIM HEALTH CORPORATION	BETHEL	AK	H80CS004472019	101050	CHC
ZUFALL HEALTH CENTER, INC.	DOVER	NJ	H80CS042112019	0213350	CHC, HCH, MHC, PHPC

Table 3A - Patients by Age and by Sex Assigned at Birth - 2019

National - Universal - 1385 Health Centers

Line	Age Groups	Male Patients (a)	Female Patients (b)	All Patients
1.	Under age 1	351,959	335,762	*687,721*
2.	Age 1	240,059	232,238	*472,297*
3.	Age 2	235,172	226,165	*461,337*
4.	Age 3	248,417	240,136	*488,553*
5.	Age 4	269,874	259,417	*529,291*
6.	Age 5	274,387	262,307	*536,694*
7.	Age 6	261,039	249,635	*510,674*
8.	Age 7	254,716	244,176	*498,892*
9.	Age 8	252,454	242,180	*494,634*
10.	Age 9	251,787	240,174	*491,961*
11.	Age 10	256,580	246,718	*503,298*
12.	Age 11	275,336	266,781	*542,117*
13.	Age 12	272,077	264,090	*536,167*
14.	Age 13	250,174	247,561	*497,735*
15.	Age 14	243,674	251,959	*495,633*
16.	Age 15	232,077	252,868	*484,945*
17.	Age 16	226,284	263,324	*489,608*
18.	Age 17	214,428	268,957	*483,385*
19.	Age 18	175,846	261,738	*437,584*
20.	Age 19	137,778	242,956	*380,734*
21.	Age 20	126,161	239,479	*365,640*
22.	Age 21	120,793	242,375	*363,168*
23.	Age 22	120,143	243,724	*363,867*
24.	Age 23	120,254	243,303	*363,557*
25.	Age 24	123,400	250,750	*374,150*
26.	Ages 25 - 29	701,108	1,363,180	*2,064,288*
27.	Ages 30 - 34	730,126	1,327,707	*2,057,833*
28.	Ages 35 - 39	738,659	1,245,642	*1,984,301*
29.	Ages 40 - 44	710,166	1,114,987	*1,825,153*
30.	Ages 45 - 49	727,476	1,061,093	*1,788,569*
31.	Ages 50 - 54	777,954	1,037,009	*1,814,963*
32.	Ages 55 - 59	837,123	1,054,084	*1,891,207*
33.	Ages 60 - 64	743,359	948,797	*1,692,156*
34.	Ages 65 - 69	507,673	661,168	*1,168,841*
35.	Ages 70 - 74	304,383	432,439	*736,822*
36.	Ages 75 - 79	186,081	270,201	*456,282*
37.	Ages 80 - 84	106,395	166,912	*273,307*
38.	Age 85 and over	77,064	152,185	*229,249*
39.	**Total Patients** (Sum of Lines 1-38)	**12,682,436**	**17,154,177**	***29,836,613***
% of Total		**42.51%**	**57.49%**	

Table 3B - Demographic Characteristics - 2019

National - Universal - 1385 Health Centers

Line	Patients by Race	Patients by Race and Hispanic or Latino Ethnicity						
		Hispanic/Latino (a)	Non-Hispanic/Latino (b)	Unreported/Refused to Report Ethnicity (c)		Total (d) (Sum Columns a+b+c)		
		Number (a)	Number (b)	Number (c)	% of Total Patients[1]	Number (d)	% of Total Patients[1]	% of Known Race[2]
1.	Asian	24,491	*1,043,465*			*1,067,956*	*3.58%*	*4.22%*
2a.	Native Hawaiian	10,856	*42,746*			*53,602*	*0.18%*	*0.21%*
2b.	Other Pacific Islander	58,627	*170,948*			*229,575*	*0.77%*	*0.91%*
2.	**Total Native Hawaiian/ Other Pacific Islander (Sum Lines 2a + 2b)**	**69,483**	***213,694***			***283,177***	***0.95%***	***1.12%***
3.	Black/African American	264,879	*5,218,819*			*5,483,698*	*18.38%*	*21.69%*
4.	American Indian/Alaska Native	106,734	*260,034*			*366,768*	*1.23%*	*1.45%*
5.	White	6,845,981	*10,365,550*			*17,211,531*	*57.69%*	*68.07%*
6.	More than one race	498,730	*373,706*			*872,436*	*2.92%*	*3.45%*
6a.	**Total Known (Sum lines 1+2+3+4+5+6)**	**7,810,298**	***17,475,268***			***25,285,566***		
7.	Unreported/Refused to report race	2,722,946	*585,204*	*1,242,897*	*4.17%*	*4,551,047*	*15.25%*	
8.	**Total Patients** (Sum of Line 1, 2, 3-6, and 7)	**10,533,244**	***18,060,472***	***1,242,897***		***29,836,613***	***100.00%***	
Total Known Ethnicity (Sum line 8, columns A + B)		**28,593,716**						
		% of Hispanic/Latino of Total Known Ethnicity[3] (a)	*% of Non-Hispanic/Latino of Total Known Ethnicity[3] (b)*					
9.	**Total Patients**	**36.84%**	***63.16%***					

Line	Patients Best Served in a Language Other than English	Number (a)	% of Total
12.	Patients Best Served in a Language Other than English	7,356,355	*24.66%*

[1] Total Patients is reported on line 8, column D.

[2] Known Race is reported on line 6a, column D.

[3] Known Ethnicity is shown on the line titled 'Total Known Ethnicity'.

% may not equal 100% due to rounding.

Table 3B - Demographic Characteristics - 2019

National - Universal - 1385 Health Centers

Line	Patients by Sexual Orientation		
		Number (a)	**% of Known**
13.	Lesbian or Gay	324,629	*2.00%*
14.	Straight (not lesbian or gay)	15,582,236	*96.05%*
15.	Bisexual	210,071	*1.29%*
16.	Something else	105,592	*0.65%*
		Number (a)	**% of Total**
17.	Don't know	10,927,771	*36.63%*
18.	Chose not to disclose	2,686,314	*9.00%*
19.	**Total Patients** (Sum of Lines 13 to 18)	**29,836,613**	***100.00%***

Line	Patients by Gender Identity		
		Number (a)	**% of Known**
20.	Male	8,544,621	*40.92%*
21.	Female	12,251,945	*58.67%*
22.	Transgender Male/ Female-to-Male	44,841	*0.21%*
23.	Transgender Female/ Male-to-Female	39,937	*0.19%*
		Number (a)	**% of Total**
24.	Other	7,789,348	*26.11%*
25.	Chose not to disclose	1,165,921	*3.91%*
26.	**Total Patients** (Sum of Lines 20 to 25)	**29,836,613**	***100.00%***

Table 4 - Selected Patient Characteristics - 2019

National - Universal - 1385 Health Centers

Line	Income as Percent of Poverty Guideline	Number of Patients (a)	% of Total	% of Known
Income as Percent of Poverty Guideline				
1.	100% and Below	14,514,557	*48.65%*	*67.97%*
2.	101–150%	3,292,411	*11.03%*	*15.42%*
3.	151–200%	1,638,570	*5.49%*	*7.67%*
4.	Over 200%	1,908,021	*6.39%*	*8.94%*
5.	Unknown	8,483,054	*28.43%*	
6.	**TOTAL** (Sum of Lines 1–5)	**29,836,613**	***100.00%***	

Line	Principal Third-Party Medical Insurance	0-17 years old (a)	18 and older (b)	Total	%
7.	**None/Uninsured**	1,194,385	5,589,325	*6,783,710*	*22.74%*
8a.	Medicaid (Title XIX)	6,540,613	7,515,612	*14,056,225*	*47.11%*
8b.	CHIP Medicaid	140,834	9,543	*150,377*	*0.50%*
8.	**Total Medicaid** (Line 8a + 8b)	**6,681,447**	**7,525,155**	***14,206,602***	***47.61%***
9a.	Dually Eligible (Medicare and Medicaid)	1,941	1,123,748	*1,125,689*	*3.77%*
9.	**Medicare** (Inclusive of dually eligible and other Title XVIII beneficiaries)	10,279	2,917,502	*2,927,781*	*9.81%*
10a.	Other Public Insurance (Non-CHIP)	22,340	72,674	*95,014*	*0.32%*
10b.	Other Public Insurance CHIP	145,956	28,294	*174,250*	*0.58%*
10.	**Total Public Insurance** (Line 10a + 10b)	**168,296**	**100,968**	***269,264***	***0.90%***
11.	**Private Insurance**	1,150,535	4,498,721	*5,649,256*	*18.93%*
12.	**TOTAL** (Sum of Lines 7 + 8 + 9 + 10 + 11)	**9,204,942**	**20,631,671**	***29,836,613***	***100.00%***

Managed Care Utilization

Line	Managed Care Utilization	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	Total (e)
13a.	Capitated Member Months	51,240,490	1,282,473	348,548	2,148,128	55,019,639
13b.	Fee-for-service Member Months	56,573,557	3,867,823	709,999	4,516,942	65,668,321
13c.	**Total Member Months** (Sum of Lines 13a + 13b)	**107,814,047**	**5,150,296**	**1,058,547**	**6,665,070**	**120,687,960**

Line	Special Populations	Number of Patients (a)	%
14.	Migratory (330g awardees only)	271,020	*26.29%*
15.	Seasonal (330g awardees only)	632,822	*61.38%*
	Migrant/Seasonal (non-330g awardees)	127,207	*12.34%*
16.	**Total Agricultural Workers or Dependents** (All health centers report this line)	**1,031,049**	***100.00%***
17.	Homeless Shelter (330h awardees only)	252,317	*17.29%*
18.	Transitional (330h awardees only)	120,349	*8.25%*
19.	Doubling Up (330h awardees only)	313,850	*21.50%*
20.	Street (330h awardees only)	98,072	*6.72%*
21a.	Permanent Supportive Housing (330h awardees only)	15,930	*1.09%*
21.	Other (330h awardees only)	125,794	*8.62%*
22.	Unknown (330h awardees only)	87,517	*6.00%*
	Homeless (non-330h awardees)	461,547	*31.62%*
23.	**Total Homeless** (All health centers report this line)	**1,459,446**	***100.00%***
24.	**Total School-Based Health Center Patients** (All health centers report this line)	**885,553**	
25.	**Total Veterans** (All health centers report this line)	**398,788**	
26.	**Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site** (All health centers report this line)	**5,165,074**	

% may not equal 100% due to rounding.

Table 5 - Staffing and Utilization - 2019

National - Universal - 1385 Health Centers

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1.	Family Physicians	6,441.49	18,233,695	24,815	
2.	General Practitioners	496.54	1,504,553	2,610	
3.	Internists	2,099.81	5,974,656	5,610	
4.	Obstetrician/Gynecologists	1,338.83	3,624,233	1,767	
5.	Pediatricians	3,082.98	9,700,043	1,602	
7.	Other Specialty Physicians	623.31	2,020,001	3,355	
8.	**Total Physicians** (Lines 1–7)	**14,082.96**	**41,057,181**	**39,759**	
9a.	Nurse Practitioners	10,512.54	26,364,336	77,727	
9b.	Physician Assistants	3,348.28	9,420,638	6,580	
10.	Certified Nurse Midwives	730.16	1,580,844	159	
10a.	**Total NPs, PAs, and CNMs** (Lines 9a–10)	**14,590.98**	**37,365,818**	**84,466**	
11.	Nurses	19,273.33	2,758,216	5,901	
12.	Other Medical Personnel	34,757.85			
13.	Laboratory Personnel	2,624.02			
14.	X-ray Personnel	1,071.79			
15.	**Total Medical** (Lines 8 + 10a through 14)	**86,400.93**	**81,181,215**	**130,126**	**25,029,835**
16.	Dentists	5,323.83	13,968,056	3,169	
17.	Dental Hygienists	2,855.58	3,267,293	1,686	
17a.	Dental Therapists	36.39	30,366	0	
18.	Other Dental Personnel	11,482.66			
19.	**Total Dental Services** (Lines 16–18)	**19,698.46**	**17,265,715**	**4,855**	**6,712,204**
20a.	Psychiatrists	896.64	1,737,826	130,363	
20a1.	Licensed Clinical Psychologists	962.24	1,042,134	5,825	
20a2.	Licensed Clinical Social Workers	4,523.91	4,123,326	27,592	
20b.	Other Licensed Mental Health Providers	4,125.26	3,829,372	79,366	
20c.	Other Mental Health Staff	3,034.29	1,256,613	4,151	
20.	**Total Mental Health** (Lines 20a–c)	**13,542.34**	**11,989,271**	**247,297**	**2,581,706**
21.	**Substance Use Disorder Services**	2,136.94	1,844,673	6,724	325,732
22.	**Other Professional Services**	1,881.13	2,654,103	2,611	858,812
22a.	Ophthalmologists	46.74	105,958	1,292	
22b.	Optometrists	398.06	985,812	886	
22c.	Other Vision Care Staff	567.00			
22d.	**Total Vision Services** (Lines 22a–c)	**1,011.80**	**1,091,770**	**2,178**	**828,977**
23.	**Pharmacy Personnel**	5,982.63			
24.	Case Managers	10,103.86	4,665,788	81,082	
25.	Patient/Community Education Specialists	2,681.75	1,611,214	3,460	
26.	Outreach Workers	2,656.12			
27.	Transportation Staff	869.15			
27a.	Eligibility Assistance Workers	4,460.65			
27b.	Interpretation Staff	1,244.41			
27c.	Community Health Workers	1,483.09			
28.	Other Enabling Services	571.73			
29.	**Total Enabling Services** (Lines 24–28)	**24,070.76**	**6,277,002**	**84,542**	**2,608,861**

Clinic and Virtual Visits are shown only for personnel that generate reportable visits.
Subtotals may differ from the sum of cells due to rounding.

Table 5 - Staffing and Utilization - 2019

National - Universal - 1385 Health Centers

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
29a.	**Other Programs/Services**	5,801.64			
29b.	**Quality Improvement Staff**	3,395.17			
30a.	Management and Support Staff	24,508.26			
30b.	Fiscal and Billing Staff	14,136.74			
30c.	IT Staff	4,212.11			
31.	Facility Staff	6,137.11			
32.	Patient Support Staff	39,951.65			
33.	**Total Facility and Non-Clinical Support Staff** (Lines 30a–32)	**88,945.87**			
34.	**Grand Total** (Lines 15+19+20+21+22+22d+23+29+29a+29b+33)	**252,867.67**	**122,303,749**	**478,333**	

Clinic and Virtual Visits are shown only for personnel that generate reportable visits.
Subtotals may differ from the sum of cells due to rounding.

Table 5 - Staffing and Utilization - 2019

National - Universal - 1385 Health Centers

Selected Service Detail Addendum					
Line	**Personnel by Major Service Category: Mental Health Service Detail**	**Personnel (a1)**	**Clinic Visits (b)**	**Virtual Visits (b2)**	**Patients (c)**
20a01.	Physicians (other than Psychiatrists)	23,015	4,050,965	2,725	2,085,256
20a02.	Nurse Practitioners	12,311	3,212,156	27,369	1,651,898
20a03.	Physician Assistants	3,959	1,024,922	2,107	552,601
20a04.	Certified Nurse Midwives	861	35,826	3	20,719
Line	**Personnel by Major Service Category: Substance Use Disorder Detail**	**Personnel (a1)**	**Clinic Visits (b)**	**Virtual Visits (b2)**	**Patients (c)**
21a.	Physicians (other than Psychiatrists)	19,196	1,667,848	1,660	745,933
21b.	Nurse Practitioners (Medical)	10,843	1,268,795	2,954	653,110
21c.	Physician Assistants	3,624	400,856	92	222,439
21d.	Certified Nurse Midwives	757	24,181	4	13,044
21e.	Psychiatrists	1,524	244,118	14,431	81,386
21f.	Licensed Clinical Psychologists	1,039	104,356	150	32,361
21g.	Licensed Clinical Social Workers	4,103	511,918	3,484	139,357
21h.	Other Licensed Mental Health Providers	3,519	488,887	5,248	127,404

Clinic and Virtual Visits are shown only for personnel that generate reportable visits.
Subtotals may differ from the sum of cells due to rounding.

Table 5 - Staffing and Utilization - 2019

National - Universal - 1385 Health Centers

Line	Personnel by Major Service Category	FTEs		Clinic Visits		Virtual Visits	
		% Group	% Total	% Group	% Total	% Group	% Total
1.	Family Physicians	7.46%	2.55%	22.46%	14.91%	19.07%	5.19%
2.	General Practitioners	0.57%	0.20%	1.85%	1.23%	2.01%	0.55%
3.	Internists	2.43%	0.83%	7.36%	4.89%	4.31%	1.17%
4.	Obstetrician/Gynecologists	1.55%	0.53%	4.46%	2.96%	1.36%	0.37%
5.	Pediatricians	3.57%	1.22%	11.95%	7.93%	1.23%	0.33%
7.	Other Specialty Physicians	0.72%	0.25%	2.49%	1.65%	2.58%	0.70%
8.	**Total Physicians** (Lines 1–7)	**16.30%**	**5.57%**	**50.57%**	**33.57%**	30.55%	8.31%
9a.	Nurse Practitioners	12.17%	4.16%	32.48%	21.56%	59.73%	16.25%
9b.	Physician Assistants	3.88%	1.32%	11.60%	7.70%	5.06%	1.38%
10.	Certified Nurse Midwives	0.85%	0.29%	1.95%	1.29%	0.12%	0.03%
10a.	**Total NPs, PAs, and CNMs** (Lines 9a–10)	**16.89%**	**5.77%**	**46.03%**	**30.55%**	64.91%	17.66%
11.	Nurses	22.31%	7.62%	3.40%	2.26%	4.53%	1.23%
12.	Other Medical Personnel	40.23%	13.75%				
13.	Laboratory Personnel	3.04%	1.04%				
14.	X-ray Personnel	1.24%	0.42%				
15.	**Total Medical** (Lines 8 + 10a through 14)	**100.00%**	**34.17%**	**100.00%**	**66.38%**	**-**	**27.20%**
16.	Dentists	27.03%	2.11%	80.90%	11.42%	**65.27%**	**0.66%**
17.	Dental Hygienists	14.50%	1.13%	18.92%	2.67%	**34.73%**	**0.35%**
17a.	Dental Therapists	0.18%	0.01%	0.18%	0.02%	**0.00%**	**0.00%**
18.	Other Dental Personnel	58.29%	4.54%				
19.	**Total Dental Services** (Lines 16–18)	**100.00%**	**7.79%**	**100.00%**	**14.12%**	**-**	**1.01%**
20a.	Psychiatrists	6.62%	0.35%	14.49%	1.42%	**52.72%**	**27.25%**
20a1.	Licensed Clinical Psychologists	7.11%	0.38%	8.69%	0.85%	2.36%	1.22%
20a2.	Licensed Clinical Social Workers	33.41%	1.79%	34.39%	3.37%	11.16%	5.77%
20b.	Other Licensed Mental Health Providers	30.46%	1.63%	31.94%	3.13%	32.09%	16.59%
20c.	Other Mental Health Staff	22.41%	1.20%	10.48%	1.03%	1.68%	0.87%
20.	**Total Mental Health** (Lines 20a–c)	**100.00%**	**5.36%**	**100.00%**	**9.80%**	-	51.70%
21.	**Substance Use Disorder Services**	100.00%	0.85%	100.00%	1.51%	-	1.41%
22.	**Other Professional Services**	100.00%	0.74%	100.00%	2.17%	-	0.55%
22a.	Ophthalmologists	4.62%	0.02%	9.71%	0.09%	59.32%	0.27%
22b.	Optometrists	39.34%	0.16%	90.29%	0.81%	40.68%	0.19%
22c.	Other Vision Care Staff	56.04%	0.22%				
22d.	**Total Vision Services** (Lines 22a–c)	**100.00%**	**0.40%**	**100.00%**	**0.89%**	**100.00%**	**0.46%**
23.	**Pharmacy Personnel**	100.00%	2.37%				
24.	Case Managers	41.98%	4.00%	74.33%	3.81%	95.91%	16.95%
25.	Patient/Community Education Specialists	11.14%	1.06%	25.67%	1.32%	4.09%	0.72%
26.	Outreach Workers	11.03%	1.05%				
27.	Transportation Staff	3.61%	0.34%				
27a.	Eligibility Assistance Workers	18.53%	1.76%				
27b.	Interpretation Staff	5.17%	0.49%				
27c.	Community Health Workers	6.16%	0.59%				
28.	Other Enabling Services	2.38%	0.23%				
29.	**Total Enabling Services** (Lines 24–28)	**100.00%**	**9.52%**	**100.00%**	**5.13%**	**-**	**17.67%**

Clinic and Virtual Visits are shown only for personnel that generate reportable visits.
Subtotals may differ from the sum of cells due to rounding.
% may not equal 100% due to rounding.

Table 5 - Staffing and Utilization - 2019

National - Universal - 1385 Health Centers

Line	Personnel by Major Service Category	FTEs		Clinic Visits		Virtual Visits	
		% Group	*% Total*	*% Group*	*% Total*	*% Group*	*% Total*
29a.	**Other Programs/Services**	*100.00%*	*2.29%*				
29b.	**Quality Improvement Staff**	*100.00%*	*1.34%*				
30a.	Management and Support Staff		*9.69%*				
30b.	Fiscal and Billing Staff		*5.59%*				
30c.	IT Staff		*1.67%*				
31.	Facility Staff		*2.43%*				
32.	Patient Support Staff		*15.80%*				
33.	**Total Facility and Non-Clinical Support Staff** (Lines 30a–32)	***100.00%***	***35.17%***				
34.	**Grand Total** (Lines 15+19+20+21+22+22d+23+29+29a+29b+33)		***100.00%***		***100.00%***		***100.00%***

Clinic and Virtual Visits are shown only for personnel that generate reportable visits.
Subtotals may differ from the sum of cells due to rounding.
% may not equal 100% due to rounding.

Table 6A - Selected Diagnoses and Services Rendered - 2019

National - Universal - 1385 Health Centers

Line	Diagnostic Category	Applicable ICD - 10 - CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)	Visits per Patient
Selected Infectious and Parasitic Diseases					
1-2.	Symptomatic/Asymptomatic human immunodeficiency virus (HIV)	B20, B97.35, O98.7-, Z21	690,255	196,218	*3.52*
3.	Tuberculosis	A15- through A19-, O98.0-	17,087	7,416	*2.30*
4.	Sexually transmitted infections	A50- through A64- (exclude A63.0)	388,267	260,136	*1.49*
4a.	Hepatitis B	B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, O98.4-	103,916	48,249	*2.15*
4b.	Hepatitis C	B17.10, B17.11, B18.2, B19.20, B19.21	437,042	192,054	*2.28*
Selected Diseases of the Respiratory System					
5.	Asthma	J45-	2,438,194	1,353,710	*1.80*
6.	Chronic lower respiratory diseases	J40- through J44-, J47-	1,721,589	827,043	*2.08*
Selected Other Medical Conditions					
7.	Abnormal breast findings, female	C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.81, D05-, D48.6-, D49.3-, N60-, N63-, R92-	469,675	320,070	*1.47*
8.	Abnormal cervical findings	C53-, C79.82, D06-, R87.61-, R87.629, R87.810, R87.820	349,824	221,230	*1.58*
9.	Diabetes mellitus	E08- through E13-, O24- (exclude O24.41-)	8,942,353	2,709,755	*3.30*
10.	Heart disease (selected)	I01-, I02- (exclude I02.9), I20- through I25-, I27-, I28-, I30- through I52-	2,064,813	882,986	*2.34*
11.	Hypertension	I10- through I16-, O10-, O11-	13,133,341	5,150,015	*2.55*
12.	Contact dermatitis and other eczema	L23- through L25-, L30- (exclude L30.1, L30.3, L30.4, L30.5), L58-	929,964	728,542	*1.28*
13.	Dehydration	E86-	62,279	50,716	*1.23*
14.	Exposure to heat or cold	T33-, T34-, T67-, T68-, T69-, W92-, W93-	29,652	16,925	*1.75*
14a.	Overweight and obesity	E66-, Z68- (exclude Z68.1, Z68.20 through Z68.24, Z68.51, Z68.52)	16,044,411	7,473,606	*2.15*
Selected Childhood Conditions (limited to ages 0 through 17)					
15.	Otitis media and Eustachian tube disorders	H65- thru H69-	1,099,113	742,789	*1.48*
16.	Selected perinatal/neonatal medical conditions	A33-, P19-, P22- through P29- (exclude P29.3), P35- through P96- (exclude P54-, P91.6-, P92-, P96.81), R78.81, R78.89	218,899	131,779	*1.66*

Table 6A - Selected Diagnoses and Services Rendered - 2019

National - Universal - 1385 Health Centers

Line	Diagnostic Category	Applicable ICD - 10 - CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)	Visits per Patient
Selected Childhood Conditions (limited to ages 0 through 17)					
17.	Lack of expected normal physiological development (such as delayed milestone, failure to gain weight, failure to thrive); nutritional deficiencies in children only. Does not include sexual or mental development	E40- through E46-, E50- through E63-, P92-, R62- (exclude R62.7), R63.3	913,840	561,232	*1.63*
Selected Mental Health Conditions and Substance Use Disorders					
18.	Alcohol-related disorders	F10-, G62.1, O99.31-	1,249,604	383,951	*3.25*
19.	Other substance-related disorders (excluding tobacco use disorders)	F11- thru F19- (Exclude F17-), G62.0, O99.32-	3,010,163	636,988	*4.73*
19a.	Tobacco use disorders	F17-, O99.33-	2,356,462	1,232,262	*1.91*
20a.	Depression and other mood disorders	F30- thru F39-	9,214,279	2,669,257	*3.45*
20b.	Anxiety disorders, including post-traumatic stress disorder (PTSD)	F06.4, F40- thru F42-, F43.0, F43.1-, F93.0	8,377,601	2,573,706	*3.26*
20c.	Attention deficit and disruptive behavior disorders	F90- thru F91-	2,318,058	595,072	*3.90*
20d.	Other mental disorders, excluding drug or alcohol dependence	F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0- and F43.1-), F50- through F99- (exclude F55-, F84.2, F90-, F91-, F93.0, F98-), 099.34-, R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0	5,840,683	1,907,913	*3.06*

Table 6A - Selected Diagnoses and Services Rendered - 2019

National - Universal - 1385 Health Centers

Line	Service Category	Applicable ICD-10-CM or CPT-4/II Code	Number of Visits (a)	Number of Patients (b)	Visits per Patient
Selected Diagnostic Tests/Screening/Preventive Services					
21.	HIV test	**CPT-4**: 86689; 86701 through 86703; 87389 through 87391, 87534 through 87539, 87806	2,713,628	2,233,156	*1.22*
21a.	Hepatitis B test	**CPT-4**: 86704 through 86707, 87340, 87341, 87350	1,200,509	928,189	*1.29*
21b.	Hepatitis C test	**CPT-4**: 86803, 86804, 87520 through 87522	1,433,282	1,178,815	*1.22*
22.	Mammogram	**CPT-4**: 77065, 77066, 77067 OR **ICD-10**: Z12.31	932,683	823,312	*1.13*
23.	Pap tests	**CPT-4**: 88141 through 88153, 88155, 88164 through 88167, 88174, 88175 OR **ICD-10**: Z01.41-, Z01.42, Z12.4 (exclude Z01.411 and Z01.419)	1,941,337	1,809,082	*1.07*
24.	Selected immunizations: hepatitis A; haemophilus influenzae B (HiB); pneumococcal, diphtheria, tetanus, pertussis (DTaP) (DTP) (DT); mumps, measles, rubella (MMR); poliovirus; varicella; hepatitis B	**CPT-4**: 90632, 90633, 90634, 90636, 90643, 90644, 90645, 90646, 90647, 90648, 90669, 90670, 90696, 90697, 90698, 90700, 90701, 90702, 90703, 90704, 90705, 90706, 90707, 90708, 90710, 90712, 90713, 90714, 90715, 90716, 90718, 90720, 90721, 90723, 90730, 90731, 90732, 90740, 90743, 90744, 90745, 90746, 90747, 90748	5,446,128	3,994,972	*1.36*
24a.	Seasonal flu vaccine	**CPT-4**: 90630, 90653 through 90657, 90658, 90661, 90662, 90672, 90673, 90674, 90682, 90685 through 90689, 90749, 90756	5,255,473	4,794,323	*1.10*
25.	Contraceptive management	**ICD-10**: Z30-	2,864,639	1,697,678	*1.69*
26.	Health supervision of infant or child (ages 0 through 11)	**CPT-4**: 99381 through 99383, 99391 through 99393 **ICD-10**: Z00.1-	5,742,883	3,744,148	*1.53*
26a.	Childhood lead test screening (ages 9 to 72 months)	**ICD-10**: Z13.88 **CPT-4**: 83655	669,316	585,807	*1.14*
26b.	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	**CPT-4**: 99408, 99409 **HCPCS**: G0396, G0397, G0443, H0050	2,336,279	1,381,408	*1.69*
26c.	Smoke and tobacco use cessation counseling	**CPT-4**: 99406, 99407 OR **HCPCS**: S9075 OR **CPT-II**: 4000F, 4001F, 4004F	2,589,125	1,393,772	*1.86*
26d.	Comprehensive and intermediate eye exams	**CPT-4**: 92002, 92004, 92012, 92014	736,626	650,106	*1.13*

Table 6A - Selected Diagnoses and Services Rendered - 2019

National - Universal - 1385 Health Centers

Line	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)	Visits per Patient
Selected Dental Services					
27.	Emergency services	**ADA**: D0140, D9110	1,490,619	1,263,425	*1.18*
28.	Oral exams	**ADA**: D0120, DO145, D0150, D0160, D0170, D0171, D0180	5,938,127	4,816,567	*1.23*
29.	Prophylaxis–adult or child	**ADA**: D1110, D1120	4,341,305	3,478,680	*1.25*
30.	Sealants	**ADA**: D1351	578,651	496,827	*1.16*
31.	Fluoride treatment–adult or child	**ADA**: D1206, D1208, **CPT-4**: 99188	3,246,348	2,549,757	*1.27*
32.	Restorative services	**ADA**: D21xx through D29xx	3,988,423	2,001,402	*1.99*
33.	Oral surgery (extractions and other surgical procedures)	**ADA**: D7xxx	1,413,573	1,051,477	*1.34*
34.	Rehabilitation services (Endo, Perio, Prostho, Ortho)	**ADA**: D3xxx, D4xxx, D5xxx, D6xxx, D8xxx	2,120,260	1,007,312	*2.10*

Sources of codes:
– International Classification of Diseases, 2019, (ICD-10-CM). National Center for Health Statistics (NCHS).
– Current Procedural Terminology (CPT), 2019, American Medical Association (AMA).
– Current Dental Terminology (CDT), 2019 – Dental Procedure Codes. American Dental Association (ADA).
Note: "X" in a code denotes any number including the absence of a number in that place.
Dashes (–) in a code indicate that additional characters are required.
ICD-10-CM codes all have at least four digits. These codes are not intended to reflect if a code is billable or not. Instead they are used to point out that other codes in the series are to be considered.

Table 6B - Quality of Care Measures - 2019

National - Universal - 1385 Health Centers

Prenatal Care Provided by Referral Only

Answer	Number of Health Centers	% Total
Yes	476	*34.37%*
No	909	*65.63%*

Section A - Age Categories for Prenatal Care Patients: (Health Centers Who Provide Prenatal Care Only)

	Demographic Characteristics of Prenatal Care Patients		
Line	**Age**	**Number of Patients (a)**	**Percent**
1.	Less than 15 Years	870	*0.15%*
2.	Ages 15–19	53,159	*9.11%*
3.	Ages 20–24	152,454	*26.14%*
4.	Ages 25–44	375,096	*64.30%*
5.	Ages 45 and Over	1,749	*0.30%*
6.	**Total Patients** (Sum of lines 1–5)	**583,328**	***100.00%***

Section B - Early Entry into Prenatal Care

Line	Early Entry into Prenatal Care	Women Having First Visit with Health Center		Women Having First Visit with Another Provider		% Total
		(a)	%	(b)	%	
7.	First Trimester	398,045	*68.24%*	32,521	*5.58%*	*73.81%*
8.	Second Trimester	108,633	*18.62%*	12,333	*2.11%*	*20.74%*
9.	Third Trimester	25,507	*4.37%*	6,289	*1.08%*	*5.45%*

Section C - Childhood Immunization Status

Line	Childhood Immunization Status	Total Patients with 2nd Birthday (a)	Estimated Number of Patients Immunized	Estimated % of Patients Immunized
10.	MEASURE: Percentage of children 2 years of age who received age appropriate vaccines by their 2nd birthday	410,408	163,156	*39.75%*

Section D - Cervical Cancer Screening

Line	Cervical Cancer Screening	Total Female Patients Aged 23 through 64 (a)	Estimated Number of Patients Tested	Estimated % of Patients Tested
11.	MEASURE: Percentage of women 23-64 years of age who were screened for cervical cancer	7,400,971	4,184,135	*56.53%*

Section E – Weight Assessment and Counseling for Nutrition and Physical Activity of Children and Adolescents

Line	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Total Patients Aged 3 through 17 (a)	Estimated Number of Patients Assessed and Counseled	Estimated % of Patients Assessed and Counseled
12.	MEASURE: Percentage of patients 3-17 years of age with a BMI percentile *and* counseling on nutrition *and* physical activity documented	5,435,757	3,870,784	*71.21%*

% may not equal 100% due to rounding.

Estimated % of Patients for Sections C through N are based on the total of the estimated number of patients included in column b for each health center, for each measure, divided by the total number of patients in the applicable category (i.e., the Universe) for each measure.

Table 6B - Quality of Care Measures - 2019

National - Universal - 1385 Health Centers

Section F – Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Line	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Total Patients Aged 18 and Older (a)	Estimated Number of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate	Estimated % of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate
13.	MEASURE: Percentage of patients 18 years of age and older with (1) BMI documented and (2) follow-up plan documented if BMI is outside normal parameters	16,240,788	11,763,627	*72.43%*

Section G – Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Line	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Total Patients Aged 18 and Older (a)	Estimated Number of Patients Assessed for Tobacco Use and Provided Intervention if a Tobacco User	Estimated % of Patients Assessed for Tobacco Use and Provided Intervention if a Tobacco User
14a.	MEASURE: Percentage of patients aged 18 years of age and older who (1) were screened for tobacco use one or more times within 24 months, *and* (2) if identified to be a tobacco user received cessation counseling intervention	12,688,867	11,060,418	*87.17%*

Section H – Use of Appropriate Medications for Asthma

Line	Use of Appropriate Medications for Asthma	Total Patients Aged 5 through 64 with Persistent Asthma (a)	Estimated Number of Patients with Acceptable Plan	Estimated % of Patients with Acceptable Plan
16.	MEASURE: Percentage of patients 5 through 64 years of age identified as having persistent asthma and were appropriately ordered medication	460,305	395,650	*85.95%*

Section I – Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Line	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Total Patients Aged 21 and Older at High Risk of Cardiovascular Events (a)	Estimated Number of Patients Prescribed or On Statin Therapy	Estimated % of Patients Prescribed or On Statin Therapy
17a.	MEASURE: Percentage of patients 21 years of age and older at high risk of cardiovascular events who were prescribed or were on statin therapy	2,744,606	1,919,567	*69.94%*

Section J – Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet

Line	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Total Patients Aged 18 and Older with IVD Diagnosis or AMI, CABG, or PCI Procedure (a)	Estimated Number of Patients with Aspirin or Other Anitplatelet Therapy	Estimated % of Patients with Documentation of Aspirin or Other Anitplatelet Therapy
18.	MEASURE: Percentage of patients 18 years of age and older with a diagnosis of IVD or AMI, CABG, or PCI procedure with aspirin or another antiplatelet	569,550	460,054	*80.78%*

% may not equal 100% due to rounding.

Estimated % of Patients for Sections C through N are based on the total of the estimated number of patients included in column b for each health center, for each measure, divided by the total number of patients in the applicable category (i.e., the Universe) for each measure.

Table 6B - Quality of Care Measures - 2019

National - Universal - 1385 Health Centers

Section K – Colorectal Cancer Screening

Line	Colorectal Cancer Screening	Total Patients Aged 50 through 75 (a)	Estimated Number of Patients with Appropriate Screening for Colorectal Cancer	Estimated % of Patients with Appropriate Screening for Colorectal Cancer
19.	MEASURE: Percentage of patients 50 through 75 years of age who had appropriate screening for colorectal cancer	6,017,345	2,741,612	*45.56%*

Section L – HIV Linkage to Care

Line	HIV Linkage to Care	Total Patients First Diagnosed with HIV (a)	Estimated Number of Patients Seen Within 90 Days of First Diagnosis of HIV	Estimated % of Patients Seen Within 90 Days of First Diagnosis of HIV
20.	MEASURE: Percentage of patients whose first ever HIV diagnosis was made by health center staff between October 1 of the prior year and September 30 of the measurement year and who were seen for follow-up treatment within 90 days of that first ever diagnosis	7,164	6,248	*87.21%*

Section M – Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Line	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Total Patients Aged 12 and Older (a)	Estimated Number of Patients Screened for Depression and Follow-up Plan Documented as Appropriate	Estimated % of Patients Screened for Depression and Follow-up Plan Documented as Appropriate
21.	MEASURE: Percentage of patients 12 years of age and older who were (1) screened for depression with a standardized tool *and*, if screening was positive, (2) had a follow-up plan documented	16,155,702	11,569,790	*71.61%*

Section N – Dental Sealants for Children between 6-9 Years

Line	Dental Sealants for Children between 6-9 Years	Total Patients Aged 6 through 9 at Moderate to High Risk for Caries (a)	Estimated Number of Patients with Sealants to First Molars	Estimated % of Patients with Sealants to First Molars
22.	MEASURE: Percentage of children 6 through 9 years of age at moderate to high risk of caries who received a sealant on a first permanent molar	252,774	143,565	*56.80%*

% may not equal 100% due to rounding.

Estimated % of Patients for Sections C through N are based on the total of the estimated number of patients included in column b for each health center, for each measure, divided by the total number of patients in the applicable category (i.e., the Universe) for each measure.

Table 7 - Health Outcomes and Disparities - 2019

National - Universal - 1385 Health Centers

Line	Description	Total (i)
0.	HIV-Positive Pregnant Women	1,076
2.	Deliveries Performed by Health Center's Providers	175,254

Section A: Deliveries And Birth Weight

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500-2499 grams (1c)	Live Births: >= 2500 grams (1d)	% Low and Very Low Birth Weight
	Hispanic/Latino					
1a.	Asian	254	4	19	252	8.36%
1b1.	Native Hawaiian	161	4	18	135	14.01%
1b2.	Other Pacific Islander	1,010	9	49	922	5.92%
1c.	Black/African American	3,907	57	298	3,529	9.14%
1d.	American Indian/Alaska Native	1,576	13	78	1,300	6.54%
1e.	White	107,214	1,058	5,858	97,496	6.62%
1f.	More than One Race	7,172	71	396	6,366	6.83%
1g.	Unreported/Refused to Report Race	35,876	363	1,984	32,421	6.75%
	Subtotal Hispanic/Latino	**157,170**	**1,579**	**8,700**	**142,421**	**6.73%**
	Non-Hispanic/Latino					
2a.	Asian	11,344	108	727	10,242	7.54%
2b1.	Native Hawaiian	582	10	48	530	9.86%
2b2.	Other Pacific Islander	3,527	58	225	3,191	8.15%
2c.	Black/African American	53,905	1,169	5,220	46,223	12.14%
2d.	American Indian/Alaska Native	2,456	29	122	2,228	6.35%
2e.	White	66,436	725	4,223	58,877	7.75%
2f.	More than One Race	3,034	47	259	2,809	9.82%
2g.	Unreported/Refused to Report Race	5,633	65	421	5,649	7.92%
	Subtotal Non-Hispanic/Latino	**146,917**	**2,211**	**11,245**	**129,749**	**9.40%**
	Unreported/Refused to Report Race and Ethnicity					
h.	Unreported/Refused to Report Race and Ethnicity	8,869	233	1,043	13,589	8.58%
i.	**Total**	**312,956**	**4,023**	**20,988**	**285,759**	**8.05%**

% shown are rounded to the .01% level for table display purposes; calculations are made using % to 8 decimal places.

Table 7 - Health Outcomes and Disparities - 2019

National - Universal - 1385 Health Centers

Section B: Controlling High Blood Pressure					
Line	**Race and Ethnicity**	**Total Patients 18 through 85 Years of Age with Hypertension (2a)**	**Number Charts Sampled or EHR Total (2b)**	**Patients with Hypertension Controlled (2c)**	**Estimated % Patients with Controlled Blood Pressure**
	Hispanic/Latino				
1a.	Asian	2,878	2,813	1,875	66.65%
1b1.	Native Hawaiian	1,103	1,082	683	63.16%
1b2.	Other Pacific Islander	6,288	6,274	4,031	64.27%
1c.	Black/African American	35,601	35,317	22,457	63.75%
1d.	American Indian/Alaska Native	11,419	11,165	7,167	64.94%
1e.	White	842,601	832,374	560,127	67.42%
1f.	More than One Race	50,332	49,656	33,407	67.45%
1g.	Unreported/Refused to Report Race	325,270	317,642	210,672	66.58%
	Subtotal Hispanic/Latino	**1,275,492**	**1,256,323**	**840,419**	**67.08%**
	Non-Hispanic/Latino				
2a.	Asian	175,530	166,091	117,790	69.85%
2b1.	Native Hawaiian	7,173	7,144	4,308	60.31%
2b2.	Other Pacific Islander	19,644	15,927	9,892	59.82%
2c.	Black/African American	1,137,275	1,114,662	632,374	57.00%
2d.	American Indian/Alaska Native	39,224	39,017	22,891	58.61%
2e.	White	1,967,737	1,935,308	1,301,530	67.33%
2f.	More than One Race	31,351	31,015	19,488	62.94%
2g.	Unreported/Refused to Report Race	67,967	66,025	41,649	62.83%
	Subtotal Non-Hispanic/Latino	**3,445,901**	**3,375,189**	**2,149,922**	**63.75%**
	Unreported/Refused to Report Race and Ethnicity				
h.	Unreported/Refused to Report Race and Ethnicity	99,295	92,361	56,786	63.09%
i.	**Total**	**4,820,688**	**4,723,873**	**3,047,127**	**64.62%**

% shown are rounded to the .01% level for table display purposes; calculations are made using % to 8 decimal places
% by race are low estimates, not adjusted at the health center level for samples with zero patients in racial categories.

Table 7 - Health Outcomes and Disparities - 2019

National - Universal - 1385 Health Centers

Line	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Number Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)	Estimated % Patients with Hba1c > 9%
	Section C: Diabetes: Hemoglobin A1c Poor Control				
	Hispanic/Latino				
1a.	Asian	1,791	1,775	534	30.08%
1b1.	Native Hawaiian	797	775	309	39.87%
1b2.	Other Pacific Islander	4,523	4,491	1,402	31.20%
1c.	Black/African American	19,459	18,558	5,924	31.87%
1d.	American Indian/Alaska Native	8,762	8,206	2,974	34.60%
1e.	White	618,743	603,777	205,968	34.06%
1f.	More than One Race	34,017	31,817	10,970	34.57%
1g.	Unreported/Refused to Report Race	244,571	238,989	82,910	34.40%
	Subtotal Hispanic/Latino	**932,663**	**908,388**	**310,991**	**34.11%**
	Non-Hispanic/Latino				
2a.	Asian	97,946	96,660	19,785	20.32%
2b1.	Native Hawaiian	4,676	4,658	1,721	36.98%
2b2.	Other Pacific Islander	17,190	13,557	5,507	43.53%
2c.	Black/African American	509,231	498,321	168,494	33.73%
2d.	American Indian/Alaska Native	22,813	22,647	8,550	37.70%
2e.	White	821,686	807,683	236,401	29.18%
2f.	More than One Race	16,419	16,123	5,431	33.57%
2g.	Unreported/Refused to Report Race	39,124	37,996	12,568	34.13%
	Subtotal Non-Hispanic/Latino	**1,529,085**	**1,497,645**	**458,457**	**30.58%**
	Unreported/Refused to Report Race and Ethnicity				
h.	Unreported/Refused to Report Race and Ethnicity	59,908	55,406	20,016	33.68%
i.	**Total**	**2,521,656**	**2,461,439**	**789,464**	**31.95%**

% shown are rounded to the .01% level for table display purposes; calculations are made using % to 8 decimal places
% by race are low estimates, not adjusted at the health center level for samples with zero patients in racial categories.

Table 8A - Financial Costs - 2019

National - Universal - 1385 Health Centers

Line	Cost Center	Accrued Cost (a) $	Allocation of Facility and Non-Clinical Support Services (b) $	Total Cost After Allocation of Facility and Non-Clinical Support Services (c) $
Financial Costs of Medical Care				
1.	Medical Staff	8,872,817,246	4,736,572,230	13,609,389,476
2.	Lab and X-ray	488,570,925	253,739,860	742,310,785
3.	Medical/Other Direct	1,684,319,912	903,275,398	2,587,595,310
4.	**Total Medical Care Services** (Sum of Lines 1 through 3)	**11,045,708,083**	**5,893,587,488**	**16,939,295,571**
Financial Costs of Other Clinical Services				
5.	Dental	2,504,948,005	1,206,693,701	3,711,641,706
6.	Mental Health	1,500,095,921	722,225,732	2,222,321,653
7.	Substance Use Disorder	207,175,622	105,685,433	312,861,055
8a.	Pharmacy not including pharmaceuticals	1,084,720,026	519,003,965	1,603,723,991
8b.	Pharmaceuticals	2,340,613,823		2,340,613,823
9.	Other Professional	242,038,723	118,189,804	360,228,527
9a.	Vision	131,460,341	66,109,189	197,569,530
10.	**Total Other Clinical Services** (Sum of Lines 5 through 9a)	**8,011,052,461**	**2,737,907,824**	**10,748,960,285**
Financial Costs of Enabling and Other Services				
11a.	Case Management	612,726,075		612,726,075
11b.	Transportation	61,885,184		61,885,184
11c.	Outreach	172,895,982		172,895,982
11d.	Patient and Community Education	178,595,427		178,595,427
11e.	Eligibility Assistance	231,847,462		231,847,462
11f.	Interpretation Services	96,001,327		96,001,327
11g.	Other Enabling Services	43,003,869		43,003,869
11h.	Community Health Workers	71,390,614		71,390,614
11.	**Total Enabling Services Cost** (Sum of Lines 11a through 11h)	**1,468,345,940**	**698,652,899**	**2,166,998,839**
12.	Other Related Services	649,548,960	230,589,406	880,138,366
12a.	Quality Improvement	292,598,349	133,377,229	425,975,578
13.	**Total Enabling and Other Services** (Sum of Lines 11, 12, and 12a)	**2,410,493,249**	**1,062,619,534**	**3,473,112,783**
Facility and Non-Clinical Support Services and Totals				
14.	Facility	2,256,263,679		
15.	Non-Clinical Support Services	7,437,851,167		
16.	**Total Facility and Non-Clinical Support Services** (Sum of Lines 14 and 15)	**9,694,114,846**		
17.	**Total Accrued Costs** (Sum of Lines 4 + 10 + 13 + 16)	**31,161,368,639**		**31,161,368,639**
18.	Value of Donated Facilities, Services and Supplies			607,824,721
19.	**Total with Donations** (Sum of Lines 17 and 18)			**31,769,193,360**

Table 9D: Patient Related Revenue - 2019

National - Universal - 1385 Health Centers

Line	Payer Category	Charges			Collections			
		Full Charges This Period (a)	*% of Payer*	*% of Total*	Amount Collected This Period (b)	*% of Payer*	*% of Total*	*% of Charges*
1.	Medicaid Non-Managed Care	6,911,950,330	*39.32%*	*19.56%*	5,426,288,944	*39.86%*	*24.96%*	*78.51%*
2a.	Medicaid Managed Care (capitated)	3,499,748,034	*19.91%*	*9.90%*	3,004,171,920	*22.07%*	*13.82%*	*85.84%*
2b.	Medicaid Managed Care (fee-for-service)	7,166,556,316	*40.77%*	*20.28%*	5,182,119,698	*38.07%*	*23.84%*	*72.31%*
3.	**Total Medicaid** (Sum of Lines 1 + 2a + 2b)	**17,578,254,680**	***100.00%***	***49.74%***	**13,612,580,562**	***100.00%***	***62.62%***	***77.44%***
4.	Medicare Non-Managed Care	3,581,005,289	*78.15%*	*10.13%*	2,111,938,118	*79.26%*	*9.71%*	*58.98%*
5a.	Medicare Managed Care (capitated)	192,696,183	*4.21%*	*0.55%*	157,079,330	*5.90%*	*0.72%*	*81.52%*
5b.	Medicare Managed Care (fee-for-service)	808,503,860	*17.64%*	*2.29%*	395,487,770	*14.84%*	*1.82%*	*48.92%*
6.	**Total Medicare** (Sum of Lines 4 + 5a + 5b)	**4,582,205,332**	***100.00%***	***12.97%***	**2,664,505,218**	***100.00%***	***12.26%***	***58.15%***
7.	Other Public, including Non-Medicaid CHIP, Non-Managed Care	457,052,703	*73.98%*	*1.29%*	279,195,263	*76.31%*	*1.28%*	*61.09%*
8a.	Other Public, including Non-Medicaid CHIP, Managed Care (capitated)	50,794,071	*8.22%*	*0.14%*	20,843,767	*5.70%*	*0.10%*	*41.04%*
8b.	Other Public, including Non-Medicaid CHIP, Managed Care (fee-for-service)	109,959,516	*17.80%*	*0.31%*	65,846,374	*18.00%*	*0.30%*	*59.88%*
9.	**Total Other Public** (Sum of Lines 7 + 8a + 8b)	**617,806,290**	***100.00%***	***1.75%***	**365,885,404**	***100.00%***	***1.68%***	***59.22%***
10.	Private Non-Managed Care	5,485,479,150	*84.08%*	*15.52%*	3,213,756,148	*86.50%*	*14.78%*	*58.59%*
11a.	Private Managed Care (capitated)	199,409,099	*3.06%*	*0.56%*	85,316,329	*2.30%*	*0.39%*	*42.78%*
11b.	Private Managed Care (fee-for-service)	839,058,753	*12.86%*	*2.37%*	416,077,360	*11.20%*	*1.91%*	*49.59%*
12.	**Total Private** (Sum of Lines 10 + 11a + 11b)	**6,523,947,002**	***100.00%***	***18.46%***	**3,715,149,837**	***100.00%***	***17.09%***	***56.95%***
13.	Self-pay	6,036,024,790	*100.00%*	*17.08%*	1,381,335,323	*100.00%*	*6.35%*	*22.88%*
14.	**TOTAL** (Sum of Lines 3 + 6 + 9 + 12 + 13)	**35,338,238,094**		***100.00%***	**21,739,456,344**		***100.00%***	***61.52%***

% may not equal 100% due to rounding.

Table 9D: Patient Related Revenue - 2019

National - Universal - 1385 Health Centers

Line	Payer Category	Retroactive Settlements, Receipts, and Paybacks (c)						Allowances	
		Collection of Recon/Wrap Around Current Year (c1)	Collection of Recon/Wrap Around Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty/ Payback (c4)	*Net Retros*	*Net Retros % of Charges*	Allowances (d)	*Allowances % of Charges*
1.	Medicaid Non-Managed Care	522,840,559	240,910,152	59,642,551	30,641,419	*792,751,843*	*11.47%*	1,636,997,676	*23.68%*
2a.	Medicaid Managed Care (capitated)	1,312,516,267	112,342,243	211,921,437	84,667,223	*1,552,112,724*	*44.35%*	524,039,599	*14.97%*
2b.	Medicaid Managed Care (fee-for-service)	998,556,436	230,646,772	186,655,801	15,336,617	*1,400,522,392*	*19.54%*	1,973,386,854	*27.54%*
3.	**Total Medicaid** (Sum of Lines 1 + 2a + 2b)	**2,833,913,262**	**583,899,167**	**458,219,789**	**130,645,259**	***3,745,386,959***	***21.31%***	**4,134,424,129**	***23.52%***
4.	Medicare Non-Managed Care	24,363,280	19,791,740	9,779,941	761,057	*53,173,904*	*1.48%*	1,342,571,519	*37.49%*
5a.	Medicare Managed Care (capitated)	3,027,867	175,310	6,360,488	9,514	*9,554,151*	*4.96%*	36,511,952	*18.95%*
5b.	Medicare Managed Care (fee-for-service)	8,780,664	6,308,321	8,064,052	113,940	*23,039,097*	*2.85%*	352,262,757	*43.57%*
6.	**Total Medicare** (Sum of Lines 4 + 5a + 5b)	**36,171,811**	**26,275,371**	**24,204,481**	**884,511**	***85,767,152***	***1.87%***	**1,731,346,228**	***37.78%***
7.	Other Public, including Non-Medicaid CHIP, Non-Managed Care	476,404	315,997	846,173	46,473	*1,592,101*	*0.35%*	161,890,909	*35.42%*
8a.	Other Public, including Non-Medicaid CHIP, Managed Care (capitated)	2,568,601	4,389,942	223,073	0	*7,181,616*	*14.14%*	27,753,339	*54.64%*
8b.	Other Public, including Non-Medicaid CHIP, Managed Care (fee-for-service)	2,405,740	2,292,478	487,310	19,210	*5,166,318*	*4.70%*	36,611,543	*33.30%*
9.	**Total Other Public** (Sum of Lines 7 + 8a + 8b)	**5,450,745**	**6,998,417**	**1,556,556**	**65,683**	***13,940,035***	***2.26%***	**226,255,791**	***36.62%***

% may not equal 100% due to rounding.

Table 9D: Patient Related Revenue - 2019

National - Universal - 1385 Health Centers

Line	Payer Category	Retroactive Settlements, Receipts, and Paybacks (c)						Allowances	
		Collection of Recon/Wrap Around Current Year (c1)	Collection of Recon/Wrap Around Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty/ Payback (c4)	*Net Retros*	*Net Retros % of Charges*	Allowances (d)	*Allowances % of Charges*
10.	Private Non-Managed Care			23,686,873	1,312,014	*22,374,859*	*0.41%*	2,003,589,129	*36.53%*
11a.	Private Managed Care (capitated)			9,429,394	107	*9,429,287*	*4.73%*	113,640,136	*56.99%*
11b.	Private Managed Care (fee-for-service)			3,668,006	25,751	*3,642,255*	*0.43%*	354,820,114	*42.29%*
12.	**Total Private** (Sum of Lines 10 + 11a + 11b)			**36,784,273**	**1,337,872**	***35,446,401***	***0.54%***	**2,472,049,379**	***37.89%***
13.	Self-pay								
14.	**TOTAL** (Sum of Lines 3 + 6 + 9 + 12 + 13)	**2,875,535,818**	**617,172,955**	**520,765,099**	**132,933,325**	***3,880,540,547***	***10.98%***	**8,564,075,527**	***24.23%***

Line		Sliding Fee Discounts (e)	Bad Debt Write Off (f)
13.	Self-pay	3,765,129,217	581,006,913

% may not equal 100% due to rounding.

Table 9E - Other Revenues - 2019

National - Universal - 1385 Health Centers

Line	Source	Amount (a)	*% Group Total*
BPHC Grants (Enter Amount Drawn Down - Consistent with PMS 272)			
1a.	Migrant Health Center	401,042,730	*8.02%*
1b.	Community Health Center	4,055,001,554	*81.05%*
1c.	Health Care for the Homeless	401,465,786	*8.02%*
1e.	Public Housing Primary Care	72,373,063	*1.45%*
1g.	**Total Health Center** (Sum of Lines 1a through 1e)	**4,929,883,133**	***98.54%***
1k.	Capital Development Grants, including School-Based Health Center Capital Grants	72,904,908	*1.46%*
1.	**Total BPHC Grants** (Sum of Lines 1g + 1k)	**5,002,788,041**	***100.00%***
Other Federal Grants			
2.	Ryan White Part C HIV Early Intervention	81,137,525	*16.85%*
3.	Other Federal Grants	337,247,567	*70.05%*
3a.	Medicare and Medicaid EHR Incentive Payments for Eligible Providers	63,085,311	*13.10%*
5.	**Total Other Federal Grants** (Sum of Lines 2–3a)	**481,470,403**	***100.00%***
Non-Federal Grants or Contracts			
6.	State Government Grants and Contracts	816,749,612	*26.42%*
6a.	State/Local Indigent Care Programs	666,720,467	*21.57%*
7.	Local Government Grants and Contracts	726,308,436	*23.49%*
8.	Foundation/Private Grants and Contracts	881,866,895	*28.52%*
9.	**Total Non-Federal Grants And Contracts** (Sum of Lines 6 + 6A + 7 + 8)	**3,091,645,410**	***100.00%***
10.	Other Revenue (non-patient related revenue not reported elsewhere)	1,117,334,920	*100.00%*
11.	**Total Revenue** (Sum of Lines 1 + 5 + 9 + 10)	**9,693,238,774**	

% may not equal 100% due to rounding.

Health Information Technology Capabilities - 2019

National - Universal - 1385 Health Centers

Line	Measures	Number of Health Centers	% of Total
1.	Does your center currently have an Electronic Health Record (EHR) system installed and in use?		
1a.	Yes, installed at all sites and used by all providers	1,361	*98.27%*
1b.	Yes, but only installed at some sites or used by some providers	18	*1.30%*
	Total Health Centers with EHR installed (Sum 1a + 1b)	**1,379**	***99.57%***
1c.	Health Centers who will install the EHR system in 3 months	0	*0.00%*
1d.	Health Centers who will install the EHR system in 6 months	0	*0.00%*
1e.	Health Centers who will install the EHR system in 1 year or more	2	*0.14%*
1f.	Health Centers who have Not Planned on installing the EHR system	4	*0.29%*
	Total Health Centers with No EHR installed (sum 1c + 1d + 1e + 1f)	**6**	***0.43%***
	Total Health Centers reported	**1,385**	***100.00%***
2.	Does your center send prescriptions to the pharmacy electronically? (Do not include faxing.)		
	a. Yes	1,366	*98.63%*
	b. No	12	*0.87%*
	c. Not Sure	1	*0.07%*
3.	Does your center use computerized, clinical decision support such as alerts for drug allergies, checks for drug-drug interations, reminders for preventive screening tests, or other similar functions?		
	a. Yes	1,372	*99.06%*
	b. No	7	*0.51%*
	c. Not Sure	0	*0.00%*
4.	With which of the following key providers/health care settings does your center electronically exchange clinical information? (Select all that apply)		
	a. Hospitals/Emergency rooms	950	*68.59%*
	b. Specialty clinicians	821	*59.28%*
	c. Other primary care providers	652	*47.08%*
	d. None of the above	212	*15.31%*
	e. Others	209	*15.09%*
5.	Does your center engage patients through health IT in any of the following ways? (Select all that apply)		
	a. Patient portals	1,231	*88.88%*
	b. Kiosks	290	*20.94%*
	c. Secure messaging	928	*67.00%*
	d. Others	102	*7.36%*
	e. No, we do not engage patients using HIT	92	*6.64%*
6.	Question Removed		
7.	How do you collect data for UDS clinical reporting (Tables 6B and 7)?		
	a. We use the EHR to extract automated reports	620	*44.77%*
	b. We use the EHR but only to access individual patient charts	11	*0.79%*
	c. We use the EHR in combination with another data analytic system	745	*53.79%*
	d. We do not use the EHR	3	*0.22%*
8.	Question Removed		
9.	Question Removed		

Health Information Technology Capabilities - 2019

National - Universal - 1385 Health Centers

Line.	Measures	Number of Health Centers	% of Total
10.	How does your health center utilize HIT and EHR data beyond direct patient care? (Select all that apply)		
	a. Quality improvement	1,367	*98.70%*
	b. Population health management	1,158	*83.61%*
	c. Program evaluation	1,085	*78.34%*
	d. Research	356	*25.70%*
	e. Other	45	*3.25%*
	f. We do not utilize HIT or EHR data beyond direct patient care	8	*0.58%*
11.	Does your health center collect data on individual patients' social risk factors, outside of the data reportable in the UDS?		
	a. Yes	979	*70.69%*
	b. No, but we are in planning stages to collect this information	316	*22.82%*
	c. No, we are not planning to collect this information	90	*6.50%*
12.	Which standardized screener(s) for social risk factors, if any, do you use? (Select all that apply)		
	a. Accountable Health Communities Screening Tools	91	*6.57%*
	b. Upstream Risks Screening Tool and Guide	12	*0.87%*
	c. iHELP	7	*0.51%*
	d. Recommend Social and Behavioral Domains for EHRs	131	*9.46%*
	e. Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)	478	*34.51%*
	f. Well Child Care, Evaluation, Community Resources, Advocacy Referral, Education (WE CARE)	84	*6.06%*
	g. WellRx	10	*0.72%*
	h. Other	267	*19.28%*
	i. We do not use a standardized screener	526	*37.98%*

Other Data Elements - 2019

National - Universal - 1385 Health Centers

Line	Measures	Number of Physicians (1a) or Patients (1b)	% of Total
1.	Medication-Assisted Treatment (MAT) for Opioid Use Disorder		
1a.	How many physicians, certified nurse practitioners and physician assistants, on-site or with whom the health center has contracts, have obtained a Drug Addiction Treatment Act of 2000 (DATA) waiver to treat opioid use disorder with medications specifically approved by the U.S. Food and Drug Administration (FDA) for that indication?	7,095	
1b.	How many patients received medication-assisted treatment for opioid use disorder from a physician, certified nurse practitioner, or physician assistant, with a DATA waiver working on behalf of the health center?	142,919	*0.48%*
Line	**Measures**	**Number of Health Centers**	**% of Total**
2.	Did your organization use telemedicine to provide remote clinical care services? (*The term "telehealth" includes "telemedicine" services, but encompasses a broader scope of remote healthcare services. Telemedicine is specific to remote clinical services whereas telehealth may include remote non-clinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services.*)		
	a. Yes	592	*42.74%*
	b. No	793	*57.26%*
2a1.	Who did you use telemedicine to communicate with? (Select all that apply)		
	a. Patients at remote locations from your organization (e.g., home telehealth, satellite locations)	357	*60.30%*
	b. Specialists outside your organization (e.g., specialists at referral centers)	330	*55.74%*
2a2.	What telehealth technologies did you use? (Select all that apply)		
	a. Real-time telehealth (e.g., live video conferencing)	533	*90.03%*
	b. Store-and-forward telehealth (e.g., secure email with photos or videos of patient examinations)	130	*21.96%*
	c. Remote patient monitoring	27	*4.56%*
	d. Mobile Health (mHealth)	22	*3.72%*
2a3.	What primary telemedicine services were used at your organization? (Select all that apply)		
	a. Primary care	165	*27.87%*
	b. Oral health	35	*5.91%*
	c. Behavioral health: Mental health	446	*75.34%*
	d. Behavioral health: Substance use disorder	192	*32.43%*
	e. Dermatology	61	*10.30%*
	f. Chronic conditions	111	*18.75%*
	g. Disaster management	10	*1.69%*
	h. Consumer health education	28	*4.73%*
	i. Provider-to-provider consultation	89	*15.03%*
	j. Radiology	28	*4.73%*
	k. Nutrition and dietary counseling	52	*8.78%*
	l. Other	89	*15.03%*

Other Data Elements - 2019

National - Universal - 1385 Health Centers

Line	Measures	Number of Physicians (1a) or Patients (1b)	% of Total
2b.	If you did not have telemedicine services, please comment why (Select all that apply)		
	a. Have not considered/unfamiliar with telehealth service options	71	*8.95%*
	b. Policy barriers (Select all that apply)	170	*21.44%*
	bi. Lack of or limited reimbursement	151	*19.04%*
	bii. Credentialing, licensing, or privileging	52	*6.56%*
	biii. Privacy and security	44	*5.55%*
	biv. Other	17	*2.14%*
	c. Inadequate broadband/telecommunication service (Select all that apply)	95	*11.98%*
	ci. Cost of Service	40	*5.04%*
	cii. Lack of Infrastructure	82	*10.34%*
	ciii. Other	7	*0.88%*
	d. Lack of funding for telehealth equipment	230	*29.00%*
	e. Lack of training for telehealth services	181	*22.82%*
	f. Not needed	111	*14.00%*
	g. Other	291	*36.70%*

Line	Measures	Number of Assists [4]
3.	Provide the number of all assists provided during the past year by all trained assisters (e.g., certified application counselor or equivalent) working on behalf of the health center (employees, contractors, or volunteers), regardless of the funding source that is supporting the assisters' activities. Outreach and enrollment assists are defined as customizable education sessions about affordable health insurance coverage options (one-on-one or small group) and any other assistance provided by a health center assister to facilitate enrollment.	104,934,254

[4] Assists do not count as visits on the UDS tables.

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Workforce - 2019

National - Universal - 1385 Health Centers

Line	Measures	Number of Health Centers	% of Total
1	Does your health center provide health professional education/training? (Health professional education/training does not include continuing education units)		
	a. Yes	960	69.31%
	b. No	425	30.69%
1a	If yes, which category best describes your health center's role in the health professional education/training process?		
	a. Sponsor	127	13.23%
	b. Training site partner	710	73.96%
	c. Other	123	12.81%
Line	**Measures**		
2	Please indicate the range of health professional education/training offered at your health center and how many individuals you have trained in each category within the last year.		
	Medical	**Number of Pre-Graduate/Certificate (a)**	**Number of Post-Graduate Training (b)**
	1. Physicians	6,798	5,801
	a. Family Physicians		4,414
	b. General Practitioners		371
	c. Internists		3,013
	d. Obstetrician/Gynecologists		1,429
	e. Pediatricians		1,982
	f. Other Specialty Physicians		914
	2. Nurse Practitioners	4,728	1,808
	3. Physician Assistants	1,640	9,560
	4. Certified Nurse Midwives	219	106
	5. Registered Nurses	6,716	803
	6. Licensed Practical Nurses/ Vocational Nurses	2,141	352
	7. Medical Assistants	4,492	11,530
	Dental	**Number of Pre-Graduate/Certificate (a)**	**Number of Post-Graduate Training (b)**
	8. Dentists	3,684	4,689
	9. Dental Hygienists	1,455	172
	10. Dental therapists	1,038	24
	Mental Health and Substance Use Disorder	**Number of Pre-Graduate/Certificate (a)**	**Number of Post-Graduate Training (b)**
	11. Psychiatrists		512
	12. Clinical Psychologists	305	332
	13. Clinical Social Workers	840	2,213
	14. Professional Counselors	221	3,266
	15. Marriage and Family therapists	74	63
	16. Psychiatric Nurse Specialists	34	25
	17. Mental Health Nurse Practitioners	171	125
	18. Mental Health Physician Assistants	33	12
	19. Substance Use Disorder Personnel	258	174
	Vision	**Number of Pre-Graduate/Certificate (a)**	**Number of Post-Graduate Training (b)**
	20. Ophthalmologists	4	39
	21. Optometrists	581	202

Workforce - 2019

National - Universal - 1385 Health Centers

Line	Measures		
	Other Professionals	**Number of Pre-Graduate/Certificate (a)**	**Number of Post-Graduate Training (b)**
	22. Chiropractors	60	34
	23. Dieticians/Nutritionists	323	132
	24. Pharmacists	1,725	602
	25. Other	1,632	300
Line	**Measures**	**Number of Health Center Staff**	**% of Total**
3	Number of health center staff serving as preceptors at your health center	14,876	100.00%
4	Number of health center staff (non-preceptors) supporting health center training programs	1,041,208	100.00%
Line	**Measures**	**Number of Health Centers**	**% of Total**
5	How often does your health center implement satisfaction surveys for providers?		
	a.Monthly	71	5.13%
	b.Quarterly	120	8.66%
	c.Annually	662	47.80%
	d.We do not currently conduct provider satisfaction surveys	306	22.09%
	e.Other	226	16.32%
6	How often does your health center implement satisfaction surveys for general staff?		
	a.Monthly	43	3.10%
	b.Quarterly	88	6.35%
	c.Annually	825	59.57%
	d.We do not currently conduct staff satisfaction surveys	196	14.15%
	e.Other	233	16.82%

List of Health Centers - 2019

National - Universal - 72 Health Centers

Health Center Name	City	State	Tracking Number	BHCMIS ID	Funding Streams
219 HEALTH NETWORK, INC.	EAST CHICAGO	IN	LALCS327512019	05E01359	
ACADIANA CARES INC	LAFAYETTE	LA	LALCS334042019	06E01365	
ADULT AND CHILD MENTAL HEALTH CENTER INC	INDIANAPOLIS	IN	LALCS315372019	05E01285	
AGHABY COMPREHENSIVE COMMUNITY HEALTH CENTER	COMPTON	CA	LALCS314202019	09E01270	
ALLIANCE FAMILY HEALTH CENTER, INC.	ALLIANCE	OH	LALCS325172019	05E01319	
ASPIRE HEALTH CENTER	NOBLESVILLE	IN	LALCS312602019	05E01271	
BLACK RIVER HEALTH SERVICES INC	BURGAW	NC	LALCS316142019	04E01290	
BRIGHTER BEGINNINGS	PLEASANT HILL	CA	LALCS001762019	09E01225	
CARETEAM PLUS, INC.	CONWAY	SC	LALCS318192019	04E01301	
CASTLE FAMILY HEALTH CENTERS, INC.	ATWATER	CA	LALCS000122019	09E00153	
CATHERINE'S HEALTH CENTER	GRAND RAPIDS	MI	LALCS307942019	05E01262	
CENTRO MEDICO COMMUNITY CLINIC INC	CORONA	CA	LALCS000622019	0928860	
CLOVER FORK OUTPATIENT MEDICAL PROJECT, INC.	EVARTS	KY	LALCS315362019	04E01286	
COMMUNITY ACCESS NETWORK, INC.	LYNCHBURG	VA	LALCS311062019	03E01267	
COMMUNITY CLINICAL SERVICES, INC.	LEWISTON	ME	LALCS000852019	01E00188	
COMMUNITY MEDICAL AND DENTAL CARE, INC	MONSEY	NY	LALCS001462019	027370	
COMMUNITY MEDICINE INC.	PARAMOUNT	CA	LALCS316182019	09E01293	
COMMUNITY SUPPORT SERVICES, INC.	AKRON	OH	LALCS316172019	05E01292	
DE NOVO HEALTH CARE, INC.	LYNWOOD	CA	LALCS327492019	09E00205	
EDGEWATER SYSTEMS FOR BALANCED LIVING, INC.	GARY	IN	LALCS331082019	05E01361	
EL PUEBLO HEALTH SERVICES INC	BERNALILLO	NM	LALCS000402019	06E00612	
EQUITAS HEALTH, INC.	COLUMBUS	OH	LALCS315392019	05E01284	
FAMILIES TOGETHER OF ORANGE COUNTY	TUSTIN	CA	LALCS001862019	09E01250	
GARFIELD HEALTH CENTER	MONTEREY PARK	CA	LALCS001242019	09E00641	
GRAND PRAIRIE SERVICES	TINLEY PARK	IL	LALCS327132019	05E01354	

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Health Center Name	City	State	Tracking Number	BHCMIS ID	Funding Streams
GREATER FRESNO HEALTH ORGANIZATION	FRESNO	CA	LALCS000412019	0924800	
GREENE COUNTY HEALTH, INC.	LINTON	IN	LALCS311072019	05E01266	
HEALTH AND LIFE ORGANIZATION, INC. (H.A.L.O.)	SACRAMENTO	CA	LALCS000182019	09E00647	
HEALTH CENTERS DETROIT FOUNDATION, INC.	DETROIT	MI	LALCS000082019	05E00936	
HEALTH SERVICE ALLIANCE	MONTCLAIR	CA	LALCS333332019	09E01363	
HEALTHRIGHT 360	SAN FRANCISCO	CA	LALCS307972019	09E01263	
HELENA INDIAN ALLIANCE	HELENA	MT	LALCS337912019	08E01372	
HIS BRANCHES, INC.	ROCHESTER	NY	LALCS316262019	02E01296	
HOPE FAMILY CARE CENTER	KANSAS CITY	MO	LALCS001752019	07E01222	
HOT SPRINGS HEALTH PROGRAM INC	MARSHALL	NC	LALCS000362019	044855E	
HYGEIA FACILITIES FOUNDATION, INC.	WHITESVILLE	WV	LALCS000392019	03E00793	
INNER CITY HEALTH CENTER	DENVER	CO	LALCS325162019	08E01320	
INTERCOMMUNITY, INC.	EAST HARTFORD	CT	LALCS001702019	01E01129	
KNOX/WINAMAC COMMUNITY HEALTH CENTERS, INC	KNOX	IN	LALCS000382019	05E00734	
LAGUNA BEACH COMMUNITY CLINIC INC	LAGUNA BEACH	CA	LALCS325822019	09E01323	
LASANTE HEALTH CENTER, INC.	BROOKLYN	NY	LALCS315982019	02E01288	
LEE MEMORIAL HEALTH SYSTEM	FORT MYERS	FL	LALCS001712019	04E01130	
LEGACY MEDICAL CARE INC.	ARLINGTON HEIGHTS	IL	LALCS001742019	05E01162	
LIVINGSTONE COMMUNITY DEVELOPMENT CORPORATION	STANTON	CA	LALCS312592019	09E01272	
MAYVIEW COMMUNITY HEALTH CENTER, INC.	PALO ALTO	CA	LALCS000012019	09E00575	
MEDICAL CENTER HOSPITAL (INC)	ODESSA	TX	LALCS000072019	06E00846	
MERCY MEDICAL HEALTH CENTER	HODGE	LA	LALCS316622019	06E01298	
METRO FAMILY PRACTICE, INC.	PITTSBURGH	PA	LALCS000132019	03E00566	
MULTI-CULTURAL HEALTH EVALUATION DELIVERY SYSTEM, INC.	ERIE	PA	LALCS327122019	03E01355	
NEIGHBORHEALTH CENTER, INC.	RALEIGH	NC	LALCS333342019	04E01364	

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National - Universal - 72 Health Centers

Health Center Name	City	State	Tracking Number	BHCMIS ID	Funding Streams
NEIGHBORHOOD HEALTH CENTER, INC	RICHMOND	IN	LALCS327172019	05E01356	
NORTHEAST COMMUNITY CLINIC, INC	ALHAMBRA	CA	LALCS000332019	09E00004	
PHILADELPHIA, CITY OF	PHILADELPHIA	PA	LALCS000842019	03E00360	
RURAL HEALTH ACCESS CORPORATION	CHAPMANVILLE	WV	LALCS001122019	03E00583	
SAN JOAQUIN, COUNTY OF	STOCKTON	CA	LALCS001582019	09E01121	
SERENITY CARE HEALTH GROUP	WOODLAND HILLS	CA	LALCS321032019	09E01313	
SHARON COMMUNITY HEALTH CENTER, INC.	SHARON	PA	LALCS000452019	03E00937	
SHAWNEE MENTAL HEALTH CENTER INC	PORTSMOUTH	OH	LALCS325832019	05E01325	
SOUTHWEST BOULEVARD FAMILY HEALTH CARE SERVICES OF GREATER KANSAS	KANSAS CITY	KS	LALCS315302019	07E01273	
SOUTHWEST C. A. R. E. CENTER	SANTA FE	NM	LALCS316152019	06E01291	
SOUTHWEST GEORGIA HEALTHCARE CLINICS, INC.	DONALSONVILLE	GA	LALCS325182019	04E01321	
STANISLAUS, COUNTY OF	MODESTO	CA	LALCS000762019	09E00703	
TODOS PARA LA SALUD	FRESNO	CA	LALCS331102019	09E01360	
TRI COUNTY FAMILY MEDICINE PROGRAM	DANSVILLE	NY	LALCS001812019	02E01238	
TRILLIUM HEALTH, INC.	ROCHESTER	NY	LALCS001822019	02E01239	
TULARE, COUNTY OF	VISALIA	CA	LALCS000702019	09E00864	
UNIVERSAL MEDICAL SERVICES, INC.	MINNEAPOLIS	MN	LALCS000282019	05E00781	
WAHIAWA CENTER FOR COMMUNITY HEALTH, THE	WAHIAWA	HI	LALCS316002019	09E01287	
WHITE MEMORIAL COMMUNITY HEALTH CENTER, A CALIFORNIA NONPROFIT PUBLIC BENEFIT CORPORATION	LOS ANGELES	CA	LALCS316252019	09E01295	
WHITE MTN CMMTY HEALTH CENTER	CONWAY	NH	LALCS316532019	01E01297	
WHOLE FAMILY HEALTH CENTER, INC.	FORT PIERCE	FL	LALCS314682019	04E01274	
WRIGHT CENTER MEDICAL GROUP, P.C., THE	SCRANTON	PA	LALCS331092019	03E00460	

Table 3A - Patients by Age and by Sex Assigned at Birth - 2019

National - Universal - 72 Health Centers

Line	Age Groups	Male Patients (a)	Female Patients (b)	All Patients
1.	Under age 1	8,296	7,568	*15,864*
2.	Age 1	4,627	4,531	*9,158*
3.	Age 2	4,471	4,302	*8,773*
4.	Age 3	4,582	4,314	*8,896*
5.	Age 4	4,981	4,712	*9,693*
6.	Age 5	4,880	4,709	*9,589*
7.	Age 6	4,520	4,303	*8,823*
8.	Age 7	4,363	4,189	*8,552*
9.	Age 8	4,338	4,109	*8,447*
10.	Age 9	4,359	4,047	*8,406*
11.	Age 10	4,594	4,308	*8,902*
12.	Age 11	4,946	4,774	*9,720*
13.	Age 12	5,093	4,813	*9,906*
14.	Age 13	4,696	4,511	*9,207*
15.	Age 14	4,623	4,710	*9,333*
16.	Age 15	4,322	4,699	*9,021*
17.	Age 16	4,264	4,752	*9,016*
18.	Age 17	4,033	5,015	*9,048*
19.	Age 18	3,378	5,039	*8,417*
20.	Age 19	2,744	4,872	*7,616*
21.	Age 20	2,485	4,792	*7,277*
22.	Age 21	2,500	4,973	*7,473*
23.	Age 22	2,468	5,001	*7,469*
24.	Age 23	2,485	5,067	*7,552*
25.	Age 24	2,597	5,309	*7,906*
26.	Ages 25 - 29	14,594	27,724	*42,318*
27.	Ages 30 - 34	14,659	25,942	*40,601*
28.	Ages 35 - 39	14,181	23,398	*37,579*
29.	Ages 40 - 44	13,559	20,956	*34,515*
30.	Ages 45 - 49	14,109	20,959	*35,068*
31.	Ages 50 - 54	16,216	21,674	*37,890*
32.	Ages 55 - 59	17,787	22,972	*40,759*
33.	Ages 60 - 64	16,622	21,353	*37,975*
34.	Ages 65 - 69	11,259	15,232	*26,491*
35.	Ages 70 - 74	6,811	9,667	*16,478*
36.	Ages 75 - 79	3,975	6,031	*10,006*
37.	Ages 80 - 84	2,342	3,788	*6,130*
38.	Age 85 and over	1,780	3,376	*5,156*
39.	**Total Patients** (Sum of Lines 1-38)	**252,539**	**342,491**	***595,030***
% of Total		**42.44%**	**57.56%**	

Table 3B - Demographic Characteristics - 2019

National - Universal - 72 Health Centers

Line	Patients by Race	Patients by Race and Hispanic or Latino Ethnicity						
		Hispanic/Latino (a)	Non-Hispanic/Latino (b)	Unreported/Refused to Report Ethnicity (c)		Total (d) (Sum Columns a+b+c)		
		Number (a)	Number (b)	Number (c)	% of Total Patients[1]	Number (d)	% of Total Patients[1]	% of Known Race[2]
1.	Asian	597	*44,577*			*45,174*	*7.59%*	*9.49%*
2a.	Native Hawaiian	130	*702*			*832*	*0.14%*	*0.17%*
2b.	Other Pacific Islander	518	*1,566*			*2,084*	*0.35%*	*0.44%*
2.	**Total Native Hawaiian/ Other Pacific Islander (Sum Lines 2a + 2b)**	**648**	***2,268***			***2,916***	***0.49%***	***0.61%***
3.	Black/African American	2,445	*115,200*			*117,645*	*19.77%*	*24.71%*
4.	American Indian/Alaska Native	2,574	*1,704*			*4,278*	*0.72%*	*0.90%*
5.	White	97,626	*193,852*			*291,478*	*48.99%*	*61.22%*
6.	More than one race	7,799	*6,850*			*14,649*	*2.46%*	*3.08%*
6a.	**Total Known (Sum lines 1+2+3+4+5+6)**	**111,689**	***364,451***			***476,140***		
7.	Unreported/Refused to report race	59,728	*25,462*	*33,700*	*5.66%*	*118,890*	*19.98%*	
8.	**Total Patients** (Sum of Line 1, 2, 3-6, and 7)	**171,417**	***389,913***	***33,700***		***595,030***	***100.00%***	
Total Known Ethnicity (Sum line 8, columns A + B)		**561,330**						
		% of Hispanic/Latino of Total Known Ethnicity[3] (a)	***% of Non-Hispanic/Latino of Total Known Ethnicity[3] (b)***					
9.	**Total Patients**	**30.54%**	***69.46%***					

Line	Patients Best Served in a Language Other than English	Number (a)	% of Total
12.	Patients Best Served in a Language Other than English	130,115	*21.87%*

[1] Total Patients is reported on line 8, column D.

[2] Known Race is reported on line 6a, column D.

[3] Known Ethnicity is shown on the line titled 'Total Known Ethnicity'.

% may not equal 100% due to rounding.

Table 3B - Demographic Characteristics - 2019

National - Universal - 72 Health Centers

Line	Patients by Sexual Orientation	Number (a)	% of Known
13.	Lesbian or Gay	9,946	*2.90%*
14.	Straight (not lesbian or gay)	326,726	*95.14%*
15.	Bisexual	4,528	*1.32%*
16.	Something else	2,234	*0.65%*
		Number (a)	**% of Total**
17.	Don't know	222,631	*37.42%*
18.	Chose not to disclose	28,965	*4.87%*
19.	**Total Patients** (Sum of Lines 13 to 18)	**595,030**	***100.00%***

Line	Patients by Gender Identity	Number (a)	% of Known
20.	Male	172,127	*40.62%*
21.	Female	249,077	*58.79%*
22.	Transgender Male/ Female-to-Male	1,202	*0.28%*
23.	Transgender Female/ Male-to-Female	1,298	*0.31%*
		Number (a)	**% of Total**
24.	Other	139,195	*23.39%*
25.	Chose not to disclose	32,131	*5.40%*
26.	**Total Patients** (Sum of Lines 20 to 25)	**595,030**	***100.00%***

Table 4 - Selected Patient Characteristics - 2019

National - Universal - 72 Health Centers

Line	Income as Percent of Poverty Guideline	Number of Patients (a)	% of Total	% of Known
Income as Percent of Poverty Guideline				
1.	100% and Below	246,718	*41.46%*	*64.89%*
2.	101–150%	62,352	*10.48%*	*16.40%*
3.	151–200%	30,265	*5.09%*	*7.96%*
4.	Over 200%	40,891	*6.87%*	*10.75%*
5.	Unknown	214,804	*36.10%*	
6.	**TOTAL** (Sum of Lines 1–5)	**595,030**	***100.00%***	

Line	Principal Third-Party Medical Insurance	0-17 years old (a)	18 and older (b)	Total	%
7.	**None/Uninsured**	13,176	70,852	*84,028*	*14.12%*
8a.	Medicaid (Title XIX)	136,476	185,145	*321,621*	*54.05%*
8b.	CHIP Medicaid	1,131	1,430	*2,561*	*0.43%*
8.	**Total Medicaid** (Line 8a + 8b)	**137,607**	**186,575**	***324,182***	***54.48%***
9a.	Dually Eligible (Medicare and Medicaid)	29	28,828	*28,857*	*4.85%*
9.	**Medicare** (Inclusive of dually eligible and other Title XVIII beneficiaries)	134	74,219	*74,353*	*12.50%*
10a.	Other Public Insurance (Non-CHIP)	404	1,956	*2,360*	*0.40%*
10b.	Other Public Insurance CHIP	1,525	136	*1,661*	*0.28%*
10.	**Total Public Insurance** (Line 10a + 10b)	**1,929**	**2,092**	***4,021***	***0.68%***
11.	**Private Insurance**	17,508	90,938	*108,446*	*18.23%*
12.	**TOTAL** (Sum of Lines 7 + 8 + 9 + 10 + 11)	**170,354**	**424,676**	***595,030***	***100.00%***

Managed Care Utilization

Line	Managed Care Utilization	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	Total (e)
13a.	Capitated Member Months	1,833,780	27,986	14,778	150,375	2,026,919
13b.	Fee-for-service Member Months	1,275,141	151,746	10,490	61,477	1,498,854
13c.	**Total Member Months** (Sum of Lines 13a + 13b)	**3,108,921**	**179,732**	**25,268**	**211,852**	**3,525,773**

Line	Special Populations	Number of Patients (a)	%
14.	Migratory (330g awardees only)	-	-
15.	Seasonal (330g awardees only)	-	-
	Migrant/Seasonal (non-330g awardees)	11,293	*100.00%*
16.	**Total Agricultural Workers or Dependents** (All health centers report this line)	**11,293**	***100.00%***
17.	Homeless Shelter (330h awardees only)	-	-
18.	Transitional (330h awardees only)	-	-
19.	Doubling Up (330h awardees only)	-	-
20.	Street (330h awardees only)	-	-
21a.	Permanent Supportive Housing (330h awardees only)	-	-
21.	Other (330h awardees only)	-	-
22.	Unknown (330h awardees only)	-	-
	Homeless (non-330h awardees)	9,941	*100.00%*
23.	**Total Homeless** (All health centers report this line)	**9,941**	***100.00%***
24.	**Total School-Based Health Center Patients** (All health centers report this line)	**5,476**	
25.	**Total Veterans** (All health centers report this line)	**7,853**	
26.	**Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site** (All health centers report this line)	**40,946**	

% may not equal 100% due to rounding.

Table 5 - Staffing and Utilization - 2019

National - Universal - 72 Health Centers

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1.	Family Physicians	137.00	430,626	53	
2.	General Practitioners	13.33	35,448	7	
3.	Internists	59.19	185,274	60	
4.	Obstetrician/Gynecologists	30.48	74,943	0	
5.	Pediatricians	62.24	207,222	14	
7.	Other Specialty Physicians	16.61	42,763	0	
8.	**Total Physicians** (Lines 1–7)	**318.85**	**976,276**	**134**	
9a.	Nurse Practitioners	197.38	483,495	170	
9b.	Physician Assistants	83.13	241,482	108	
10.	Certified Nurse Midwives	12.08	28,470	0	
10a.	**Total NPs, PAs, and CNMs** (Lines 9a–10)	**292.59**	**753,447**	**278**	
11.	Nurses	321.76	29,232	0	
12.	Other Medical Personnel	807.08			
13.	Laboratory Personnel	50.81			
14.	X-ray Personnel	16.42			
15.	**Total Medical** (Lines 8 + 10a through 14)	**1,807.51**	**1,758,955**	**412**	**546,017**
16.	Dentists	41.65	115,504	0	
17.	Dental Hygienists	22.94	21,736	0	
17a.	Dental Therapists	0.00	0	0	
18.	Other Dental Personnel	85.77			
19.	**Total Dental Services** (Lines 16–18)	**150.36**	**137,240**	**0**	**56,978**
20a.	Psychiatrists	24.42	63,151	384	
20a1.	Licensed Clinical Psychologists	9.80	9,529	86	
20a2.	Licensed Clinical Social Workers	107.82	105,676	89	
20b.	Other Licensed Mental Health Providers	83.17	82,010	152	
20c.	Other Mental Health Staff	48.90	27,881	63	
20.	**Total Mental Health** (Lines 20a–c)	**274.11**	**288,247**	**774**	**53,909**
21.	**Substance Use Disorder Services**	16.36	13,210	5	2,781
22.	**Other Professional Services**	10.70	31,605	3	11,075
22a.	Ophthalmologists	1.43	2,062	0	
22b.	Optometrists	2.33	7,009	0	
22c.	Other Vision Care Staff	8.28			
22d.	**Total Vision Services** (Lines 22a–c)	**12.04**	**9,071**	**0**	**6,970**
23.	**Pharmacy Personnel**	122.53			
24.	Case Managers	224.98	114,246	0	
25.	Patient/Community Education Specialists	33.48	7,377	11	
26.	Outreach Workers	55.30			
27.	Transportation Staff	12.30			
27a.	Eligibility Assistance Workers	65.10			
27b.	Interpretation Staff	25.87			
27c.	Community Health Workers	38.56			
28.	Other Enabling Services	59.43			
29.	**Total Enabling Services** (Lines 24–28)	**515.02**	**121,623**	**11**	**32,374**

Clinic and Virtual Visits are shown only for personnel that generate reportable visits.
Subtotals may differ from the sum of cells due to rounding.

Table 5 - Staffing and Utilization - 2019

National - Universal - 72 Health Centers

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
29a.	**Other Programs/Services**	8.46			
29b.	**Quality Improvement Staff**	57.62			
30a.	Management and Support Staff	654.15			
30b.	Fiscal and Billing Staff	297.51			
30c.	IT Staff	96.26			
31.	Facility Staff	116.13			
32.	Patient Support Staff	716.51			
33.	**Total Facility and Non-Clinical Support Staff** (Lines 30a–32)	**1,880.56**			
34.	**Grand Total** (Lines 15+19+20+21+22+22d+23+29+29a+29b+33)	**4,855.27**	**2,359,951**	**1,205**	

Clinic and Virtual Visits are shown only for personnel that generate reportable visits.
Subtotals may differ from the sum of cells due to rounding.

Table 5 - Staffing and Utilization - 2019

National - Universal - 72 Health Centers

Selected Service Detail Addendum					
Line	**Personnel by Major Service Category: Mental Health Service Detail**	**Personnel (a1)**	**Clinic Visits (b)**	**Virtual Visits (b2)**	**Patients (c)**
20a01.	Physicians (other than Psychiatrists)	368	97,795	50	42,728
20a02.	Nurse Practitioners	241	66,259	17	28,713
20a03.	Physician Assistants	95	30,513	21	14,884
20a04.	Certified Nurse Midwives	10	865	0	387
Line	**Personnel by Major Service Category: Substance Use Disorder Detail**	**Personnel (a1)**	**Clinic Visits (b)**	**Virtual Visits (b2)**	**Patients (c)**
21a.	Physicians (other than Psychiatrists)	296	43,825	62	15,677
21b.	Nurse Practitioners (Medical)	185	28,016	18	11,518
21c.	Physician Assistants	76	5,162	3	3,051
21d.	Certified Nurse Midwives	5	300	0	152
21e.	Psychiatrists	49	5,425	6	1,641
21f.	Licensed Clinical Psychologists	18	674	1	259
21g.	Licensed Clinical Social Workers	128	28,091	12	4,426
21h.	Other Licensed Mental Health Providers	50	7,670	9	2,517

Clinic and Virtual Visits are shown only for personnel that generate reportable visits.
Subtotals may differ from the sum of cells due to rounding.

Table 5 - Staffing and Utilization - 2019

National - Universal - 72 Health Centers

Line	Personnel by Major Service Category	FTEs		Clinic Visits		Virtual Visits	
		% Group	% Total	% Group	% Total	% Group	% Total
1.	Family Physicians	7.58%	2.82%	24.48%	18.25%	12.86%	4.40%
2.	General Practitioners	0.74%	0.27%	2.02%	1.50%	1.70%	0.58%
3.	Internists	3.27%	1.22%	10.53%	7.85%	14.56%	4.98%
4.	Obstetrician/Gynecologists	1.69%	0.63%	4.26%	3.18%	0.00%	0.00%
5.	Pediatricians	3.44%	1.28%	11.78%	8.78%	3.40%	1.16%
7.	Other Specialty Physicians	0.92%	0.34%	2.43%	1.81%	0.00%	0.00%
8.	**Total Physicians** (Lines 1–7)	**17.64%**	**6.57%**	**55.50%**	**41.37%**	32.52%	11.12%
9a.	Nurse Practitioners	10.92%	4.07%	27.49%	20.49%	41.26%	14.11%
9b.	Physician Assistants	4.60%	1.71%	13.73%	10.23%	26.21%	8.96%
10.	Certified Nurse Midwives	0.67%	0.25%	1.62%	1.21%	0.00%	0.00%
10a.	**Total NPs, PAs, and CNMs** (Lines 9a–10)	**16.19%**	**6.03%**	**42.83%**	**31.93%**	67.48%	23.07%
11.	Nurses	17.80%	6.63%	1.66%	1.24%	0.00%	0.00%
12.	Other Medical Personnel	44.65%	16.62%				
13.	Laboratory Personnel	2.81%	1.05%				
14.	X-ray Personnel	0.91%	0.34%				
15.	**Total Medical** (Lines 8 + 10a through 14)	**100.00%**	**37.23%**	**100.00%**	**74.53%**	**-**	**34.19%**
16.	Dentists	27.70%	0.86%	84.16%	4.89%	**-**	**0.00%**
17.	Dental Hygienists	15.26%	0.47%	15.84%	0.92%	**-**	**0.00%**
17a.	Dental Therapists	0.00%	0.00%	0.00%	0.00%	**-**	**0.00%**
18.	Other Dental Personnel	57.04%	1.77%				
19.	**Total Dental Services** (Lines 16–18)	**100.00%**	**3.10%**	**100.00%**	**5.82%**	**-**	**0.00%**
20a.	Psychiatrists	8.91%	0.50%	21.91%	2.68%	**49.61%**	**31.87%**
20a1.	Licensed Clinical Psychologists	3.58%	0.20%	3.31%	0.40%	11.11%	7.14%
20a2.	Licensed Clinical Social Workers	39.33%	2.22%	36.66%	4.48%	11.50%	7.39%
20b.	Other Licensed Mental Health Providers	30.34%	1.71%	28.45%	3.48%	19.64%	12.61%
20c.	Other Mental Health Staff	17.84%	1.01%	9.67%	1.18%	8.14%	5.23%
20.	**Total Mental Health** (Lines 20a–c)	**100.00%**	**5.65%**	**100.00%**	**12.21%**	-	64.23%
21.	**Substance Use Disorder Services**	100.00%	0.34%	100.00%	0.56%	-	0.41%
22.	**Other Professional Services**	100.00%	0.22%	100.00%	1.34%	-	0.25%
22a.	Ophthalmologists	11.88%	0.03%	22.73%	0.09%	-	0.00%
22b.	Optometrists	19.35%	0.05%	77.27%	0.30%	-	0.00%
22c.	Other Vision Care Staff	68.77%	0.17%				
22d.	**Total Vision Services** (Lines 22a–c)	**100.00%**	**0.25%**	**100.00%**	**0.38%**	**-**	**0.00%**
23.	**Pharmacy Personnel**	100.00%	2.52%				
24.	Case Managers	43.68%	4.63%	93.93%	4.84%	0.00%	0.00%
25.	Patient/Community Education Specialists	6.50%	0.69%	6.07%	0.31%	100.00%	0.91%
26.	Outreach Workers	10.74%	1.14%				
27.	Transportation Staff	2.39%	0.25%				
27a.	Eligibility Assistance Workers	12.64%	1.34%				
27b.	Interpretation Staff	5.02%	0.53%				
27c.	Community Health Workers	7.49%	0.79%				
28.	Other Enabling Services	11.54%	1.22%				
29.	**Total Enabling Services** (Lines 24–28)	**100.00%**	**10.61%**	**100.00%**	**5.15%**	**-**	**0.91%**

Clinic and Virtual Visits are shown only for personnel that generate reportable visits.
Subtotals may differ from the sum of cells due to rounding.
% may not equal 100% due to rounding.

Table 5 - Staffing and Utilization - 2019

National - Universal - 72 Health Centers

Line	Personnel by Major Service Category	FTEs		Clinic Visits		Virtual Visits	
		% Group	% Total	% Group	% Total	% Group	% Total
29a.	**Other Programs/Services**	100.00%	0.17%				
29b.	**Quality Improvement Staff**	100.00%	1.19%				
30a.	Management and Support Staff		13.47%				
30b.	Fiscal and Billing Staff		6.13%				
30c.	IT Staff		1.98%				
31.	Facility Staff		2.39%				
32.	Patient Support Staff		14.76%				
33.	**Total Facility and Non-Clinical Support Staff** (Lines 30a–32)	**100.00%**	**38.73%**				
34.	**Grand Total** (Lines 15+19+20+21+22+22d+23+29+29a+29b+33)		**100.00%**		**100.00%**		**100.00%**

Clinic and Virtual Visits are shown only for personnel that generate reportable visits.
Subtotals may differ from the sum of cells due to rounding.
% may not equal 100% due to rounding.

Table 6A - Selected Diagnoses and Services Rendered - 2019

National - Universal - 72 Health Centers

Line	Diagnostic Category	Applicable ICD - 10 - CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)	Visits per Patient
Selected Infectious and Parasitic Diseases					
1-2.	Symptomatic/Asymptomatic human immunodeficiency virus (HIV)	B20, B97.35, O98.7-, Z21	23,650	8,148	*2.90*
3.	Tuberculosis	A15- through A19-, O98.0-	288	178	*1.62*
4.	Sexually transmitted infections	A50- through A64- (exclude A63.0)	8,459	5,405	*1.57*
4a.	Hepatitis B	B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, O98.4-	5,015	1,864	*2.69*
4b.	Hepatitis C	B17.10, B17.11, B18.2, B19.20, B19.21	11,204	5,021	*2.23*
Selected Diseases of the Respiratory System					
5.	Asthma	J45-	56,638	29,160	*1.94*
6.	Chronic lower respiratory diseases	J40- through J44-, J47-	46,171	19,053	*2.42*
Selected Other Medical Conditions					
7.	Abnormal breast findings, female	C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.81, D05-, D48.6-, D49.3-, N60-, N63-, R92-	10,951	6,731	*1.63*
8.	Abnormal cervical findings	C53-, C79.82, D06-, R87.61-, R87.629, R87.810, R87.820	6,998	4,251	*1.65*
9.	Diabetes mellitus	E08- through E13-, O24- (exclude O24.41-)	194,357	57,121	*3.40*
10.	Heart disease (selected)	I01-, I02- (exclude I02.9), I20- through I25-, I27-, I28-, I30- through I52-	53,923	21,404	*2.52*
11.	Hypertension	I10- through I16-, O10-, O11-	316,927	115,027	*2.76*
12.	Contact dermatitis and other eczema	L23- through L25-, L30- (exclude L30.1, L30.3, L30.4, L30.5), L58-	22,560	16,362	*1.38*
13.	Dehydration	E86-	1,453	1,026	*1.42*
14.	Exposure to heat or cold	T33-, T34-, T67-, T68-, T69-, W92-, W93-	104	78	*1.33*
14a.	Overweight and obesity	E66-, Z68- (exclude Z68.1, Z68.20 through Z68.24, Z68.51, Z68.52)	278,365	137,850	*2.02*
Selected Childhood Conditions (limited to ages 0 through 17)					
15.	Otitis media and Eustachian tube disorders	H65- thru H69-	22,947	15,934	*1.44*
16.	Selected perinatal/neonatal medical conditions	A33-, P19-, P22- through P29- (exclude P29.3), P35- through P96- (exclude P54-, P91.6-, P92-, P96.81), R78.81, R78.89	3,815	2,425	*1.57*

Table 6A - Selected Diagnoses and Services Rendered - 2019

National - Universal - 72 Health Centers

Line	Diagnostic Category	Applicable ICD - 10 - CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)	Visits per Patient
Selected Childhood Conditions (limited to ages 0 through 17)					
17.	Lack of expected normal physiological development (such as delayed milestone, failure to gain weight, failure to thrive); nutritional deficiencies in children only. Does not include sexual or mental development	E40- through E46-, E50- through E63-, P92-, R62- (exclude R62.7), R63.3	23,430	14,321	*1.64*
Selected Mental Health Conditions and Substance Use Disorders					
18.	Alcohol-related disorders	F10-, G62.1, O99.31-	29,758	8,817	*3.38*
19.	Other substance-related disorders (excluding tobacco use disorders)	F11- thru F19- (Exclude F17-), G62.0, O99.32-	55,251	14,881	*3.71*
19a.	Tobacco use disorders	F17-, O99.33-	63,035	30,812	*2.05*
20a.	Depression and other mood disorders	F30- thru F39-	218,454	64,174	*3.40*
20b.	Anxiety disorders, including post-traumatic stress disorder (PTSD)	F06.4, F40- thru F42-, F43.0, F43.1-, F93.0	186,752	57,933	*3.22*
20c.	Attention deficit and disruptive behavior disorders	F90- thru F91-	43,057	12,403	*3.47*
20d.	Other mental disorders, excluding drug or alcohol dependence	F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0- and F43.1-), F50- through F99- (exclude F55-, F84.2, F90-, F91-, F93.0, F98-), 099.34-, R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0	109,218	38,029	*2.87*

Table 6A - Selected Diagnoses and Services Rendered - 2019

National - Universal - 72 Health Centers

Line	Service Category	Applicable ICD-10-CM or CPT-4/II Code	Number of Visits (a)	Number of Patients (b)	Visits per Patient
Selected Diagnostic Tests/Screening/Preventive Services					
21.	HIV test	**CPT-4**: 86689; 86701 through 86703; 87389 through 87391, 87534 through 87539, 87806	32,652	25,782	*1.27*
21a.	Hepatitis B test	**CPT-4**: 86704 through 86707, 87340, 87341, 87350	12,375	11,234	*1.10*
21b.	Hepatitis C test	**CPT-4**: 86803, 86804, 87520 through 87522	14,004	12,755	*1.10*
22.	Mammogram	**CPT-4**: 77065, 77066, 77067 OR **ICD-10**: Z12.31	25,131	21,854	*1.15*
23.	Pap tests	**CPT-4**: 88141 through 88153, 88155, 88164 through 88167, 88174, 88175 OR **ICD-10**: Z01.41-, Z01.42, Z12.4 (exclude Z01.411 and Z01.419)	31,421	29,723	*1.06*
24.	Selected immunizations: hepatitis A; haemophilus influenzae B (HiB); pneumococcal, diphtheria, tetanus, pertussis (DTaP) (DTP) (DT); mumps, measles, rubella (MMR); poliovirus; varicella; hepatitis B	**CPT-4**: 90632, 90633, 90634, 90636, 90643, 90644, 90645, 90646, 90647, 90648, 90669, 90670, 90696, 90697, 90698, 90700, 90701, 90702, 90703, 90704, 90705, 90706, 90707, 90708, 90710, 90712, 90713, 90714, 90715, 90716, 90718, 90720, 90721, 90723, 90730, 90731, 90732, 90740, 90743, 90744, 90745, 90746, 90747, 90748	100,116	73,720	*1.36*
24a.	Seasonal flu vaccine	**CPT-4**: 90630, 90653 through 90657, 90658, 90661, 90662, 90672, 90673, 90674, 90682, 90685 through 90689, 90749, 90756	97,579	90,431	*1.08*
25.	Contraceptive management	**ICD-10**: Z30-	50,601	29,775	*1.70*
26.	Health supervision of infant or child (ages 0 through 11)	**CPT-4**: 99381 through 99383, 99391 through 99393 **ICD-10**: Z00.1-	113,878	73,986	*1.54*
26a.	Childhood lead test screening (ages 9 to 72 months)	**ICD-10**: Z13.88 **CPT-4**: 83655	8,034	7,383	*1.09*
26b.	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	**CPT-4**: 99408, 99409 **HCPCS**: G0396, G0397, G0443, H0050	4,170	3,918	*1.06*
26c.	Smoke and tobacco use cessation counseling	**CPT-4**: 99406, 99407 OR **HCPCS**: S9075 OR **CPT-II**: 4000F, 4001F, 4004F	43,426	26,287	*1.65*
26d.	Comprehensive and intermediate eye exams	**CPT-4**: 92002, 92004, 92012, 92014	5,995	5,702	*1.05*

Table 6A - Selected Diagnoses and Services Rendered - 2019

National - Universal - 72 Health Centers

Line	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)	Visits per Patient
Selected Dental Services					
27.	Emergency services	**ADA**: D0140, D9110	5,801	4,814	*1.21*
28.	Oral exams	**ADA**: D0120, DO145, D0150, D0160, D0170, D0171, D0180	49,108	41,165	*1.19*
29.	Prophylaxis–adult or child	**ADA**: D1110, D1120	36,285	28,760	*1.26*
30.	Sealants	**ADA**: D1351	4,246	3,544	*1.20*
31.	Fluoride treatment–adult or child	**ADA**: D1206, D1208, **CPT-4**: 99188	24,220	20,426	*1.19*
32.	Restorative services	**ADA**: D21xx through D29xx	29,934	15,067	*1.99*
33.	Oral surgery (extractions and other surgical procedures)	**ADA**: D7xxx	8,087	5,473	*1.48*
34.	Rehabilitation services (Endo, Perio, Prostho, Ortho)	**ADA**: D3xxx, D4xxx, D5xxx, D6xxx, D8xxx	13,249	6,206	*2.13*

Sources of codes:
– International Classification of Diseases, 2019, (ICD-10-CM). National Center for Health Statistics (NCHS).
– Current Procedural Terminology (CPT), 2019, American Medical Association (AMA).
– Current Dental Terminology (CDT), 2019 – Dental Procedure Codes. American Dental Association (ADA).
Note: "X" in a code denotes any number including the absence of a number in that place.
Dashes (–) in a code indicate that additional characters are required.
ICD-10-CM codes all have at least four digits. These codes are not intended to reflect if a code is billable or not. Instead they are used to point out that other codes in the series are to be considered.

Table 6B - Quality of Care Measures - 2019

National - Universal - 72 Health Centers

Prenatal Care Provided by Referral Only		
Answer	**Number of Health Centers**	**% Total**
Yes	31	*43.06%*
No	41	*56.94%*

Section A - Age Categories for Prenatal Care Patients: (Health Centers Who Provide Prenatal Care Only)			
	Demographic Characteristics of Prenatal Care Patients		
Line	**Age**	**Number of Patients (a)**	**Percent**
1.	Less than 15 Years	24	*0.19%*
2.	Ages 15–19	806	*6.40%*
3.	Ages 20–24	3,364	*26.69%*
4.	Ages 25–44	8,352	*66.28%*
5.	Ages 45 and Over	56	*0.44%*
6.	**Total Patients** (Sum of lines 1–5)	**12,602**	***100.00%***

Section B - Early Entry into Prenatal Care						
Line	**Early Entry into Prenatal Care**	**Women Having First Visit with Health Center**		**Women Having First Visit with Another Provider**		**% Total**
		(a)	**%**	**(b)**	**%**	
7.	First Trimester	9,007	*71.47%*	628	*4.98%*	*76.46%*
8.	Second Trimester	2,125	*16.86%*	264	*2.09%*	*18.96%*
9.	Third Trimester	465	*3.69%*	113	*0.90%*	*4.59%*

Section C - Childhood Immunization Status				
Line	**Childhood Immunization Status**	**Total Patients with 2nd Birthday (a)**	**Estimated Number of Patients Immunized**	**Estimated % of Patients Immunized**
10.	MEASURE: Percentage of children 2 years of age who received age appropriate vaccines by their 2nd birthday	8,133	3,475	*42.73%*

Section D - Cervical Cancer Screening				
Line	**Cervical Cancer Screening**	**Total Female Patients Aged 23 through 64 (a)**	**Estimated Number of Patients Tested**	**Estimated % of Patients Tested**
11.	MEASURE: Percentage of women 23-64 years of age who were screened for cervical cancer	162,890	83,791	*51.44%*

Section E – Weight Assessment and Counseling for Nutrition and Physical Activity of Children and Adolescents				
Line	**Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents**	**Total Patients Aged 3 through 17 (a)**	**Estimated Number of Patients Assessed and Counseled**	**Estimated % of Patients Assessed and Counseled**
12.	MEASURE: Percentage of patients 3-17 years of age with a BMI percentile *and* counseling on nutrition *and* physical activity documented	110,673	71,574	*64.67%*

% may not equal 100% due to rounding.

Estimated % of Patients for Sections C through N are based on the total of the estimated number of patients included in column b for each health center, for each measure, divided by the total number of patients in the applicable category (i.e., the Universe) for each measure.

Table 6B - Quality of Care Measures - 2019

National - Universal - 72 Health Centers

Section F – Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Line	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Total Patients Aged 18 and Older (a)	Estimated Number of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate	Estimated % of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate
13.	MEASURE: Percentage of patients 18 years of age and older with (1) BMI documented and (2) follow-up plan documented if BMI is outside normal parameters	355,933	200,739	*56.40%*

Section G – Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Line	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Total Patients Aged 18 and Older (a)	Estimated Number of Patients Assessed for Tobacco Use and Provided Intervention if a Tobacco User	Estimated % of Patients Assessed for Tobacco Use and Provided Intervention if a Tobacco User
14a.	MEASURE: Percentage of patients aged 18 years of age and older who (1) were screened for tobacco use one or more times within 24 months, *and* (2) if identified to be a tobacco user received cessation counseling intervention	280,108	222,995	*79.61%*

Section H – Use of Appropriate Medications for Asthma

Line	Use of Appropriate Medications for Asthma	Total Patients Aged 5 through 64 with Persistent Asthma (a)	Estimated Number of Patients with Acceptable Plan	Estimated % of Patients with Acceptable Plan
16.	MEASURE: Percentage of patients 5 through 64 years of age identified as having persistent asthma and were appropriately ordered medication	8,717	7,179	*82.36%*

Section I – Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Line	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Total Patients Aged 21 and Older at High Risk of Cardiovascular Events (a)	Estimated Number of Patients Prescribed or On Statin Therapy	Estimated % of Patients Prescribed or On Statin Therapy
17a.	MEASURE: Percentage of patients 21 years of age and older at high risk of cardiovascular events who were prescribed or were on statin therapy	52,868	37,335	*70.62%*

Section J – Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet

Line	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Total Patients Aged 18 and Older with IVD Diagnosis or AMI, CABG, or PCI Procedure (a)	Estimated Number of Patients with Aspirin or Other Anitplatelet Therapy	Estimated % of Patients with Documentation of Aspirin or Other Anitplatelet Therapy
18.	MEASURE: Percentage of patients 18 years of age and older with a diagnosis of IVD or AMI, CABG, or PCI procedure with aspirin or another antiplatelet	14,568	10,523	*72.24%*

% may not equal 100% due to rounding.

Estimated % of Patients for Sections C through N are based on the total of the estimated number of patients included in column b for each health center, for each measure, divided by the total number of patients in the applicable category (i.e., the Universe) for each measure.

Table 6B - Quality of Care Measures - 2019

National - Universal - 72 Health Centers

Section K – Colorectal Cancer Screening

Line	Colorectal Cancer Screening	Total Patients Aged 50 through 75 (a)	Estimated Number of Patients with Appropriate Screening for Colorectal Cancer	Estimated % of Patients with Appropriate Screening for Colorectal Cancer
19.	MEASURE: Percentage of patients 50 through 75 years of age who had appropriate screening for colorectal cancer	140,096	59,696	*42.61%*

Section L – HIV Linkage to Care

Line	HIV Linkage to Care	Total Patients First Diagnosed with HIV (a)	Estimated Number of Patients Seen Within 90 Days of First Diagnosis of HIV	Estimated % of Patients Seen Within 90 Days of First Diagnosis of HIV
20.	MEASURE: Percentage of patients whose first ever HIV diagnosis was made by health center staff between October 1 of the prior year and September 30 of the measurement year and who were seen for follow-up treatment within 90 days of that first ever diagnosis	233	207	*88.84%*

Section M – Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Line	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Total Patients Aged 12 and Older (a)	Estimated Number of Patients Screened for Depression and Follow-up Plan Documented as Appropriate	Estimated % of Patients Screened for Depression and Follow-up Plan Documented as Appropriate
21.	MEASURE: Percentage of patients 12 years of age and older who were (1) screened for depression with a standardized tool *and*, if screening was positive, (2) had a follow-up plan documented	359,423	205,723	*57.24%*

Section N – Dental Sealants for Children between 6-9 Years

Line	Dental Sealants for Children between 6-9 Years	Total Patients Aged 6 through 9 at Moderate to High Risk for Caries (a)	Estimated Number of Patients with Sealants to First Molars	Estimated % of Patients with Sealants to First Molars
22.	MEASURE: Percentage of children 6 through 9 years of age at moderate to high risk of caries who received a sealant on a first permanent molar	2,019	1,089	*53.93%*

% may not equal 100% due to rounding.

Estimated % of Patients for Sections C through N are based on the total of the estimated number of patients included in column b for each health center, for each measure, divided by the total number of patients in the applicable category (i.e., the Universe) for each measure.

Table 7 - Health Outcomes and Disparities - 2019

National - Universal - 72 Health Centers

Line	Description	Total (i)
0.	HIV-Positive Pregnant Women	30
2.	Deliveries Performed by Health Center's Providers	1,587

Section A: Deliveries And Birth Weight

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500-2499 grams (1c)	Live Births: >= 2500 grams (1d)	% Low and Very Low Birth Weight
	Hispanic/Latino					
1a.	Asian	6	0	0	6	0.00%
1b1.	Native Hawaiian	1	0	0	1	0.00%
1b2.	Other Pacific Islander	7	0	0	2	0.00%
1c.	Black/African American	34	0	5	30	14.29%
1d.	American Indian/Alaska Native	46	1	4	42	10.64%
1e.	White	1,657	18	96	1,525	6.96%
1f.	More than One Race	30	0	1	29	3.33%
1g.	Unreported/Refused to Report Race	1,025	10	73	937	8.14%
	Subtotal Hispanic/Latino	**2,806**	**29**	**179**	**2,572**	**7.48%**
	Non-Hispanic/Latino					
2a.	Asian	387	3	31	347	8.92%
2b1.	Native Hawaiian	14	0	2	12	14.29%
2b2.	Other Pacific Islander	17	0	1	17	5.56%
2c.	Black/African American	1,187	19	115	1,120	10.69%
2d.	American Indian/Alaska Native	16	0	0	12	0.00%
2e.	White	2,176	16	90	1,991	5.05%
2f.	More than One Race	27	0	5	24	17.24%
2g.	Unreported/Refused to Report Race	333	2	18	277	6.73%
	Subtotal Non-Hispanic/Latino	**4,157**	**40**	**262**	**3,800**	**7.36%**
	Unreported/Refused to Report Race and Ethnicity					
h.	Unreported/Refused to Report Race and Ethnicity	181	10	22	269	10.63%
i.	**Total**	**7,144**	**79**	**463**	**6,641**	**7.55%**

% shown are rounded to the .01% level for table display purposes; calculations are made using % to 8 decimal places.

Table 7 - Health Outcomes and Disparities - 2019

National - Universal - 72 Health Centers

Section B: Controlling High Blood Pressure					
Line	**Race and Ethnicity**	**Total Patients 18 through 85 Years of Age with Hypertension (2a)**	**Number Charts Sampled or EHR Total (2b)**	**Patients with Hypertension Controlled (2c)**	**Estimated % Patients with Controlled Blood Pressure**
	Hispanic/Latino				
1a.	Asian	74	73	41	56.16%
1b1.	Native Hawaiian	18	17	11	64.71%
1b2.	Other Pacific Islander	45	43	26	60.47%
1c.	Black/African American	238	222	120	54.05%
1d.	American Indian/Alaska Native	251	95	58	61.05%
1e.	White	11,797	10,661	6,829	62.63%
1f.	More than One Race	690	682	409	59.97%
1g.	Unreported/Refused to Report Race	5,637	3,965	2,474	66.13%
	Subtotal Hispanic/Latino	**18,750**	**15,758**	**9,968**	**63.38%**
	Non-Hispanic/Latino				
2a.	Asian	10,431	10,326	6,460	62.94%
2b1.	Native Hawaiian	119	118	73	61.86%
2b2.	Other Pacific Islander	290	279	157	56.27%
2c.	Black/African American	28,803	27,661	15,185	55.73%
2d.	American Indian/Alaska Native	408	394	249	63.75%
2e.	White	38,091	37,564	25,570	68.16%
2f.	More than One Race	782	768	473	61.59%
2g.	Unreported/Refused to Report Race	3,069	2,929	1,770	59.96%
	Subtotal Non-Hispanic/Latino	**81,993**	**80,039**	**49,937**	**62.72%**
	Unreported/Refused to Report Race and Ethnicity				
h.	Unreported/Refused to Report Race and Ethnicity	3,905	3,261	1,898	65.09%
i.	**Total**	**104,648**	**99,058**	**61,803**	**62.98%**

% shown are rounded to the .01% level for table display purposes; calculations are made using % to 8 decimal places
% by race are low estimates, not adjusted at the health center level for samples with zero patients in racial categories.

Table 7 - Health Outcomes and Disparities - 2019

National - Universal - 72 Health Centers

Section C: Diabetes: Hemoglobin A1c Poor Control					
Line	**Race and Ethnicity**	**Total Patients 18 through 75 Years of Age with Diabetes (3a)**	**Number Charts Sampled or EHR Total (3b)**	**Patients with HbA1c >9% or No Test During Year (3f)**	**Estimated % Patients with Hba1c > 9%**
	Hispanic/Latino				
1a.	Asian	54	52	22	42.31%
1b1.	Native Hawaiian	14	14	7	50.00%
1b2.	Other Pacific Islander	52	50	22	44.00%
1c.	Black/African American	115	106	47	44.34%
1d.	American Indian/Alaska Native	194	92	38	19.59%
1e.	White	8,179	7,238	2,665	35.09%
1f.	More than One Race	510	506	215	42.24%
1g.	Unreported/Refused to Report Race	4,606	3,378	1,265	33.23%
	Subtotal Hispanic/Latino	**13,724**	**11,436**	**4,281**	**34.51%**
	Non-Hispanic/Latino				
2a.	Asian	5,210	5,149	1,234	23.97%
2b1.	Native Hawaiian	108	108	40	37.04%
2b2.	Other Pacific Islander	203	198	92	46.46%
2c.	Black/African American	13,415	12,911	4,562	35.44%
2d.	American Indian/Alaska Native	247	242	86	35.54%
2e.	White	16,071	15,889	5,054	31.78%
2f.	More than One Race	474	465	187	40.22%
2g.	Unreported/Refused to Report Race	2,412	2,343	1,041	43.16%
	Subtotal Non-Hispanic/Latino	**38,140**	**37,305**	**12,296**	**32.98%**
	Unreported/Refused to Report Race and Ethnicity				
h.	Unreported/Refused to Report Race and Ethnicity	2,167	1,775	731	37.75%
i.	**Total**	**54,031**	**50,516**	**17,308**	**33.50%**

% shown are rounded to the .01% level for table display purposes; calculations are made using % to 8 decimal places
% by race are low estimates, not adjusted at the health center level for samples with zero patients in racial categories.

Table 8A - Financial Costs - 2019

National - Universal - 72 Health Centers

Line	Cost Center	Accrued Cost (a) $	Allocation of Facility and Non-Clinical Support Services (b) $	Total Cost After Allocation of Facility and Non-Clinical Support Services (c) $
Financial Costs of Medical Care				
1.	Medical Staff	183,336,873	103,204,218	286,541,091
2.	Lab and X-ray	6,552,976	4,343,562	10,896,538
3.	Medical/Other Direct	41,529,249	20,931,938	62,461,187
4.	**Total Medical Care Services** (Sum of Lines 1 through 3)	**231,419,098**	**128,479,718**	**359,898,816**
Financial Costs of Other Clinical Services				
5.	Dental	16,369,521	9,237,513	25,607,034
6.	Mental Health	31,158,558	16,346,879	47,505,437
7.	Substance Use Disorder	990,110	830,226	1,820,336
8a.	Pharmacy not including pharmaceuticals	19,485,987	7,706,716	27,192,703
8b.	Pharmaceuticals	125,940,469		125,940,469
9.	Other Professional	1,840,950	1,337,617	3,178,567
9a.	Vision	1,456,179	796,637	2,252,816
10.	**Total Other Clinical Services** (Sum of Lines 5 through 9a)	**197,241,774**	**36,255,588**	**233,497,362**
Financial Costs of Enabling and Other Services				
11a.	Case Management	13,797,109		13,797,109
11b.	Transportation	858,950		858,950
11c.	Outreach	4,021,450		4,021,450
11d.	Patient and Community Education	1,750,976		1,750,976
11e.	Eligibility Assistance	2,934,129		2,934,129
11f.	Interpretation Services	1,233,428		1,233,428
11g.	Other Enabling Services	3,347,593		3,347,593
11h.	Community Health Workers	2,063,300		2,063,300
11.	**Total Enabling Services Cost** (Sum of Lines 11a through 11h)	**30,006,935**	**16,274,351**	**46,281,286**
12.	Other Related Services	6,997,505	2,004,450	9,001,955
12a.	Quality Improvement	5,327,220	2,608,580	7,935,800
13.	**Total Enabling and Other Services** (Sum of Lines 11, 12, and 12a)	**42,331,660**	**20,887,381**	**63,219,041**
Facility and Non-Clinical Support Services and Totals				
14.	Facility	42,064,748		
15.	Non-Clinical Support Services	143,557,939		
16.	**Total Facility and Non-Clinical Support Services** (Sum of Lines 14 and 15)	**185,622,687**		
17.	**Total Accrued Costs** (Sum of Lines 4 + 10 + 13 + 16)	**656,615,219**		**656,615,219**
18.	Value of Donated Facilities, Services and Supplies			6,559,665
19.	**Total with Donations** (Sum of Lines 17 and 18)			**663,174,884**

Table 9D: Patient Related Revenue - 2019

National - Universal - 72 Health Centers

Line	Payer Category	Charges			Collections			
		Full Charges This Period (a)	***% of Payer***	***% of Total***	**Amount Collected This Period (b)**	***% of Payer***	***% of Total***	***% of Charges***
1.	Medicaid Non-Managed Care	151,783,582	*39.23%*	*19.11%*	106,136,782	*38.25%*	*21.05%*	*69.93%*
2a.	Medicaid Managed Care (capitated)	99,288,585	*25.66%*	*12.50%*	85,098,039	*30.67%*	*16.88%*	*85.71%*
2b.	Medicaid Managed Care (fee-for-service)	135,863,768	*35.11%*	*17.11%*	86,228,364	*31.08%*	*17.10%*	*63.47%*
3.	**Total Medicaid** (Sum of Lines 1 + 2a + 2b)	**386,935,935**	***100.00%***	***48.72%***	**277,463,185**	***100.00%***	***55.03%***	***71.71%***
4.	Medicare Non-Managed Care	109,342,508	*82.53%*	*13.77%*	68,221,232	*86.82%*	*13.53%*	*62.39%*
5a.	Medicare Managed Care (capitated)	3,034,259	*2.29%*	*0.38%*	2,335,984	*2.97%*	*0.46%*	*76.99%*
5b.	Medicare Managed Care (fee-for-service)	20,105,100	*15.18%*	*2.53%*	8,020,637	*10.21%*	*1.59%*	*39.89%*
6.	**Total Medicare** (Sum of Lines 4 + 5a + 5b)	**132,481,867**	***100.00%***	***16.68%***	**78,577,853**	***100.00%***	***15.59%***	***59.31%***
7.	Other Public, including Non-Medicaid CHIP, Non-Managed Care	19,512,018	*91.33%*	*2.46%*	11,523,217	*94.33%*	*2.29%*	*59.06%*
8a.	Other Public, including Non-Medicaid CHIP, Managed Care (capitated)	765,606	*3.58%*	*0.10%*	162,262	*1.33%*	*0.03%*	*21.19%*
8b.	Other Public, including Non-Medicaid CHIP, Managed Care (fee-for-service)	1,085,921	*5.08%*	*0.14%*	530,327	*4.34%*	*0.11%*	*48.84%*
9.	**Total Other Public** (Sum of Lines 7 + 8a + 8b)	**21,363,545**	***100.00%***	***2.69%***	**12,215,806**	***100.00%***	***2.42%***	***57.18%***
10.	Private Non-Managed Care	150,568,855	*85.98%*	*18.96%*	96,245,049	*87.00%*	*19.09%*	*63.92%*
11a.	Private Managed Care (capitated)	3,827,751	*2.19%*	*0.48%*	1,390,608	*1.26%*	*0.28%*	*36.33%*
11b.	Private Managed Care (fee-for-service)	20,721,751	*11.83%*	*2.61%*	12,988,568	*11.74%*	*2.58%*	*62.68%*
12.	**Total Private** (Sum of Lines 10 + 11a + 11b)	**175,118,357**	***100.00%***	***22.05%***	**110,624,225**	***100.00%***	***21.94%***	***63.17%***
13.	Self-pay	78,276,085	*100.00%*	*9.86%*	25,283,514	*100.00%*	*5.01%*	*32.30%*
14.	**TOTAL** (Sum of Lines 3 + 6 + 9 + 12 + 13)	**794,175,789**		***100.00%***	**504,164,583**		***100.00%***	***63.48%***

% may not equal 100% due to rounding.

Table 9D: Patient Related Revenue - 2019

National - Universal - 72 Health Centers

Line	Payer Category	Retroactive Settlements, Receipts, and Paybacks (c)						Allowances	
		Collection of Recon/Wrap Around Current Year (c1)	Collection of Recon/Wrap Around Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty/ Payback (c4)	*Net Retros*	*Net Retros % of Charges*	Allowances (d)	*Allowances % of Charges*
1.	Medicaid Non-Managed Care	5,060,374	4,039,671	391,831	956,271	*8,535,605*	*5.62%*	50,266,962	*33.12%*
2a.	Medicaid Managed Care (capitated)	46,701,483	1,314,614	4,294,386	4,141,841	*48,168,642*	*48.51%*	14,172,798	*14.27%*
2b.	Medicaid Managed Care (fee-for-service)	10,386,869	4,526,675	2,676,161	585	*17,589,120*	*12.95%*	37,635,604	*27.70%*
3.	**Total Medicaid** (Sum of Lines 1 + 2a + 2b)	**62,148,726**	**9,880,960**	**7,362,378**	**5,098,697**	***74,293,367***	***19.20%***	**102,075,364**	***26.38%***
4.	Medicare Non-Managed Care	960,725	606,653	72,946	866	*1,639,458*	*1.50%*	36,399,983	*33.29%*
5a.	Medicare Managed Care (capitated)	0	0	19,232	0	*19,232*	*0.63%*	702,440	*23.15%*
5b.	Medicare Managed Care (fee-for-service)	1,060,054	18,659	135,407	0	*1,214,120*	*6.04%*	10,762,191	*53.53%*
6.	**Total Medicare** (Sum of Lines 4 + 5a + 5b)	**2,020,779**	**625,312**	**227,585**	**866**	***2,872,810***	***2.17%***	**47,864,614**	***36.13%***
7.	Other Public, including Non-Medicaid CHIP, Non-Managed Care	0	1,383	0	0	*1,383*	*0.01%*	5,595,358	*28.68%*
8a.	Other Public, including Non-Medicaid CHIP, Managed Care (capitated)	32,646	0	0	0	*32,646*	*4.26%*	603,227	*78.79%*
8b.	Other Public, including Non-Medicaid CHIP, Managed Care (fee-for-service)	92,915	61,614	40,697	0	*195,226*	*17.98%*	447,170	*41.18%*
9.	**Total Other Public** (Sum of Lines 7 + 8a + 8b)	**125,561**	**62,997**	**40,697**	**0**	***229,255***	***1.07%***	**6,645,755**	***31.11%***

% may not equal 100% due to rounding.

Table 9D: Patient Related Revenue - 2019

National - Universal - 72 Health Centers

Line	Payer Category	Retroactive Settlements, Receipts, and Paybacks (c)						Allowances	
		Collection of Recon/Wrap Around Current Year (c1)	Collection of Recon/Wrap Around Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty/ Payback (c4)	*Net Retros*	*Net Retros % of Charges*	Allowances (d)	*Allowances % of Charges*
10.	Private Non-Managed Care			876,726	0	*876,726*	*0.58%*	48,603,932	*32.28%*
11a.	Private Managed Care (capitated)			41,910	0	*41,910*	*1.09%*	2,402,754	*62.77%*
11b.	Private Managed Care (fee-for-service)			196,249	0	*196,249*	*0.95%*	4,762,049	*22.98%*
12.	**Total Private** (Sum of Lines 10 + 11a + 11b)			**1,114,885**	**0**	***1,114,885***	***0.64%***	**55,768,735**	***31.85%***
13.	Self-pay								
14.	**TOTAL** (Sum of Lines 3 + 6 + 9 + 12 + 13)	**64,295,066**	**10,569,269**	**8,745,545**	**5,099,563**	***78,510,317***	***9.89%***	**212,354,468**	***26.74%***

Line		Sliding Fee Discounts (e)	Bad Debt Write Off (f)
13.	Self-pay	32,377,821	9,060,345

% may not equal 100% due to rounding.

Table 9E - Other Revenues - 2019

National - Universal - 72 Health Centers

Line	Source	Amount (a)	% Group Total
BPHC Grants (Enter Amount Drawn Down - Consistent with PMS 272)			
1a.	Migrant Health Center	-	-
1b.	Community Health Center	-	-
1c.	Health Care for the Homeless	-	-
1e.	Public Housing Primary Care	-	-
1g.	**Total Health Center** (Sum of Lines 1a through 1e)	**-**	**-**
1k.	Capital Development Grants, including School-Based Health Center Capital Grants	-	-
1.	**Total BPHC Grants** (Sum of Lines 1g + 1k)	**-**	**-**
Other Federal Grants			
2.	Ryan White Part C HIV Early Intervention	4,359,974	*43.20%*
3.	Other Federal Grants	5,224,410	*51.76%*
3a.	Medicare and Medicaid EHR Incentive Payments for Eligible Providers	509,292	*5.05%*
5.	**Total Other Federal Grants** (Sum of Lines 2–3a)	**10,093,676**	***100.00%***
Non-Federal Grants or Contracts			
6.	State Government Grants and Contracts	19,822,048	*25.80%*
6a.	State/Local Indigent Care Programs	1,669,272	*2.17%*
7.	Local Government Grants and Contracts	30,850,138	*40.16%*
8.	Foundation/Private Grants and Contracts	24,484,001	*31.87%*
9.	**Total Non-Federal Grants And Contracts** (Sum of Lines 6 + 6A + 7 + 8)	**76,825,459**	***100.00%***
10.	Other Revenue (non-patient related revenue not reported elsewhere)	36,866,418	*100.00%*
11.	**Total Revenue** (Sum of Lines 1 + 5 + 9 + 10)	**123,785,553**	

% may not equal 100% due to rounding.

Health Information Technology Capabilities - 2019

National - Universal - 72 Health Centers

Line	Measures	Number of Health Centers	% of Total
1.	Does your center currently have an Electronic Health Record (EHR) system installed and in use?		
1a.	Yes, installed at all sites and used by all providers	70	*97.22%*
1b.	Yes, but only installed at some sites or used by some providers	2	*2.78%*
	Total Health Centers with EHR installed (Sum 1a + 1b)	**72**	***100.00%***
1c.	Health Centers who will install the EHR system in 3 months	0	*0.00%*
1d.	Health Centers who will install the EHR system in 6 months	0	*0.00%*
1e.	Health Centers who will install the EHR system in 1 year or more	0	*0.00%*
1f.	Health Centers who have Not Planned on installing the EHR system	0	*0.00%*
	Total Health Centers with No EHR installed (sum 1c + 1d + 1e + 1f)	**0**	***0.00%***
	Total Health Centers reported	**72**	***100.00%***
2.	Does your center send prescriptions to the pharmacy electronically? (Do not include faxing.)		
	a. Yes	71	*98.61%*
	b. No	1	*1.39%*
	c. Not Sure	0	*0.00%*
3.	Does your center use computerized, clinical decision support such as alerts for drug allergies, checks for drug-drug interations, reminders for preventive screening tests, or other similar functions?		
	a. Yes	70	*97.22%*
	b. No	2	*2.78%*
	c. Not Sure	0	*0.00%*
4.	With which of the following key providers/health care settings does your center electronically exchange clinical information? (Select all that apply)		
	a. Hospitals/Emergency rooms	49	*68.06%*
	b. Specialty clinicians	41	*56.94%*
	c. Other primary care providers	31	*43.06%*
	d. None of the above	17	*23.61%*
	e. Others	7	*9.72%*
5.	Does your center engage patients through health IT in any of the following ways? (Select all that apply)		
	a. Patient portals	57	*79.17%*
	b. Kiosks	14	*19.44%*
	c. Secure messaging	32	*44.44%*
	d. Others	2	*2.78%*
	e. No, we do not engage patients using HIT	14	*19.44%*
6.	Question Removed		
7.	How do you collect data for UDS clinical reporting (Tables 6B and 7)?		
	a. We use the EHR to extract automated reports	35	*48.61%*
	b. We use the EHR but only to access individual patient charts	2	*2.78%*
	c. We use the EHR in combination with another data analytic system	35	*48.61%*
	d. We do not use the EHR	0	*0.00%*
8.	Question Removed		
9.	Question Removed		

Health Information Technology Capabilities - 2019

National - Universal - 72 Health Centers

Line.	Measures	Number of Health Centers	% of Total
10.	How does your health center utilize HIT and EHR data beyond direct patient care? (Select all that apply)		
	a. Quality improvement	70	*97.22%*
	b. Population health management	51	*70.83%*
	c. Program evaluation	47	*65.28%*
	d. Research	18	*25.00%*
	e. Other	2	*2.78%*
	f. We do not utilize HIT or EHR data beyond direct patient care	1	*1.39%*
11.	Does your health center collect data on individual patients' social risk factors, outside of the data reportable in the UDS?		
	a. Yes	39	*54.17%*
	b. No, but we are in planning stages to collect this information	28	*38.89%*
	c. No, we are not planning to collect this information	5	*6.94%*
12.	Which standardized screener(s) for social risk factors, if any, do you use? (Select all that apply)		
	a. Accountable Health Communities Screening Tools	4	*5.56%*
	b. Upstream Risks Screening Tool and Guide	1	*1.39%*
	c. iHELP	0	*0.00%*
	d. Recommend Social and Behavioral Domains for EHRs	10	*13.89%*
	e. Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)	17	*23.61%*
	f. Well Child Care, Evaluation, Community Resources, Advocacy Referral, Education (WE CARE)	6	*8.33%*
	g. WellRx	0	*0.00%*
	h. Other	6	*8.33%*
	i. We do not use a standardized screener	36	*50.00%*

Other Data Elements - 2019

National - Universal - 72 Health Centers

Line	Measures	Number of Physicians (1a) or Patients (1b)	% of Total
1.	Medication-Assisted Treatment (MAT) for Opioid Use Disorder		
1a.	How many physicians, certified nurse practitioners and physician assistants, on-site or with whom the health center has contracts, have obtained a Drug Addiction Treatment Act of 2000 (DATA) waiver to treat opioid use disorder with medications specifically approved by the U.S. Food and Drug Administration (FDA) for that indication?	156	
1b.	How many patients received medication-assisted treatment for opioid use disorder from a physician, certified nurse practitioner, or physician assistant, with a DATA waiver working on behalf of the health center?	3,207	*0.54%*
Line	**Measures**	**Number of Health Centers**	**% of Total**
2.	Did your organization use telemedicine to provide remote clinical care services? (*The term "telehealth" includes "telemedicine" services, but encompasses a broader scope of remote healthcare services. Telemedicine is specific to remote clinical services whereas telehealth may include remote non-clinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services.*)		
	a. Yes	14	*19.44%*
	b. No	58	*80.56%*
2a1.	Who did you use telemedicine to communicate with? (Select all that apply)		
	a. Patients at remote locations from your organization (e.g., home telehealth, satellite locations)	7	*50.00%*
	b. Specialists outside your organization (e.g., specialists at referral centers)	9	*64.29%*
2a2.	What telehealth technologies did you use? (Select all that apply)		
	a. Real-time telehealth (e.g., live video conferencing)	10	*71.43%*
	b. Store-and-forward telehealth (e.g., secure email with photos or videos of patient examinations)	4	*28.57%*
	c. Remote patient monitoring	1	*7.14%*
	d. Mobile Health (mHealth)	0	*0.00%*
2a3.	What primary telemedicine services were used at your organization? (Select all that apply)		
	a. Primary care	3	*21.43%*
	b. Oral health	0	*0.00%*
	c. Behavioral health: Mental health	9	*64.29%*
	d. Behavioral health: Substance use disorder	3	*21.43%*
	e. Dermatology	2	*14.29%*
	f. Chronic conditions	4	*28.57%*
	g. Disaster management	0	*0.00%*
	h. Consumer health education	0	*0.00%*
	i. Provider-to-provider consultation	1	*7.14%*
	j. Radiology	1	*7.14%*
	k. Nutrition and dietary counseling	3	*21.43%*
	l. Other	1	*7.14%*

Other Data Elements - 2019

National - Universal - 72 Health Centers

Line	Measures	Number of Physicians (1a) or Patients (1b)	% of Total
2b.	If you did not have telemedicine services, please comment why (Select all that apply)		
	a. Have not considered/unfamiliar with telehealth service options	10	*17.24%*
	b. Policy barriers (Select all that apply)	5	*8.62%*
	bi. Lack of or limited reimbursement	4	*6.90%*
	bii. Credentialing, licensing, or privileging	1	*1.72%*
	biii. Privacy and security	0	*0.00%*
	biv. Other	1	*1.72%*
	c. Inadequate broadband/telecommunication service (Select all that apply)	3	*5.17%*
	ci. Cost of Service	3	*5.17%*
	cii. Lack of Infrastructure	3	*5.17%*
	ciii. Other	0	*0.00%*
	d. Lack of funding for telehealth equipment	35	*60.34%*
	e. Lack of training for telehealth services	17	*29.31%*
	f. Not needed	8	*13.79%*
	g. Other	10	*17.24%*

Line	Measures	Number of Assists [4]
3.	Provide the number of all assists provided during the past year by all trained assisters (e.g., certified application counselor or equivalent) working on behalf of the health center (employees, contractors, or volunteers), regardless of the funding source that is supporting the assisters' activities. Outreach and enrollment assists are defined as customizable education sessions about affordable health insurance coverage options (one-on-one or small group) and any other assistance provided by a health center assister to facilitate enrollment.	58,078

[4] Assists do not count as visits on the UDS tables.

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Workforce - 2019

National - Universal - 72 Health Centers

Line	Measures	Number of Health Centers	% of Total
1	Does your health center provide health professional education/training? (Health professional education/training does not include continuing education units)		
	a. Yes	39	54.17%
	b. No	33	45.83%
1a	If yes, which category best describes your health center's role in the health professional education/training process?		
	a. Sponsor	7	17.95%
	b. Training site partner	27	69.23%
	c. Other	5	12.82%
Line	**Measures**		
2	Please indicate the range of health professional education/training offered at your health center and how many individuals you have trained in each category within the last year.		
	Medical	**Number of Pre-Graduate/Certificate (a)**	**Number of Post-Graduate Training (b)**
	1. Physicians	181	110
	a. Family Physicians		164
	b. General Practitioners		2
	c. Internists		151
	d. Obstetrician/Gynecologists		6
	e. Pediatricians		2
	f. Other Specialty Physicians		27
	2. Nurse Practitioners	183	23
	3. Physician Assistants	63	10
	4. Certified Nurse Midwives	0	0
	5. Registered Nurses	79	8
	6. Licensed Practical Nurses/ Vocational Nurses	100	5
	7. Medical Assistants	65	28
	Dental	**Number of Pre-Graduate/Certificate (a)**	**Number of Post-Graduate Training (b)**
	8. Dentists	24	3
	9. Dental Hygienists	0	1
	10. Dental therapists	0	0
	Mental Health and Substance Use Disorder	**Number of Pre-Graduate/Certificate (a)**	**Number of Post-Graduate Training (b)**
	11. Psychiatrists		32
	12. Clinical Psychologists	0	2
	13. Clinical Social Workers	14	9
	14. Professional Counselors	6	8
	15. Marriage and Family therapists	0	0
	16. Psychiatric Nurse Specialists	6	0
	17. Mental Health Nurse Practitioners	5	1
	18. Mental Health Physician Assistants	0	0
	19. Substance Use Disorder Personnel	1	6
	Vision	**Number of Pre-Graduate/Certificate (a)**	**Number of Post-Graduate Training (b)**
	20. Ophthalmologists	0	0
	21. Optometrists	18	2

Workforce - 2019

National - Universal - 72 Health Centers

Line	Measures		
	Other Professionals	**Number of Pre-Graduate/Certificate (a)**	**Number of Post-Graduate Training (b)**
	22. Chiropractors	0	0
	23. Dieticians/Nutritionists	0	7
	24. Pharmacists	55	2
	25. Other	0	2
Line	**Measures**	**Number of Health Center Staff**	**% of Total**
3	Number of health center staff serving as preceptors at your health center	213	100.00%
4	Number of health center staff (non-preceptors) supporting health center training programs	432	100.00%
Line	**Measures**	**Number of Health Centers**	**% of Total**
5	How often does your health center implement satisfaction surveys for providers?		
	a.Monthly	7	9.72%
	b.Quarterly	12	16.67%
	c.Annually	26	36.11%
	d.We do not currently conduct provider satisfaction surveys	17	23.61%
	e.Other	10	13.89%
6	How often does your health center implement satisfaction surveys for general staff?		
	a.Monthly	2	2.78%
	b.Quarterly	7	9.72%
	c.Annually	38	52.78%
	d.We do not currently conduct staff satisfaction surveys	18	25.00%
	e.Other	7	9.72%

List of Health Centers - 2019

National - Universal - 21 Health Centers

Health Center Name	City	State	Tracking Number
FAMILY HEALTH CENTERS OF SAN DIEGO, INC.	SAN DIEGO	CA	UD7HP298672019
GEORGE MASON UNIVERSITY	FAIRFAX	VA	UD7HP309232019
HEALTHRIGHT 360	SAN FRANCISCO	CA	UD7HP316102019
IDAHO STATE UNIVERSITY	POCATELLO	ID	UD7HP285282019
LOYOLA UNIVERSITY OF CHICAGO	MAYWOOD	IL	UD7HP298682019
NATIONAL UNIVERSITY	LA JOLLA	CA	UD7HP285332019
PIEDMONT HEALTH SERVICES, INC.	CARRBORO	NC	UD7HP298692019
REGENTS OF THE UNIVERSITY OF COLORADO, THE	AURORA	CO	UD7HP302612019
REGENTS OF THE UNIVERSITY OF MICHIGAN	ANN ARBOR	MI	UD7HP285362019
RESOURCES FOR HUMAN DEVELOPMENT, INC.	PHILADELPHIA	PA	UD7HP298702019
SAGINAW VALLEY STATE UNIVERSITY	UNIVERSITY CENTER	MI	UD7HP298712019
ST. VINCENT HEALTHCARE FOUNDATION, INC.	BILLINGS	MT	UD7HP309252019
TRUSTEES OF COLUMBIA UNIVERSITY IN THE CITY OF NEW YORK	NEW YORK	NY	UD7HP298722019
UNIVERISTY OF MISSISSIPPI MEDICAL CENTER	JACKSON	MS	UD7HP309262019
UNIVERSITY OF ALABAMA	TUSCALOOSA	AL	UD7HP309272019
UNIVERSITY OF ALABAMA AT BIRMINGHAM	BIRMINGHAM	AL	UD7HP298732019
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO	SAN FRANCISCO	CA	UD7HP298742019
UNIVERSITY OF DETROIT MERCY	DETROIT	MI	UD7HP309282019
UNIVERSITY OF ILLINOIS	CHICAGO	IL	UD7HP309292019
UNIVERSITY OF WISCONSIN SYSTEM	MILWAUKEE	WI	UD7HP309302019
VANDERBILT UNIVERSITY, THE	NASHVILLE	TN	UD7HP309322019

Table 3A - Patients by Age and by Sex Assigned at Birth - 2019

National - Universal - 21 Health Centers

Line	Age Groups	Male Patients (a)	Female Patients (b)	All Patients
1.	Under age 1	119	129	*248*
2.	Age 1	94	117	*211*
3.	Age 2	112	85	*197*
4.	Age 3	94	78	*172*
5.	Age 4	95	95	*190*
6.	Age 5	97	84	*181*
7.	Age 6	89	89	*178*
8.	Age 7	109	100	*209*
9.	Age 8	90	94	*184*
10.	Age 9	106	94	*200*
11.	Age 10	106	100	*206*
12.	Age 11	128	113	*241*
13.	Age 12	104	117	*221*
14.	Age 13	102	97	*199*
15.	Age 14	121	160	*281*
16.	Age 15	137	206	*343*
17.	Age 16	141	263	*404*
18.	Age 17	186	239	*425*
19.	Age 18	142	252	*394*
20.	Age 19	98	182	*280*
21.	Age 20	74	176	*250*
22.	Age 21	65	196	*261*
23.	Age 22	56	168	*224*
24.	Age 23	54	180	*234*
25.	Age 24	60	197	*257*
26.	Ages 25 - 29	394	1,230	*1,624*
27.	Ages 30 - 34	431	1,262	*1,693*
28.	Ages 35 - 39	453	1,186	*1,639*
29.	Ages 40 - 44	554	1,403	*1,957*
30.	Ages 45 - 49	575	1,099	*1,674*
31.	Ages 50 - 54	548	985	*1,533*
32.	Ages 55 - 59	602	861	*1,463*
33.	Ages 60 - 64	413	754	*1,167*
34.	Ages 65 - 69	241	528	*769*
35.	Ages 70 - 74	132	307	*439*
36.	Ages 75 - 79	84	184	*268*
37.	Ages 80 - 84	48	104	*152*
38.	Age 85 and over	33	101	*134*
39.	**Total Patients** (Sum of Lines 1-38)	**7,087**	**13,615**	***20,702***
% of Total		**34.23%**	**65.77%**	

Table 3B - Demographic Characteristics - 2019

National - Universal - 21 Health Centers

Line	Patients by Race	Patients by Race and Hispanic or Latino Ethnicity						
		Hispanic/Latino (a)	Non-Hispanic/Latino (b)	Unreported/Refused to Report Ethnicity (c)		Total (d) (Sum Columns a+b+c)		
		Number (a)	Number (b)	Number (c)	% of Total Patients[1]	Number (d)	% of Total Patients[1]	% of Known Race[2]
1.	Asian	29	724			753	3.64%	4.65%
2a.	Native Hawaiian	14	6			20	0.10%	0.12%
2b.	Other Pacific Islander	24	38			62	0.30%	0.38%
2.	**Total Native Hawaiian/ Other Pacific Islander (Sum Lines 2a + 2b)**	**38**	**44**			**82**	**0.40%**	**0.51%**
3.	Black/African American	391	6,422			6,813	32.91%	42.05%
4.	American Indian/Alaska Native	8	162			170	0.82%	1.05%
5.	White	3,405	4,762			8,167	39.45%	50.41%
6.	More than one race	70	146			216	1.04%	1.33%
6a.	**Total Known (Sum lines 1+2+3+4+5+6)**	**3,941**	**12,260**			**16,201**		
7.	Unreported/Refused to report race	698	280	3,523	17.02%	4,501	21.74%	
8.	**Total Patients** (Sum of Line 1, 2, 3-6, and 7)	**4,639**	**12,540**	**3,523**		**20,702**	**100.00%**	
Total Known Ethnicity (Sum line 8, columns A + B)		**17,179**						
		% of Hispanic/Latino of Total Known Ethnicity[3] (a)	*% of Non-Hispanic/Latino of Total Known Ethnicity[3] (b)*					
9.	**Total Patients**	**27.00%**	**73.00%**					

Line	Patients Best Served in a Language Other than English	Number (a)	% of Total
12.	Patients Best Served in a Language Other than English	5,884	28.42%

[1] Total Patients is reported on line 8, column D.

[2] Known Race is reported on line 6a, column D.

[3] Known Ethnicity is shown on the line titled 'Total Known Ethnicity'.

% may not equal 100% due to rounding.

Table 3B - Demographic Characteristics - 2019

National - Universal - 21 Health Centers

Line	Patients by Sexual Orientation	Number (a)	% of Known
13.	Lesbian or Gay	271	*2.51%*
14.	Straight (not lesbian or gay)	10,095	*93.62%*
15.	Bisexual	317	*2.94%*
16.	Something else	100	*0.93%*
		Number (a)	**% of Total**
17.	Don't know	8,348	*40.32%*
18.	Chose not to disclose	1,571	*7.59%*
19.	**Total Patients** (Sum of Lines 13 to 18)	**20,702**	***100.00%***

Line	Patients by Gender Identity	Number (a)	% of Known
20.	Male	4,489	*34.24%*
21.	Female	8,570	*65.37%*
22.	Transgender Male/ Female-to-Male	26	*0.20%*
23.	Transgender Female/ Male-to-Female	24	*0.18%*
		Number (a)	**% of Total**
24.	Other	7,359	*35.55%*
25.	Chose not to disclose	234	*1.13%*
26.	**Total Patients** (Sum of Lines 20 to 25)	**20,702**	***100.00%***

Table 4 - Selected Patient Characteristics - 2019

National - Universal - 21 Health Centers

Line	Income as Percent of Poverty Guideline		Number of Patients (a)	% of Total	% of Known
Income as Percent of Poverty Guideline					
1.	100% and Below		11,530	55.70%	82.01%
2.	101–150%		1,539	7.43%	10.95%
3.	151–200%		628	3.03%	4.47%
4.	Over 200%		363	1.75%	2.58%
5.	Unknown		6,642	32.08%	
6.	**TOTAL** (Sum of Lines 1–5)		**20,702**	**100.00%**	
Principal Third-Party Medical Insurance		**0-17 years old (a)**	**18 and older (b)**	**Total**	**%**
7.	**None/Uninsured**	866	5,192	6,058	29.26%
8a.	Medicaid (Title XIX)	2,832	5,023	7,855	37.94%
8b.	CHIP Medicaid	231	15	246	1.19%
8.	**Total Medicaid** (Line 8a + 8b)	**3,063**	**5,038**	**8,101**	**39.13%**
9a.	Dually Eligible (Medicare and Medicaid)	2	415	417	2.01%
9.	**Medicare** (Inclusive of dually eligible and other Title XVIII beneficiaries)	3	1,856	1,859	8.98%
10a.	Other Public Insurance (Non-CHIP)	10	71	81	0.39%
10b.	Other Public Insurance CHIP	3	0	3	0.01%
10.	**Total Public Insurance** (Line 10a + 10b)	**13**	**71**	**84**	**0.41%**
11.	**Private Insurance**	345	4,255	4,600	22.22%
12.	**TOTAL** (Sum of Lines 7 + 8 + 9 + 10 + 11)	**4,290**	**16,412**	**20,702**	**100.00%**

Managed Care Utilization

Line	Managed Care Utilization	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	Total (e)
13a.	Capitated Member Months	772	2,847	0	24	3,643
13b.	Fee-for-service Member Months	18,967	731	0	2,804	22,502
13c.	**Total Member Months** (Sum of Lines 13a + 13b)	**19,739**	**3,578**	**0**	**2,828**	**26,145**

Line	Special Populations	Number of Patients (a)	%
14.	Migratory (330g awardees only)	-	-
15.	Seasonal (330g awardees only)	-	-
	Migrant/Seasonal (non-330g awardees)	124	100.00%
16.	**Total Agricultural Workers or Dependents** (All health centers report this line)	**124**	**100.00%**
17.	Homeless Shelter (330h awardees only)	-	-
18.	Transitional (330h awardees only)	-	-
19.	Doubling Up (330h awardees only)	-	-
20.	Street (330h awardees only)	-	-
21a.	Permanent Supportive Housing (330h awardees only)	-	-
21.	Other (330h awardees only)	-	-
22.	Unknown (330h awardees only)	-	-
	Homeless (non-330h awardees)	543	100.00%
23.	**Total Homeless** (All health centers report this line)	**543**	**100.00%**
24.	**Total School-Based Health Center Patients** (All health centers report this line)	**1,946**	
25.	**Total Veterans** (All health centers report this line)	**168**	
26.	**Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site** (All health centers report this line)	**13,021**	

% may not equal 100% due to rounding.

Table 5 - Staffing and Utilization - 2019

National - Universal - 21 Health Centers

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1.	Family Physicians	4.50	3,026	0	
2.	General Practitioners	0.05	79	0	
3.	Internists	0.48	196	0	
4.	Obstetrician/Gynecologists	0.00	0	0	
5.	Pediatricians	0.00	0	0	
7.	Other Specialty Physicians	1.10	30	29	
8.	**Total Physicians** (Lines 1–7)	**6.13**	**3,331**	**29**	
9a.	Nurse Practitioners	26.99	30,727	241	
9b.	Physician Assistants	1.00	200	0	
10.	Certified Nurse Midwives	0.35	25	0	
10a.	**Total NPs, PAs, and CNMs** (Lines 9a–10)	**28.34**	**30,952**	**241**	
11.	Nurses	7.59	632	0	
12.	Other Medical Personnel	12.91			
13.	Laboratory Personnel	0.20			
14.	X-ray Personnel	0.00			
15.	**Total Medical** (Lines 8 + 10a through 14)	**55.17**	**34,915**	**270**	**13,900**
16.	Dentists	0.00	0	0	
17.	Dental Hygienists	0.00	0	0	
17a.	Dental Therapists	0.00	0	0	
18.	Other Dental Personnel	0.00			
19.	**Total Dental Services** (Lines 16–18)	**0.00**	**0**	**0**	**0**
20a.	Psychiatrists	0.80	451	54	
20a1.	Licensed Clinical Psychologists	2.08	713	0	
20a2.	Licensed Clinical Social Workers	19.12	14,746	8	
20b.	Other Licensed Mental Health Providers	14.89	10,332	173	
20c.	Other Mental Health Staff	4.98	2,650	0	
20.	**Total Mental Health** (Lines 20a–c)	**41.87**	**28,892**	**235**	**9,860**
21.	**Substance Use Disorder Services**	2.06	673	0	121
22.	**Other Professional Services**	1.50	322	0	134
22a.	Ophthalmologists	0.00	0	0	
22b.	Optometrists	0.10	68	0	
22c.	Other Vision Care Staff	0.00			
22d.	**Total Vision Services** (Lines 22a–c)	**0.10**	**68**	**0**	**59**
23.	**Pharmacy Personnel**	0.80			
24.	Case Managers	8.04	3,663	0	
25.	Patient/Community Education Specialists	0.02	74	0	
26.	Outreach Workers	0.11			
27.	Transportation Staff	0.15			
27a.	Eligibility Assistance Workers	0.00			
27b.	Interpretation Staff	0.52			
27c.	Community Health Workers	3.56			
28.	Other Enabling Services	1.20			
29.	**Total Enabling Services** (Lines 24–28)	**13.60**	**3,737**	**0**	**862**

Clinic and Virtual Visits are shown only for personnel that generate reportable visits.
Subtotals may differ from the sum of cells due to rounding.

Table 5 - Staffing and Utilization - 2019

National - Universal - 21 Health Centers

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
29a.	**Other Programs/Services**	1.05			
29b.	**Quality Improvement Staff**	0.76			
30a.	Management and Support Staff	15.80			
30b.	Fiscal and Billing Staff	3.07			
30c.	IT Staff	0.44			
31.	Facility Staff	0.30			
32.	Patient Support Staff	10.77			
33.	**Total Facility and Non-Clinical Support Staff** (Lines 30a–32)	**30.38**			
34.	**Grand Total** (Lines 15+19+20+21+22+22d+23+29+29a+29b+33)	**147.29**	**68,607**	**505**	

Clinic and Virtual Visits are shown only for personnel that generate reportable visits.
Subtotals may differ from the sum of cells due to rounding.

Table 5 - Staffing and Utilization - 2019

National - Universal - 21 Health Centers

Selected Service Detail Addendum					
Line	**Personnel by Major Service Category: Mental Health Service Detail**	**Personnel (a1)**	**Clinic Visits (b)**	**Virtual Visits (b2)**	**Patients (c)**
20a01.	Physicians (other than Psychiatrists)	1	30	0	11
20a02.	Nurse Practitioners	36	5,562	122	1,981
20a03.	Physician Assistants	0	0	0	0
20a04.	Certified Nurse Midwives	0	0	0	0
Line	**Personnel by Major Service Category: Substance Use Disorder Detail**	**Personnel (a1)**	**Clinic Visits (b)**	**Virtual Visits (b2)**	**Patients (c)**
21a.	Physicians (other than Psychiatrists)	3	7	29	35
21b.	Nurse Practitioners (Medical)	29	1,516	119	633
21c.	Physician Assistants	0	0	0	0
21d.	Certified Nurse Midwives	0	0	0	0
21e.	Psychiatrists	2	23	0	13
21f.	Licensed Clinical Psychologists	3	28	0	7
21g.	Licensed Clinical Social Workers	35	3,513	0	1,459
21h.	Other Licensed Mental Health Providers	13	1,899	0	770

Clinic and Virtual Visits are shown only for personnel that generate reportable visits.
Subtotals may differ from the sum of cells due to rounding.

Table 5 - Staffing and Utilization - 2019

National - Universal - 21 Health Centers

Line	Personnel by Major Service Category	FTEs		Clinic Visits		Virtual Visits	
		% Group	% Total	% Group	% Total	% Group	% Total
1.	Family Physicians	8.16%	3.06%	8.67%	4.41%	0.00%	0.00%
2.	General Practitioners	0.09%	0.03%	0.23%	0.12%	0.00%	0.00%
3.	Internists	0.87%	0.33%	0.56%	0.29%	0.00%	0.00%
4.	Obstetrician/Gynecologists	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
5.	Pediatricians	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
7.	Other Specialty Physicians	1.99%	0.75%	0.09%	0.04%	10.74%	5.74%
8.	**Total Physicians** (Lines 1–7)	**11.11%**	**4.16%**	**9.54%**	**4.86%**	10.74%	5.74%
9a.	Nurse Practitioners	48.92%	18.32%	88.01%	44.79%	89.26%	47.72%
9b.	Physician Assistants	1.81%	0.68%	0.57%	0.29%	0.00%	0.00%
10.	Certified Nurse Midwives	0.63%	0.24%	0.07%	0.04%	0.00%	0.00%
10a.	**Total NPs, PAs, and CNMs** (Lines 9a–10)	**51.37%**	**19.24%**	**88.65%**	**45.11%**	89.26%	47.72%
11.	Nurses	13.76%	5.15%	1.81%	0.92%	0.00%	0.00%
12.	Other Medical Personnel	23.40%	8.77%				
13.	Laboratory Personnel	0.36%	0.14%				
14.	X-ray Personnel	0.00%	0.00%				
15.	**Total Medical** (Lines 8 + 10a through 14)	**100.00%**	**37.46%**	**100.00%**	**50.89%**	**-**	**53.47%**
16.	Dentists	-	0.00%	-	0.00%	**-**	**0.00%**
17.	Dental Hygienists	-	0.00%	-	0.00%	**-**	**0.00%**
17a.	Dental Therapists	-	0.00%	-	0.00%	**-**	**0.00%**
18.	Other Dental Personnel	-	0.00%				
19.	**Total Dental Services** (Lines 16–18)	**-**	**0.00%**	**-**	**0.00%**	**-**	**0.00%**
20a.	Psychiatrists	1.91%	0.54%	1.56%	0.66%	**22.98%**	**10.69%**
20a1.	Licensed Clinical Psychologists	4.97%	1.41%	2.47%	1.04%	0.00%	0.00%
20a2.	Licensed Clinical Social Workers	45.67%	12.98%	51.04%	21.49%	3.40%	1.58%
20b.	Other Licensed Mental Health Providers	35.56%	10.11%	35.76%	15.06%	73.62%	34.26%
20c.	Other Mental Health Staff	11.89%	3.38%	9.17%	3.86%	0.00%	0.00%
20.	**Total Mental Health** (Lines 20a–c)	**100.00%**	**28.43%**	**100.00%**	**42.11%**	-	46.53%
21.	**Substance Use Disorder Services**	100.00%	1.40%	100.00%	0.98%	-	0.00%
22.	**Other Professional Services**	100.00%	1.02%	100.00%	0.47%	-	0.00%
22a.	Ophthalmologists	0.00%	0.00%	0.00%	0.00%	-	0.00%
22b.	Optometrists	100.00%	0.07%	100.00%	0.10%	-	0.00%
22c.	Other Vision Care Staff	0.00%	0.00%				
22d.	**Total Vision Services** (Lines 22a–c)	**100.00%**	**0.07%**	**100.00%**	**0.10%**	**-**	**0.00%**
23.	**Pharmacy Personnel**	100.00%	0.54%				
24.	Case Managers	59.12%	5.46%	98.02%	5.34%	-	0.00%
25.	Patient/Community Education Specialists	0.15%	0.01%	1.98%	0.11%	-	0.00%
26.	Outreach Workers	0.81%	0.07%				
27.	Transportation Staff	1.10%	0.10%				
27a.	Eligibility Assistance Workers	0.00%	0.00%				
27b.	Interpretation Staff	3.82%	0.35%				
27c.	Community Health Workers	26.18%	2.42%				
28.	Other Enabling Services	8.82%	0.81%				
29.	**Total Enabling Services** (Lines 24–28)	**100.00%**	**9.23%**	**100.00%**	**5.45%**	**-**	**0.00%**

Clinic and Virtual Visits are shown only for personnel that generate reportable visits.
Subtotals may differ from the sum of cells due to rounding.
% may not equal 100% due to rounding.

Table 5 - Staffing and Utilization - 2019

National - Universal - 21 Health Centers

Line	Personnel by Major Service Category	FTEs		Clinic Visits		Virtual Visits	
		% Group	% Total	% Group	% Total	% Group	% Total
29a.	**Other Programs/Services**	100.00%	0.71%				
29b.	**Quality Improvement Staff**	100.00%	0.52%				
30a.	Management and Support Staff		10.73%				
30b.	Fiscal and Billing Staff		2.08%				
30c.	IT Staff		0.30%				
31.	Facility Staff		0.20%				
32.	Patient Support Staff		7.31%				
33.	**Total Facility and Non-Clinical Support Staff** (Lines 30a–32)	**100.00%**	**20.63%**				
34.	**Grand Total** (Lines 15+19+20+21+22+22d+23+29+29a+29b+33)		**100.00%**		**100.00%**		**100.00%**

Clinic and Virtual Visits are shown only for personnel that generate reportable visits.
Subtotals may differ from the sum of cells due to rounding.
% may not equal 100% due to rounding.

Table 6A - Selected Diagnoses and Services Rendered - 2019

National - Universal - 21 Health Centers

Line	Diagnostic Category	Applicable ICD - 10 - CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)	Visits per Patient
Selected Infectious and Parasitic Diseases					
1-2.	Symptomatic/Asymptomatic human immunodeficiency virus (HIV)	B20, B97.35, O98.7-, Z21	247	120	*2.06*
3.	Tuberculosis	A15- through A19-, O98.0-	17	13	*1.31*
4.	Sexually transmitted infections	A50- through A64- (exclude A63.0)	278	220	*1.26*
4a.	Hepatitis B	B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, O98.4-	41	20	*2.05*
4b.	Hepatitis C	B17.10, B17.11, B18.2, B19.20, B19.21	197	93	*2.12*
Selected Diseases of the Respiratory System					
5.	Asthma	J45-	891	525	*1.70*
6.	Chronic lower respiratory diseases	J40- through J44-, J47-	663	310	*2.14*
Selected Other Medical Conditions					
7.	Abnormal breast findings, female	C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.81, D05-, D48.6-, D49.3-, N60-, N63-, R92-	194	140	*1.39*
8.	Abnormal cervical findings	C53-, C79.82, D06-, R87.61-, R87.629, R87.810, R87.820	101	83	*1.22*
9.	Diabetes mellitus	E08- through E13-, O24- (exclude O24.41-)	6,215	2,210	*2.81*
10.	Heart disease (selected)	I01-, I02- (exclude I02.9), I20- through I25-, I27-, I28-, I30- through I52-	1,376	471	*2.92*
11.	Hypertension	I10- through I16-, O10-, O11-	8,286	3,395	*2.44*
12.	Contact dermatitis and other eczema	L23- through L25-, L30- (exclude L30.1, L30.3, L30.4, L30.5), L58-	338	287	*1.18*
13.	Dehydration	E86-	55	51	*1.08*
14.	Exposure to heat or cold	T33-, T34-, T67-, T68-, T69-, W92-, W93-	40	38	*1.05*
14a.	Overweight and obesity	E66-, Z68- (exclude Z68.1, Z68.20 through Z68.24, Z68.51, Z68.52)	2,747	1,489	*1.84*
Selected Childhood Conditions (limited to ages 0 through 17)					
15.	Otitis media and Eustachian tube disorders	H65- thru H69-	187	152	*1.23*
16.	Selected perinatal/neonatal medical conditions	A33-, P19-, P22- through P29- (exclude P29.3), P35- through P96- (exclude P54-, P91.6-, P92-, P96.81), R78.81, R78.89	53	50	*1.06*

Table 6A - Selected Diagnoses and Services Rendered - 2019

National - Universal - 21 Health Centers

Line	Diagnostic Category	Applicable ICD - 10 - CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)	Visits per Patient
Selected Childhood Conditions (limited to ages 0 through 17)					
17.	Lack of expected normal physiological development (such as delayed milestone, failure to gain weight, failure to thrive); nutritional deficiencies in children only. Does not include sexual or mental development	E40- through E46-, E50- through E63-, P92-, R62- (exclude R62.7), R63.3	369	154	*2.40*
Selected Mental Health Conditions and Substance Use Disorders					
18.	Alcohol-related disorders	F10-, G62.1, O99.31-	1,468	695	*2.11*
19.	Other substance-related disorders (excluding tobacco use disorders)	F11- thru F19- (Exclude F17-), G62.0, O99.32-	4,748	1,245	*3.81*
19a.	Tobacco use disorders	F17-, O99.33-	3,371	1,948	*1.73*
20a.	Depression and other mood disorders	F30- thru F39-	16,194	4,217	*3.84*
20b.	Anxiety disorders, including post-traumatic stress disorder (PTSD)	F06.4, F40- thru F42-, F43.0, F43.1-, F93.0	14,513	3,882	*3.74*
20c.	Attention deficit and disruptive behavior disorders	F90- thru F91-	1,388	355	*3.91*
20d.	Other mental disorders, excluding drug or alcohol dependence	F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0- and F43.1-), F50- through F99- (exclude F55-, F84.2, F90-, F91-, F93.0, F98-), 099.34-, R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0	11,444	3,928	*2.91*

Table 6A - Selected Diagnoses and Services Rendered - 2019

National - Universal - 21 Health Centers

Line	Service Category	Applicable ICD-10-CM or CPT-4/II Code	Number of Visits (a)	Number of Patients (b)	Visits per Patient
Selected Diagnostic Tests/Screening/Preventive Services					
21.	HIV test	**CPT-4**: 86689; 86701 through 86703; 87389 through 87391, 87534 through 87539, 87806	923	820	*1.13*
21a.	Hepatitis B test	**CPT-4**: 86704 through 86707, 87340, 87341, 87350	280	268	*1.04*
21b.	Hepatitis C test	**CPT-4**: 86803, 86804, 87520 through 87522	619	594	*1.04*
22.	Mammogram	**CPT-4**: 77065, 77066, 77067 OR **ICD-10**: Z12.31	357	330	*1.08*
23.	Pap tests	**CPT-4**: 88141 through 88153, 88155, 88164 through 88167, 88174, 88175 OR **ICD-10**: Z01.41-, Z01.42, Z12.4 (exclude Z01.411 and Z01.419)	1,063	1,029	*1.03*
24.	Selected immunizations: hepatitis A; haemophilus influenzae B (HiB); pneumococcal, diphtheria, tetanus, pertussis (DTaP) (DTP) (DT); mumps, measles, rubella (MMR); poliovirus; varicella; hepatitis B	**CPT-4**: 90632, 90633, 90634, 90636, 90643, 90644, 90645, 90646, 90647, 90648, 90669, 90670, 90696, 90697, 90698, 90700, 90701, 90702, 90703, 90704, 90705, 90706, 90707, 90708, 90710, 90712, 90713, 90714, 90715, 90716, 90718, 90720, 90721, 90723, 90730, 90731, 90732, 90740, 90743, 90744, 90745, 90746, 90747, 90748	1,466	1,236	*1.19*
24a.	Seasonal flu vaccine	**CPT-4**: 90630, 90653 through 90657, 90658, 90661, 90662, 90672, 90673, 90674, 90682, 90685 through 90689, 90749, 90756	2,276	2,236	*1.02*
25.	Contraceptive management	**ICD-10**: Z30-	892	612	*1.46*
26.	Health supervision of infant or child (ages 0 through 11)	**CPT-4**: 99381 through 99383, 99391 through 99393 **ICD-10**: Z00.1-	995	765	*1.30*
26a.	Childhood lead test screening (ages 9 to 72 months)	**ICD-10**: Z13.88 **CPT-4**: 83655	66	60	*1.10*
26b.	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	**CPT-4**: 99408, 99409 **HCPCS**: G0396, G0397, G0443, H0050	2,554	1,257	*2.03*
26c.	Smoke and tobacco use cessation counseling	**CPT-4**: 99406, 99407 OR **HCPCS**: S9075 OR **CPT-II**: 4000F, 4001F, 4004F	762	500	*1.52*
26d.	Comprehensive and intermediate eye exams	**CPT-4**: 92002, 92004, 92012, 92014	60	59	*1.02*

Table 6A - Selected Diagnoses and Services Rendered - 2019

National - Universal - 21 Health Centers

Line	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)	Visits per Patient
Selected Dental Services					
27.	Emergency services	**ADA**: D0140, D9110	0	0	-
28.	Oral exams	**ADA**: D0120, DO145, D0150, D0160, D0170, D0171, D0180	0	0	-
29.	Prophylaxis–adult or child	**ADA**: D1110, D1120	0	0	-
30.	Sealants	**ADA**: D1351	0	0	-
31.	Fluoride treatment–adult or child	**ADA**: D1206, D1208, **CPT-4**: 99188	0	0	-
32.	Restorative services	**ADA**: D21xx through D29xx	0	0	-
33.	Oral surgery (extractions and other surgical procedures)	**ADA**: D7xxx	0	0	-
34.	Rehabilitation services (Endo, Perio, Prostho, Ortho)	**ADA**: D3xxx, D4xxx, D5xxx, D6xxx, D8xxx	0	0	-

Sources of codes:
– International Classification of Diseases, 2019, (ICD-10-CM). National Center for Health Statistics (NCHS).
– Current Procedural Terminology (CPT), 2019, American Medical Association (AMA).
– Current Dental Terminology (CDT), 2019 – Dental Procedure Codes. American Dental Association (ADA).
Note: "X" in a code denotes any number including the absence of a number in that place.
Dashes (–) in a code indicate that additional characters are required.
ICD-10-CM codes all have at least four digits. These codes are not intended to reflect if a code is billable or not. Instead they are used to point out that other codes in the series are to be considered.

Table 6B - Quality of Care Measures - 2019

National - Universal - 21 Health Centers

Prenatal Care Provided by Referral Only		
Answer	**Number of Health Centers**	**% Total**
Yes	6	*28.57%*
No	15	*71.43%*

Section A - Age Categories for Prenatal Care Patients: (Health Centers Who Provide Prenatal Care Only)			
	Demographic Characteristics of Prenatal Care Patients		
Line	**Age**	**Number of Patients (a)**	**Percent**
1.	Less than 15 Years	0	*0.00%*
2.	Ages 15–19	22	*8.46%*
3.	Ages 20–24	64	*24.62%*
4.	Ages 25–44	173	*66.54%*
5.	Ages 45 and Over	1	*0.38%*
6.	**Total Patients** (Sum of lines 1–5)	**260**	***100.00%***

Section B - Early Entry into Prenatal Care						
Line	**Early Entry into Prenatal Care**	**Women Having First Visit with Health Center**		**Women Having First Visit with Another Provider**		**% Total**
		(a)	**%**	**(b)**	**%**	
7.	First Trimester	183	*70.38%*	7	*2.69%*	*73.08%*
8.	Second Trimester	65	*25.00%*	1	*0.38%*	*25.38%*
9.	Third Trimester	3	*1.15%*	1	*0.38%*	*1.54%*

Section C - Childhood Immunization Status				
Line	**Childhood Immunization Status**	**Total Patients with 2nd Birthday (a)**	**Estimated Number of Patients Immunized**	**Estimated % of Patients Immunized**
10.	MEASURE: Percentage of children 2 years of age who received age appropriate vaccines by their 2nd birthday	94	55	*58.51%*

Section D - Cervical Cancer Screening				
Line	**Cervical Cancer Screening**	**Total Female Patients Aged 23 through 64 (a)**	**Estimated Number of Patients Tested**	**Estimated % of Patients Tested**
11.	MEASURE: Percentage of women 23-64 years of age who were screened for cervical cancer	5,566	2,600	*46.71%*

Section E – Weight Assessment and Counseling for Nutrition and Physical Activity of Children and Adolescents				
Line	**Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents**	**Total Patients Aged 3 through 17 (a)**	**Estimated Number of Patients Assessed and Counseled**	**Estimated % of Patients Assessed and Counseled**
12.	MEASURE: Percentage of patients 3-17 years of age with a BMI percentile *and* counseling on nutrition *and* physical activity documented	1,965	1,559	*79.34%*

% may not equal 100% due to rounding.

Estimated % of Patients for Sections C through N are based on the total of the estimated number of patients included in column b for each health center, for each measure, divided by the total number of patients in the applicable category (i.e., the Universe) for each measure.

Table 6B - Quality of Care Measures - 2019

National - Universal - 21 Health Centers

Section F – Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Line	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Total Patients Aged 18 and Older (a)	Estimated Number of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate	Estimated % of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate
13.	MEASURE: Percentage of patients 18 years of age and older with (1) BMI documented and (2) follow-up plan documented if BMI is outside normal parameters	11,105	7,473	*67.29%*

Section G – Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Line	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Total Patients Aged 18 and Older (a)	Estimated Number of Patients Assessed for Tobacco Use and Provided Intervention if a Tobacco User	Estimated % of Patients Assessed for Tobacco Use and Provided Intervention if a Tobacco User
14a.	MEASURE: Percentage of patients aged 18 years of age and older who (1) were screened for tobacco use one or more times within 24 months, *and* (2) if identified to be a tobacco user received cessation counseling intervention	9,510	7,244	*76.17%*

Section H – Use of Appropriate Medications for Asthma

Line	Use of Appropriate Medications for Asthma	Total Patients Aged 5 through 64 with Persistent Asthma (a)	Estimated Number of Patients with Acceptable Plan	Estimated % of Patients with Acceptable Plan
16.	MEASURE: Percentage of patients 5 through 64 years of age identified as having persistent asthma and were appropriately ordered medication	294	239	*81.29%*

Section I – Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Line	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Total Patients Aged 21 and Older at High Risk of Cardiovascular Events (a)	Estimated Number of Patients Prescribed or On Statin Therapy	Estimated % of Patients Prescribed or On Statin Therapy
17a.	MEASURE: Percentage of patients 21 years of age and older at high risk of cardiovascular events who were prescribed or were on statin therapy	1,411	967	*68.53%*

Section J – Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet

Line	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Total Patients Aged 18 and Older with IVD Diagnosis or AMI, CABG, or PCI Procedure (a)	Estimated Number of Patients with Aspirin or Other Anitplatelet Therapy	Estimated % of Patients with Documentation of Aspirin or Other Anitplatelet Therapy
18.	MEASURE: Percentage of patients 18 years of age and older with a diagnosis of IVD or AMI, CABG, or PCI procedure with aspirin or another antiplatelet	290	223	*76.90%*

% may not equal 100% due to rounding.

Estimated % of Patients for Sections C through N are based on the total of the estimated number of patients included in column b for each health center, for each measure, divided by the total number of patients in the applicable category (i.e., the Universe) for each measure.

Table 6B - Quality of Care Measures - 2019

National - Universal - 21 Health Centers

Section K – Colorectal Cancer Screening				
Line	**Colorectal Cancer Screening**	**Total Patients Aged 50 through 75 (a)**	**Estimated Number of Patients with Appropriate Screening for Colorectal Cancer**	**Estimated % of Patients with Appropriate Screening for Colorectal Cancer**
19.	MEASURE: Percentage of patients 50 through 75 years of age who had appropriate screening for colorectal cancer	4,028	2,217	*55.04%*

Section L – HIV Linkage to Care				
Line	**HIV Linkage to Care**	**Total Patients First Diagnosed with HIV (a)**	**Estimated Number of Patients Seen Within 90 Days of First Diagnosis of HIV**	**Estimated % of Patients Seen Within 90 Days of First Diagnosis of HIV**
20.	MEASURE: Percentage of patients whose first ever HIV diagnosis was made by health center staff between October 1 of the prior year and September 30 of the measurement year and who were seen for follow-up treatment within 90 days of that first ever diagnosis	3	3	*100.00%*

Section M – Preventive Care and Screening: Screening for Depression and Follow-Up Plan				
Line	**Preventive Care and Screening: Screening for Depression and Follow-Up Plan**	**Total Patients Aged 12 and Older (a)**	**Estimated Number of Patients Screened for Depression and Follow-up Plan Documented as Appropriate**	**Estimated % of Patients Screened for Depression and Follow-up Plan Documented as Appropriate**
21.	MEASURE: Percentage of patients 12 years of age and older who were (1) screened for depression with a standardized tool *and*, if screening was positive, (2) had a follow-up plan documented	10,730	8,212	*76.53%*

Section N – Dental Sealants for Children between 6-9 Years				
Line	**Dental Sealants for Children between 6-9 Years**	**Total Patients Aged 6 through 9 at Moderate to High Risk for Caries (a)**	**Estimated Number of Patients with Sealants to First Molars**	**Estimated % of Patients with Sealants to First Molars**
22.	MEASURE: Percentage of children 6 through 9 years of age at moderate to high risk of caries who received a sealant on a first permanent molar	0	-	-

% may not equal 100% due to rounding.

Estimated % of Patients for Sections C through N are based on the total of the estimated number of patients included in column b for each health center, for each measure, divided by the total number of patients in the applicable category (i.e., the Universe) for each measure.

Table 7 - Health Outcomes and Disparities - 2019

National - Universal - 21 Health Centers

Line	Description	Total (i)
0.	HIV-Positive Pregnant Women	0
2.	Deliveries Performed by Health Center's Providers	1

Section A: Deliveries And Birth Weight

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500-2499 grams (1c)	Live Births: >= 2500 grams (1d)	% Low and Very Low Birth Weight
	Hispanic/Latino					
1a.	Asian	0	0	0	0	-
1b1.	Native Hawaiian	0	0	0	0	-
1b2.	Other Pacific Islander	0	0	0	0	-
1c.	Black/African American	2	0	0	2	0.00%
1d.	American Indian/Alaska Native	0	0	0	0	-
1e.	White	92	0	5	87	5.43%
1f.	More than One Race	2	0	0	2	0.00%
1g.	Unreported/Refused to Report Race	2	0	0	2	0.00%
	Subtotal Hispanic/Latino	**98**	**0**	**5**	**93**	**5.10%**
	Non-Hispanic/Latino					
2a.	Asian	11	0	1	10	9.09%
2b1.	Native Hawaiian	0	0	0	0	-
2b2.	Other Pacific Islander	0	0	0	0	-
2c.	Black/African American	15	0	1	13	7.14%
2d.	American Indian/Alaska Native	0	0	0	0	-
2e.	White	29	0	3	26	10.34%
2f.	More than One Race	0	0	0	0	-
2g.	Unreported/Refused to Report Race	1	0	0	1	0.00%
	Subtotal Non-Hispanic/Latino	**56**	**0**	**5**	**50**	**9.09%**
	Unreported/Refused to Report Race and Ethnicity					
h.	Unreported/Refused to Report Race and Ethnicity	3	0	0	3	0.00%
i.	**Total**	**157**	**0**	**10**	**146**	**6.41%**

% shown are rounded to the .01% level for table display purposes; calculations are made using % to 8 decimal places.

Table 7 - Health Outcomes and Disparities - 2019

National - Universal - 21 Health Centers

Line	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Number Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)	Estimated % Patients with Controlled Blood Pressure
	Section B: Controlling High Blood Pressure				
	Hispanic/Latino				
1a.	Asian	4	4	3	75.00%
1b1.	Native Hawaiian	0	0	0	-
1b2.	Other Pacific Islander	4	4	2	50.00%
1c.	Black/African American	59	59	35	59.32%
1d.	American Indian/Alaska Native	2	2	2	100.00%
1e.	White	484	484	353	72.93%
1f.	More than One Race	17	17	12	70.59%
1g.	Unreported/Refused to Report Race	74	74	58	78.38%
	Subtotal Hispanic/Latino	**644**	**644**	**465**	**72.21%**
	Non-Hispanic/Latino				
2a.	Asian	53	53	36	67.92%
2b1.	Native Hawaiian	0	0	0	-
2b2.	Other Pacific Islander	8	8	4	50.00%
2c.	Black/African American	932	932	558	59.87%
2d.	American Indian/Alaska Native	5	5	3	60.00%
2e.	White	711	711	476	66.95%
2f.	More than One Race	17	17	8	47.06%
2g.	Unreported/Refused to Report Race	55	55	33	60.00%
	Subtotal Non-Hispanic/Latino	**1,781**	**1,781**	**1,118**	**62.77%**
	Unreported/Refused to Report Race and Ethnicity				
h.	Unreported/Refused to Report Race and Ethnicity	1,228	1,228	703	57.25%
i.	**Total**	**3,653**	**3,653**	**2,286**	**62.58%**

% shown are rounded to the .01% level for table display purposes; calculations are made using % to 8 decimal places
% by race are low estimates, not adjusted at the health center level for samples with zero patients in racial categories.

Table 7 - Health Outcomes and Disparities - 2019

National - Universal - 21 Health Centers

Section C: Diabetes: Hemoglobin A1c Poor Control					
Line	**Race and Ethnicity**	**Total Patients 18 through 75 Years of Age with Diabetes (3a)**	**Number Charts Sampled or EHR Total (3b)**	**Patients with HbA1c >9% or No Test During Year (3f)**	**Estimated % Patients with Hba1c > 9%**
	Hispanic/Latino				
1a.	Asian	6	6	2	33.33%
1b1.	Native Hawaiian	0	0	0	-
1b2.	Other Pacific Islander	3	3	1	33.33%
1c.	Black/African American	45	45	14	31.11%
1d.	American Indian/Alaska Native	1	1	0	0.00%
1e.	White	364	364	125	34.34%
1f.	More than One Race	12	12	5	41.67%
1g.	Unreported/Refused to Report Race	48	48	17	35.42%
	Subtotal Hispanic/Latino	**479**	**479**	**164**	**34.24%**
	Non-Hispanic/Latino				
2a.	Asian	38	38	10	26.32%
2b1.	Native Hawaiian	0	0	0	-
2b2.	Other Pacific Islander	10	10	3	30.00%
2c.	Black/African American	478	478	181	37.87%
2d.	American Indian/Alaska Native	4	4	2	50.00%
2e.	White	412	412	124	30.10%
2f.	More than One Race	3	3	1	33.33%
2g.	Unreported/Refused to Report Race	26	26	10	38.46%
	Subtotal Non-Hispanic/Latino	**971**	**971**	**331**	**34.09%**
	Unreported/Refused to Report Race and Ethnicity				
h.	Unreported/Refused to Report Race and Ethnicity	779	779	269	34.53%
i.	**Total**	**2,229**	**2,229**	**764**	**34.28%**

% shown are rounded to the .01% level for table display purposes; calculations are made using % to 8 decimal places
% by race are low estimates, not adjusted at the health center level for samples with zero patients in racial categories.

Table 8A - Financial Costs - 2019

National - Universal - 21 Health Centers

Line	Cost Center	Accrued Cost (a) $	Allocation of Facility and Non-Clinical Support Services (b) $	Total Cost After Allocation of Facility and Non-Clinical Support Services (c) $
Financial Costs of Medical Care				
1.	Medical Staff	2,995,167	912,112	3,907,279
2.	Lab and X-ray	28,426	10,631	39,057
3.	Medical/Other Direct	788,145	500,319	1,288,464
4.	**Total Medical Care Services** (Sum of Lines 1 through 3)	**3,811,738**	**1,423,062**	**5,234,800**
Financial Costs of Other Clinical Services				
5.	Dental	0	0	0
6.	Mental Health	3,837,093	1,411,946	5,249,039
7.	Substance Use Disorder	177,634	67,422	245,056
8a.	Pharmacy not including pharmaceuticals	72,814	2,733	75,547
8b.	Pharmaceuticals	73,540		73,540
9.	Other Professional	98,667	10,509	109,176
9a.	Vision	0	0	0
10.	**Total Other Clinical Services** (Sum of Lines 5 through 9a)	**4,259,748**	**1,492,610**	**5,752,358**
Financial Costs of Enabling and Other Services				
11a.	Case Management	429,132		429,132
11b.	Transportation	42,600		42,600
11c.	Outreach	37,733		37,733
11d.	Patient and Community Education	4,463		4,463
11e.	Eligibility Assistance	17,872		17,872
11f.	Interpretation Services	30,867		30,867
11g.	Other Enabling Services	93,413		93,413
11h.	Community Health Workers	27,898		27,898
11.	**Total Enabling Services Cost** (Sum of Lines 11a through 11h)	**683,978**	**267,371**	**951,349**
12.	Other Related Services	84,620	4,058	88,678
12a.	Quality Improvement	75,704	33,887	109,591
13.	**Total Enabling and Other Services** (Sum of Lines 11, 12, and 12a)	**844,302**	**305,316**	**1,149,618**
Facility and Non-Clinical Support Services and Totals				
14.	Facility	598,670		
15.	Non-Clinical Support Services	2,622,318		
16.	**Total Facility and Non-Clinical Support Services** (Sum of Lines 14 and 15)	**3,220,988**		
17.	**Total Accrued Costs** (Sum of Lines 4 + 10 + 13 + 16)	**12,136,776**		**12,136,776**
18.	Value of Donated Facilities, Services and Supplies			802,961
19.	**Total with Donations** (Sum of Lines 17 and 18)			**12,939,737**

Table 9D: Patient Related Revenue - 2019

National - Universal - 21 Health Centers

Line	Payer Category	Charges			Collections			
		Full Charges This Period (a)	***% of Payer***	***% of Total***	**Amount Collected This Period (b)**	***% of Payer***	***% of Total***	***% of Charges***
1.	Medicaid Non-Managed Care	1,953,336	*54.72%*	*22.48%*	1,108,611	*41.56%*	*24.95%*	*56.75%*
2a.	Medicaid Managed Care (capitated)	90,473	*2.53%*	*1.04%*	204,209	*7.65%*	*4.60%*	*225.71%*
2b.	Medicaid Managed Care (fee-for-service)	1,526,112	*42.75%*	*17.56%*	1,354,962	*50.79%*	*30.50%*	*88.79%*
3.	**Total Medicaid** (Sum of Lines 1 + 2a + 2b)	**3,569,921**	***100.00%***	***41.08%***	**2,667,782**	***100.00%***	***60.04%***	***74.73%***
4.	Medicare Non-Managed Care	1,086,711	*85.83%*	*12.50%*	373,465	*84.73%*	*8.41%*	*34.37%*
5a.	Medicare Managed Care (capitated)	47,492	*3.75%*	*0.55%*	17,843	*4.05%*	*0.40%*	*37.57%*
5b.	Medicare Managed Care (fee-for-service)	131,922	*10.42%*	*1.52%*	49,443	*11.22%*	*1.11%*	*37.48%*
6.	**Total Medicare** (Sum of Lines 4 + 5a + 5b)	**1,266,125**	***100.00%***	***14.57%***	**440,751**	***100.00%***	***9.92%***	***34.81%***
7.	Other Public, including Non-Medicaid CHIP, Non-Managed Care	66,328	*100.00%*	*0.76%*	19,531	*100.00%*	*0.44%*	*29.45%*
8a.	Other Public, including Non-Medicaid CHIP, Managed Care (capitated)	0	*0.00%*	*0.00%*	0	*0.00%*	*0.00%*	-
8b.	Other Public, including Non-Medicaid CHIP, Managed Care (fee-for-service)	0	*0.00%*	*0.00%*	0	*0.00%*	*0.00%*	-
9.	**Total Other Public** (Sum of Lines 7 + 8a + 8b)	**66,328**	***100.00%***	***0.76%***	**19,531**	***100.00%***	***0.44%***	***29.45%***
10.	Private Non-Managed Care	2,483,525	*97.11%*	*28.58%*	1,096,267	*98.59%*	*24.67%*	*44.14%*
11a.	Private Managed Care (capitated)	1,021	*0.04%*	*0.01%*	777	*0.07%*	*0.02%*	*76.10%*
11b.	Private Managed Care (fee-for-service)	72,878	*2.85%*	*0.84%*	14,928	*1.34%*	*0.34%*	*20.48%*
12.	**Total Private** (Sum of Lines 10 + 11a + 11b)	**2,557,424**	***100.00%***	***29.43%***	**1,111,972**	***100.00%***	***25.03%***	***43.48%***
13.	Self-pay	1,230,667	*100.00%*	*14.16%*	203,010	*100.00%*	*4.57%*	*16.50%*
14.	**TOTAL** (Sum of Lines 3 + 6 + 9 + 12 + 13)	**8,690,465**		***100.00%***	**4,443,046**		***100.00%***	***51.13%***

% may not equal 100% due to rounding.

Table 9D: Patient Related Revenue - 2019

National - Universal - 21 Health Centers

Line	Payer Category	Retroactive Settlements, Receipts, and Paybacks (c)						Allowances	
		Collection of Recon/Wrap Around Current Year (c1)	Collection of Recon/Wrap Around Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty/ Payback (c4)	*Net Retros*	*Net Retros % of Charges*	Allowances (d)	*Allowances % of Charges*
1.	Medicaid Non-Managed Care	0	43,251	0	5,592	*37,659*	*1.93%*	692,336	*35.44%*
2a.	Medicaid Managed Care (capitated)	135,370	0	3,572	0	*138,942*	*153.57%*	8,826	*9.76%*
2b.	Medicaid Managed Care (fee-for-service)	491	101,038	0	0	*101,529*	*6.65%*	412,204	*27.01%*
3.	**Total Medicaid** (Sum of Lines 1 + 2a + 2b)	**135,861**	**144,289**	**3,572**	**5,592**	***278,130***	***7.79%***	**1,113,366**	***31.19%***
4.	Medicare Non-Managed Care	0	0	0	223	*-223*	*-0.02%*	618,176	*56.89%*
5a.	Medicare Managed Care (capitated)	0	0	0	0	*0*	*0.00%*	3,073	*6.47%*
5b.	Medicare Managed Care (fee-for-service)	0	0	0	0	*0*	*0.00%*	28,575	*21.66%*
6.	**Total Medicare** (Sum of Lines 4 + 5a + 5b)	**0**	**0**	**0**	**223**	***-223***	***-0.02%***	**649,824**	***51.32%***
7.	Other Public, including Non-Medicaid CHIP, Non-Managed Care	0	0	0	0	*0*	*0.00%*	4,884	*7.36%*
8a.	Other Public, including Non-Medicaid CHIP, Managed Care (capitated)	0	0	0	0	*0*	-	0	-
8b.	Other Public, including Non-Medicaid CHIP, Managed Care (fee-for-service)	0	0	0	0	*0*	-	0	-
9.	**Total Other Public** (Sum of Lines 7 + 8a + 8b)	**0**	**0**	**0**	**0**	***0***	***0.00%***	**4,884**	***7.36%***

% may not equal 100% due to rounding.

Table 9D: Patient Related Revenue - 2019

National - Universal - 21 Health Centers

Line	Payer Category	Retroactive Settlements, Receipts, and Paybacks (c)						Allowances	
		Collection of Recon/Wrap Around Current Year (c1)	Collection of Recon/Wrap Around Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty/ Payback (c4)	*Net Retros*	*Net Retros % of Charges*	Allowances (d)	*Allowances % of Charges*
10.	Private Non-Managed Care			2,931	0	*2,931*	*0.12%*	1,159,326	*46.68%*
11a.	Private Managed Care (capitated)			0	0	*0*	*0.00%*	66	*6.46%*
11b.	Private Managed Care (fee-for-service)			0	0	*0*	*0.00%*	46,770	*64.18%*
12.	**Total Private** (Sum of Lines 10 + 11a + 11b)			**2,931**	**0**	***2,931***	***0.11%***	**1,206,162**	***47.16%***
13.	Self-pay								
14.	**TOTAL** (Sum of Lines 3 + 6 + 9 + 12 + 13)	**135,861**	**144,289**	**6,503**	**5,815**	***280,838***	***3.23%***	**2,974,236**	***34.22%***

Line		Sliding Fee Discounts (e)	Bad Debt Write Off (f)
13.	Self-pay	834,443	16,933

% may not equal 100% due to rounding.

Table 9E - Other Revenues - 2019

National - Universal - 21 Health Centers

Line	Source	Amount (a)	*% Group Total*
BPHC Grants (Enter Amount Drawn Down - Consistent with PMS 272)			
1a.	Migrant Health Center	-	-
1b.	Community Health Center	-	-
1c.	Health Care for the Homeless	-	-
1e.	Public Housing Primary Care	-	-
1g.	**Total Health Center** (Sum of Lines 1a through 1e)	**-**	**-**
1k.	Capital Development Grants, including School-Based Health Center Capital Grants	-	-
1.	**Total BPHC Grants** (Sum of Lines 1g + 1k)	**-**	**-**
Other Federal Grants			
2.	Ryan White Part C HIV Early Intervention	0	*0.00%*
3.	Other Federal Grants	7,788,450	*99.69%*
3a.	Medicare and Medicaid EHR Incentive Payments for Eligible Providers	24,000	*0.31%*
5.	**Total Other Federal Grants** (Sum of Lines 2–3a)	**7,812,450**	***100.00%***
Non-Federal Grants or Contracts			
6.	State Government Grants and Contracts	241,000	*52.56%*
6a.	State/Local Indigent Care Programs	20,943	*4.57%*
7.	Local Government Grants and Contracts	0	*0.00%*
8.	Foundation/Private Grants and Contracts	196,605	*42.88%*
9.	**Total Non-Federal Grants And Contracts** (Sum of Lines 6 + 6A + 7 + 8)	**458,548**	***100.00%***
10.	Other Revenue (non-patient related revenue not reported elsewhere)	41,389	*100.00%*
11.	**Total Revenue** (Sum of Lines 1 + 5 + 9 + 10)	**8,312,387**	

% may not equal 100% due to rounding.

Health Information Technology Capabilities - 2019

National - Universal - 21 Health Centers

Line	Measures	Number of Health Centers	% of Total
1.	Does your center currently have an Electronic Health Record (EHR) system installed and in use?		
1a.	Yes, installed at all sites and used by all providers	18	*85.71%*
1b.	Yes, but only installed at some sites or used by some providers	1	*4.76%*
	Total Health Centers with EHR installed (Sum 1a + 1b)	**19**	***90.48%***
1c.	Health Centers who will install the EHR system in 3 months	0	*0.00%*
1d.	Health Centers who will install the EHR system in 6 months	0	*0.00%*
1e.	Health Centers who will install the EHR system in 1 year or more	1	*4.76%*
1f.	Health Centers who have Not Planned on installing the EHR system	1	*4.76%*
	Total Health Centers with No EHR installed (sum 1c + 1d + 1e + 1f)	**2**	***9.52%***
	Total Health Centers reported	**21**	***100.00%***
2.	Does your center send prescriptions to the pharmacy electronically? (Do not include faxing.)		
	a. Yes	18	*85.71%*
	b. No	1	*4.76%*
	c. Not Sure	0	*0.00%*
3.	Does your center use computerized, clinical decision support such as alerts for drug allergies, checks for drug-drug interations, reminders for preventive screening tests, or other similar functions?		
	a. Yes	18	*85.71%*
	b. No	1	*4.76%*
	c. Not Sure	0	*0.00%*
4.	With which of the following key providers/health care settings does your center electronically exchange clinical information? (Select all that apply)		
	a. Hospitals/Emergency rooms	13	*61.90%*
	b. Specialty clinicians	10	*47.62%*
	c. Other primary care providers	11	*52.38%*
	d. None of the above	4	*19.05%*
	e. Others	1	*4.76%*
5.	Does your center engage patients through health IT in any of the following ways? (Select all that apply)		
	a. Patient portals	13	*61.90%*
	b. Kiosks	1	*4.76%*
	c. Secure messaging	12	*57.14%*
	d. Others	1	*4.76%*
	e. No, we do not engage patients using HIT	4	*19.05%*
6.	Question Removed		
7.	How do you collect data for UDS clinical reporting (Tables 6B and 7)?		
	a. We use the EHR to extract automated reports	6	*28.57%*
	b. We use the EHR but only to access individual patient charts	1	*4.76%*
	c. We use the EHR in combination with another data analytic system	12	*57.14%*
	d. We do not use the EHR	0	*0.00%*
8.	Question Removed		
9.	Question Removed		

Health Information Technology Capabilities - 2019

National - Universal - 21 Health Centers

Line.	Measures	Number of Health Centers	% of Total
10.	How does your health center utilize HIT and EHR data beyond direct patient care? (Select all that apply)		
	a. Quality improvement	17	*80.95%*
	b. Population health management	13	*61.90%*
	c. Program evaluation	17	*80.95%*
	d. Research	11	*52.38%*
	e. Other	0	*0.00%*
	f. We do not utilize HIT or EHR data beyond direct patient care	0	*0.00%*
11.	Does your health center collect data on individual patients' social risk factors, outside of the data reportable in the UDS?		
	a. Yes	9	*42.86%*
	b. No, but we are in planning stages to collect this information	5	*23.81%*
	c. No, we are not planning to collect this information	7	*33.33%*
12.	Which standardized screener(s) for social risk factors, if any, do you use? (Select all that apply)		
	a. Accountable Health Communities Screening Tools	1	*4.76%*
	b. Upstream Risks Screening Tool and Guide	0	*0.00%*
	c. iHELP	0	*0.00%*
	d. Recommend Social and Behavioral Domains for EHRs	1	*4.76%*
	e. Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)	6	*28.57%*
	f. Well Child Care, Evaluation, Community Resources, Advocacy Referral, Education (WE CARE)	2	*9.52%*
	g. WellRx	0	*0.00%*
	h. Other	2	*9.52%*
	i. We do not use a standardized screener	11	*52.38%*

Other Data Elements - 2019

National - Universal - 21 Health Centers

Line	Measures	Number of Physicians (1a) or Patients (1b)	% of Total
1.	Medication-Assisted Treatment (MAT) for Opioid Use Disorder		
1a.	How many physicians, certified nurse practitioners and physician assistants, on-site or with whom the health center has contracts, have obtained a Drug Addiction Treatment Act of 2000 (DATA) waiver to treat opioid use disorder with medications specifically approved by the U.S. Food and Drug Administration (FDA) for that indication?	33	
1b.	How many patients received medication-assisted treatment for opioid use disorder from a physician, certified nurse practitioner, or physician assistant, with a DATA waiver working on behalf of the health center?	124	*0.60%*
Line	**Measures**	**Number of Health Centers**	**% of Total**
2.	Did your organization use telemedicine to provide remote clinical care services? (*The term "telehealth" includes "telemedicine" services, but encompasses a broader scope of remote healthcare services. Telemedicine is specific to remote clinical services whereas telehealth may include remote non-clinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services.*)		
	a. Yes	4	*19.05%*
	b. No	17	*80.95%*
2a1.	Who did you use telemedicine to communicate with? (Select all that apply)		
	a. Patients at remote locations from your organization (e.g., home telehealth, satellite locations)	4	*100.00%*
	b. Specialists outside your organization (e.g., specialists at referral centers)	2	*50.00%*
2a2.	What telehealth technologies did you use? (Select all that apply)		
	a. Real-time telehealth (e.g., live video conferencing)	4	*100.00%*
	b. Store-and-forward telehealth (e.g., secure email with photos or videos of patient examinations)	0	*0.00%*
	c. Remote patient monitoring	1	*25.00%*
	d. Mobile Health (mHealth)	1	*25.00%*
2a3.	What primary telemedicine services were used at your organization? (Select all that apply)		
	a. Primary care	1	*25.00%*
	b. Oral health	0	*0.00%*
	c. Behavioral health: Mental health	2	*50.00%*
	d. Behavioral health: Substance use disorder	2	*50.00%*
	e. Dermatology	0	*0.00%*
	f. Chronic conditions	0	*0.00%*
	g. Disaster management	0	*0.00%*
	h. Consumer health education	0	*0.00%*
	i. Provider-to-provider consultation	0	*0.00%*
	j. Radiology	0	*0.00%*
	k. Nutrition and dietary counseling	0	*0.00%*
	l. Other	0	*0.00%*

Other Data Elements - 2019

National - Universal - 21 Health Centers

Line	Measures	Number of Physicians (1a) or Patients (1b)	% of Total
2b.	If you did not have telemedicine services, please comment why (Select all that apply)		
	a. Have not considered/unfamiliar with telehealth service options	1	*5.88%*
	b. Policy barriers (Select all that apply)	6	*35.29%*
	bi. Lack of or limited reimbursement	5	*29.41%*
	bii. Credentialing, licensing, or privileging	2	*11.76%*
	biii. Privacy and security	3	*17.65%*
	biv. Other	0	*0.00%*
	c. Inadequate broadband/telecommunication service (Select all that apply)	2	*11.76%*
	ci. Cost of Service	2	*11.76%*
	cii. Lack of Infrastructure	2	*11.76%*
	ciii. Other	0	*0.00%*
	d. Lack of funding for telehealth equipment	6	*35.29%*
	e. Lack of training for telehealth services	4	*23.53%*
	f. Not needed	3	*17.65%*
	g. Other	5	*29.41%*

Line	Measures	Number of Assists [4]
3.	Provide the number of all assists provided during the past year by all trained assisters (e.g., certified application counselor or equivalent) working on behalf of the health center (employees, contractors, or volunteers), regardless of the funding source that is supporting the assisters' activities. Outreach and enrollment assists are defined as customizable education sessions about affordable health insurance coverage options (one-on-one or small group) and any other assistance provided by a health center assister to facilitate enrollment.	4,778

[4] Assists do not count as visits on the UDS tables.

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Workforce - 2019

National - Universal - 21 Health Centers

Line	Measures	Number of Health Centers	% of Total
1	Does your health center provide health professional education/training? (Health professional education/training does not include continuing education units)		
	a. Yes	17	80.95%
	b. No	4	19.05%
1a	If yes, which category best describes your health center's role in the health professional education/training process?		
	a. Sponsor	5	29.41%
	b. Training site partner	10	58.82%
	c. Other	2	11.76%
Line	**Measures**		
2	Please indicate the range of health professional education/training offered at your health center and how many individuals you have trained in each category within the last year.		
	Medical	**Number of Pre-Graduate/Certificate (a)**	**Number of Post-Graduate Training (b)**
	1. Physicians	10	47
	a. Family Physicians		39
	b. General Practitioners		12
	c. Internists		117
	d. Obstetrician/Gynecologists		1
	e. Pediatricians		26
	f. Other Specialty Physicians		0
	2. Nurse Practitioners	100	32
	3. Physician Assistants	16	3
	4. Certified Nurse Midwives	0	0
	5. Registered Nurses	258	4
	6. Licensed Practical Nurses/ Vocational Nurses	0	3
	7. Medical Assistants	13	0
	Dental	**Number of Pre-Graduate/Certificate (a)**	**Number of Post-Graduate Training (b)**
	8. Dentists	0	1
	9. Dental Hygienists	4	0
	10. Dental therapists	0	0
	Mental Health and Substance Use Disorder	**Number of Pre-Graduate/Certificate (a)**	**Number of Post-Graduate Training (b)**
	11. Psychiatrists		19
	12. Clinical Psychologists	4	0
	13. Clinical Social Workers	7	7
	14. Professional Counselors	1	0
	15. Marriage and Family therapists	0	0
	16. Psychiatric Nurse Specialists	1	5
	17. Mental Health Nurse Practitioners	10	8
	18. Mental Health Physician Assistants	0	0
	19. Substance Use Disorder Personnel	0	2
	Vision	**Number of Pre-Graduate/Certificate (a)**	**Number of Post-Graduate Training (b)**
	20. Ophthalmologists	0	1
	21. Optometrists	0	6

Workforce - 2019

National - Universal - 21 Health Centers

Line	Measures		
	Other Professionals	**Number of Pre-Graduate/Certificate (a)**	**Number of Post-Graduate Training (b)**
	22. Chiropractors	0	1
	23. Dieticians/Nutritionists	20	0
	24. Pharmacists	7	28
	25. Other	10	10
Line	**Measures**	**Number of Health Center Staff**	**% of Total**
3	Number of health center staff serving as preceptors at your health center	72	100.00%
4	Number of health center staff (non-preceptors) supporting health center training programs	123	100.00%
Line	**Measures**	**Number of Health Centers**	**% of Total**
5	How often does your health center implement satisfaction surveys for providers?		
	a.Monthly	2	9.52%
	b.Quarterly	0	0.00%
	c.Annually	9	42.86%
	d.We do not currently conduct provider satisfaction surveys	7	33.33%
	e.Other	3	14.29%
6	How often does your health center implement satisfaction surveys for general staff?		
	a.Monthly	1	4.76%
	b.Quarterly	0	0.00%
	c.Annually	8	38.10%
	d.We do not currently conduct staff satisfaction surveys	8	38.10%
	e.Other	4	19.05%