HRSA
Health Resources & Services Administration

# Uniform Data System (UDS) Reporting Requirements Training

## Calendar Year 2021

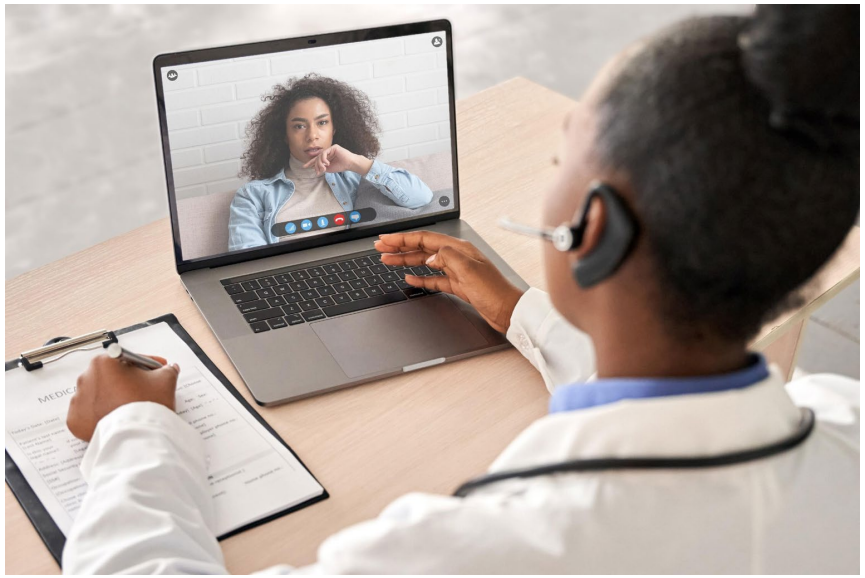
**Bureau of Primary Health Care (BPHC)**

**Health Resources and Services Administration (HRSA)**

Vision: Healthy Communities, Healthy People

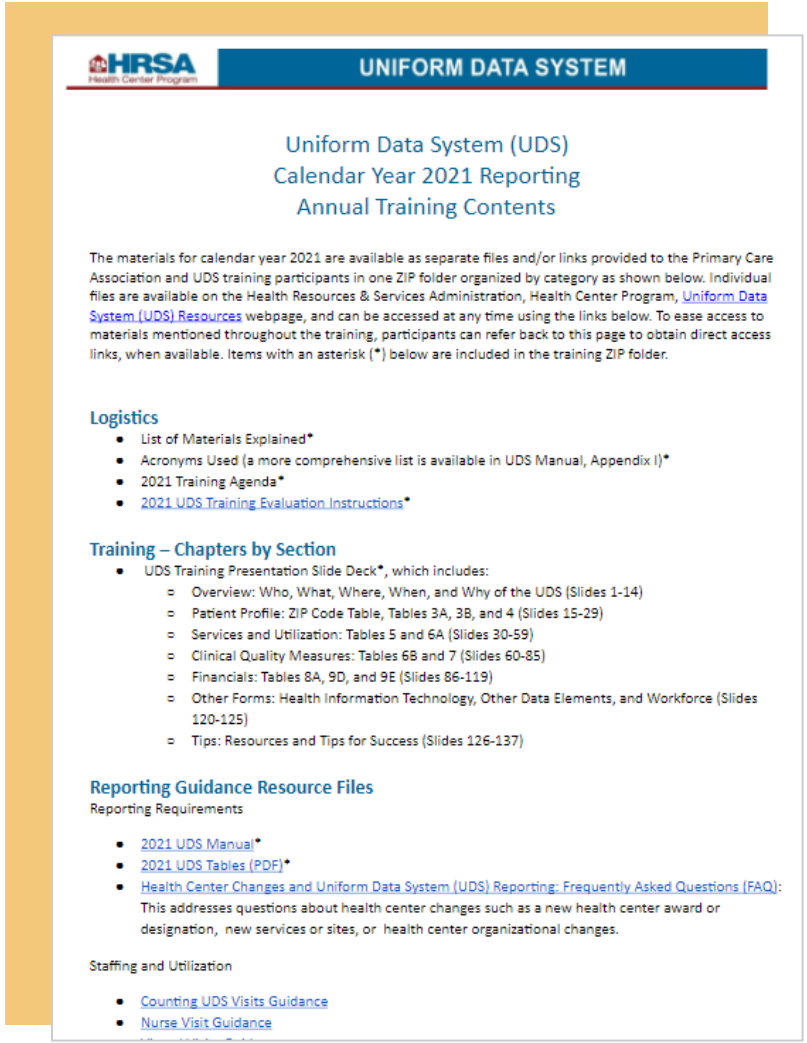
# Agenda

- Welcome and Logistics
- Overview of the UDS
- 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



Source: Adobe Stock

# Key Materials Provided with This Training



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UNIFORM DATA SYSTEM

Uniform Data System (UDS)
Calendar Year 2021 Reporting
Annual Training Contents

The materials for calendar year 2021 are available as separate files and/or links provided to the Primary Care Association and UDS training participants in one ZIP folder organized by category as shown below. Individual files are available on the Health Resources & Services Administration, Health Center Program, Uniform Data System (UDS) Resources webpage, and can be accessed at any time using the links below. To ease access to materials mentioned throughout the training, participants can refer back to this page to obtain direct access links, when available. Items with an asterisk (*) below are included in the training ZIP folder.

**Logistics**

- List of Materials Explained*
- Acronyms Used (a more comprehensive list is available in UDS Manual, Appendix I)*
- 2021 Training Agenda*
- 2021 UDS Training Evaluation Instructions*

**Training – Chapters by Section**

- UDS Training Presentation Slide Deck*, which includes:
  - Overview: Who, What, Where, When, and Why of the UDS (Slides 1-14)
  - Patient Profile: ZIP Code Table, Tables 3A, 3B, and 4 (Slides 15-29)
  - Services and Utilization: Tables 5 and 6A (Slides 30-59)
  - Clinical Quality Measures: Tables 6B and 7 (Slides 60-85)
  - Financials: Tables 8A, 9D, and 9E (Slides 86-119)
  - Other Forms: Health Information Technology, Other Data Elements, and Workforce (Slides 120-125)
  - Tips: Resources and Tips for Success (Slides 126-137)

**Reporting Guidance Resource Files**

Reporting Requirements

- 2021 UDS Manual*
- 2021 UDS Tables (PDF)*
- Health Center Changes and Uniform Data System (UDS) Reporting: Frequently Asked Questions (FAQ): This addresses questions about health center changes such as a new health center award or designation, new services or sites, or health center organizational changes.

Staffing and Utilization

- Counting UDS Visits Guidance
- Nurse Visit Guidance

- **ZIP Folder of Resources**
- **Links to HRSA BPHC's UDS Resource Site**
- **Note these NEW** materials available for 2021 reporting:
  - Health Center Changes and UDS Reporting: Frequently Asked Questions (FAQs)
  - COVID-19 Funding UDS Reporting Guidance
  - UDS Countable Visit Guidance and FAQ

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# Overview of the UDS

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

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

**WHO:** CHCs, HCHs, MHCs, PHPCs, LALs, and BHW primary care clinics funded or designated before October 2021

**WHAT:** 11 tables and 3 forms that provide an annual snapshot of all in-scope activities; Universal and Grant Reports (if applicable)

**WHERE:** Report the UDS Performance Report in the Electronic Handbooks (EHBs).

**WHEN:** Reporting occurs between Jan. 1 and Feb. 15, 2022; reporting covers the calendar year from January 1 to December 31, 2021

**WHY:** Legislatively mandated; used for program monitoring and improvement

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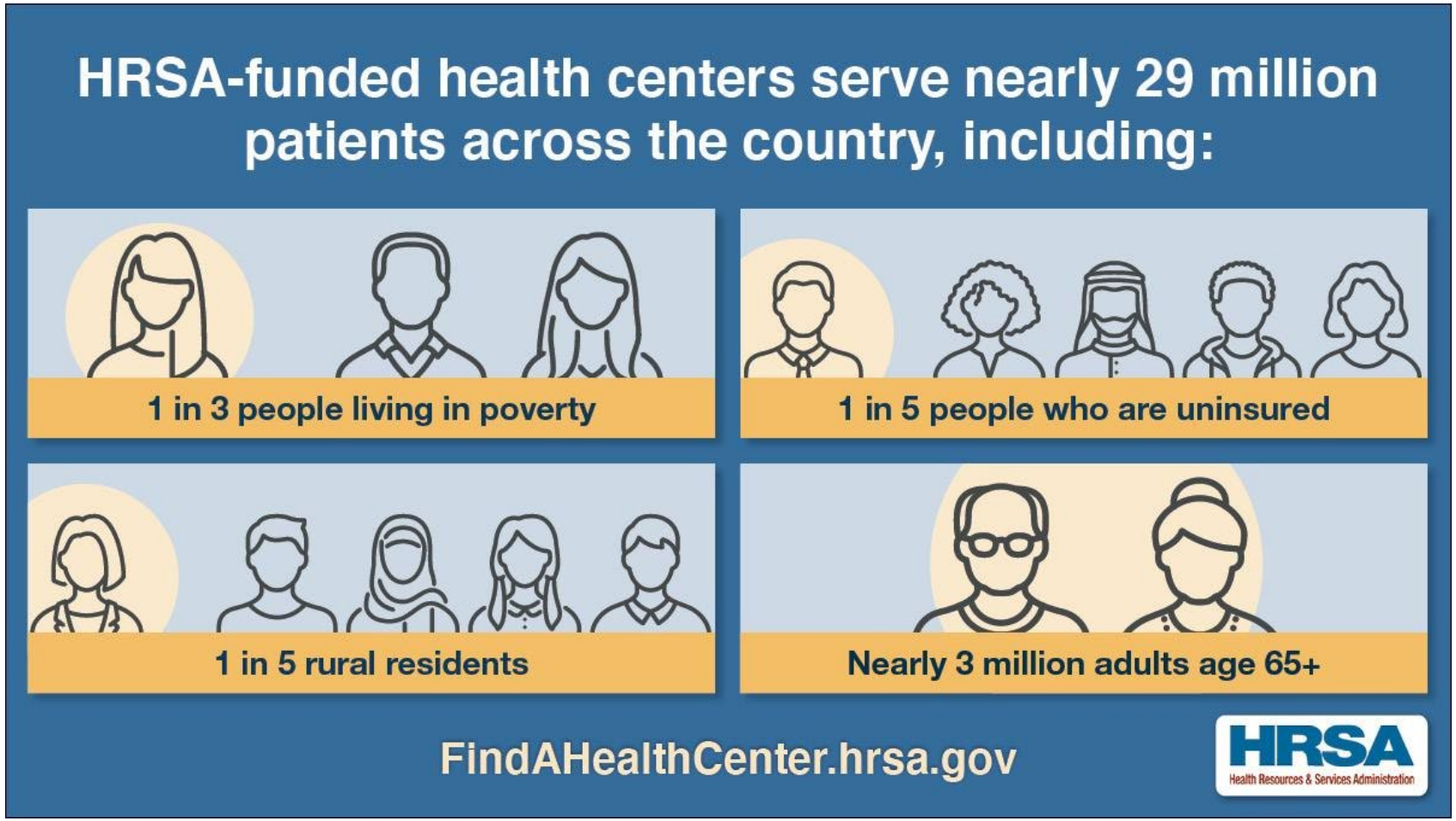
# Value of the UDS

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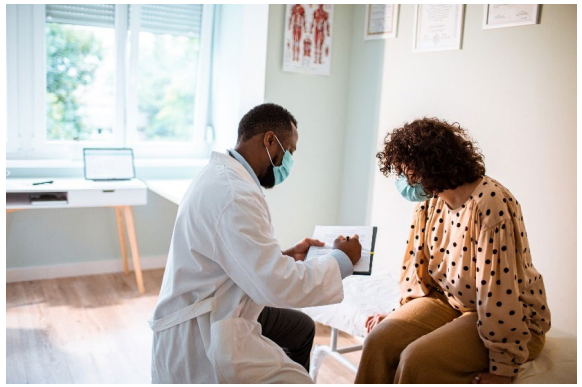
# Overview of UDS Report

## Four Primary Sections

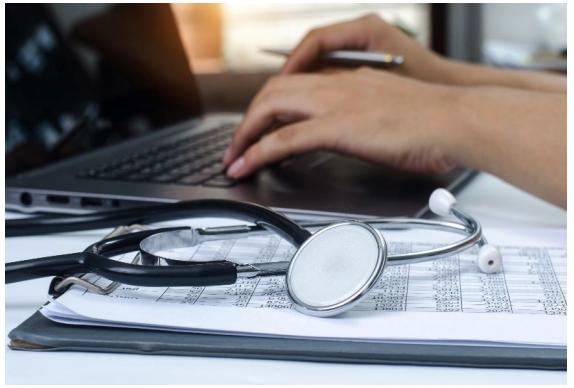
### Patient Demographic Profile

- **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



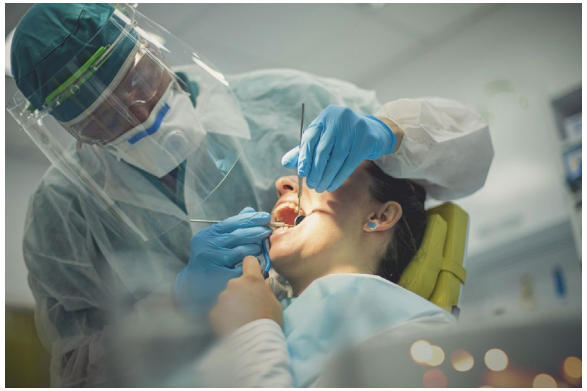
### Clinical Services and Outcomes

- **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 service-related charges and collections
- **Table 9E:** Other revenue



### Other Forms

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

Source: Adobe Stock, iStock

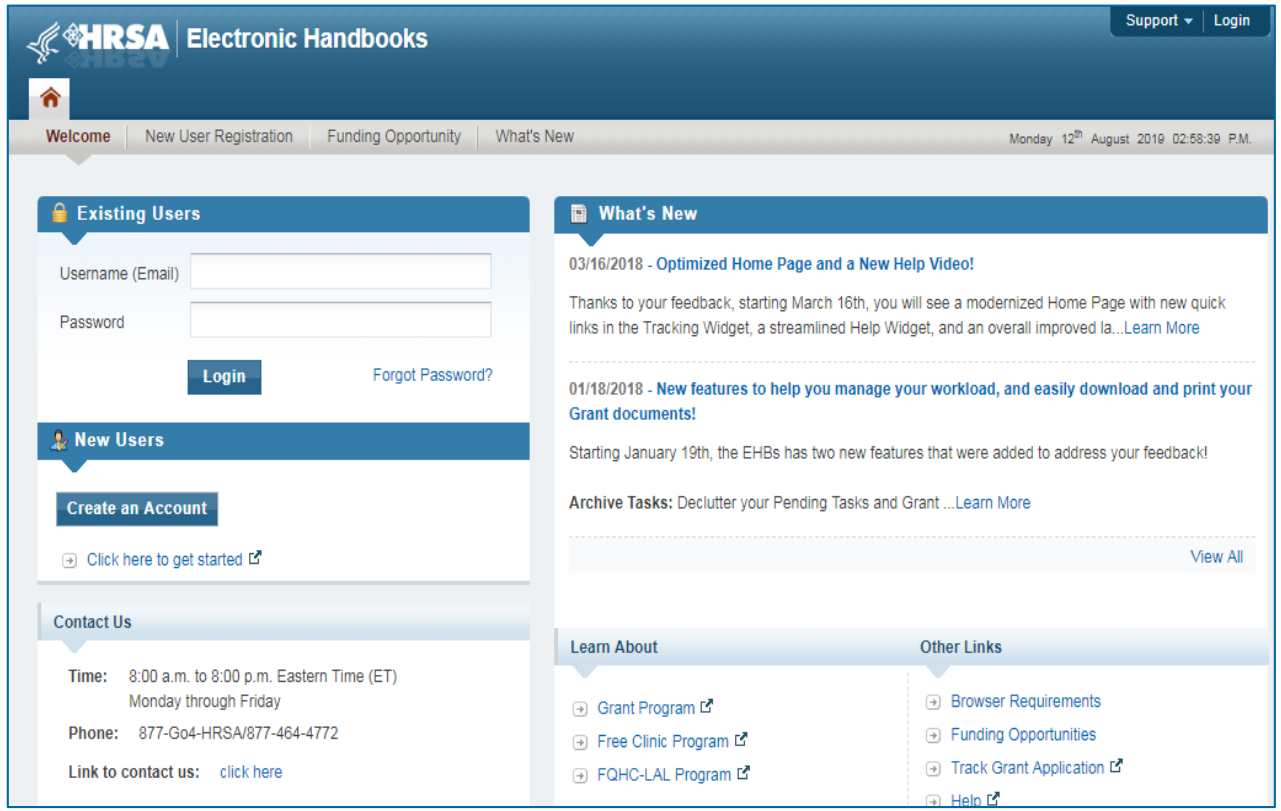
# Overview of UDS Report

## 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 multiple 330 grants (e.g., CHC, MHC, HCH, PHPC)

| Table | Report *GRANT REPORT(S)* if you receive 330 grants under multiple program authorities: |
|---|---|
| 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)




- All people who will be tasked with data entry or review need a login to the EHBs.
- Tools to Assist with Reporting
  - Preliminary Reporting Environment (PRE; for early access)
  - Excel Template (download/upload in the EHBs)
  - Comparison Tool
  - Edits
- **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)

Strategies for Successful Submission webinar provides a live demo of the PRE and helpful tools to assist with reporting.

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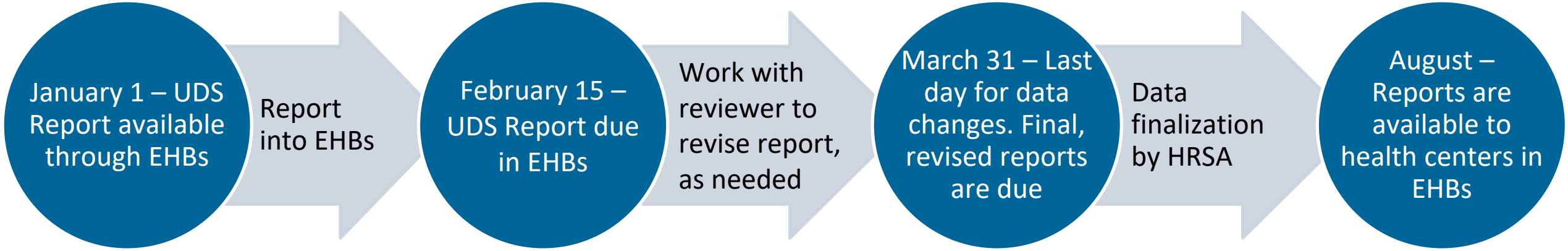
# Reporting Timeline




PRE available (Oct.–Dec.)

UDS support available (all year)

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# 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)!

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# As Always, This Is All Interrelated!

"Health center patient" is a patient with a UDS countable visit (on Table 5) in the calendar year.

Demographic information must be captured and reported for all unduplicated health center patients (Tables ZIP, 3A, 3B, 4).

Services & clinical tables (Tables 5, 6A, 6B, 7) reflect ONLY services provided to health center patients and reflect ALL health center patients who meet criteria.

Financial tables (Tables 8A, 9D, 9E) include ALL and ONLY in-scope services that are reflected in all other tables and the UDS as a whole.

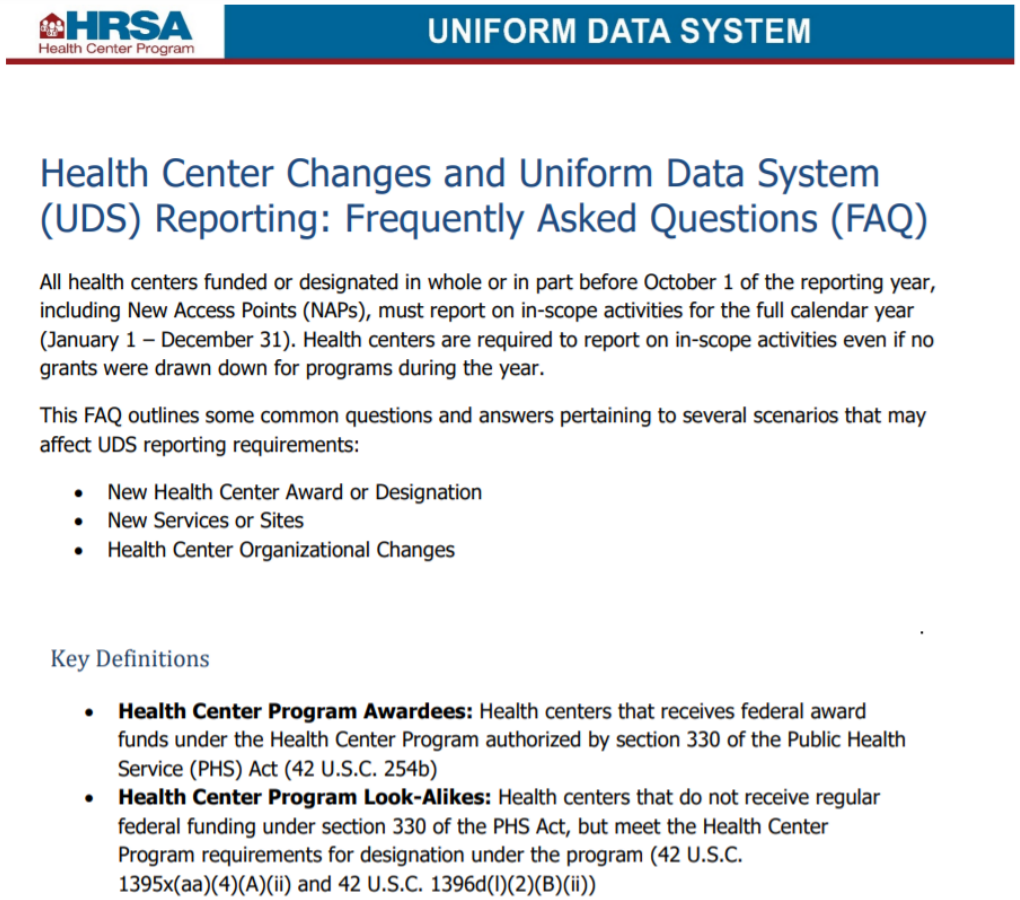
**Step 1:** Determine what sites/locations and services are in-scope (sites: Form 5B, services: Form 5A).

**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.

# New Resource: Health Center Changes and FAQs

- All health centers funded or designated in whole or in part before October 1 of the reporting year, including New Access Points (NAPs), must report on in-scope activities for the full calendar year (January 1 – December 31).
- Review this resource if your health center has experienced organizational changes, added new services or sites, or is a new health center awardee/designation.



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## Health Center Changes and Uniform Data System (UDS) Reporting: Frequently Asked Questions (FAQ)

All health centers funded or designated in whole or in part before October 1 of the reporting year, including New Access Points (NAPs), must report on in-scope activities for the full calendar year (January 1 – December 31). Health centers are required to report on in-scope activities even if no grants were drawn down for programs during the year.

This FAQ outlines some common questions and answers pertaining to several scenarios that may affect UDS reporting requirements:

- New Health Center Award or Designation
- New Services or Sites
- Health Center Organizational Changes

### Key Definitions

- **Health Center Program Awardees:** Health centers that receives federal award funds under the Health Center Program authorized by section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b)
- **Health Center Program Look-Alikes:** Health centers that do not receive regular 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))

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

2021 Changes: No major changes to reporting from 2020 UDS

# Patients

- **Patient:** A person who has at least one *countable* visit in one or more service category during the calendar 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.

Source: Shutterstock

# ZIP Code Table

- Report total patients by **ZIP code of residence** and primary medical insurance.
- List all ZIP codes in which your health center has 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 of patients by insurance 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) |
|---|---|---|---|---|---|
| <Patients’ ZIP codes will be entered here> | | | | | |
| <Patients’ ZIP codes will be entered here> | | | | | |
| Other ZIP Codes | | | | | |
| Unknown Residence | | | | | |
| **Total** | | | | | |

# 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 | | |
| 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 | | |
| … | … | | |
| 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) | | |

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# Ethnicity, Race, and Language

## Table 3B

| | 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 | | | <cell not reported> | |
| 2a | Native Hawaiian | | | <cell not reported> | |
| 2b | Other Pacific Islander | | | <cell not reported> | |
| 2 | Total Native Hawaiian/Other Pacific Islander (Sum Lines 2a + 2b) | | | <cell not reported> | |
| 3 | Black/African American | | | <cell not reported> | |
| 4 | American Indian/Alaska Native | | | <cell not reported> | |
| 5 | White | | | <cell not reported> | |
| 6 | More than one race | | | <cell not reported> | |
| 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 | |

- Report total patients by **ethnicity and race**.
  - This is to be self-reported by patients or caregivers (and should not be inferred).
  - If race is known, but ethnicity is not, report in Column B.
  - If patient identifies as or selects multiple races, report on Line 6.
  - **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

Report total patients by self-reported **sexual orientation** and **gender identity**.

| 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/Transgender Masculine | |
| 23 | Transgender Woman/Transgender Female/Transgender Feminine | |
| 24 | Other | |
| 25 | Chose not to disclose | |
| 25a | Unknown | |
| 26 | **Total Patients** (Sum of Lines 20 to 25a) | |

- **Something else (Line 16)/Other (Line 24):** Patients who do not identify with other available categories. For example:
  - ✓ Genderqueer or non-binary for gender identity
  - ✓ Asexual or pansexual for sexual orientation

- **Chose not to disclose (Lines 18 and 25):** Patients who chose 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.

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# Income and Insurance

## Table 4

| 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) | | |

- **Patients by income**
  - 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.
      - ✓ Income is 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
- **Patients by primary medical insurance**
  - 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.

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# Primary Medical 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 received from or 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 | 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) | | |

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# Managed Care

## Table 4

- Managed care organizations (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) | | | | | |

Only the member months for assigned patients who have medical or comprehensive managed care are reported here.

# 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

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# 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!

# Special Populations

## Table 4

- **All health centers** report the following:
  - Total Agricultural Workers or Dependents (Lines 16)
  - Total Homeless (Line 23)
  - Total School-Based Health Center Patients (Line 24)
  - Total Veterans (Line 25)
  - Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site (Line 26)

| 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) | |

*Special Populations Resources: HRSA-funded* National TTA Partners

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# Special Populations

## Table 4

- **Health centers who have a Migrant Health Center (MHC) grant:**
  - Report migratory (**Line 14**—temporary home) and seasonal (**Line 15**).
- **Health centers who have a Health Care for the Homeless (HCH) grant:**
  - Report (**Lines 17–22**) where individuals who experience homelessness are housed as of their ***first visit*** during the calendar 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 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) | |

*Special Populations Resources: HRSA-funded* National TTA Partners

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

## DO

- ✓ **Do** roll up data into the UDS categories if you collect race and ethnicity or SOGI data in more granular detail than the UDS.
- ✓ **Do** 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).
- ✓ **Do** ensure demographic information is updated regularly in accordance with UDS Manual.
- ✓ **Do** collect special population information, even if you do not have a special population grant.

## DON'T

- ❑ **Don't** include patients on the demographic tables (ZIP, 3A, 3B, and 4) who have not had a countable visit on Table 5.
- ❑ **Don't** submit without double checking that all tables align—for example, age across Table 3A and insurance on Table 4, and primary medical insurance across ZIP Table and Table 4.
- ❑ **Don't** report patients with unknown medical insurance as uninsured on ZIP Code Table and Table 4; be sure to collect medical insurance information!

# Example: Table 4

**Ramy was seen by the health center twice in 2021.**

- **First visit:** Ramy had no reportable income because he was a seasonal agricultural worker and it wasn't yet apple picking season. When seen, he was couch-surfing, staying with friends and family. At this visit, he had no medical insurance.
- **Second visit:** Ramy reported that he was now making about $300 per week doing seasonal agricultural work. He was now staying in a worker's dormitory. At this visit, he had COVID-19, and his COVID-related care was covered by HRSA's COVID-19 Uninsured Program.

Source: iStock

**Where would this patient be reported on Table 4?**

- **Income**
- **Medical Insurance**
- **Special Populations**

# Reporting Services and Quality of Care Indicators

## Tables 5, 6A, 6B, and 7

# Table 5: Staffing and Utilization

2021 Changes: No major changes to reporting

# Full-Time Equivalent (FTE) by Position and Service Category

## Table 5

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

| Line | Personnel by Major Service Category | FTEs (a) |
|---|---|---|
| 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 Personnel | |
| 20 | **Total Mental Health Services** (Lines 20a–c) | |
| 21 | **Substance Use Disorder Services** | |
| 22 | **Other Professional Services** (specify ___) | |

# Reporting Personnel FTEs

## Table 5

- Personnel are reported by position and service category.
- To determine where given personnel is reported, consider the following:
  - Licensed providers are reported on the line of their licensure.
    - ✓ Example: An internist should be reported as an internist, even if they work in a pediatric setting.
  - Personnel who are not licensed or who are not working in the area of their licensure are reported based on primary job duties.
    - ✓ Example: A nurse who primarily provides case management or care coordination should be reported as a case manager/care coordinator.
- Note that ONLY personnel reported on certain lines can generate visits.

**Key Reminders:**

➔ Appendix A in the 2021 UDS Manual outlines where (e.g., on which line) many personnel should be reported AND specifies whether a given position is a provider or not, and therefore whether the position can generate visits.

➔ Visits, *when countable*, must be reported **on the line with the provider** who conducted the visit.

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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*

Together, 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

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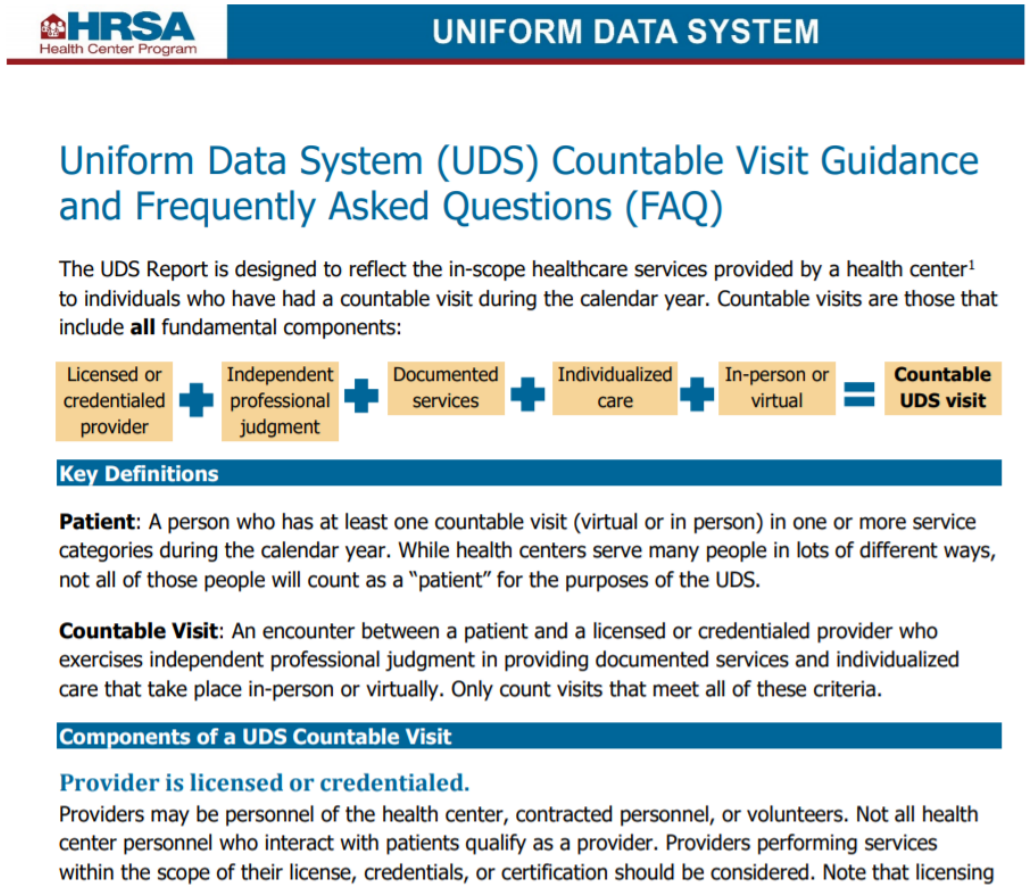
# IMPORTANT KEY:

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

We will discuss Table 8A later!

# New Resource: UDS Countable Visit Guidance and Frequently Asked Questions

- UDS Countable Visit Guidance and FAQ includes:
  - Key definitions
  - Components of a UDS countable visit
  - Example of NOT countable visits
  - Directions to report visit activity in the UDS Report
  - Frequently asked questions
  - Supporting visit definition resources



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UNIFORM DATA SYSTEM

## Uniform Data System (UDS) Countable Visit Guidance and Frequently Asked Questions (FAQ)

The UDS Report is designed to reflect the in-scope healthcare services provided by a health center[1] to individuals who have had a countable visit during the calendar year. Countable visits are those that include **all** fundamental components:

Licensed or credentialed provider + Independent professional judgment + Documented services + Individualized care + In-person or virtual = **Countable UDS visit**

### Key Definitions

**Patient**: A person who has at least one countable visit (virtual or in person) in one or more service categories during the calendar year. While health centers serve many people in lots of different ways, not all of those people will count as a "patient" for the purposes of the UDS.

**Countable Visit**: An encounter between a patient and a licensed or credentialed provider who exercises independent professional judgment in providing documented services and individualized care that take place in-person or virtually. Only count visits that meet all of these criteria.

### Components of a UDS Countable Visit

**Provider is licensed or credentialed.**

Providers may be personnel of the health center, contracted personnel, or volunteers. Not all health center personnel who interact with patients qualify as a provider. Providers performing services within the scope of their license, credentials, or certification should be considered. Note that licensing

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# Defining a Visit

Licensed or credentialed provider + Independent professional judgement + Services documented in the individual patient chart + Individualized care + Real-time in-person or virtual engagement =

**Countable UDS Visit**

# COVID-19 Testing or Vaccination and Visits

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 countable visit (and that is their only contact with the health center), 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 UDS countable visit**, this patient and visit are reported in UDS Report.

If an **individual receives a COVID-19 vaccine, but the health center *does not* provide additional services** that meet the criteria of a countable visit (and that is their only contact with the health center), this person and visit are not reported in the UDS Report.

If an individual receives a COVID-19 vaccine *and* the health center **provides additional services that meet the criteria of a UDS countable visit**, this patient and visit are reported in the UDS Report.

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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.

Page 19 of the 2021 UDS Manual has additional information.

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# Contacts That Do Not, ALONE, Count as Visits

| Health 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 or vaccines | Providing narcotic agonists or antagonists, MAT, etc. | Taking health histories |

# Examples: Are These Countable Visits on Table 5?

1. Yvonne has not been seen at the health center before. She comes to the health center to get a COVID-19 vaccine. Yvonne signs in, filling out a brief form, and then a nurse administers the one-dose COVID-19 vaccine. Yvonne leaves and is not seen at the health center again.

2. Charles is seen by his primary care provider at the health center for a regular check up. In that visit, his primary care provider conducts a COVID-19 test and provides a flu vaccine.

3. A nurse at the health center calls a patient to complete several screenings, including social need screening and PHQ-9, in advance of a scheduled appointment the patient has 3 days later.

Source: iStock

# Examples: Are These Countable Visits on Table 5?

1. Yvonne has not been seen at the health center before. She comes to the health center to get a COVID-19 vaccine. Yvonne signs in, filling out a brief form, and then a nurse administers the one-dose COVID-19 vaccine. Yvonne leaves and is not seen at the health center again. **NOT A VISIT.**

2. Charles is seen by his primary care provider at the health center for a regular check up. In that visit, his primary care provider conducts a COVID-19 test and provides a flu vaccine. **YES, A VISIT.**

3. A nurse at the health center calls a patient to complete several screenings, including social need screening and PHQ-9, in advance of a scheduled appointment the patient has 3 days later. **The nurse's contact with the patient to conduct screening is *NOT* a visit. The visit with the provider 3 days later where the PHQ-9 is reviewed (for example) *IS* a visit.**

Source: iStock

# 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 providers.
- Count virtual visits.
- Include completed 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) | | | | |
| 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 | | | | |

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# Location of Visits: Clinic

## Table 5

- **Clinic Visits (Column B):** Report visits conducted through *in-person contact* that meet all the requirements discussed earlier for countable visits.

| 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 | | | | |

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# Location of Visits: Virtual

## Table 5

- **Virtual visits (Column B2):** Report documented *virtual (telemedicine) contact* between a patient and provider that meet all the requirements discussed earlier for countable visits.
- 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.

**View the** virtual visits guidance file**.**

| 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 | | | | |

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# Discussion: What Counts as a Virtual Visit?

| Examples of Type of Service |
| --- |
| 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 professional judgment).

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# 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 professional judgment).

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# Patients and Visits by Service and Provider Type

## Table 5

| Visits (Columns B and B2) | Patients (Column C) | Key Reminders |
|---|---|---|
| Count clinic and virtual visits that meet definition discussed.<br><br>Visits must be *on the same line* with the FTE of the provider who conducted the visit.<br><br>If a visit is counted in either of these columns, the patient MUST be reported in Column C *and* be included in the unduplicated patient count on all demographic tables. | This is an unduplicated count of patients *by service category*.<br><br>A patient may have visits in multiple service categories, such as having medical, dental, and vision visits in the year. Patients for whom that is true are *counted in each of those service categories in Column C*. As a result, the total number of patients reported across Column C is generally larger than the unduplicated patient count. | • Not all personnel generate visits.<br>• Not all contacts are countable visits.<br>• A single visit may consist of multiple services, but it counts as only one visit.<br>• Only those patients reported on this table are included in the unduplicated patient count on demographic tables and in clinical care tables. |

# Table 5: Completing the Selected Service Detail Addendum

2021 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 *in medical visits*.
- Capturing data on **substance use disorder (SUD) services** provided by medical providers *and* MH providers *in medical and MH visits*.

| 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 (shown left).

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

# Example: Integrated MH in Medical Visit

A family physician sees a patient in person with a diagnosis of depression and manages their medication for that depression during the medical visit.

- **Table 5, Staffing and Utilization:** The family physician FTE is reported in Line 1, Column A of Table 5. The visit is reported on Line 1, Column B.
- **Table 5, Selected Service Detail Addendum, Mental Health Service Detail:** Due to the integrated behavioral health, the family physician is *also* counted as 1 personnel in Line 20a01, Column A1, and the visit is *also* counted in Line 20a01, Column B.

**This visit is counted twice on Table 5: *once* in the main part of Table 5 and *once* in the addendum. In no case can a visit be reported twice on the main part of Table 5.**

Source: Adobe Stock

# 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 the 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 | | | | |

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

**MH FTEs, visits, and patients** are reported on Lines 20a–20 of the main part of Table 5. These MH personnel, 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 Personnel | | | | |
| 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 the main part of Table 5 fully captures **SUD FTEs, visits, and patients. These personnel, visits, and patients are *NOT* repeated in the addendum.**

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# Example: Integrated SUD in MH Visit

A licensed clinical psychologist sees a patient via telehealth for depression complicated by an alcohol-related disorder.

- **Table 5, Staffing and Utilization:** Report the depression treatment services visit and clinical psychologist FTE on Line 20a1, and the patient in the total on Line 20. The visit would be in Column B2, because it's a virtual visit.
- **Table 5, Selected Service Detail Addendum, Substance Use Disorder Service Detail:** Due to the integrated SUD services, report the alcohol-related treatment provided by the clinical psychologist (personnel, visit, & patient) on Line 21f. The visit would be in Column B2, because it's a virtual visit.

**As described above, this visit is counted twice on Table 5: once in the primary part of Table 5 and once in the addendum. *In no case can a visit be reported twice on the main part of Table 5*.**

Source: iStock

# Determining Visits to Include in Addendum

Include, *at minimum*, all countable visits with providers included in **Table 5 Selected Services Addendum, Column A1**, with 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, 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 | | |

Visits reported here that were with **medical** or **mental health** providers are reported on SUD detail section of T5 addendum.

Visits reported here that were with **medical providers** are reported on MH detail section of Table 5 selected service addendum.

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# Determining Visits to Include in Addendum

## 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 | | |

## Table 5: 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 | | | | |

# Resources to Support Table 5 Reporting

- BPHC UDS Reporting Resources
  - UDS Countable Visit Guidance and FAQ
  - Virtual Visit Reporting Handout
  - Mental Health/Substance Use Disorder Services Detail Handout
  - Nurse Visit Guidance Handout
  - UDS Reporting Instructions Appendix A: Listing of Personnel (page 157)
- Telehealth Resource Centers: 12 HRSA-supported regional and 2 national centers (including the Center for Connected Health Policy) provide expert and customizable technical assistance and 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

# Table 6A: Selected Diagnoses and Services Rendered

2021 Changes:

- New line for coronavirus (SARS-CoV-2) vaccine visits and patients
- ICD-10 and HCPCs codes updated for 9 existing lines

# 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 | | |
| | **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 (count only when code U07.1 **is** present), J22, J98.8, J80 | | |

- Report all visits meeting the specified criteria for a health center patient.
- Diagnoses lines are reported where the indicated diagnosis is listed as part of a countable visit; services and procedures are counted when provided at any point during the year to a health center patient and documented in that patient's chart.
- **Column A:** Report the number of *visits* with the selected service or diagnosis.
  - If a patient has more than one category of 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

- **One New Row: Line 24b: Coronavirus (SARS-CoV-2) vaccine**
  - Reported on Other Data Elements form last year, moved to Table 6A this year.
  - Report ONLY those provided to health center patients; not mass vaccination.

- If an individual is a patient of the health center, meaning that they had at least one UDS countable visit (reported on Table 5) during the reporting year, and received a vaccine which was documented in their chat, then their vaccine should be reported on Table 6A.
- Therefore, on Line 24b (Coronavirus (SARS-CoV-2) vaccine), report vaccines that your health center provided to its patients during the reporting year. The vaccine does not need to have been administered to the patient on the same day as a UDS countable visit to be counted on Table 6A.

Table 6A Changes Handout outlines changes from the prior year.

# 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.

# Tables 6B & 7: Clinical Quality Measures (CQMs)

2021 Changes:

- Measures aligned with updated eCQMs, wherever available
- In alignment with those updated eCQMs, two existing measures have modifications

To learn more about how these measures align with other national reporting, please visit *UDS CQMs and National Programs Crosswalk* on pages 195–196 in the 2021 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 |

Pink highlighting and/or bolded text in the table signifies measures that were updated for CY2021 reporting.

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# General Reminders for CQMs

- *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 2021 UDS Manual.
- Be sure to use the **birthdates specified in the 2021 UDS Manual**, which typically align with the patient's age before the start of the reporting year.
- 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 EHR/health IT vendors to ensure systems have been updated with required specifications.
  - Validate your data to ensure that workflows are successfully capturing data.
  - Educate affected personnel regarding any changes, as appropriate.

**These are general reminders, but remember that each CQM has its own specified criteria!**

# Telehealth and CQMs

**General Rule (which is notably relevant during increased telehealth use):**

- ***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 UDS Clinical Measure Reporting
- 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).
  - ✓ 2021 UDS Clinical Quality Measures Criteria
  - ✓ The measure steward for each measure can be found in Appendix G of the UDS Manual, pages 195–196.

# Clinical Process and Outcome Measures

## Table 6B Format

### Format

| Line | Measure Name | Denominator (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 measure requirements |

### Example

| 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 | 250 | 215 | 139 |

| | |
|---|---|
| **Measure Description** | Describes the quantifiable indicator to be evaluated |
| **Denominator** | Patients who fit the detailed criteria described for inclusion in the measure |
| **Numerator** | Patients included in the denominator whose records meet the requirements for the specified 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 and Outcome Measures

## Table 7 Format

- Report by race and ethnicity.
- High blood pressure and diabetes:
  - **Column A:** Denominator
  - **Column B:** Denominator, at least 80% of denominator, 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 Non-Hispanic or Latino/a* | | | |
| | **Unreported/Refused to Report Race and Ethnicity** | | | |
| h | Unreported/Refused to Report Race and Ethnicity | | | |
| i | **Total** | | | |

***See page 176 of the UDS Manual for Table 3B/7 crosswalk.***

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# 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.
- The majority of UDS measures align with eCQMs.
- eCQMs are used across many national programs, so may be monitored on an ongoing basis.

- To accurately report, you need to:
  1. Understand how to access and read specifications of the eCQM.
  2. Know where your EHR is looking for specified data elements for the eCQM to calculate performance.
  3. Make sure your providers and staff are recording required data in correct fields.

# Summary of CQM Changes

- **Two measures have been *updated*:**
  - Tobacco Use: Screening and Cessation Intervention (CMS138v9)
  - Cervical Cancer Screening (CMS124v9)
- **No *new* CQMs for 2021.**

Source: iStock

# Table 6B CQMs

| Line | Measure | eCQM | Brief Measure Description |
|---|---|---|---|
| 7–9 | **Early Entry into Prenatal Care** | no eCQM | Percentage of prenatal care patients who entered prenatal care during their first trimester |
| 10 | **Childhood Immunization Status** | CMS117v9 | 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 |
| 11 | **Cervical Cancer Screening** | CMS124v9 | Percentage of women 21*–64** years of age who were screened for cervical cancer using either of the following criteria:<br>• Women age 21*–64** who had cervical cytology performed within the last 3 years<br>• Women age 30–64** who had human papillomavirus (HPV) testing performed within the last 5 years<br>*Note: *Use 23 as the initial age to include in assessment. **63 is the final age to include in assessment. Again, refer to ages in the 2021 UDS Manual.* |

**The Cervical Cancer Screening measure was changed from the prior year. Details can be found in the 2021 UDS Clinical Quality Measures Handout.**

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# Table 6B CQMs

| Line | Measure | eCQM | Brief Measure Description |
|---|---|---|---|
| 11a | **Breast Cancer Screening** | CMS125v9 | 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<br><br>*Note: *Use 51 as the initial age to include in assessment.* |
| 12 | **Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents** | CMS155v9 | 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<br><br>*Note: *Use 16 as the oldest age at the start of the measurement period to include in assessment.* |
| 13 | **Body Mass Index (BMI) Screening and Follow-Up Plan** | CMS69v9 | 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 who had a follow-up plan documented if the most recent BMI was outside of normal parameters |

# Table 6B CQMs

| Line | Measure | eCQM | Brief Measure Description |
|---|---|---|---|
| 14a | **Tobacco Use: Screening and Cessation Intervention** | CMS138v9 | Percentage of patients aged 18 and older who were screened for tobacco use one or more times within 12 months and who received tobacco cessation intervention if identified as a tobacco user |
| 17a | **Statin Therapy for the Prevention and Treatment of Cardiovascular Disease** | CMS347v4 | 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:<br>● 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<br>● 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<br>● 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 |

**The Tobacco Use: Screening and Cessation Intervention measure was changed from the prior year. Details can be found in the 2021 UDS Clinical Quality Measures Handout.**

# Table 6B CQMs

| Line | Measure | eCQM | Brief Measure Description |
|---|---|---|---|
| 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<br>*Note that the IVD eCQM is has not been updated; the Version 7 specifications should continue to be used for 2021 reporting. Details can be found in the 2021 UDS Clinical Quality Measures Handout.* |
| 19 | **Colorectal Cancer Screening** | CMS130v9 | Percentage of adults 50–75 years of age who had appropriate screening for colorectal cancer |
| 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 |
| 20a | **HIV Screening** | CMS349v3 | Percentage of patients aged 15–65 at the start of the measurement period who were between 15–65 years old when tested for HIV |

# Table 6B CQMs

| Line | Measure | eCQM | Brief Measure Description |
|---|---|---|---|
| 21 | **Preventive Care and Screening: Screening for Depression and Follow-Up Plan** | CMS2v10 | 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 |
| 21a | **Depression Remission at Twelve Months** | CMS159v9 | Percentage of patients aged 12 years and older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event |
| 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<br>*Note that the Dental Sealant eCQM is has not been updated; the Version 0 specifications should continue to be used for 2021 reporting. Details can be found in the 2021 UDS Clinical Quality Measures Handout.* |

# Table 7 Clinical Quality Outcome Measures

| Section | Measure | eCQM | Brief Measure Description |
|---|---|---|---|
| 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) |
| Section B | **Controlling High Blood Pressure** | CMS165v9 | Percentage of patients 18–85 years of age who had a diagnosis of hypertension overlapping the measurement period or the year prior and whose most recent blood pressure (BP) was adequately controlled (less than 140/90 mmHg) during the measurement period |
| Section C | **Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)** | CMS122v9 | Percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c (HbA1c) greater than 9.0 percent during the measurement period |

**Table 7 measures are reported by race and ethnicity.**

**Details can be found in the 2021 UDS Clinical Quality Measures Handout.**

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# Table 6B: Existing Measure Modified

## Cervical Cancer Screening (CMS124v9)

- Updated description removes cytology and co-testing for women age 30–64 and replaces "every" with "within the last" in "Women age 30–64 who had human papillomavirus (HPV) testing performed **within the last** 5 years."
- **Numerator (Column C)** revised to align with updated clinical recommendations.
  - For patients age 30 years and older, permits HPV testing alone every 5 years.

| 2020 | 2021 |
|---|---|
| Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: | Percentage of women 21–64 years of age who were screened for cervical cancer using either 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.<br>• 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. | • 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.<br>• Cervical HPV testing performed during the measurement period or the 4 years prior to the measurement period for women who are 30 years or older at the time of the test. |

# Table 6B: Existing Measure Modified

## Tobacco Use: Screening and Cessation Intervention (CMS138v9)

- Revised timeframes for **numerator** from **24** to **12** months.
- Revised timing associated with performing a tobacco cessation intervention in the numerator.
- Removes constraint that the intervention occur *after* the most recent tobacco use screening during which the patient was identified as a tobacco user and ties these actions to the measurement period.

| 2020 | 2021 |
|---|---|
| • Patients who were screened for tobacco use at least once within 24 months.<br>• Patients who received tobacco cessation intervention.<br>• Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.<br>• Pharmacotherapy or cessation intervention on the same date or after the positive screening. | • Patients who were screened for tobacco use at least once within 12 months.<br>• Patients who received tobacco cessation intervention.<br>• Patients who were screened for tobacco use at least once within 12 months AND who received tobacco cessation intervention if identified as a tobacco user.<br>• Pharmacotherapy or cessation intervention during the measurement period. |

# Tables 6A, 6B, and 7 Resources

- BPHC UDS Reporting Resources
  - Telehealth Impact on Clinical Measure Reporting
  - Clinical Quality Measures Handout
  - Clinical Quality Measure Exclusions and Exceptions
  - Helpful Codes for HIV and PrEP
  - Table 6A Code Changes Handout
  - Three-part clinical measures webinar series
    - Screening and Preventive Care
    - Maternal Care and Children's Health
    - Chronic Disease Management
- eCQI Resource Center: Eligible Professional/ Eligible Clinician eCQMs
- Health Information Technology, Evaluation, and Quality (HITEQ) Center
  - A HRSA-funded National Training/TA Partner

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

## DO

- ✓ **Do** know that all involved recognize the many challenges that COVID-19 has presented in the last 2 years in providing care.
- ✓ **Do** report clinical measures (at least the Denominator, Column A) if you have medical patients in the age range who meet requirements, even if compliance is 0.
- ✓ **Do** remember to consider the lookback period for the numerator as defined by certain clinical quality measures.
- ✓ **Do** remember that Table 6A diagnoses and services relate to health center patients.
- ✓ **Do** 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

- ❑ **Don't** forget that the Tobacco Screening and Cessation Intervention measure has shortened the timeframe from 24 months to 12 months. There may be a drop in compliance related to this, particularly if processes haven't been updated.
- ❑ **Don't** exclude patients who meet the denominator criteria, unless they meet specified exclusion or exception criteria.
  - ❑ Patients who have medical visits, including virtual visits, are generally eligible for inclusion in measures.
- ❑ **Don't** try to interpret age or other aspects from the measure title—apply CQL logic!
  - ❑ Review the specifications!

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# Tables 6B and 7: Prenatal Care and Birth Outcome Measures

2021 Changes: No major changes to reporting

# Tables 6B and 7: Prenatal and Birth Outcome Measures

- Health center patients who *initiate prenatal care with the health center or its referral network* are counted in the **Prenatal section of Table 6B** and tracked and reported in **Delivery and Birth Outcomes section of Table 7**.
  - Pages 86–89 and 117–119 of the 2021 UDS Manual detail the health center UDS reporting requirements for prenatal care and related delivery and birth outcomes.
- **Prenatal care initiated with "the health center or its referral network" refers to:**
  - Prenatal care initiated with the health center directly *OR*
  - Prenatal care initiated with provider/entity with which the health center has *formal referral **contractual** agreements* (as recorded on Column II of Form 5A) *OR*
  - Prenatal care initiated with a provider/entity with which the health center has *formal written **referral** arrangements* (as recorded on Column III of Form 5A).
- Prenatal care and related delivery and birth weight outcomes are reported on the UDS from all three of the scenarios listed above, therefore *tracking systems must be in place for all three*.

"Initiated with the health center or its referral network" for UDS reporting purposes does NOT include other forms of referral, such as those that are **less formal** or those where the patient self-referred.

# Maternal Care: Prenatal and Birth Outcome Measures

**Table 6B: Prenatal Care Patients**

Report **ALL**** (no sampling) **prenatal care** patients who directly received, or were referred for, prenatal care services during the calendar year

≠

**Table 7: Deliveries**

Report all prenatal care patients who **delivered** regardless of outcome (*exclude miscarriages*) during calendar year by **race and ethnicity of mother**.

≠

**Table 7: Birth Outcomes**

Report babies according to their **birth weight** in grams (*exclude stillbirths*) by **race and ethnicity** of baby; if multiple births, report each baby separately

**Include patients who a) began prenatal care in previous year (2020) and delivered in the calendar year (2021), b) began and delivered in calendar period (2021), and c) began in calendar year (2021) and will not deliver until next year (2022).

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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.

**Line 0, Section A (Lines 1–6), and Section B (Lines 7–9)**

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

| 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)** | |

| 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 | | |

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# Deliveries and Birth Outcomes

## Table 7

- **Column 1A:** Report prenatal care *patients who delivered* during the year (*exclude miscarriages*) *by their race and 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 *birth weight* (exclude stillbirths) *and by race and ethnicity of baby*.
  - Count twins as two births, triplets as three, etc.
  - Column 1D ( ≥ 2,500 grams) is normal birth weight.
  - Column 1C (1,500–2,499 grams) is low birth weight.
  - Column 1B (< 1,500 grams) is very low.

| 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 and Ethnicity** | | | | |
| h | Unreported/Refused to Report Race and Ethnicity | | | | |
| i | **Total** | | | | |

HRSA Health Center Program

# 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

| Line | Description | Patients (a) |
|---|---|---|
| 0 | HIV-Positive Pregnant Patients | |
| 2 | Deliveries Performed by Health Center's Providers | |

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

HRSA Health Center Program

# Where Are These Patients Reported in Prenatal Section(s)?

1. A 23-year-old patient was seen in December of 2020 for prenatal care in the health center. The patient then had a 2,750-gram baby on January 13, 2021.

Source: iStock

2. A 32-year-old patient is seen in the health center in early 2021, has a pregnancy test, and is found to be pregnant. The nurse gives the patient a list of nearby prenatal care providers who are accepting new patients. The patient is seen again in late 2021 for allergies and a COVID test. At that visit, the patient has the new baby in tow.

# Where Is This Patient Reported in Prenatal Section(s)?

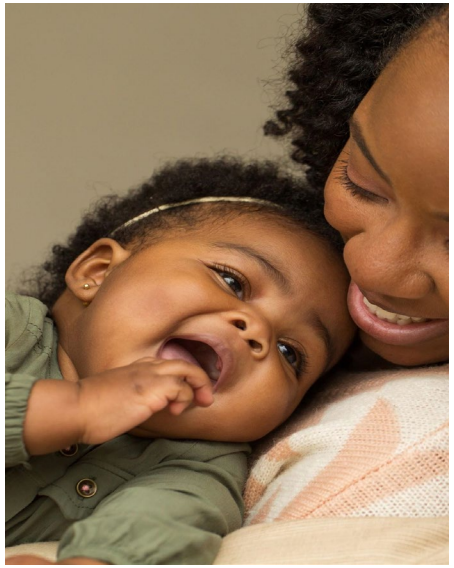
Source: iStock

A 23-year-old patient was seen in December of 2020 for prenatal care in the health center. The patient then had a 2,750-gram baby on January 13, 2021.

## The patient is reported in the following prenatal-related sections:

- This patient is reported on **Table 6B** as a prenatal patient, by **age** (Line 3) and **Trimester of Entry.**
- This patient is ALSO **reported as a delivery on Table 7**, Column 1A by their race and ethnicity.
- The patient's baby is reported in **Column 1D** ( ≥ 2,500 grams) by the race and ethnicity of the baby.

# Where Is This Patient Reported in Prenatal Section(s)?



Source: iStock

A 32-year-old patient is seen in the health center in early 2021, has a pregnancy test, and is found to be pregnant. The nurse gives the patient a list of nearby prenatal care providers who are accepting new patients. The patient is seen again in late 2021 for allergies and a COVID test. At that visit, the patient has the new baby in tow.

- **This patient is not reported as a prenatal patient on the UDS.** The patient was not referred for prenatal care and therefore is not a prenatal patient of the health center.

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

## DO

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

## DON'T

- ❑ **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.
- ❑ **Don't** report patients as having delivered during the reporting period when there is no evidence of delivery.
- ❑ **Don't** forget to track delivery outcomes for prenatal care patients, even if they transferred out of the health center.

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

2021 Changes:
Update to COVID-related funding lines on Table 9E

# Costs and Revenues

## Table 8A: Financial Costs

- **Accrued costs**, including staff and contracted 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 service** receipts or funds drawn down in the calendar year
- Grants, contracts, and other funds
- Reported on a cash basis

# Table 8A: Financial Costs

2021 Changes: No major changes

# Financial Costs

## Table 8A

| Cost Center (Lines 1–15) | Accrued Cost (Column A) | Allocation of Facility and Non-Clinical Support Services (Column B) | Total Cost After Allocation of Facility and Non-Clinical Support Services (Column C) |
|---|---|---|---|
| • Medical<br>• Dental<br>• Mental Health<br>• Substance Use Disorder<br>• Pharmacy & Pharmaceuticals<br>• Other Professional<br>• Vision<br>• Enabling<br>• Other Program-Related Services<br>• Administration (non-clinical support)<br>• Facility | • Report **accrued** direct costs<br>• Include costs of:<br>  ▪ Personnel (both staff and contracted)<br>  ▪ Fringe benefits<br>  ▪ Supplies<br>  ▪ Equipment<br>  ▪ Depreciation<br>  ▪ Related travel<br>• No bad debt costs | • Allocate Facility and Non-Clinical Support Services costs to all other cost centers (Lines):<br>  ▪ Medical<br>  ▪ Dental<br>  ▪ Mental Health<br>  ▪ Substance Use Disorder<br>  ▪ Pharmacy & Pharmaceuticals<br>  ▪ Other Professional<br>  ▪ Vision<br>  ▪ Enabling<br>  ▪ Other Program-Related Services<br>• Must equal Line 16, Column A, representing overhead costs incurred by all cost centers | • Sum of Columns A + B (calculated automatically in EHBs)<br>• Represents cost to operate service by category<br>• Used to calculate cost per visit and cost per patient |

# Tables 5 and 8A Crosswalk

| 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) | | | | |

| 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 Personnel | | | |
| 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) | | | |

Left: Excerpt of Table 5; Above: Excerpt of Table 8A.

**Key Takeaway:** If a service line on Table 5 has FTEs, visits, and/or patients, then the corresponding cost center on Table 8A should have corresponding costs.

# Financial Costs

## Table 8A

### Report costs by Cost Center

- **Line 1:** Medical personnel 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 medical 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 & 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:** Personnel who support use of EHR and QI

| Line | Cost Center | Accrued Cost (a) |
|---|---|---|
| | **Financial Costs of Medical Care** | |
| 1 | Medical Personnel | |
| 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) | |

HRSA Health Center Program

# 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.

Source: iStock

# Column A, Lines 14–16

## Table 8A

- **Line 14:** Facility-related expenses, including direct personnel costs, rent or depreciation, mortgage interest payments, utilities, security, groundskeeping, janitorial services, maintenance, etc. Includes personnel whose FTEs are reported on Table 5, Line 31.
- **Line 15:** Costs for all personnel whose FTE is reported on Table 5, Lines 30a–30c and 32, including corporate administration, billing collections, medical records and intake personnel, 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 16:** Total indirect costs to be allocated in Column B.

| 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) | | | |

# Allocating Overhead Expenses to Column B: Two-Step Method

## Facility (Line 14)

- Identify square footage utilized by each cost center and cost per square foot (using UDS reportable costs).
- Distribute square footage costs to each cost center.

## Non-Clinical Support Services (Line 15)

- Distribute non-clinical support costs to the applicable service.
  - Include decentralized front desk personnel, billing and collection systems and personnel, etc.
  - Consider lower allocation of overhead to contracted services.
- Allocate remaining overhead costs using straight-line method.
  - Straight-line method means allocating non-clinical support services costs based on the proportion of net costs that is assigned 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.

# Reporting Donations

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

**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-service-related revenue not reported elsewhere)

*Resource: Reporting Donations in the UDS*

# Table 9D: Patient Service Revenue

2021 Change: No major changes

# Patient Service Revenue

## Table 9D

| | | | | Retroactive | Settlements, Receipts, | 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) | | | | | | | | | |

### Report (Columns)

- Column A: Charges (2021)
- 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 (sub-lines a & b)

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

HRSA Health Center Program

# Column A: Full Charges

## Table 9D

| 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) |
|---|---|---|---|---|---|---|---|---|---|---|

- **Column a: Full Charges:** Total billable charges across all services, reported by payer source:
  - Undiscounted, unadjusted, gross charges for services owed by payer
  - Based on health center 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

| 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) |
|---|---|---|---|---|---|---|---|---|---|---|

- **Column b: Collections:** Include **all payments** received in 2021 **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 tied to patient care.
- Do not include Promoting Interoperability payments from Medicaid and Medicare here.
- Do not include *pay-for-participation* or *pay-for-reporting* incentives here (report on Table 9E). *Pay-for-performance* incentives (tied to patient services) ARE reported here.

HRSA Health Center Program

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

## Table 9D

| | Retroactive Settlements, Receipts, and Paybacks (c) | | | |
|---|---|---|---|---|
| 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) |
| 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)*<br>• **Wraparound payments** *(additional amount per visit to bring payment up to FQHC level)* | • **FQHC prospective payment system (PPS) reconciliations** *(based on filing of cost report)*<br>• **Wraparound payments** *(additional amount per visit to bring payment up to FQHC level)* | • **Managed care pool distributions**<br>• **Pay for performance (P4P)**<br>• **Other incentive payments**<br>• **Quality bonuses**<br>• **Value-based payments** | **Paybacks or deductions by payers because of overpayments or penalty** *(report as a positive number)* |

# Column D: Adjustments

## Table 9D

| 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) |
|---|---|---|---|---|---|---|---|---|---|---|

- **Column D: Adjustments:** 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 (most common when with large retro payments in C1–C3).
- For managed care capitated Lines (2a, 5a, 8a, and 11a) *only*, adjustments equal the difference between charges and collections (Column D = A–B).

# Column E: Sliding Fee Discounts

## Table 9D

| 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) |
|---|---|---|---|---|---|---|---|---|---|---|

**ONLY applicable to charges reported in Column A of Line 13, Self-Pay**

- **Column E: 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

| 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:** Amounts owed by patients considered to be uncollectable and formally written off during 2021, regardless of when service was provided.
- Only report **patient bad debt** (not third-party payer bad debt):
  - ONLY related to charges reported in **Column A** of **Line 13, Self-Pay**.
  - 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).

# Payer Categories for Patient Service 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/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
- Commercial insurance purchased by patient and/or their 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

HRSA Health Center Program

# COVID-19 Uninsured Program Reporting

## Table 9D

| Federal Funding | Other Names | Reported on UDS |
|---|---|---|
| Reimbursement for COVID-related costs of uninsured patients from HRSA | HRSA Uninsured Claims Program (administered by United Health/ Optum Pay) | **Table 9D, Line 8c: Other Public Including COVID-19 Uninsured Program**<br><br>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.***

# Forms of Payment

- Revenue for each third-party payer is generally divided into **three forms of payment**: Non-Managed Care, Managed Care Capitation, and Managed Care Fee-for-Service (FFS).
  - **Non-Managed Care** refers to the payment model in which procedures and services are separately charged and paid for by a third-party payer, generally based on FFS. The third-party payers pay some or all of the bill based on agreed-upon maximums or discounts.
    - ✓ Payments for services to patients who are *not assigned to the health center* as part of a managed care plan are reported as *non-managed care*.
  - **Managed Care Capitation** refers to a payment model in which a health center contracts with a managed care organization for a specified set of services, for which the managed care plan pays the health center a set amount for each patient assigned to the health center. This is called a capitation fee and is typically paid per member per month.
  - **Managed Care FFS** refers to a payment model in which a health center contracts with a managed care organization and is assigned a set of patients for whose care the health center is responsible. The health center is reimbursed on an FFS (or encounter-rate) basis for covered services.
- Note that **charges** for each of these forms of payment are still reported based on the *health center's fee schedule*. So, although Managed Care Capitation is paid regardless of services rendered, charges still need to be reported based on services rendered.

# Example

## Table 9D

A patient is seen at the health center and at check-in states that they still have the same private health plan as the last time that they were seen. The patient then has a visit with a health center provider.

When the health center bills the insurance for the visit, 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** | |
| 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 (Line 13), the charge may be paid, may be written off as sliding fee if the patient has qualified, or may be written off as bad debt. Must reclassify the charge first!

HRSA Health Center Program

# Example

## How is this reported across Tables 4 and 9D?

Source: iStock

- Rhonda is a patient at the health center and comes in for a COVID test.
- At the time of the visit, Rhonda is uninsured.
- When Rhonda comes in for the COVID test, she is experiencing shortness of breath and a cough. She is seen by a provider who takes her history, including symptoms, onset, etc., and does a full physical exam.
- Rhonda's COVID test is positive. The provider prescribes Rhonda an inhaler and medication for her cough.
- The health center submits the claim for Rhonda's care to the HRSA COVID-19 Uninsured Program.

# Example

**This is how Rhonda's visit is reported on Tables 4 and 9D.**

Source: iStock

- **Recap:** Rhonda is a patient at the health center and comes in for a COVID test. At the time of the visit, Rhonda is uninsured. When Rhonda comes in for the COVID test, she is experiencing shortness of breath and a cough. She is seen by a provider who takes her history, including symptoms, onset, etc., and does a full physical exam. Rhonda's COVID test is positive. The provider prescribes Rhonda an inhaler and medication for her cough. The health center submits the claim for Rhonda's care to the HRSA COVID-19 Uninsured Program.
- **Answer:**
  - Rhonda is **uninsured on Table 4**.
  - On Table 9D, the full charges for the COVID care she received are reported in **Column A of Line 8c, HRSA COVID-19 Uninsured Program.** Then the amount received from the HRSA COVID-19 Uninsured Program is reported in **Column B of Line 8c**.

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.<br>• Report the **full amount paid for drugs, either directly (by clinic) or indirectly (by contract pharmacy)** on Line 8b, Pharmaceuticals.<br>• 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, even though Line 8a Column A is blank.<br>• Report payments to pharmacy benefit managers on Line 8a, Pharmacy.<br>• Some pharmacies split the fee or keep a share of profit. Report this as a payment to the pharmacy on Line 8a, Pharmacy. |
| **9D (Patient Service 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.<br>• **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.<br>• **Adjustments (Column D) is the amount disallowed by a third party for the charge** (if on Lines 1–12).<br>• **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 revenue on Table 9E, and do not use Table 9E to report net revenue from the pharmacy. Report actual gross revenue on Table 9D. |

**Key Takeaway: The breakdowns outlined here are needed to report correctly.**

HRSA Health Center Program

# Table 9E: Other Revenue

2021 Changes:

- Change of one line to American Rescue Plan funding

# Other Revenue

## Table 9E

- Report **non-patient-service receipts** or funds drawn down in 2021.
  - **Cash basis**—amount drawn down (not award).
    - Tip: do not exceed the amount awarded on any given line.
  - Include income that supported activities described in your scope of services.
  - Report funds by the entity from which you received them.
  - Complete “specify” fields.
- The total amount reported on Tables 9E and 9D represents total revenue supporting the health center’s scope of services.
- Guidance surrounding common funding sources administered to health centers in response to the COVID-19 pandemic can be found here.

# Revenue Categories

## Table 9E

- **BPHC Grants:** Funds you received directly from BPHC, including funds passed through to another agency.
  - Include 330 grant(s) drawn down in the year.
  - Include the amounts directly received under the various COVID funding streams.
- **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 | American Rescue Plan | |
| 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 service revenue not reported elsewhere) (specify _____) | |
| 11 | **Total Revenue** (Sum of Lines 1 + 5 + 9 + 10) | |

HRSA Health Center Program

# BPHC COVID-19 Funding Lines

## Table 9E

| 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 | American Rescue Plan | |
| 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) | |

- Lines 1l through 1p capture COVID-related funding *from HRSA BPHC*.
- **Report the amount drawn down in the year**; some of these funds may have been awarded in 2020, but if they were not drawn down until 2021, then they're reported in Calendar Year 2021 UDS.
  - Lines 1l–1n were awarded in 2020 but may have been drawn down in 2021.
  - Line 1o awarded in 2021, H8F funding.
- At this time, there will be **no reporting on Line 1p**, as no other BPHC COVID-19 funding exists.
- Detailed guidance in COVID-19 funding.

HRSA Health Center Program

# Revenue Categories

## Table 9E

- **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.

| | 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 service revenue not reported elsewhere) (specify _____) | |
| 11 | **Total Revenue** (Sum of Lines 1 + 5 + 9 + 10) | |

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

## DO

- ✓ **Do** use at least a two-step process for allocating overhead in Column B of Table 8A.
- ✓ **Do** ensure you have or are receiving detailed payer information for your 340B or contract pharmacy, to accurately report Table 9D.
- ✓ **Do** 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

- ❑ **Don't** report patient-generated revenue, such as contract/340B pharmacy revenue or pay-for-performance distributions, on Table 9E.
- ❑ **Don't** forget to compare managed care reporting on Table 9D to managed care member months on Table 4.
- ❑ **Don't** report adjustments on anything except contractual adjustments, adjusted by Columns C1 through C4.

# Resources to Support Financial and Operational Reporting

- BPHC UDS Reporting Resources
  - Operational Costs and Revenues Training Module
  - Reporting Donations Guide
  - Financial Tables Guidance Handout (common error checks)
  - COVID-19 Funding UDS Reporting Guidance
  - Table 8A Fact Sheet
  - Table 9D Fact Sheet
  - Table 9E Fact Sheet
- Reporting UDS Financial and Operational Tables Webinar

# Other Forms to Complete

Health Information Technology Form

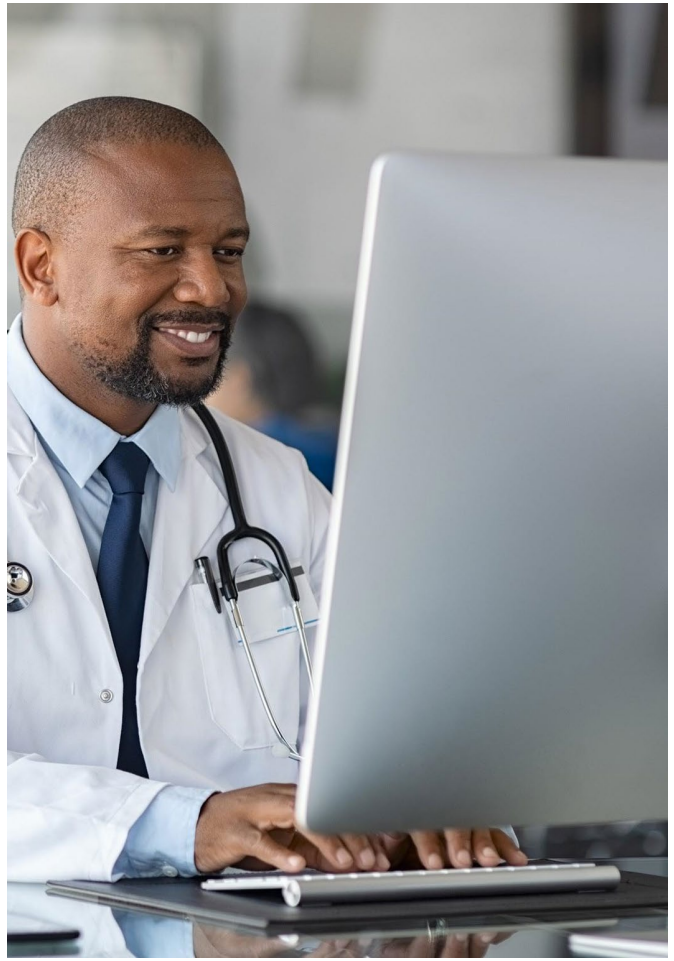
Other Data Elements Form

Workforce Form

# Health Center Health Information Technology (HIT) Capabilities: Appendix D

**A series of approximately 15 questions that assess:**

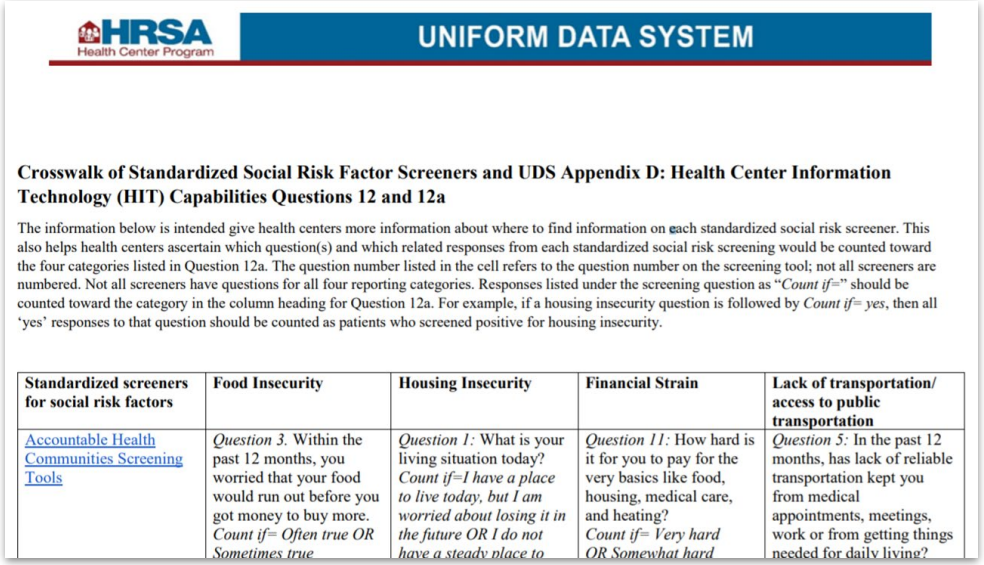
- **EHR adoption and use in your health center**
  - How widely is the EHR used in the organization?
  - What EHR? Is it CEHRT? Did you switch? Is it updated?
  - Do you use more than one system?
- **Data Exchange:** What other healthcare entities do you exchange information with?
- What else do you use HIT/EHR for?
- **Social risk screening**
  - Standardized tools
  - Patients identified with social risks
  - If no, why not?
- **Integration of Prescription Drug Monitoring Program (PDMP)**



Source: IStock

# Positive Screens for Selected Social Risks

- In addition to asking whether a health center is using a standardized social risk screener, the HIT form also collects the **number of health center patients who screened positive** in four areas:
  - ❑ Food insecurity
  - ❑ Housing insecurity
  - ❑ Financial strain
  - ❑ Lack of transportation/access to public transportation



HRSA Health Center Program | 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 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* | *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? |

- This crosswalk identifies the questions on each standardized screener and what constitutes a positive screen in each of the selected areas.
- **Do not use proxies (such as patients who are low income) to report social risks.**

# 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 (buprenorphine) provided by providers with a DATA waiver.
    - ✓ Check information with reporting on Table 5.
- **Outreach and enrollment assistance**
  - Report number of assists.
  - Outreach and enrollment assists are defined as customizable education sessions about affordable health insurance coverage options and any other assistance provided by a trained assister from the health center to facilitate enrollment.
    - ✓ Assists reported here do not count as visits on the UDS tables, only on this form.

# 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, SUD, dermatology, etc.?
- **If you do not offer telemedicine services, why not?**
  - Policy barriers, inadequate broadband, funding, training, etc.?

## Key to Remember

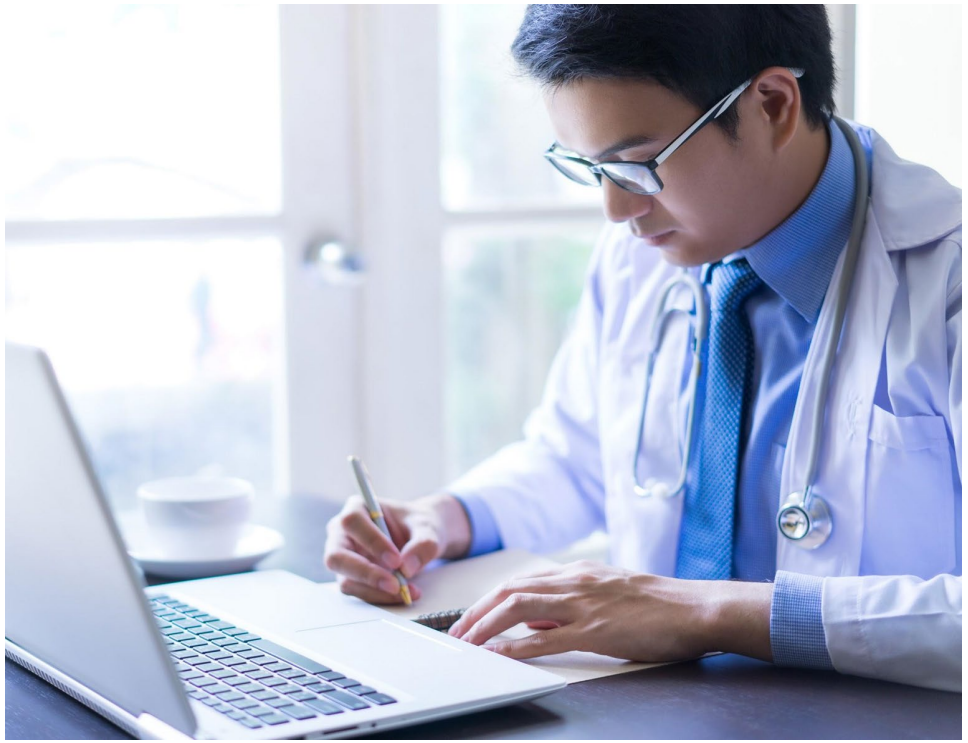
*This form uses the term "telemedicine":*
Telemedicine is specific to remote clinical services, whereas telehealth may include remote non-clinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services.

**Limit your responses to clinical services.**

# Workforce Form

## Appendix F

- Helps clarify current state of health center workforce training and staffing models.
- Topics include:
  - Professional education/training
    - ✓ Report health professional training/education provided by category and whether that training is pre-graduate/certificate or post-graduate.
    - ✓ Note that this is NOT staff training like continuing education, CMEs, or first aid training, but training of the health professional workforce.
  - Satisfaction surveys
    - ✓ Note that this is STAFF satisfaction, not patient satisfaction surveys.



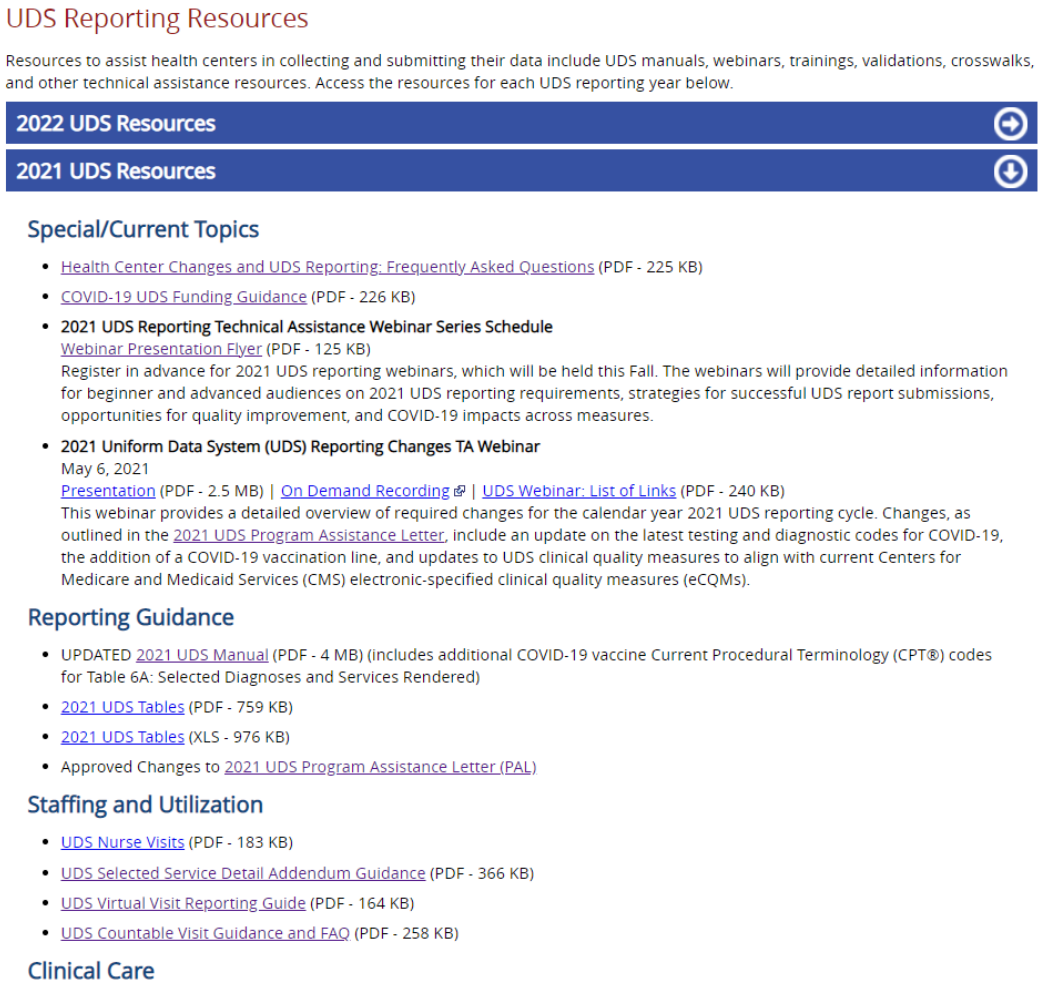
Source: iStock

# Available Resources

There are a host of resources available to support your UDS reporting!

# BPHC UDS Reporting Resources

- **Now available: UDS Reporting Resources on the BPHC website**
- Resources now regrouped by topic to better align with UDS tables:
  - Special/Current Topics
  - Reporting Guidance
  - Staffing and Utilization
  - Clinical Care
  - Financials
  - Additional Reporting Topics
  - UDS Data



UDS Reporting Resources

Resources to assist health centers in collecting and submitting their data include UDS manuals, webinars, trainings, validations, crosswalks, and other technical assistance resources. Access the resources for each UDS reporting year below.

2022 UDS Resources

2021 UDS Resources

Special/Current Topics

- Health Center Changes and UDS Reporting: Frequently Asked Questions (PDF - 225 KB)
- COVID-19 UDS Funding Guidance (PDF - 226 KB)
- **2021 UDS Reporting Technical Assistance Webinar Series Schedule**
  Webinar Presentation Flyer (PDF - 125 KB)
  Register in advance for 2021 UDS reporting webinars, which will be held this Fall. The webinars will provide detailed information for beginner and advanced audiences on 2021 UDS reporting requirements, strategies for successful UDS report submissions, opportunities for quality improvement, and COVID-19 impacts across measures.
- **2021 Uniform Data System (UDS) Reporting Changes TA Webinar**
  May 6, 2021
  Presentation (PDF - 2.5 MB) | On Demand Recording | UDS Webinar: List of Links (PDF - 240 KB)
  This webinar provides a detailed overview of required changes for the calendar year 2021 UDS reporting cycle. Changes, as outlined in the 2021 UDS Program Assistance Letter, include an update on the latest testing and diagnostic codes for COVID-19, the addition of a COVID-19 vaccination line, and updates to UDS clinical quality measures to align with current Centers for Medicare and Medicaid Services (CMS) electronic-specified clinical quality measures (eCQMs).

Reporting Guidance

- UPDATED 2021 UDS Manual (PDF - 4 MB) (includes additional COVID-19 vaccine Current Procedural Terminology (CPT®) codes for Table 6A: Selected Diagnoses and Services Rendered)
- 2021 UDS Tables (PDF - 759 KB)
- 2021 UDS Tables (XLS - 976 KB)
- Approved Changes to 2021 UDS Program Assistance Letter (PAL)

Staffing and Utilization

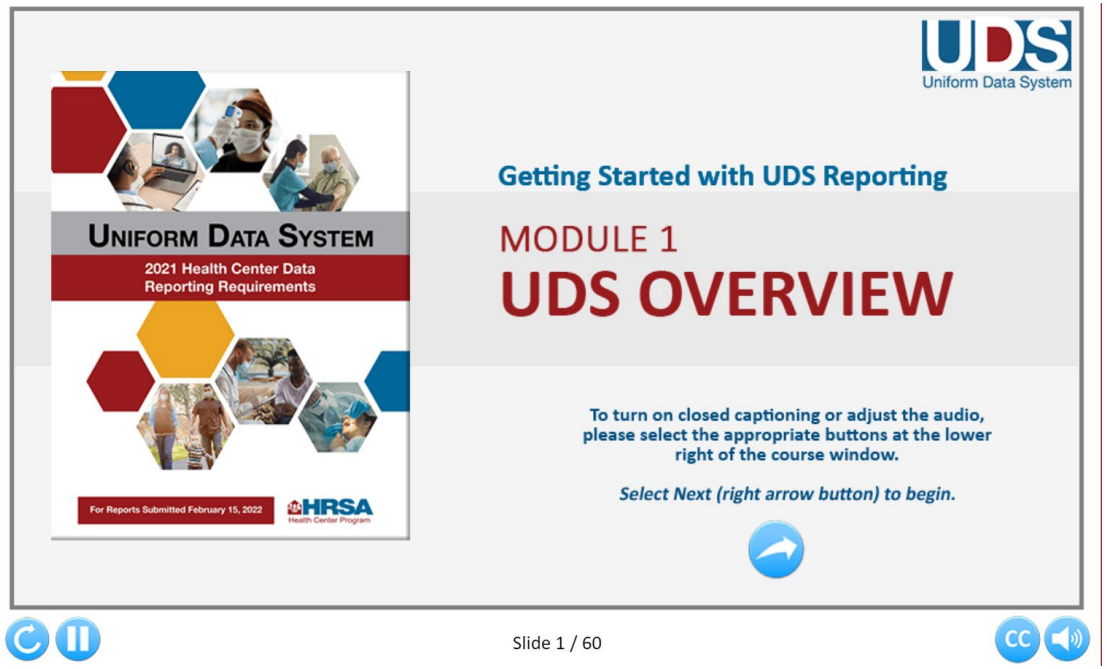
- UDS Nurse Visits (PDF - 183 KB)
- UDS Selected Service Detail Addendum Guidance (PDF - 366 KB)
- UDS Virtual Visit Reporting Guide (PDF - 164 KB)
- UDS Countable Visit Guidance and FAQ (PDF - 258 KB)

Clinical Care

HRSA Health Center Program

# 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 HRSA BPHC's UDS resource page.

# Training Webinar Series for 2021 UDS Reporting

- Counting 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: Chronic Disease Management
- Reporting UDS Financial and Operational Tables
- Successful Submission Strategies

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. ET, M–F<br>Extended hours during UDS reporting period | 7:00 a.m. to 8:00 p.m. ET, M–F<br>Extended hours during UDS reporting period | 8:00 a.m. to 8:00 p.m. ET, M–F |

# Tips for Success

# Tips for Success

- **Tables are interrelated**, so sit with team to agree on correct and related reporting:
  - Sites
  - Personnel, FTEs, and roles
  - Patients and services
  - Expenses
  - Revenues

Source: IStock

- Adhere to **definitions and instructions.**
- **Check your data** before submitting.
  - Refer to the comments you received from your reviewer last year. This document is emailed to the UDS Contact each year.
  - 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

# Available Assistance

- Technical assistance materials, including local trainings, are available online:
  - HRSA Health Center Program website
- UDS Support Center for assistance with UDS reporting questions:
  - udshelp330@bphcdata.net
  - 866-UDS-HELP (866-837-4357)
- Health Center Program support for questions about the Health Center Program.
- Office of the National Coordinator for Health Information Technology (ONC) Issue Tracking System (OITS) JIRA project eCQM Issue Tracker:
  - Sign up for an OITS account
  - Post questions in the eCQM Issue Tracker
- EHBs support
  - UDS Report and Preliminary Reporting Environment access (in EHBs)
  - EHBs system issues: 877-464-4772, Option 1
  - EHBs account access and roles: 877-464-4772, Option 3
- National Training and Technical Assistance Partners

# 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 Resources & Services Administration

# Please Complete an Evaluation! Your feedback is important to us.

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

Evaluation Link

Vision: Healthy Communities, Healthy People

# 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**

HRSA Health Center Program