HRSA
Health Resources & Services Administration

Uniform Data System (UDS) Reporting Requirements Training

Calendar Year 2020

Bureau of Primary Health Care (BPHC)

Health Resources and Services Administration (HRSA)

Vision: Healthy Communities, Healthy People

Agenda

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

Key Materials Provided with This Training

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

Overview of the UDS and the Impact of COVID-19

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

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

WHO: CHCs, HCHs, MHCs, PHPCs, LALs and BHW primary care clinics funded or designated before October 2020

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

WHERE: Report through the EHBs between Jan. 1, 2021 and Feb. 15, 2021; PRE and offline reporting tools available in fall 2020

WHEN: For the period from January 1 to December 31, 2020

WHY: Legislatively mandated; used for program monitoring and improvement

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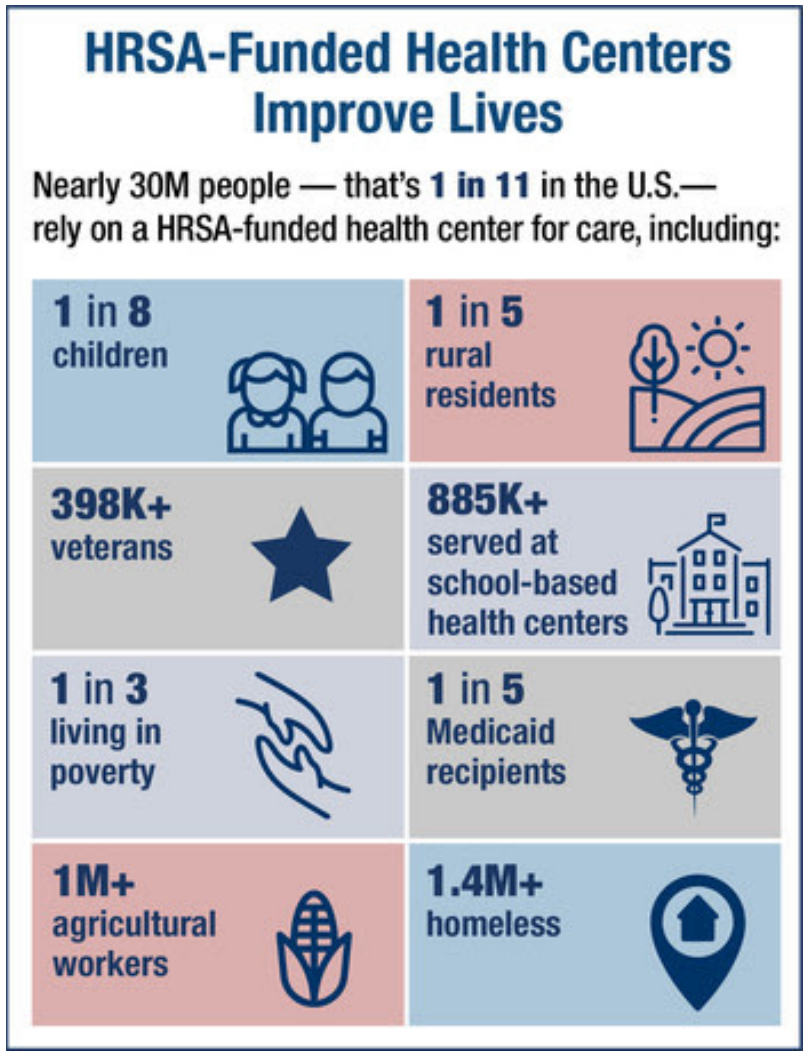
Value of the UDS



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

Other Forms

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

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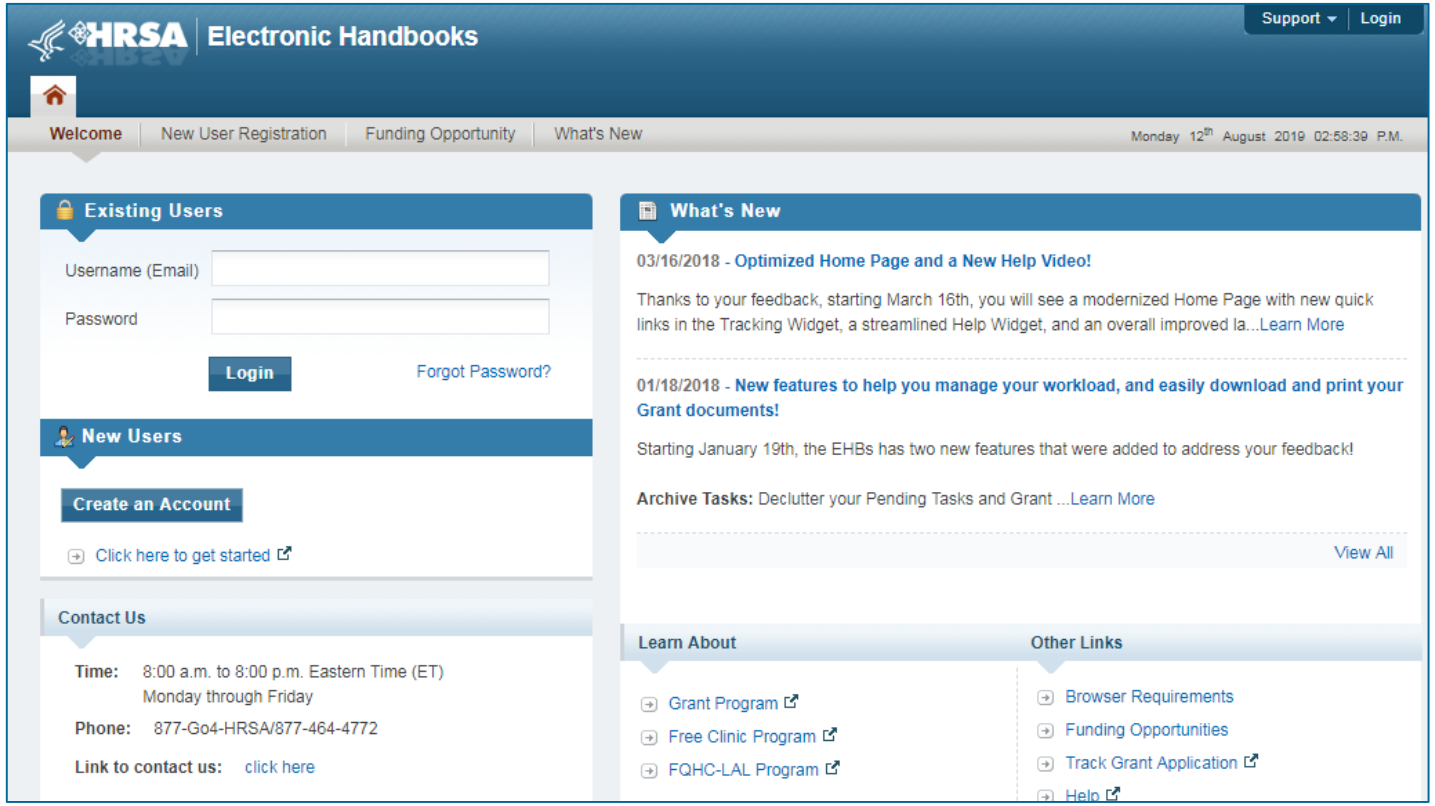
Overview of UDS Report

Eleven Tables and Three Forms

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

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

Where to Report: The Electronic Handbooks (EHBs)



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

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

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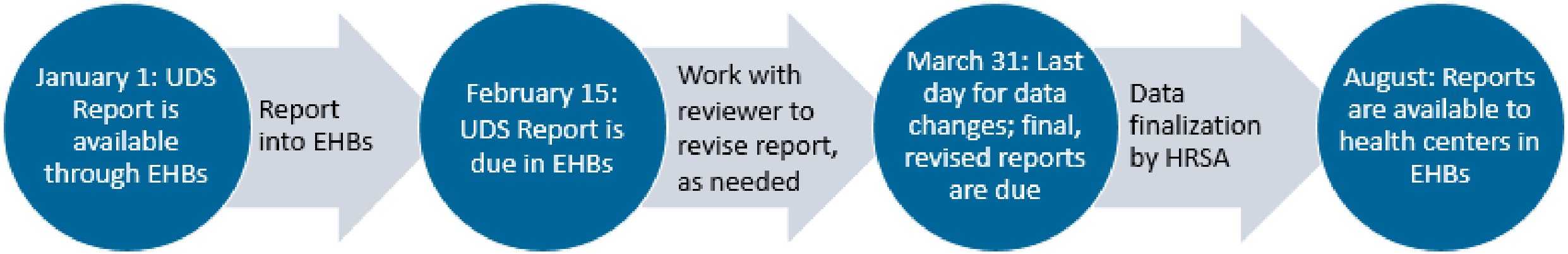
Reporting Timeline



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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UDS in the Time of COVID-19

Impact of Service Changes in 2020

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Health Centers May Have Many Changes in 2020

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

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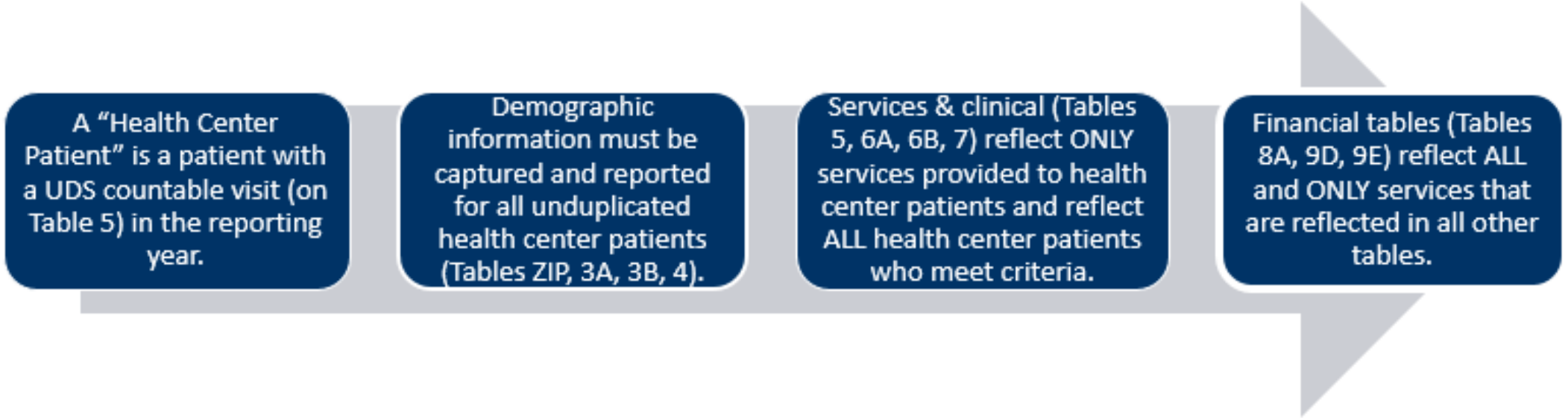
As Always, This Is All Interrelated!



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

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

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

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

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

Patients

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

ZIP Code Table

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

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

Patients by Age and Sex at Birth

Table 3A

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

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

Ethnicity, Race, and Language

Table 3B

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

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

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

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Sexual Orientation and Gender Identity (SOGI)

Table 3B

Line	Patients by Sexual Orientation	Number (a)
13	Lesbian or Gay	2
14	Heterosexual (or straight)	6
15	Bisexual	
16	Something else	
17	Don't know	1
18	Chose not to disclose	1
18a	Unknown	2
19	**Total Patients** (Sum of Lines 13 to 18a)	12
Line	**Patients by Gender Identity**	**Number (a)**
20	Male	2
21	Female	6
22	Transgender Man/Transgender Male	
23	Transgender Woman/Transgender Female	
24	Other	1
25	Chose not to disclose	1
25a	Unknown	2
26	**Total Patients (**Sum of Lines 20 to 25a)	12

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

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

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Income and Insurance

Table 4

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

Line	Principal Third-Party Medical Insurance	0-17 years old (a)	18 and older (b)
7	**None/Uninsured**	1	1
8a	Medicaid (Title XIX)		1
8b	CHIP Medicaid	1	
8	**Total Medicaid** (Line 8a + 8b)	1	1
9a	Dually Eligible (Medicare and Medicaid)		
9	**Medicare** (Inclusive of dually eligible and other Title XVIII beneficiaries)		2
10a	Other Public Insurance (Non-CHIP) (specify ____)	1	
10b	Other Public Insurance CHIP		
10	**Total Public Insurance** (Line 10a + 10b)	1	
11	**Private Insurance**	4	1
12	**TOTAL** (Sum of Lines 7 + 8 + 9 + 10 + 11)	7	5

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

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Insurance Categories

Table 4

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

Line	Principal Third-Party Medical Insurance
7	**None/Uninsured**
8a	Medicaid (Title XIX)
8b	CHIP Medicaid
8	**Total Medicaid** (Line 8a + 8b)
9a	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)

Managed Care
Table 4

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

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

Does your state have managed care?

Yes. | No. | Not sure.

Managed Care Utilization
Table 4 (and Table 9D)

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

A member month = one member enrolled for 1 month

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

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

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

There is generally a relationship between:

Member months on Table 4

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

Insurance categories on Table 4

Example: 4,174 Medicaid patients

Managed care lines on Table 9D

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

IMPORTANT KEY:

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

We will discuss Table 9D later!

Considerations When Reporting Income- and Insurance-Related Data

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

Special Populations

Table 4

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

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

Special Populations Resources: HRSA-funded National TTA Partners

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

DO…

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

DON'T…

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

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Considerations When Reporting Patient-Related Data

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

Reporting Services and Quality of Care Indicators

Tables 5, 6A, 6B, and 7

Table 5: Staffing and Utilization

2020 Changes: No major changes to reporting

Full Time Equivalent (FTE) by Provider Type

Table 5

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

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

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Example: Calculate FTE

Employees with full benefits*

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

1. Calculate base hours for full-time:
   - Total hours per year:
   - 40 hours/week x 52 weeks = 2,080 hours
2. Calculate this staff person's paid hours:
   - Total hours for 6 months:
   - 40 hours/week x 26 weeks = 1,040 hours
3. Calculate FTE for this person:
   - 1,040 hours/2,080 hours = **0.50 FTE**

Employees with no or reduced benefits*

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

1. Calculate base hours for full-time:
   - Total hours per year:
   - 40 hours/week x 52 weeks = 2,080 hours
2. Deduct benefits: (10 holidays, 12 sick days, 5 continuing medical education [CME] days, and 3 weeks vacation)
   - 10 + 12 + 5 + 15 = 42 days x 8 hours = 336
   - 2,080 – 336 = 1,744
3. Calculate combined person hours:
   - Total hours: 1,040 hours
4. Calculate FTE:
   - 1,040 hours/1,744 hours = **0.60 FTE**

*Benefits defined as vacation/holidays/sick benefits

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Reporting FTEs During COVID-19

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

Source: Pexels

IMPORTANT KEY:

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

We will discuss Table 8A later!

Defining a Visit

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

Reporting Visits During COVID-19

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

Source: Pexels

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.

Contacts That Do Not, ALONE, Count as Visits

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

Locations of Visits

Table 5

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

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

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Location of Visits: Clinic

Table 5

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

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

Location of Visits: Virtual

Table 5

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

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

View the Virtual Visits guidance file here.

HRSA Health Center Program

Two Telehealth Situations That May Be New

Virtual Visits: Health center is not the originating site

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

Virtual Visits: Audio-only visits

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

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

HRSA Health Center Program

Discussion: What Counts as a Virtual Visit?

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

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

HRSA Health Center Program

What Counts as a Virtual Visit?

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

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

HRSA Health Center Program

Patients and Visits by Service and Provider Type

Table 5

Visits (b and b2)

Count clinic and virtual visits that meet definition

- Not all staff generate visits
- Not all contacts = visits
- A single visit may consist of multiple services, but counts as only one

Report in column (b) or (b2) by service provider

Patients (c)

Unduplicated count of patients by service category

- Same person can receive multiple services
- Sum of patients by service ≠ total patients

Report in column (c) by service category

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

HRSA Health Center Program

Table 5: Completing the Selected Service Detail Addendum

2020 Changes: No major changes to reporting

Addendum Captures Integrated Behavioral Health

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

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

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

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

Reporting Personnel in Addendum

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

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

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

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

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

Determining Visits to Include in Addendum

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

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

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

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

Table 6A

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

Addendum

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

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

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

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

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

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

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

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

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

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

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

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

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Considerations When Reporting Virtual Visits and MH/SUD Addendum Data

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

Resources to Support Table 5 Reporting

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

Table 6A: Selected Diagnoses and Services Rendered

2020 Changes:

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

Selected Diagnoses and Services

Table 6A

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

Excerpted from Table 6A

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

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New Reporting on Table 6A

Seven NEW rows

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

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

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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 and 7: Clinical Quality Measures (CQMs)

2020 Changes:

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

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

Clinical Process and Outcome Measures

Tables 6B and 7

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

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

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

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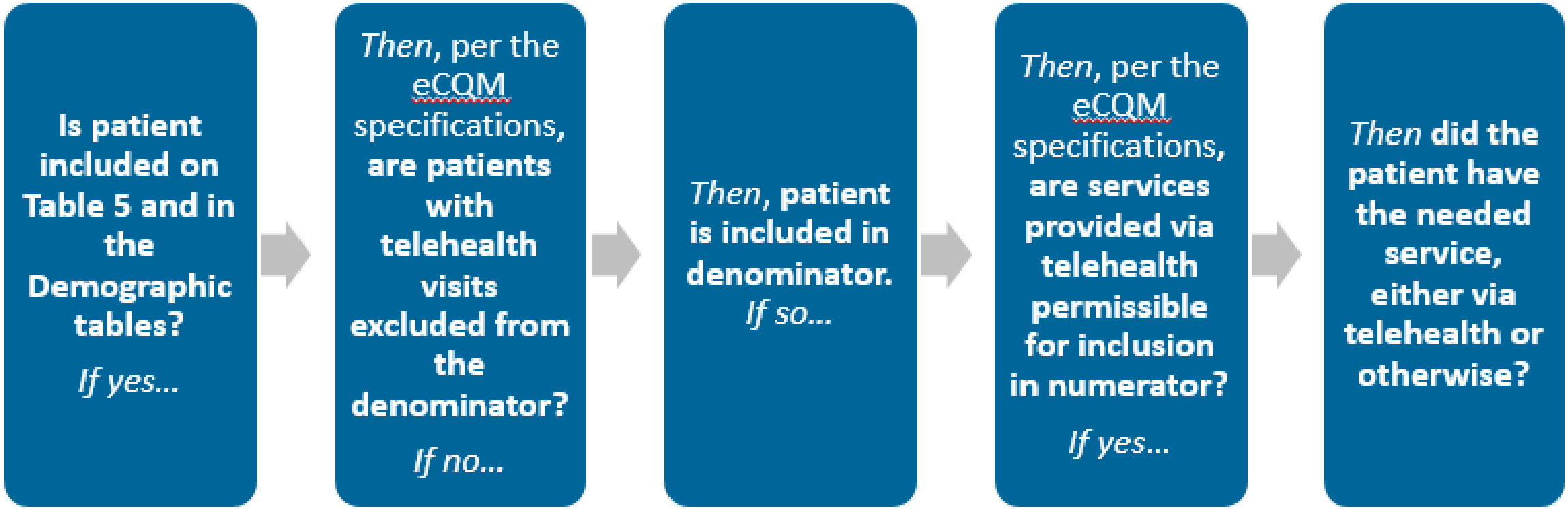
General Reminders for Clinical Quality Measures

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

Telehealth and Clinical Quality Measures

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

Assessing Telehealth in Clinical Quality Measures



Clinical Process and Outcome Measures

Table 6B Format

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

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

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

Clinical Process cont'd.

Table 7 Format

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

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

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

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Summary of Clinical Quality Measure Changes

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

Alignment with eCQMs

- An eCQM is a clinical quality measure that is specified in a standard electronic format and is designed to use structured, encoded data present in the EHR.
- Most UDS measures align with eCQMs.
  - All 3 new CQMs added in 2020 UDS are aligned with eCQMS.

- To accurately report, you need to:
  - Understand how to access and read specifications
  - Know where your EHR is looking for required data elements to calculate eCQMs
  - Make sure your providers are recording required data in correct fields

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

Resources to Support Clinical Process and Outcomes Reporting

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

*** New for 2020**

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Resources to Support Clinical Process and Outcomes Reporting

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

*** New for 2020**

HRSA Health Center Program

Resources to Support Clinical Process and Outcomes Reporting

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

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Overview of New Measures

Breast Cancer Screening

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

Depression Remission at Twelve Months

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

HIV Screening

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

Breast Cancer Screening *(New for 2020 UDS)*

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

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

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

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

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

HRSA Health Center Program

HIV Screening *(New for 2020 UDS)*

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

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

HIV Linkage to Care *(Updated for 2020)*

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

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

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

HRSA Health Center Program

Hypertension *(Clarified for 2020)*

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

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

Tables 6A, 6B, and 7 Resources

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

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

DO…

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

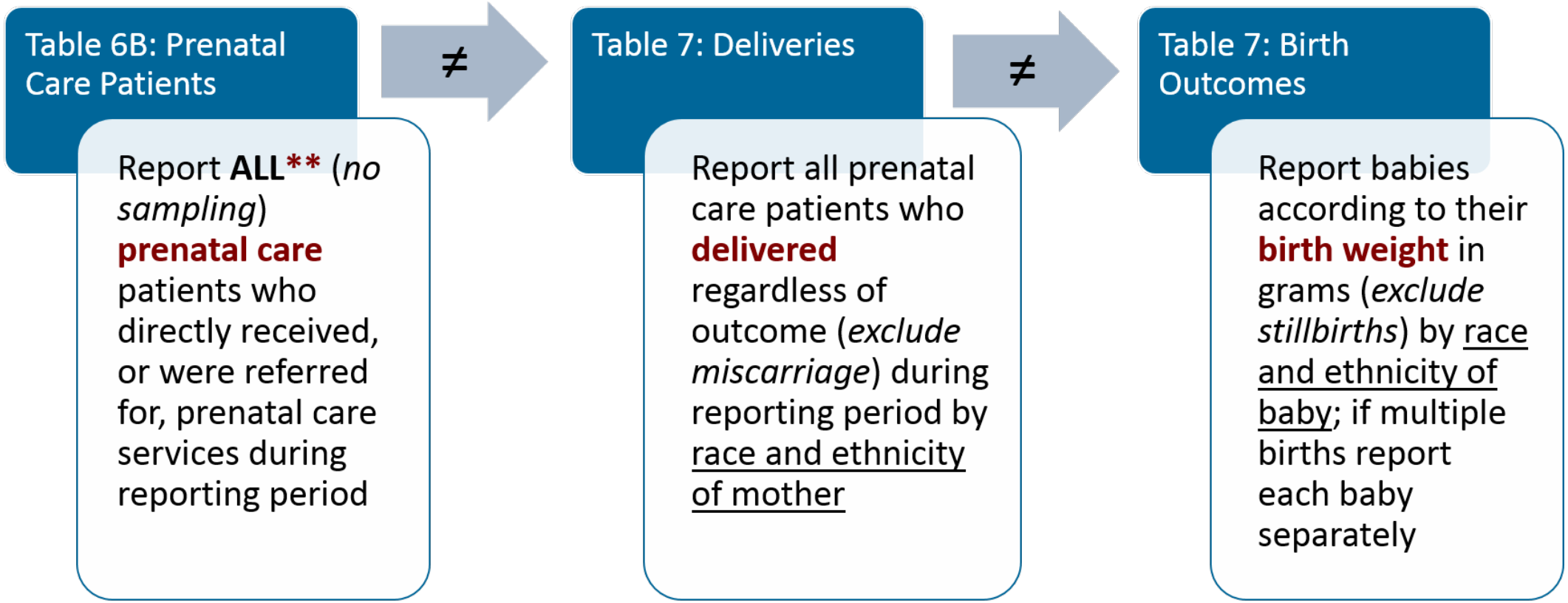
DON'T…

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

Tables 6B and 7: Prenatal and Birth Outcome Measures

2020 Changes: No major changes to reporting

Maternal Care: Prenatal and Birth Outcome Measures



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

HRSA Health Center Program

Prenatal Patients by Age and Entry into Prenatal Care

Table 6B

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

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

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

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

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

Deliveries and Birth Outcomes

Table 7

- Column 1A: Report prenatal care *patients who delivered* during the measurement year (*exclude miscarriages*) *by race/ethnicity*:
  - Report only one patient as having delivered for multiple births.
  - Report on patients who were successfully referred out for care.

- Columns 1B–1D: Report each live birth by *birthweight* (exclude stillbirths) and race/ethnicity of baby:
  - Count twins as two births, triplets as three, etc.
  - Very low (VLBW) (Column 1B) is < 1,500 grams.
  - Low (LBW) (Column 1C) is 1,500–2,499 grams.
  - Normal (Column 1D) is ≥ 2,500 grams.

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

Deliveries and Birth Outcomes

Table 7

Section A

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

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

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

HRSA Health Center Program

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

DO…

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

DON'T…

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

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

2020 Changes:

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

Costs and Patient-Related Revenues

Table 8A: Financial Costs

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

Table 9D: Patient-Related Revenue

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

Table 9E: Other Revenue

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

Table 8A: Financial Costs

2020 Changes: No major changes

Financial Costs

Table 8A

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

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

Tables 5 and 8A Crosswalk

Table 5

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

Table 8A

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

HRSA Health Center Program

Financial Costs

Table 8A

Report costs by cost center

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

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

Pharmacy Reporting on Table 8A

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

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

Column A, Lines 14–16

Table 8A

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

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

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

Allocating Overhead Expenses to Column B

Table 8A

Facility (Line 14)

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

Non-Clinical Support (Line 15)

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

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

Reporting Donations

Donations of Goods and Services

↓

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

Cash Donations/Fundraising Revenue

↓

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

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

Resource: Reporting Donations in the UDS

HRSA Health Center Program

Table 9D: Patient-Related Revenue

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

Payer Categories for Patient-Related Revenue

Table 9D

Medicaid

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

Medicare

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

Other Public

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

Private

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

Self-Pay

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

COVID-19 Uninsured Program Reporting

Table 9D

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

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

HRSA Health Center Program

Patient-Related Revenue

Table 9D

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

Report (Columns)

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

By Payer (Lines)

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

By Form of Payment

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

HRSA Health Center Program

Column A: Full Charges

Table 9D

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

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

Column B: Collections

Table 9D

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

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

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

Table 9D

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

Column D: Adjustments

Table 9D

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

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

Column E: Sliding Fee Discounts

Table 9D

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

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

Column F: Bad Debt Write Off

Table 9D

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

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

Table 9D Example #1

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

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

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

Table 9D Example #2

Reclassify Charge

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

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

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

How do you reclassify the charge?

HRSA Health Center Program

Table 9D Example #2

Reclassify Charge

				Retroactive Settlements, Receipts, and Pa ybacks (c)						
Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Collection of Reconciliation/ Wraparound Current Year (c1)	Collection of Reconciliation/ Wraparound Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty/ Payback (c4)	Adjustments (d)	Sliding Fee Discounts (e)	Bad Debt Write-Off (f)
10	Private Non-Managed Care	~~$200~~ $170	$120					$50		
13	Self-Pay	$30	$10						$10	$10

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

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

HRSA Health Center Program

Table 9D Example #3

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

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

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

HRSA Health Center Program

Table 9D Example #4

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

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

1. BPHC Coronavirus Funding FAQs

Reporting 340B Contract Pharmacy

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

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

HRSA Health Center Program

Considerations When Reporting Patient Revenue–Related Data

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

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

Table 9E: Non-Patient-Related Revenue

2020 Changes:

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

Other Revenue

Table 9E

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

Revenue Categories

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

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

HRSA Health Center Program

Table 9E: COVID-19 Funding Lines

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

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

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

HRSA Health Center Program

Revenue Categories

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

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

HRSA Health Center Program

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

DO…

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

DON'T…

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

Resources to Support Financial and Operational Reporting

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

Other Forms to Complete

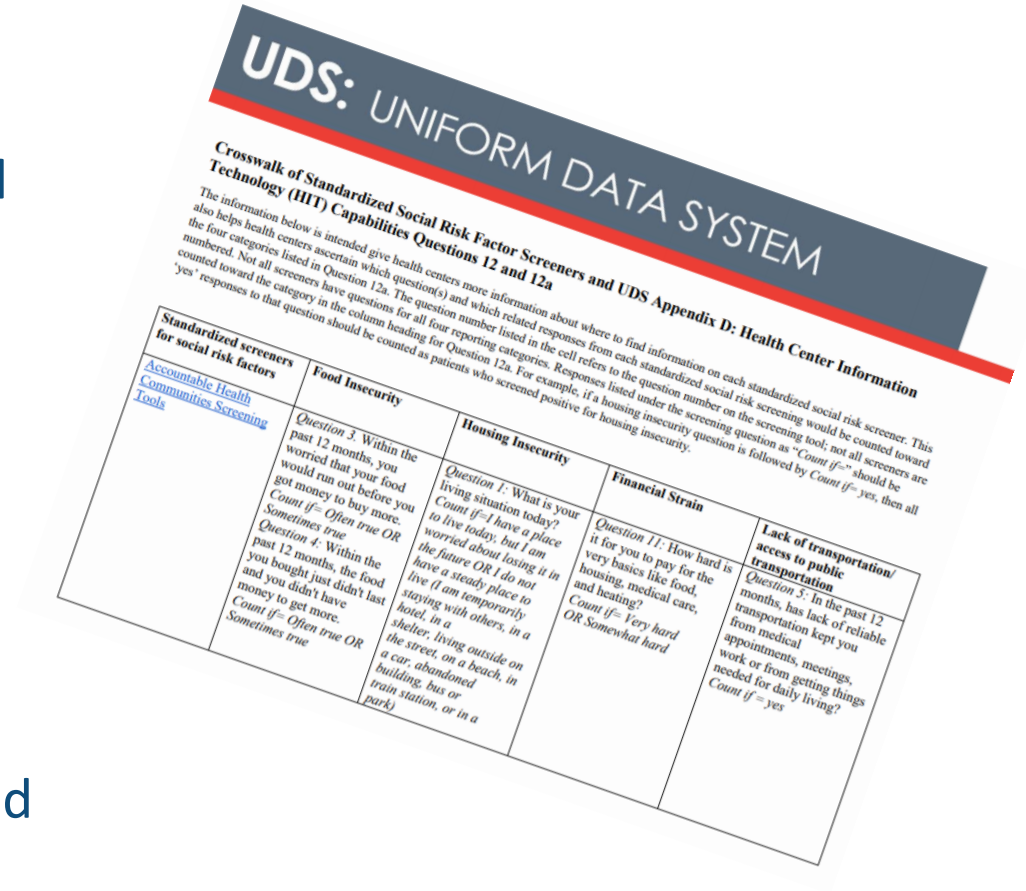
Health Center Health Information Technology (HIT) Capabilities

Appendix D

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

Positive Screens for Selected Social Risks

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


UDS: UNIFORM DATA SYSTEM

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

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

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

Other Data Elements

Appendix E

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

Telemedicine Reporting

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

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

Report on your telemedicine offerings in 2020 specifically.

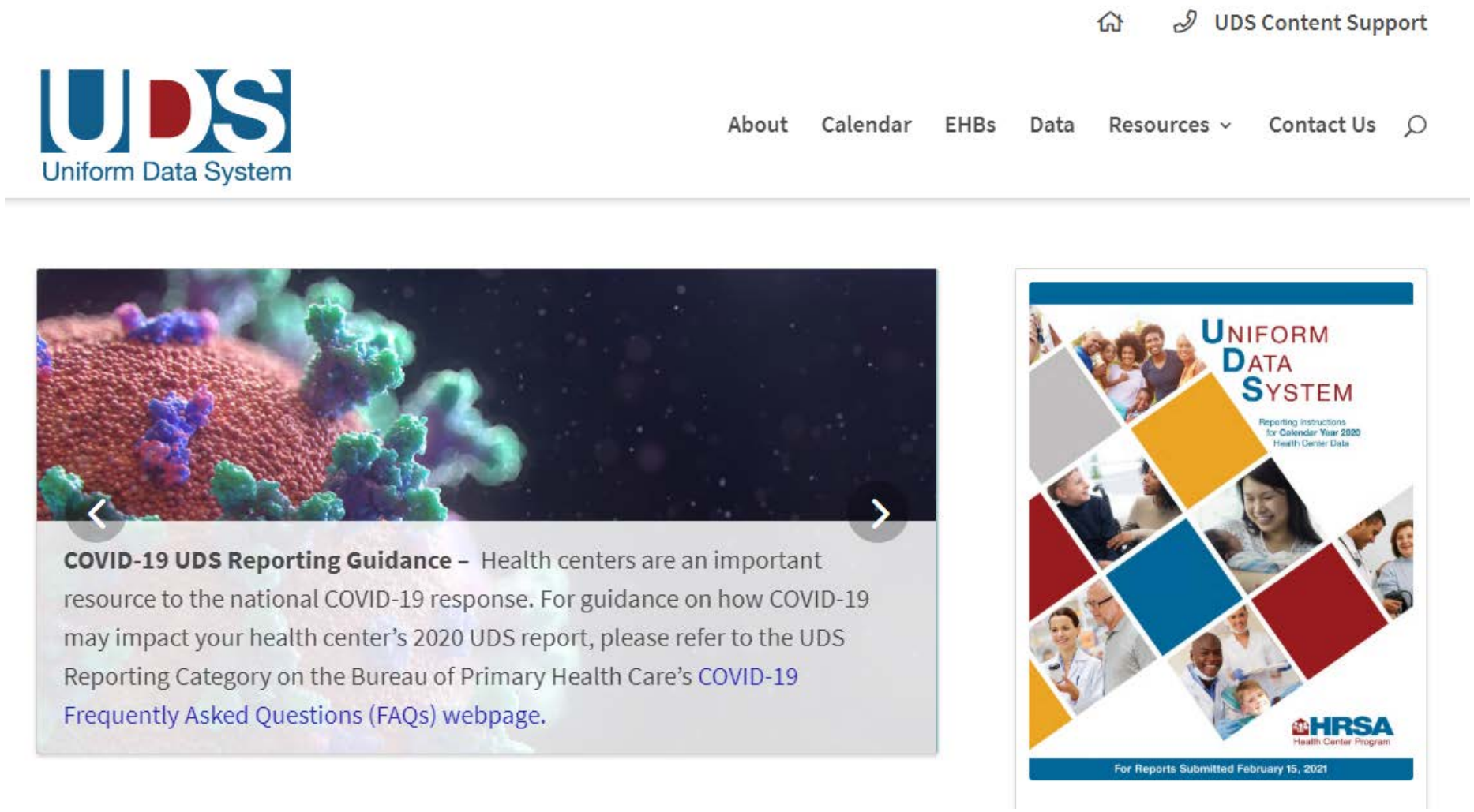
Workforce Form

Appendix F

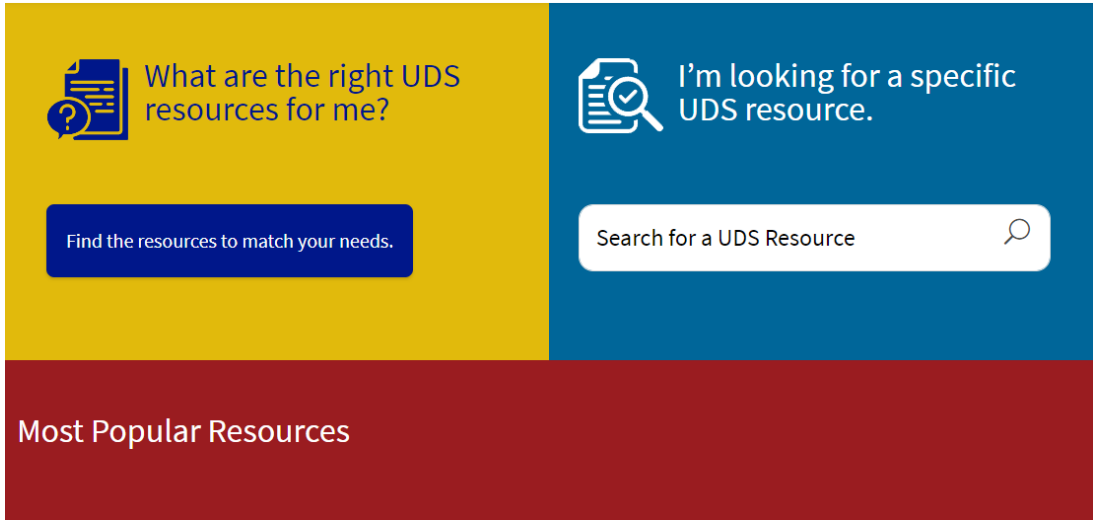
- Helps clarify current state of health center workforce training and staffing models
- Topics include:
  - Professional education/training
  - Satisfaction surveys

Available Resources

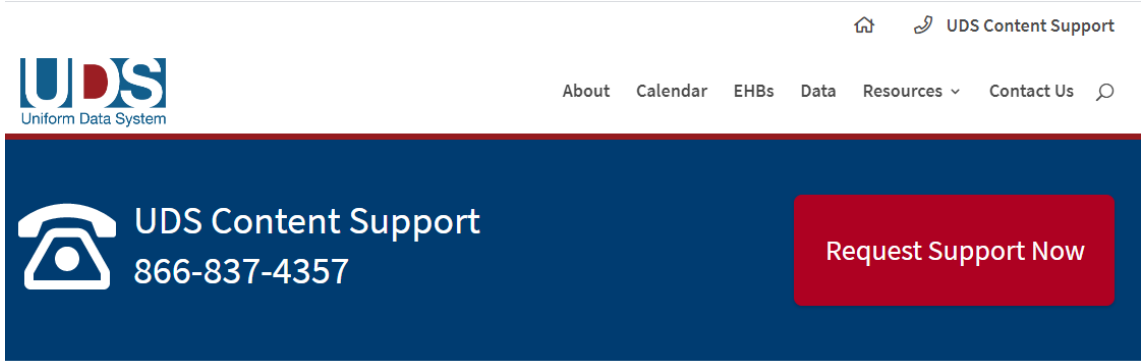
UDS Training Website: BPHCdata.net



Finding Support on BPHCdata.net



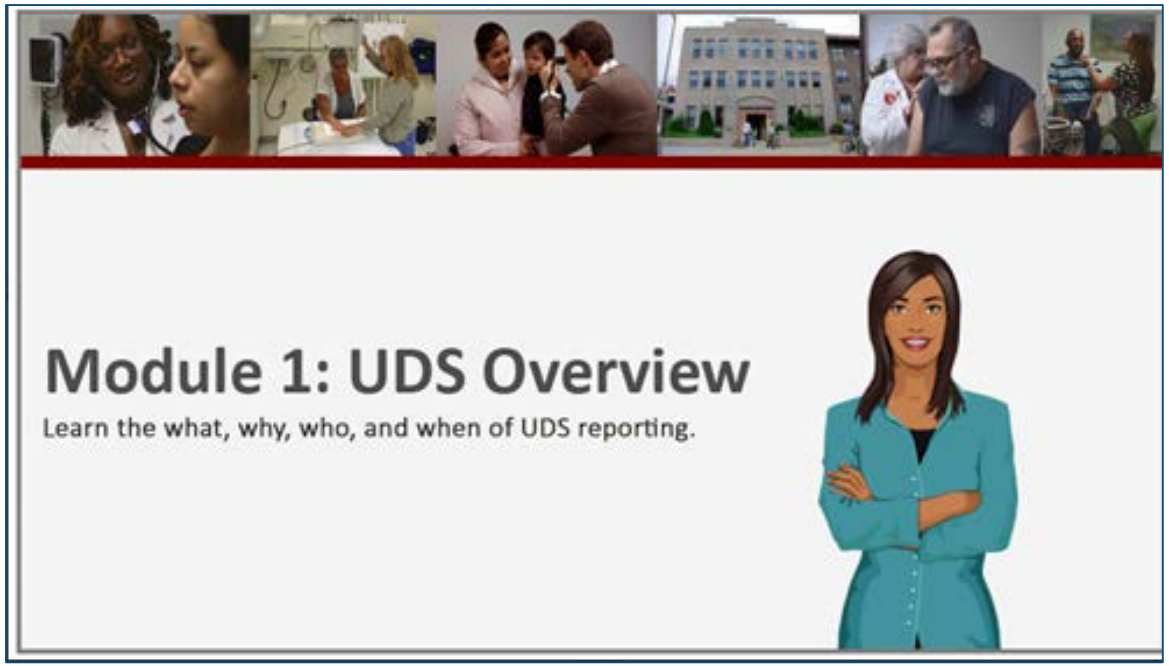
Scroll down on the home page for options to help you navigate to the resources you need.



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

Recorded Training Modules

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



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

Training Webinar Series for 2020 UDS Reporting

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

All webinars are archived on the HRSA website.

HRSA Health Center Program

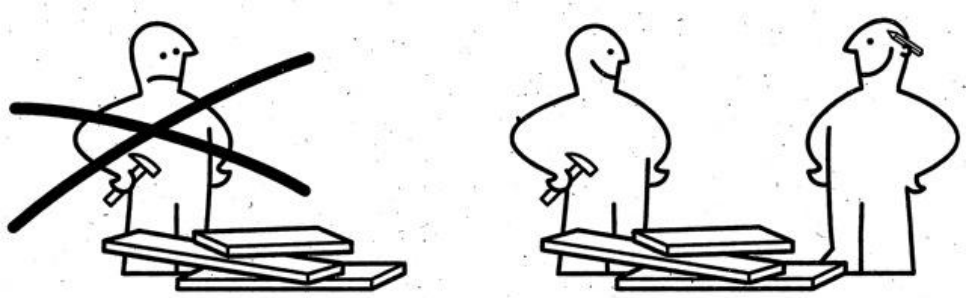
Support Available

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

Tips for Success

Tips for Success

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



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

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.

Please Complete an Evaluation!

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

https://redcap.link/UDSWebinarEvaluation

Your input is important to us.

Question and Answer Session

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

Contact Information

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

1-866-UDS-HELP

or

1-866-837-4357

udshelp330@bphcdata.net