

HRSA
Health Resources & Services Administration

**Uniform Data System (UDS)
Reporting Requirements Training
Calendar Year 2021**

Bureau of Primary Health Care (BPHC)
Health Resources and Services Administration (HRSA)

Vision: Healthy Communities, Healthy People

Agenda

- Welcome and Logistics
- Overview of the UDS
- Reporting the Patient Profile
- Reporting Clinical Services and Quality of Care Indicators
- Reporting Operational and Financial Tables
- Other Required UDS Reporting Forms
- Tips for Success

Source: Adobe Stock

2



Key Materials Provided with This Training

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

3

Overview of the UDS

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

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



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

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

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

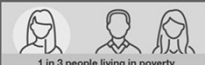
WHEN: Reporting occurs between Jan. 1 and Feb. 15, 2022; reporting covers the calendar year from January 1 to December 31, 2021

WHY: Legislatively mandated; used for program monitoring and improvement





Value of the UDS


HRSA-funded health centers serve nearly 29 million patients across the country, including:




1 in 3 people living in poverty



1 in 5 people who are uninsured





1 in 5 rural residents




Nearly 3 million adults age 65+

FindAHealthCenter.hrsa.gov


Overview of UDS Report

Four Primary Sections




Patient Demographic Profile

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




Clinical Services and Outcomes

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



Financial Tables


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



Other Forms

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

Source: Ashlee Steink, OHSU




7

Overview of UDS Report

Eleven Tables and Three Forms

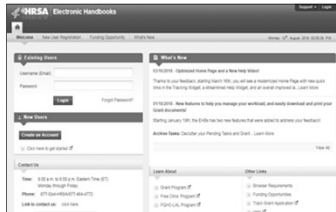
- All tables and forms are completed in a Universal Report.
 - **Universal Report**—completed by all reporting health centers
 - **Grant Report(s)**—completed only by awardees that receive multiple 330 grants (e.g., CHC, MHC, HCH, PHPC)

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




8

Where to Report: The Electronic Handbooks (EHBs)

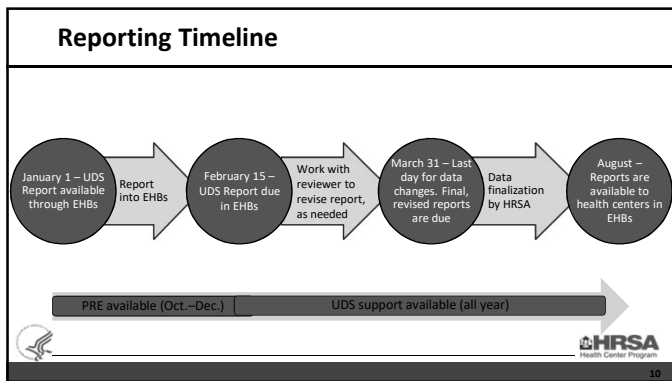


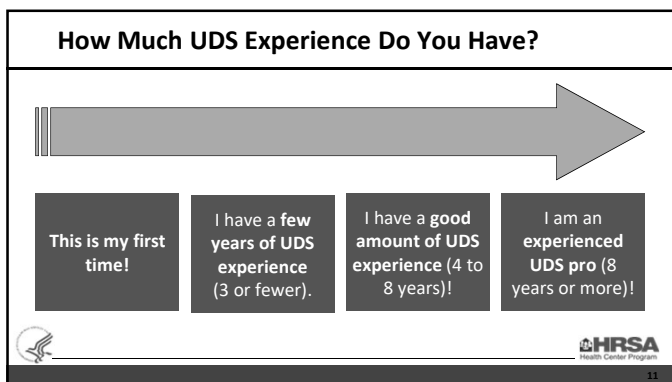
Strategies for Successful Submission webinar provides a live demo of the PRE and helpful tools to assist with reporting.

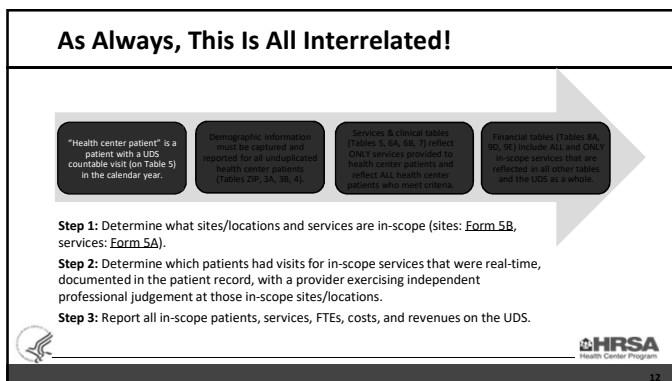


9

- All people who will be tasked with data entry or review need a login to the **EHBs**.
- Tools to Assist with Reporting
 - Preliminary Reporting Environment (PRE; for early access)
 - Excel Template (download/upload in the EHBs)
 - Comparison Tool
 - Edits
- **EHBs Helplines**
 - For account or login issues: HRSA Call Center (877-464-4772, Option 3)
 - For functionality issues: Health Center Program Support (877-464-4772, Option 1)








Managed Care Table 4

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

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

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



22

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




23



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

We will discuss Table 9D later!



Special Populations Table 4

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

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

Special Populations Resources: HRSA-funded National TTA Partners

25

Special Populations Table 4

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

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

Special Populations Resources: HRSA-funded National TTA Partners

26

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

DO	DON'T
<ul style="list-style-type: none"> Do roll up data into the UDS categories if you collect race and ethnicity or SOGI data in more granular detail than the UDS. Do report all patients by income on Table 4. <ul style="list-style-type: none"> ✓ Patient income can be self-reported if consistent with the health center's board-approved policies and procedures. ✓ If patient reports 0 income, then they are reported at below 100% (Line 1). If unknown, report as unknown (Line 5). Do ensure demographic information is updated regularly in accordance with UDS Manual. Do collect special population information, even if you do not have a special population grant. 	<ul style="list-style-type: none"> Don't include patients on the demographic tables (ZIP, 3A, 3B, and 4) who have not had a countable visit on Table 5. Don't submit without double checking that all tables align—for example, age across Table 3A and insurance on Table 4, and primary medical insurance across ZIP Table and Table 4. Don't report patients with unknown medical insurance as uninsured on ZIP Code Table and Table 4; be sure to collect medical insurance information!


Special Populations Resources: HRSA-funded National TTA Partners

27

Example: Table 4

Ramy was seen by the health center twice in 2021.


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



Source: iStock

Where would this patient be reported on Table 4?

- Income
- Medical Insurance
- Special Populations



28

Reporting Services and Quality of Care Indicators

Tables 5, 6A, 6B, and 7

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





Table 5: Staffing and Utilization

2021 Changes: No major changes to reporting

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



Full-Time Equivalent (FTE) by Position and Service Category
Table 5

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

Line	Personnel by Major Service Category	FTEs (1)
1	Family Physicians	
2	General Practitioners	
3	Internists	
4	Obstetrics/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	Nurse Personnel	
15	Total Medical Care Services (Lines 8 + 10a through 14)	
16	Dentists	
17	Dental Hygienists	
17a	Dental Therapists	
18	Other Dental Personnel	
19	Total Dental Services (Lines 16-19)	
20a	Psychiatrists	
20b1	Licensed Clinical Psychologists	
20b2	Licensed Clinical Social Workers	
20b	Other Licensed Mental Health Providers	
20c	Other Mental Health Personnel	
20	Total Mental Health Services (Lines 20a-c)	
21	Substance Use Disorder Services	
22	Other Professional Services (specify)	

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Reporting Personnel FTEs
Table 5

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

Key Reminders:

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

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

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Example: Calculate FTE

Employees with full benefits*

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


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

Employees with no or reduced benefits*

Together, four individuals worked 1,040 hours scattered throughout the year:


- Calculate base hours for full-time:
Total hours per year: 40 hours/week x 52 weeks = 2,080 hours
- 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
- Calculate combined person hours:
Total hours: 1,040 hours
- Calculate FTE:
1,040 hours / 1,744 hours = 0.60 FTE

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

We will discuss Table 8A later!



New Resource: UDS Countable Visit Guidance and Frequently Asked Questions

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



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

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

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


UDS Definitions

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

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

Components of UDS Reporting on UDS

Provider is licensed or credentialed. Providers may be personnel of the health center, contracted personnel, or volunteers, but all health center personnel who interact with patients qualify as a provider. Provider performing services within the scope of their license, credentials, or certification should be considered. Note that licensing



Defining a Visit

Licensed or credentialed provider

+

Independent professional judgement

+

Services documented in the individual patient chart

+


Individualized care

+


Real-time in-person or virtual engagement

==

Countable UDS Visit




COVID-19 Testing or Vaccination and Visits





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

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



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


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


37

Counting Multiple Visits

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





Page 19 of the 2021 UDS Manual has additional information.



38




Contacts That Do Not, ALONE, Count as Visits

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






39




Examples: Are These Countable Visits on Table 5?



1. Yvonne has not been seen at the health center before. She comes to the health center to get a COVID-19 vaccine. Yvonne signs in, filling out a brief form, and then a nurse administers the one-dose COVID-19 vaccine. Yvonne leaves and is not seen at the health center again.
2. Charles is seen by his primary care provider at the health center for a regular check up. In that visit, his primary care provider conducts a COVID-19 test and provides a flu vaccine.
3. A nurse at the health center calls a patient to complete several screenings, including social need screening and PHQ-9, in advance of a scheduled appointment the patient has 3 days later.

Examples: Are These Countable Visits on Table 5?

1. Yvonne has not been seen at the health center before. She comes to the health center to get a COVID-19 vaccine. Yvonne signs in, filling out a brief form, and then a nurse administers the one-dose COVID-19 vaccine. Yvonne leaves and is not seen at the health center again. **NOT A VISIT.**
2. Charles is seen by his primary care provider at the health center for a regular check up. In that visit, his primary care provider conducts a COVID-19 test and provides a flu vaccine. **YES, A VISIT.**
3. A nurse at the health center calls a patient to complete several screenings, including social need screening and PHQ-9, in advance of a scheduled appointment the patient has 3 days later. **The nurse's contact with the patient to conduct screening is NOT a visit. The visit with the provider 3 days later where the PHQ-9 is reviewed (for example) IS a visit.**






Locations of Visits

Table 5

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

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1	Family Physicians				
2	General Practitioners				
3	Internists				
4	Obstetrician/Gynecologists				
5	Pediatricians				
7	Other Specialty Physicians				
8	Total Physicians (Lines 1-7)				
9a	Nurse Practitioners				
9b	Physician Assistants				
10	Certified Nurse Midwives				
10a	Total NPs, PAs, and CNMs (Lines 9a-10)				
11	Nurses				
12	Other Medical Personnel				
13	Laboratory Personnel				
14	X-ray Personnel				
15	Total Medical Care Services (Lines 9 - 10a through 14)				
16	Dentists				
17	Dental Hygienists				
17a	Dental Therapists				
18	Other Dental Personnel				
19	Total Dental Services (Lines 16-18)				
20a	Psychiatrists				
20b1	Licensed Clinical Psychologists				

Location of Visits: Clinic Table 5

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

Line	Personally Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1	Family Physicians				
2	General Practitioners				
3	Infectious				
4	Obstetrician-Gynecologists				
5	Pediatricians				
6	Other Specialty Physicians				
7	Total Physicians (Lines 1-7)				
8	Nurse Practitioners				
9a	Physician Assistants				
9b	Certified Nurse-Midwives				
10a	Total NPs, PAs, and CNMs (Lines 9a-10)				
11	Nurses				
12	Other Medical Personnel				
13	Laboratory Personnel				
14	X-ray Personnel				
15	Total Medical Care Services (Lines 8 + 10a through 14)				
16	Dentists				
17	Dental Hygienists				
17a	Dental Therapists				
18	Other Dental Personnel				
19	Total Dental Services (Lines 16-18)				
20a	Psychiatrists				
20a1	Licensed Clinical Psychologists				

43

Location of Visits: Virtual Table 5

- Virtual visits (Column B2):** Report documented *virtual (telemedicine)* contact between a patient and provider that meet all the requirements discussed earlier for countable visits.
- Must be provided using interactive, synchronous audio and/or video telecommunication systems that permit *real-time communication* between the provider and a patient.
 - “Store and forward” methods or other asynchronous contacts are not countable.

View the [virtual visits guidance file](#).

Line	Personally Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1	Family Physicians				
2	General Practitioners				
3	Infectious				
4	Obstetrician-Gynecologists				
5	Pediatricians				
6	Other Specialty Physicians				
7	Total Physicians (Lines 1-7)				
8	Nurse Practitioners				
9a	Physician Assistants				
9b	Certified Nurse-Midwives				
10a	Total NPs, PAs, and CNMs (Lines 9a-10)				
11	Nurses				
12	Other Medical Personnel				
13	Laboratory Personnel				
14	X-ray Personnel				
15	Total Medical Care Services (Lines 8 + 10a through 14)				
16	Dentists				
17	Dental Hygienists				
17a	Dental Therapists				
18	Other Dental Personnel				
19	Total Dental Services (Lines 16-18)				
20a	Psychiatrists				
20a1	Licensed Clinical Psychologists				

44

Discussion: What Counts as a Virtual Visit?

Examples of Type of Service

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


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

45

What Counts as a Virtual Visit?

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

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




46

Patients and Visits by Service and Provider Type

Table 5

Visits (Columns B and B2)	Patients (Column C)	Key Reminders
<p>Count clinic and virtual visits that meet definition discussed.</p> <p>Visits must be on the same line with the FTE of the provider who conducted the visit.</p> <p>If a visit is counted in either of these columns, the patient MUST be reported in Column C and be included in the unduplicated patient count on all demographic tables.</p>	<p>This is an unduplicated count of patients by service category.</p> <p>A patient may have visits in multiple service categories, such as having medical, dental, and vision visits in the year. Patients for whom that is true are counted in each of those service categories in Column C. As a result, the total number of patients reported across Column C is generally larger than the unduplicated patient count.</p>	<ul style="list-style-type: none">• Not all personnel generate visits.• Not all contacts are countable visits.• A single visit may consist of multiple services, but it counts as only one visit.• Only those patients reported on this table are included in the unduplicated patient count on demographic tables and in clinical care tables.




47

Table 5: Completing the Selected Service Detail Addendum

2021 Changes: No major changes to reporting

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



48

Reporting Personnel in Addendum


In Column A1, report the **number** of providers by type of MH and/or SUD services.

- Medical providers can be counted once in each section if they provide both MH and SUD services.

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

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

Line	Personnel by Major Service Category: Mental Health Service Detail	Personnel (A1)	Clinic Visits (B)	Virtual Visits (B2)	Patients (C)
20A01	Physicians (other than Psychiatrists)				
20A02	Nurse Practitioners				
20A03	Physician Assistants				
20A04	Certified Nurse Midwives				
Line	Personnel by Major Service Category: Substance Use Disorder Detail	Personnel (A1)	Clinic Visits (B)	Virtual Visits (B2)	Patients (C)
21a	Physicians (other than Psychiatrists)				
21b	Nurse Practitioners (Medical)				
21c	Physician Assistants				
21d	Certified Nurse Midwives				
21e	Psychiatrists				
21f	Licensed Clinical Psychologists				
21g	Licensed Clinical Social Workers				
21h	Other Licensed Mental Health Providers				



52


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

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

Line	Personnel by Major Service Category	FTEs (A)	Clinic Visits (B)	Virtual Visits (B2)	Patients (C)
20a	Psychiatrists				
20a1	Licensed Clinical Psychologists				
20a2	Licensed Clinical Social Workers				
20b	Other Licensed Mental Health Providers				
20c	Other Mental Health Personnel				
20	Total Mental Health Services (Lines 20a–c)				
21	Substance Use Disorder Services				

Line	Personnel by Major Service Category: Substance Use Disorder Detail	Personnel (A1)	Clinic Visits (B)	Virtual Visits (B2)	Patients (C)
21a	Physicians (other than Psychiatrists)				
21b	Nurse Practitioners (Medical)				
21c	Physician Assistants				
21d	Certified Nurse Midwives				
21e	Psychiatrists				
21f	Licensed Clinical Psychologists				
21g	Licensed Clinical Social Workers				
21h	Other Licensed Mental Health Providers				

Line 21 in the main part of Table 5 fully captures SUD FTEs, visits, and patients. These personnel, visits, and patients are NOT repeated in the addendum.





53

Example: Integrated SUD in MH Visit

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

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

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



54

Determining Visits to Include in Addendum

Include, at minimum, all countable visits with providers included in **Table 5 Selected Services Addendum, Column A1**, with ICD-10-CM codes:

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

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primary (a)	Number of Patients with Diagnosis (b)
Selected Mental Health Conditions, Substance Use Disorders, and Exclusions				
18	Alcohol-related disorders	F10, G62.1, O99.31	Visits reported here that were with medical or mental health providers are reported on SUD detail section of T5 addendum.	
19	Other substance-related disorders (excluding tobacco use disorders)	F11- through F19- (exclude F17.5, 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)	F40.4, F40- through F42-, F43.0, F43.1, F43.8		
20c	Attention deficit and disruptive behavior disorders	F90- through F91-	Visits reported here that were with medical providers are reported on MH detail section of Table 5 selected service addendum.	
20d	Other mental disorders, excluding drug or alcohol dependence	F00- through F09- (exclude F06.4), F20- through F29-, F41- through F43.9 (exclude F43.8 and F43.9), F50- through F59- (exclude F55, F56.2, F60, F61-, F69.0, F69.8, O99.34, R45.1, R45.2, R45.5, R45.6, R45.7, R45.8), R45.92, R46.0		

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55

Determining Visits to Include in Addendum

Table 6A

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primary (a)	Number of Patients with Diagnosis (b)
Selected Mental Health Conditions, Substance Use Disorders, and Exclusions				
18	Alcohol-related disorders	F10, G62.1, O99.31	★	★
19	Other substance-related disorders (excluding tobacco use disorders)	F11- through F19- (exclude F17.5, 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)	F40.4, F40- through F42-, F43.0, F43.1, F43.8		
20c	Attention deficit and disruptive behavior disorders	F90- through F91-	★	★
20d	Other mental disorders, excluding drug or alcohol dependence	F00- through F09- (exclude F06.4), F20- through F29-, F41- through F43.9 (exclude F43.8 and F43.9), F50- through F59- (exclude F55, F56.2, F60, F61-, F69.0, F69.8, O99.34, R45.1, R45.2, R45.5, R45.6, R45.7, R45.8), R45.92, R46.0		

Table 5: Addendum

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

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56

Resources to Support Table 5 Reporting

- BPHC UDS Reporting Resources
 - UDS Countable Visit Guidance and FAQ
 - Virtual Visit Reporting Handout
 - Mental Health/Substance Use Disorder Services Detail Handout
 - Nurse Visit Guidance Handout
 - UDS Reporting Instructions Appendix A: Listing of Personnel (page 157)
- Telehealth Resource Centers: 12 HRSA-supported regional and 2 national centers (including the Center for Connected Health Policy) provide expert and customizable technical assistance and advice on telehealth technology and state-specific regulations and policies such as Medicaid or private payers as well as Medicare
- HRSA BPHC COVID-19 Frequently Asked Questions (FAQs): UDS Reporting and Telehealth
- Centers for Medicare & Medicaid Services: Telehealth: Provides Medicare telehealth services definitions

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57

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

Table 6A: Selected Diagnoses and Services Rendered

2021 Changes:

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

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Reported as Primary (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, B19.1, B19.1-, O98.4-		
4b	Hepatitis C	B17.1-, B19.2, B19.2-		
4c	Novel coronavirus (SARS-CoV-2) disease	U07.1		
Selected Diseases of the Respiratory System				
5	Asthma	J45-		
6	Chronic lower respiratory diseases	J40 (count only when code U07.1 is also present), J41- through J44-, J47-		
6a	Acute respiratory illness due to novel coronavirus (SARS-CoV-2) disease	J12.89, J20.A, J40 (count only when code U07.1 is present), J22, J98.8, J99		

- Report all visits meeting the specified criteria for a health center patient.
- Diagnoses lines are reported where the indicated diagnosis is listed as part of a countable visit; services and procedures are counted when provided at any point during the year to a health center patient and documented in that patient's chart.
- Column A:** Report the number of visits with the selected service or diagnosis.
 - If a patient has more than one category of reportable service or diagnosis during a visit, count each.
 - Do not count multiple services of the same type at one visit (e.g., two immunizations, two fillings).
 - Resource: [Code Changes Handout](#).
- Column B:** Report the number of *unduplicated* patients receiving the service.

New Reporting on Table 6A

- One New Row: Line 24b: Coronavirus (SARS-CoV-2) vaccine**
 - Reported on Other Data Elements form last year, moved to Table 6A this year.
 - Report **ONLY** those provided to health center patients; not mass vaccination.
- If an individual is a patient of the health center, meaning that they had at least one UDS countable visit (reported on Table 5) during the reporting year, and received a vaccine which was documented in their chart, then their vaccine should be reported on Table 6A.
- Therefore, on Line 24b (Coronavirus (SARS-CoV-2) vaccine), report vaccines that your health center provided to its patients during the reporting year. The vaccine does not need to have been administered to the patient on the same day as a UDS countable visit to be counted on Table 6A.



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

Key Notes for Table 6A

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

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

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

61



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

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

2021 Changes:

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

To learn more about how these measures align with other national reporting, please visit [UDS CQMs and National Programs Crosswalk](#) on pages 195–196 in the [2021 UDS Manual](#).



62

Clinical Process and Outcome Measures

Tables 6B and 7

Screening and Preventive Care	Maternal Care and Children's Health	Chronic Disease Management
Cervical Cancer Screening	Early Entry into Prenatal Care	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
Breast Cancer Screening	Low Birth Weight	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet
Body Mass Index (BMI) Screening and Follow-Up Plan	Childhood Immunization Status	HIV Linkage to Care
Tobacco Use: Screening and Cessation Intervention	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Depression Remission at Twelve Months
Colorectal Cancer Screening	Dental Sealants for Children between 6-9 Years	Controlling High Blood Pressure
HIV Screening		Diabetes: Hemoglobin A1c (HbA1c) Poor Control
Screening for Depression and Follow-Up Plan		

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





63

General Reminders for CQMs

- For all measures except the one dental measure, all patients who had one or more medical visits (including virtual medical visits) are eligible for inclusion in the measure according to definitions in the CQM and the 2021 UDS Manual.
- Be sure to use the birthdates specified in the 2021 UDS Manual, which typically align with the patient's age before the start of the reporting year.
- To ensure data are accurate, it is important to:
 - Ensure that systems are configured to capture and report new data elements, including updating EHR, installing patches, updating modules, etc.
 - Work with EHR/health IT vendors to ensure systems have been updated with required specifications.
 - Validate your data to ensure that workflows are successfully capturing data.
 - Educate affected personnel regarding any changes, as appropriate.

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




64

Telehealth and CQMs

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

- If the telehealth visit meets a specific CQM's denominator and/or numerator definition, specifications, and UDS virtual visit definition as written in the eCQM and UDS Manual, then it may be counted toward the measure.
 - ✓ [Telehealth Impact on UDS Clinical Measure Reporting](#)
- Each eCQM is defined by the specified measure steward, and the UDS Report aligns with their instruction for inclusion (or removal) of telehealth in the evaluation of each component (denominator, exclusion, and numerator).
 - ✓ [2021 UDS Clinical Quality Measures Criteria](#)
 - ✓ The measure steward for each measure can be found in Appendix G of the [UDS Manual](#), pages 195–196.



65


Clinical Process and Outcome Measures

Table 6B Format

Line	Measure Name	Denominator (a)	Number Charts Sampled or EHR Total (b)	Numerator (c)
#	Measure Description	All eligible patients (N)	=N, 70, or ≥80%(N)	# in (b) that meet measure requirements

Line	Childhood Immunization Status	Total Patients with 2nd Birthday (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Immunized (c)
10	MEASURE: Percentage of children 2 years of age who received age-appropriate vaccines by their 2nd birthday.	250	215	139

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



66


Clinical Process and Outcome Measures

Table 7 Format

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

Line	Race and Ethnicity	Total Patients 18 through 64 Years of Age with Hypertension (2a)	Number Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)
<i>Hispanic or Latino/a</i>				
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			
<i>Subtotal: Hispanic or Latino/a</i>				
<i>Non-Hispanic or Latino/a</i>				
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			
<i>Subtotal: Non-Hispanic or Latino/a</i>				
<i>Unreported/Refused to Report Race and Ethnicity</i>				
h	Unreported/Refused to Report Race and Ethnicity			
i	Total			


See page 176 of the UDS Manual for Table 38/7 crosswalk.



Alignment with eCQMs


- An **eCQM** is a clinical quality measure that is specified in a standard electronic format and is designed to use structured, encoded data present in the EHR.
- The majority of UDS measures align with **eCQMs**.
- eCQMs are used across many national programs, so may be monitored on an ongoing basis.

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



Summary of CQM Changes

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



Source: Stock





Table 6B CQMs

Line	Measure	eCQM	Brief Measure Description
7-9	Early Entry into Prenatal Care	no eCQM	Percentage of prenatal care patients who entered prenatal care during their first trimester
10	Childhood Immunization Status	CMS117v9	Percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three or four H influenza type B (HIB); three Hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one Hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday
11	Cervical Cancer Screening	CMS124v9	Percentage of women 21*-64** years of age who were screened for cervical cancer using either of the following criteria: <ul style="list-style-type: none"> • Women age 21*-64** who had cervical cytology performed within the last 3 years • Women age 30-64** who had human papillomavirus (HPV) testing performed within the last 5 years Note: *Use 23 as the initial age to include in assessment. **63 is the final age to include in assessment. Again, refer to ages in the 2021 UDS Manual.


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



70

Table 6B CQMs

Line	Measure	eCQM	Brief Measure Description
11a	Breast Cancer Screening	CMS125v9	Percentage of women 50*-74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period Note: *Use 51 as the initial age to include in assessment.
12	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	CMS155v9	Percentage of patients 3-17* years of age who had an outpatient medical visit and who had evidence of height, weight, and body mass index (BMI) percentile documentation and who had documentation of counseling for nutrition and who had documentation of counseling for physical activity during the measurement period Note: *Use 16 as the oldest age at the start of the measurement period to include in assessment.
13	Body Mass Index (BMI) Screening and Follow-Up Plan	CMS69v9	Percentage of patients aged 18 years and older with BMI documented during the most recent visit or within the previous 12 months to that visit and who had a follow-up plan documented if the most recent BMI was outside of normal parameters




71

Table 6B CQMs

Line	Measure	eCQM	Brief Measure Description
14a	Tobacco Use: Screening and Cessation Intervention	CMS138v9	Percentage of patients aged 18 and older who were screened for tobacco use one or more times within 12 months and who received tobacco cessation intervention if identified as a tobacco user
17a	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS347v4	Percentage of the following patients at high risk of cardiovascular events aged 21 years and older who were prescribed or were on statin therapy during the measurement period: <ul style="list-style-type: none"> • Patients 21 years of age or older who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD), or • Patients 21 years of age or older who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level greater than or equal to 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia, or • Patients 40 through 75 years of age with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL


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



72

Table 6B CQMs


Line	Measure	eCQM	Brief Measure Description
18	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	CMS164v7	Percentage of patients aged 18 years of age and older who were diagnosed with acute myocardial infarction (AMI), or who had a coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCIs) in the 12 months prior to the measurement period, or who had an active diagnosis of IVD during the measurement period, and who had documentation of use of aspirin or another antiplatelet during the measurement period <i>Note that the IVD eCQM is has not been updated; the Version 7 specifications should continue to be used for 2021 reporting. Details can be found in the 2021 UDS Clinical Quality Measures Handout.</i>
19	Colorectal Cancer Screening	CMS130v9	Percentage of adults 50–75 years of age who had appropriate screening for colorectal cancer
20	HIV Linkage to Care	no eCQM	Percentage of patients newly diagnosed with HIV who were seen for follow-up treatment within 30 days of diagnosis
20a	HIV Screening	CMS349v3	Percentage of patients aged 15–65 at the start of the measurement period who were between 15–65 years old when tested for HIV

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73

Table 6B CQMs


Line	Measure	eCQM	Brief Measure Description
21	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	CMS210	Percentage of patients aged 12 years and older screened for depression on the date of the visit or 14 days prior to the visit using an age-appropriate standardized depression screening tool and, if positive, had a follow-up plan documented on the date of the visit
21a	Depression Remission at Twelve Months	CMS159v9	Percentage of patients aged 12 years and older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event
22	Dental Sealants for Children between 6–9 Years	CMS277v0	Percentage of children, age 6–9 years, at moderate to high risk for caries who received a sealant on a first permanent molar during the measurement period <i>Note that the Dental Sealant eCQM is has not been updated; the Version 0 specifications should continue to be used for 2021 reporting. Details can be found in the 2021 UDS Clinical Quality Measures Handout.</i>

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74

Table 7 Clinical Quality Outcome Measures

Section	Measure	eCQM	Brief Measure Description
Section A	Low Birth Weight	no eCQM	Percentage of babies of health center prenatal care patients born whose birth weight was below normal (less than 2,500 grams)
Section B	Controlling High Blood Pressure	CMS165v9	Percentage of patients 18–85 years of age who had a diagnosis of hypertension overlapping the measurement period or the year prior and whose most recent blood pressure (BP) was adequately controlled (less than 140/90 mmHg) during the measurement period
Section C	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	CMS122v9	Percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c (HbA1c) greater than 9.0 percent during the measurement period

 Table 7 measures are reported by race and ethnicity. Details can be found in the 2021 UDS Clinical Quality Measures Handout.



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75

Table 6B: Existing Measure Modified
Cervical Cancer Screening (CMS124v9)

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

2020	2021
Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: <ul style="list-style-type: none"> Cervical cytology performed during the measurement period or the 2 years prior to the measurement period for women who are at least 21 years old at the time of the test. Cervical cytology/HPV co-testing performed during the measurement period or the 4 years prior to the measurement period for women who are at least 30 years old at the time of the test. 	Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: <ul style="list-style-type: none"> Cervical cytology performed during the measurement period or the 2 years prior to the measurement period for women who are at least 21 years old at the time of the test. Cervical HPV testing performed during the measurement period or the 4 years prior to the measurement period for women who are 30 years or older at the time of the test.






76

Table 6B: Existing Measure Modified
Tobacco Use: Screening and Cessation Intervention (CMS138v9)

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



2020	2021
<ul style="list-style-type: none"> Patients who were screened for tobacco use at least once within 24 months. Patients who received tobacco cessation intervention. Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user. Pharmacotherapy or cessation intervention on the same date or after the positive screening. 	<ul style="list-style-type: none"> Patients who were screened for tobacco use at least once within 12 months. Patients who received tobacco cessation intervention. Patients who were screened for tobacco use at least once within 12 months AND who received tobacco cessation intervention if identified as a tobacco user. Pharmacotherapy or cessation intervention during the measurement period.

77

Tables 6A, 6B, and 7 Resources


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

78

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


DO	DON'T
<ul style="list-style-type: none"> ✓ Do know that all involved recognize the many challenges that COVID-19 has presented in the last 2 years in providing care. ✓ Do report clinical measures (at least the Denominator, Column A) if you have medical patients in the age range who meet requirements, even if compliance is 0. ✓ Do remember to consider the lookback period for the numerator as defined by certain clinical quality measures. ✓ Do remember that Table 6A diagnoses and services relate to health center patients. ✓ Do remember that the diabetes measure is a "negative" measure (lower is better). <ul style="list-style-type: none"> • Column 3F is patients who are <i>uncontrolled</i> (no test in the year or HbA1c was >9%). 	<ul style="list-style-type: none"> ❑ Don't forget that the Tobacco Screening and Cessation intervention measure has shortened the timeframe from 24 months to 12 months. There may be a drop in compliance related to this, particularly if processes haven't been updated. ❑ Don't exclude patients who meet the denominator criteria, unless they meet specified exclusion or exception criteria. <ul style="list-style-type: none"> ❑ Patients who have medical visits, including virtual visits, are generally eligible for inclusion in measures. ❑ Don't try to interpret age or other aspects from the measure title—apply CQL logic! <ul style="list-style-type: none"> ❑ Review the specifications!

 79

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


2021 Changes: No major changes to reporting


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

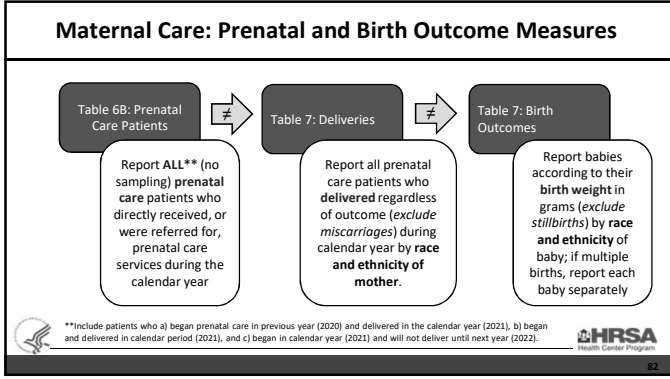


Tables 6B and 7: Prenatal and Birth Outcome Measures

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

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

 81



Prenatal Patients by Age and Entry into Prenatal Care

Table 6B

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

Line 0, Section A (Lines 1-6), and Section B (Lines 7-9)		
Line	Age	Number of Patients (a)
1	Less than 15 years	
2	Ages 15-19	
3	Ages 20-24	
4	Ages 25-34	
5	Ages 35 and over	
6	Total Patients (Sum of Lines 1-5)	

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

Deliveries and Birth Outcomes

Table 7

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

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1A)	Live Births: <1500 grams (1B)	Live Births: 1500-2499 grams (1C)	Live Births: ≥2500 grams (1D)
Hispanic or Latina					
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				
Hispanic Ethnicity or Latina					
Non-Hispanic or Latina					
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				
Hispanic Non-Hispanic or Latina					
Unreported/Refused to Report Race and Ethnicity					
3	Unreported/Refused to Report Race and Ethnicity				
4	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

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


View the [Prenatal and Birth Outcomes Fact Sheet](#) for more information.




85

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

- A 23-year-old patient was seen in December of 2020 for prenatal care in the health center. The patient then had a 2,750-gram baby on January 13, 2021.
- A 32-year-old patient is seen in the health center in early 2021, has a pregnancy test, and is found to be pregnant. The nurse gives the patient a list of nearby prenatal care providers who are accepting new patients. The patient is seen again in late 2021 for allergies and a COVID test. At that visit, the patient has the new baby in tow.




Source: iStock



86


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



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


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

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





87

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





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

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

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



DO	DON'T
<ul style="list-style-type: none"> ✓ Do include patients still pregnant at the end of the prior calendar year in the current calendar year prenatal and delivery (considering evidence of delivery) sections. ✓ Do report all prenatal patients whether you provide prenatal services within your health center or refer out for these services. ✓ Do report each baby in the live births by birth weight columns on Table 7—this means with twins, report two babies for one delivery. 	<ul style="list-style-type: none"> ❑ Don't report health center patients who are referred out for prenatal care in Column B for trimester of entry into prenatal care; report in Column A instead. ❑ Don't report patients as having delivered during the reporting period when there is no evidence of delivery. ❑ Don't forget to track delivery outcomes for prenatal care patients, even if they transferred out of the health center.

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

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

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

Costs and Revenues

**Table 8A:
Financial Costs**

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

**Table 9D:
Patient-Related Revenue**

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

**Table 9E:
Other Revenue**

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

91

Table 8A: Financial Costs

2021 Changes: No major changes

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

92

Financial Costs

Table 8A

Cost Center (Lines 1-15)	Accrued Cost (Column A)	Allocation of Facility and Non-Clinical Support Services (Column B)	Total Cost After Allocation of Facility and Non-Clinical Support Services (Column C)
<ul style="list-style-type: none"> • Medical • Dental • Mental Health • Substance Use Disorder • Pharmacy & Pharmaceuticals • Other Professional • Vision • Enabling • Other Program-Related Services • Administration (non-clinical support) • Facility 	<ul style="list-style-type: none"> • Report accrued direct costs • Include costs of: <ul style="list-style-type: none"> • Personnel (both staff and contracted) • Fringe benefits • Supplies • Equipment • Depreciation • Related travel • No bad debt costs 	<ul style="list-style-type: none"> • Allocate Facility and Non-Clinical Support Services costs to all other cost centers (Lines): <ul style="list-style-type: none"> • Medical • Dental • Mental Health • Substance Use Disorder • Pharmacy & Pharmaceuticals • Other Professional • Vision • Enabling • Other Program-Related Services • Must equal Line 16, Column A, representing overhead costs incurred by all cost centers 	<ul style="list-style-type: none"> • Sum of Columns A + B (calculated automatically in EHBs) • Represents cost to operate service by category • Used to calculate cost per visit and cost per patient

93

Tables 5 and 8A Crosswalk

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)	Line	Cost Center	Accrued Cost (d)	Allocation of Facility and Non-Clinical Support Services (e)	Total Cost Other Allocation of Facility and Non-Clinical Support Services
1	Family Physicians					1	Financial Costs of Medical Care			
2	General Practitioners					1	Medical Personnel			
3	Internists					2	Lab and X-ray			
4	Ophthalmologist/Ophthalmologist					3	Medical Other Direct			
5	Podiatrists					4	Total Medical Care Services (Sum of Lines 1 through 3)			
7	Other Specialty Physicians					1	Financial Costs of Other Clinical Services			
8	Total Physicians (Lines 1-7)					2	Diagn			
9a	Nurse Practitioners					3	Diagn			
9b	Physician Assistants					4	Medical Health			
10	Certified Nurse Midwives					5	Substance Use Disorder			
10a	Total NPs, PAs, and CNMs (Lines 9a-10)					6	Pharmacy (not including pharmaceuticals)			
11	Nurses					7	Pharmaceuticals (excluding...)			
12	Other Medical Personnel					8	Other Professional (excluding...)			
13	Laboratory Personnel					9	Other Professional (excluding...)			
14	X-ray Personnel					10	Total Other Clinical Services (Sum of Lines 5 through 10)			
15	Total Medical Care Services (Lines 1-4 + 10 through 14)					11a	Financial Costs of Enabling and Other Services			
16	Dentists					11b	Case Management			
17	Dental Hygienists					11c	Transportation			
17a	Dental Therapists					11d	Outreach			
18	Other Dental Personnel					11e	Patient and Community Education			
19	Total Dental Services (Lines 16-18)					11f	Healthcare Assistance			

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

Financial Costs Table 8A

Report costs by Cost Center


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

Line	Cost Center	Accrued Cost (d)
1	Financial Costs of Medical Care	
1	Medical Personnel	
2	Lab and X-ray	
3	Medical Other Direct	
4	Total Medical Care Services (Sum of Lines 1 through 3)	
5	Financial Costs of Other Clinical Services	
6	Diagn	
7	Medical Health	
8	Substance Use Disorder	
9a	Pharmacy (not including pharmaceuticals)	
9b	Pharmaceuticals (excluding...)	
9	Other Professional (excluding...)	
10	Total Other Clinical Services (Sum of Lines 5 through 10)	
11a	Financial Costs of Enabling and Other Services	
11b	Case Management	
11c	Transportation	
11d	Outreach	
11e	Patient and Community Education	
11f	Healthcare Assistance	
11g	Other Enabling Services	
11h	Community Health Workers	
11	Total Enabling Services (Sum of Lines 11a through 11h)	
12	Other Program-Related Services (excluding...)	
12a	Quality Improvement	
13	Total Enabling and Other Services (Sum of Lines 11, 12, and 12a)	

Pharmacy Reporting on Table 8A

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

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



Source: Stock

Column A, Lines 14–16

Table 8A

- Line 14:** Facility-related expenses, including direct personnel costs, rent or depreciation, mortgage interest payments, utilities, security, groundskeeping, janitorial services, maintenance, etc. Includes personnel whose FTEs are reported on Table 5, Line 31.
- Line 15:** Costs for all personnel whose FTE is reported on Table 5, Lines 30a–30c and 32, including corporate administration, billing collections, medical records and intake personnel, facility and liability insurance, legal fees, practice management system, and direct non-clinical support costs (travel, supplies, etc.).
 - Include malpractice insurance in the service categories, not here.
- Line 16:** Total indirect costs to be allocated in Column B.

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

97

Allocating Overhead Expenses to Column B: Two-Step Method

Facility (Line 14)

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

Non-Clinical Support Services (Line 15)

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

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

98

Reporting Donations

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

```


    graph TD
      A[Donations of Goods and Services] --> B[Table 8A, Line 18: Value of Donated Facilities, Services, and Supplies]
      C[Cash Donations/Fundraising Revenue] --> D[Table 9E, Line 10: Other Revenue (non-patient-service-related revenue not reported elsewhere)]
    
```

Resource: Reporting Donations in the UDS 99

Column B: Collections
Table 9D

Line	Payer Category	Fall Charges Collected 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)
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- Column b: Collections:** Include all payments received in 2021 for services to patients:
 - Capitation payments
 - Contracted payments
 - Payments from patients
 - Third-party insurance
 - Retroactive settlements, receipts, and payments
 - ✓ Include pay for performance, quality bonuses, and other incentive payments tied to patient care.
- Do not include Promoting Interoperability payments from Medicaid and Medicare here.
- Do not include *pay-for-participation* or *pay-for-reporting* incentives here (report on Table 9E). *Pay-for-performance* incentives (tied to patient services) ARE reported here.



103

Columns C1–C4: Retroactive Settlements, Receipts, and Paybacks
Table 9D

Amount Collected This Period (b)	Retroactive Settlements, Receipts, and Paybacks (c)			
	Collection of Reconciliation/ Wraparound Current Year (c1)	Collection of Reconciliation/ Wraparound Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty/Payback (c4)
Payments reported in C1–C4 are part of Column B total, but do not equal Column B	<ul style="list-style-type: none"> • FQHC prospective payment system (PPS) reconciliations (based on filing of cost report) • Wraparound payments (additional amount per visit to bring payment up to FQHC level) 	<ul style="list-style-type: none"> • FQHC prospective payment system (PPS) reconciliations (based on filing of cost report) • Wraparound payments (additional amount per visit to bring payment up to FQHC level) 	<ul style="list-style-type: none"> • Managed care pool distributions • Pay for performance (P4P) • Other incentive payments • Quality bonuses • Value-based payments 	<ul style="list-style-type: none"> • Paybacks or deductions by payers because of overpayments or penalty (report as a positive number)




104

Column D: Adjustments
Table 9D

Line	Payer Category	Fall Charges Collected 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)
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- Column D: Adjustments:** Agreed-upon reductions/write-offs in payment by a third-party payer:
 - Reduce by amount of retroactive payments in C1, C2, and C3.
 - + Add paybacks reported in C4.
- May result in a negative number (most common when with large retro payments in C1–C3).
- For managed care capitated Lines (2a, 5a, 8a, and 11a) *only*, adjustments equal the difference between charges and collections (Column D = A–B).



105


Column E: Sliding Fee Discounts

Table 9D

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

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

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




106

Column F: Bad Debt Write-Off

Table 9D

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

- Bad debt:** Amounts owed by patients considered to be uncollectable and formally written off during 2021, regardless of when service was provided.
- Only report **patient bad debt** (not third-party payer bad debt):
 - ONLY related to charges reported in **Column A of Line 13, Self-Pay**.
 - Third-party payer bad debt is not reported in the UDS.
- Do not change bad debt to a sliding discount.
- Discounts (e.g., to specific groups of patients, cash discounts) or forgiveness is not patient bad debt (or a sliding discount).




107

Payer Categories for Patient Service Revenue

Table 9D

<p>Medicaid</p> <ul style="list-style-type: none"> 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 <p>Medicare</p> <ul style="list-style-type: none"> Medicare managed care programs, including Medicare Advantage run by commercial insurers ADHC or PACE, if administered by Medicare 	<p>Other Public</p> <ul style="list-style-type: none"> CHIP, when NOT administered by Medicaid Public programs that pay for limited services, such as BCCCP and Title X State- or county-run insurance plans, such as the Massachusetts CommonHealth plan Service contracts with municipal/county jails, state prisons, public schools, or other public entities Testing and treatment associated with caring for uninsured patients with suspected or actual COVID-19 administered by HRSA under the COVID-19 Uninsured Program on Line 8c (more on the next slide) <p>Private</p> <ul style="list-style-type: none"> Tricare, Trigon, Federal Employees Insurance Program, workers' compensation Insurance purchased through state exchanges or provided by employers Commercial insurance purchased by patient and/or their employers <p>Self-Pay</p> <ul style="list-style-type: none"> 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
--	---





108

COVID-19 Uninsured Program Reporting

Table 9D

Federal Funding	Other Names	Reported on UDS
Reimbursement for COVID-related costs of uninsured patients from HRSA	HRSA Uninsured Claims Program (administered by United Health/ Optum Pay)	<p>Table 9D, Line 8c: Other Public Including COVID-19 Uninsured Program</p> <p>Report full charges in Column A, collections in Column B, etc., as with all other lines.</p>



- 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.

109

Forms of Payment

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

110

Example



Table 9D

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

When the health center bills the insurance for the visit, the claim is denied because the patient was no longer covered by that insurer on the date the patient was seen.

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


After reclassifying to Self-Pay (Line 13), the charge may be paid, may be written off as sliding fee if the patient has qualified, or may be written off as bad debt. Must reclassify the charge first!


111

Example

How is this reported across Tables 4 and 9D?




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




112

Example

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



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




113

Reporting 340B Contract Pharmacy

Table	Related Reporting/Impact
8A (Costs)	<ul style="list-style-type: none"> 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, even though Line 8a Column A is blank. Report payments to pharmacy benefit managers on Line 8a, Pharmacy. Some pharmacies split the fee or keep a share of profit. Report this as a payment to the pharmacy on Line 8a, Pharmacy.
9D (Patient Service Revenue)	<ul style="list-style-type: none"> Charge (Column A) is the health center/contract pharmacy's full retail charge for the drugs dispensed, by paper. 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 revenue on Table 9E, and do not use Table 9E to report net revenue from the pharmacy. Report actual gross revenue on Table 9D.

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




114

BPHC COVID-19 Funding Lines

Table 9E

Line	Source	Amount (a)
BPHC Grants (Enter Amount Drawn Down—Consistent with FMS 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 1c)	
1k	Capital Development Grants, including School-Based Health Center Capital Grants	
1l	Coronavirus Preparedness and Response Supplemental Appropriations Act (HRA)	
1m	Coronavirus Aid, Relief, and Economic Security Act (CARES) (HRD)	
1n	Expanding Capacity for Coronavirus Testing (ECT) (HRE and L&L ECT)	
1o	American Rescue Plan	
1p	Other COVID-19-Related Funding from BPHC (specify _____)	
1q	Total COVID-19 Supplemental (Sum of Lines 1l through 1p)	
1	Total BPHC Grants (Sum of Lines 1g + 1k + 1q)	

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




118

Revenue Categories

Table 9E

Non-Federal Grants or Contracts	
6	State Government Grants and Contracts (specify _____)
6a	State/Local Indigent Care Programs (specify _____)
7	Local Government Grants and Contracts (specify _____)
8	Foundation/Private Grants and Contracts (specify _____)
9	Total Non-Federal Grants and Contracts (Sum of Lines 6 + 6a + 7 + 8)
10	Other Revenue (non-patient service revenue not reported elsewhere) (specify _____)
11	Total Revenue (Sum of Lines 1 + 5 + 9 + 10)


- 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.



119

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



DO	DON'T
<ul style="list-style-type: none"> Do use at least a two-step process for allocating overhead in Column B of Table 8A. Do ensure you have or are receiving detailed payer information for your 340B or contract pharmacy, to accurately report Table 9D. Do be sure Table 9D, Column A is reported based solely on your set fee schedule or the fee schedule of any contractor you are paying (such as a pharmacy), not based on your PPS rate or other adjusted rates. 	<ul style="list-style-type: none"> Don't report patient-generated revenue, such as contract/340B pharmacy revenue or pay-for-performance distributions, on Table 9E. Don't forget to compare managed care reporting on Table 9D to managed care member months on Table 4. Don't report adjustments on anything except contractual adjustments, adjusted by Columns C1 through C4.



120

Resources to Support Financial and Operational Reporting



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

121

Other Forms to Complete

Health Information Technology Form
Other Data Elements Form
Workforce Form




122

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

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

A series of approximately 15 questions that assess:


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


123

Recorded Training Modules

1. [UDS Overview](#)
2. [Patient Characteristics](#)
3. [Clinical Services and Performance](#)
4. [Operational Costs and Revenues](#)
5. [Submission Success](#)




Find the modules on HRSA BPHC's [UDS resource page](#).




130

Training Webinar Series for 2021 UDS Reporting

- Counting Visits in the UDS
- UDS Clinical Tables Part 1: Screening and Preventive Care
- UDS Clinical Tables Part 2: Maternal Care and Children's Health
- UDS Clinical Tables Part 3: Chronic Disease Management
- Reporting UDS Financial and Operational Tables
- Successful Submission Strategies




All webinars are archived on the [HRSA website](#).



131



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/hphc.aspx	http://www.hrsa.gov/about/contact/ehbhelp.aspx
Hours of Operation	8:30 a.m. to 5:00 p.m. ET, M-F Extended hours during UDS reporting period	7:00 a.m. to 8:00 p.m. ET, M-F Extended hours during UDS reporting period	8:00 a.m. to 8:00 p.m. ET, M-F






132

Tips for Success

Tips for Success



- **Tables are interrelated**, so sit with team to agree on correct and related reporting:
 - Sites
 - Personnel, FTEs, and roles
 - Patients and services
 - Expenses
 - Revenues
- **Adhere to definitions and instructions.**
- **Check your data** before submitting.
 - Refer to the comments you received from your reviewer last year. This document is emailed to the UDS Contact each year.
 - Compare with benchmarks/trends.
 - Review the Comparison Tool.
 - Understand system changes that justify the data.
- **Address edits** in EHBs by correcting or providing explanations that demonstrate your understanding.
- Work with your **reviewer**.

134

Available Assistance

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

135



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! Your feedback is important to us.
Please be sure to select your PCA at the top of the evaluation.

[Evaluation Link](#)

Vision: Healthy Communities, Healthy People



Contact Information

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

1-866-UDS-HELP

or

1-866-837-4357

udshelp330@bphcdata.net