
HRSA
Health Resources & Services Administration
Uniform Data System (UDS)
Reporting Requirements Training
Annual State-Based Training
Calendar Year 2023
Bureau of Primary Health Care (BPHC)
Vision: Healthy Communities, Healthy People

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Training Agenda
1. Welcome and Logistics
2. Overview of the UDS
3. Reporting Patient Demographic Profile
4. Reporting Clinical Services and Quality of Care Indicators
5. Reporting Operational and Financial Tables
6. Other Required UDS Reporting Forms
7. Tips for Success
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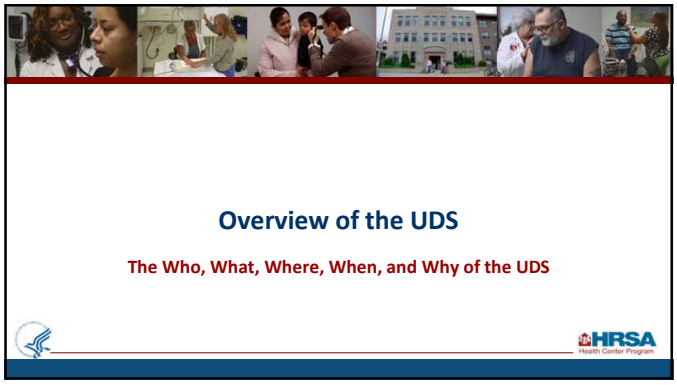
Overview of the UDS
The Who, What, Where, When, and Why of the UDS
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Key Facts About Reporting the UDS

WHO	WHAT	WHERE	WHEN	WHY
CHCs, HCHs, MHCs, PHPCs, LALs, and BHW primary care clinics funded or designated before Oct. 2023 all complete a UDS Report.	The UDS includes 11 tables and 3 forms that provide an annual snapshot of all in-scope activities; Universal and, if applicable, Grant Reports.	The UDS Report is completed in the Performance Report in the Electronic Handbooks (EHBs).	All health centers complete their UDS Report between Jan. 1 and Feb. 15, 2024; reporting covers health center services in the calendar year from Jan. 1 to Dec. 31, 2023.	The UDS is legislatively mandated as part of the Health Center Program; used for program monitoring and improvement.

For a full list of acronyms, refer to Appendix J of the UDS Manual.
In addition to submitting UDS Reports within the EHBs, health centers may voluntarily submit certain de-identified patient-level report data using HL7® FHIR® R4 standards. Visit the UDS Modernization FAQ for more on that process.

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UDS Patient-Level Reporting: UDS+

- **All health centers are required to submit an aggregate UDS Report within HRSA's EHBs by Feb. 15, 2024.**
- Additionally, health centers *may* voluntarily submit de-identified patient-level data (UDS+) using Fast Healthcare Interoperability Resources Release 4 (FHIR R4) standards for data elements on the following UDS tables:
  - Patients by ZIP Code Table
  - Table 3A: Patients by Age and by Sex Assigned at Birth
  - Table 3B: Demographic Characteristics
  - Table 4: Selected Patient Characteristics
  - Table 6A: Selected Diagnoses and Services Rendered
  - Table 6B: Quality of Care Measures
  - Table 7: Health Outcomes and Disparities
- **If you are interested in learning more, including how to get involved, visit the UDS Modernization Frequently Asked Questions (FAQ).**

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Health Center Program Grants and Designations

Some health centers have a single 330 grant: CHC, HCH, MHC, or PHPC.

Some health centers have more than one 330 grant: these health centers have two or more grants, in any combination of CHC, HCH, MHC, and/or PHPC.

Some health centers have a Health Center Program look-alike (LAL) designation or are **Bureau of Health Workforce (BHW) awardees**. These health centers do not have a 330 grant.

Additional definitions can be found on HRSA's "What is a health center?" page.

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Value of the UDS

The UDS demonstrates **the scope of the Health Center Program**, including type, volume, and outcomes, for each calendar year.

Because it captures this data each year, it allows stakeholders to **understand how each health center and health centers in aggregate have changed** year over year.

The UDS captures and conveys to HRSA the work that you have been doing and, all together, conveys to Congress and other stakeholders the **important work that the entire Health Center Program is doing**.

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Overview of UDS Report

Four Primary Sections

Patient Demographic Profile

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

Clinical Services and Outcomes

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

Financial Performance

- **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

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Overview of UDS Report

Eleven Tables and Three Forms

- All tables and forms are completed in a Universal Report.
  - **Universal Report**—completed by all reporting health centers (those with one or more 330 grant, those designated as LALs, and those with BHW grants).
  - **Grant Report(s)**—completed only by awardees that receive multiple 330 grants (e.g., CHC, MHC, HCH, PHPC).

Table *All reported in Universal Report*	Table in Grant-Specific Report(s)? *For those health centers with multiple 330 grants*
ZIP Code	No
3A, 3B, 4	Yes
5	Yes, but patients and visits only
6A	Yes
6B, 7, 8A, 9D, 9E	No
HIT, ODE, and Workforce Forms	No

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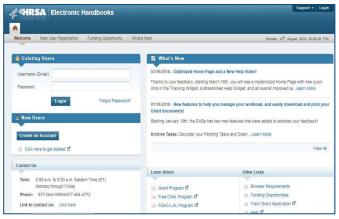
Where to Report: The EHBs



- **The UDS is the Performance Report for your H80 grant or LAL designation in the EHBs.**
- Each person tasked with UDS data entry or review needs a login to the EHBs.
- UDS Modernization tools to assist with reporting:
  - Preliminary Reporting Environment (PRE; for early access)
  - Excel Template (download/upload in the EHBs)
  - Comparison Tool
  - Edits

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

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Reporting Timeline

January 1: UDS Report is available through EHBs → Report in EHBs → February 15: UDS Report is due in EHBs → Work with reviewer to revise report, as needed → March 31: Last day for data changes; final, revised reports are due → Data finalization by HRSA → Summer: Reports are available to health centers in EHBs

PRE available (Oct.–Dec.) | UDS support available (all year)

In addition to submitting UDS Reports in the EHBs, health centers may voluntarily submit certain de-identified patient-level report data using HL7® FHIR® R4 standards. Visit the UDS Modernization FAQ for more on that process.

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Picture That These Data Paint

UDS data allows insight into who is served and with what services across the nation.

HRSA-funded health centers provide quality care to 30M+ people across the country, serving:

- **90%** of patients at or below 200% of the poverty line
- **1 in 11** people in the U.S.
- **1 in 9** children
- **9.6M+** rural residents

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Key Definitions

Understanding Terms Foundational to the UDS

Health Center Patient | Countable Visit | Health Center Scope

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Health Center Patient

UDS Definition: A person who has at least one countable visit, reported on Table 5, in one or more service categories during the calendar year, is a **health center patient**.

- The patient demographic tables (ZIP Code Table and Tables 3A, 3B, and 4) provide an **unduplicated count of health center patients**.
  - In the patient demographic profile tables, **each patient counts once** regardless of the number of visits or services received.
  - All patients must be included in the patient demographic tables by their demographic characteristics.
- People who are not patients by this definition are not counted anywhere on the UDS.
- Health center patients are reported on all service and clinical tables for which they meet the criteria.

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Countable Visit

UDS Definition: Encounters between a patient and a licensed or credentialed provider who exercises independent professional judgment in providing services that are individualized to the patient and documented in the patient's record are countable visits, reported on Table 5.

- Visits can be **clinic (in-person) or virtual**; the requirements to be countable are the same for each.
- Only **certain personnel are classified as providers** and can therefore generate countable visits.
  - Appendix A of the UDS Manual specifies what personnel (by line on Table 5) can be providers on the UDS. Page 67 spells out lines that cannot have visits.
- A countable visit in ANY service category on Table 5 makes someone a health center patient in the UDS.
  - Page 55 of the UDS Manual outlines the different service categories reported in the UDS.
- An encounter is a countable visit when it is **one-to-one with a provider and a patient**.
  - Exception: mental health and substance use disorder visits, which can be group visits.

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Health Center Scope
UDS Definition: Health center scope of project is a health center's approved service sites, services, providers, service area, and target populations.
Only services in the health center scope of project, meaning the scope of your 330 grant (or LAL or BHW designation), are captured in the UDS.
For some, all sites and services are within the health center scope of project. For others, the health center scope of project is a subset of the larger organization.
It is important to understand your health center's scope of project to report correctly.
Sites that are part of your health center scope of project are spelled out on Form 5B, in-scope services for your health center are on Form 5A, and other activities and locations are on Form 5C.
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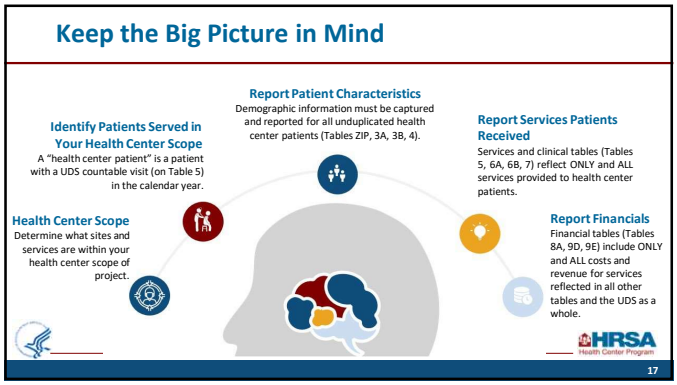
Keep the Big Picture in Mind
Identify Patients Served in Your Health Center Scope
A "health center patient" is a patient with a UDS countable visit (on Table 5) in the calendar year.
Report Patient Characteristics
Demographic information must be captured and reported for all unduplicated health center patients (Tables ZIP, 3A, 3B, 4).
Report Services Patients Received
Services and clinical tables (Tables 5, 6A, 6B, 7) reflect ONLY and ALL services provided to health center patients.
Health Center Scope
Determine what sites and services are within your health center scope of project.
Report Financials
Financial tables (Tables 8A, 9D, 9E) include ONLY and ALL costs and revenue for services reflected in all other tables and the UDS as a whole.
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Overview of the UDS Tables and Forms
Understanding What Data Is Reported and Why
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ZIP Code Table, Tables 3A, 3B, and 4

Understanding Who You Are Serving

In addition to submitting these tables within the EHBs, health centers may voluntarily submit de-identified patient-level report data using HL7® FHIR® R4 standards. Visit the UDS Modernization FAQ for more on that process.

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Overview of Patient Demographic Tables

	ZIP Code Table	Table 3A	Table 3B	Table 4
Captures	Patients by **ZIP code** and **primary medical insurance**	Patients by **age** and **sex assigned at birth**	• Patients by **race** and **ethnicity** • Patients **best served in a language other than English*** • Patients by **sexual orientation** and **gender identity**	• Patients by **income as percent of poverty guideline** • Patients by **primary medical insurance** • Patients by **managed care*** • **Special population status***
Purpose	To understand the distribution of your health center patients by geography and medical insurance	To understand the age and sex distribution of patients and offer comparative information for services (such as pediatrics and OB/GYN)	To understand the reach and distribution of health center services to patients and understand/support equity of access	To understand efficacy of the Health Center Program mission of reaching underserved patients, including special populations

*Remember, all sections of these tables (except those that are *starred) equal each other because they describe the same group of patients, just by different characteristics.*

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Patients by ZIP Code Table

Report total patients by **ZIP code of residence** and **primary medical insurance**.

- Rows are ZIP codes (which you will enter or import); columns are primary medical insurance categories.
  - List all ZIP codes in which your health center has 11 or more patients in Column A.
- Aggregate ZIP codes with 10 or fewer patients into the Other ZIP Codes line.
- Use the patient's local address for migratory agricultural workers and people from other countries; use clinic address for patients experiencing homelessness if they have no other address.

ZIP Code (a)	None/ Uninsured (b)	Medicaid/ CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
<ZIP codes will be entered here>					
<ZIP codes will be entered here>					
Other ZIP Codes					
Unknown Residence					
Total					

Keys to remember:

- There is **no unknown primary medical insurance**; all patients must have primary medical insurance as of their last visit in the year captured.
- On this table, Medicaid, CHIP, and Other Public are combined in Column C. (They are separate on Table 4.)
- Total patients' ZIP code by medical insurance **must equal** counts of patients by insurance on Table 4.

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Patients by Age and Sex Assigned at Birth

Table 3A

Report all patients by **age** and **sex assigned at birth**, or sex reported on the birth certificate.

- Rows are age; columns are sex assigned at birth.
- Use age as of **December 31, 2023**.

Keys to remember:

- All patients must be reported as either male or female for sex assigned at birth; there is no unknown.
- Patients by age in Table 3A must equal insurance by age groups (0–17 years old and 18 and older) in Table 4.
- Information is used for cross-table comparisons.

Line	Age Groups	Male Patients (a)	Female Patients (b)
1	Under age 1		
2	Age 1		
3	Age 2		
4	Age 3		
5	Age 4		
6	Age 5		
7	Age 6		
8	Age 7		
9	Age 8		
10	Age 9		
11	Age 10		
…	…		
29	Ages 40–44		
30	Ages 45–49		
31	Ages 50–54		
32	Ages 55–59		
33	Ages 60–64		
34	Ages 65–69		
35	Ages 70–74		
36	Ages 75–79		
37	Ages 80–84		
38	Age 85 and over		
39	**Total Patients** (Sum of Lines 1–38)		

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Table 3B: Demographic Characteristics

2023 Changes:

- New sub-categories have been added for race and ethnicity.

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Tables 3B Has Been Updated

New Sub-Categories Have Been Added for Race and Ethnicity

- **Updates to Race:** Sub-categories for Asian and Other Pacific Islander:
  - **Asian:** Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Other Asian
  - **Native Hawaiian/Other Pacific Islander:** Native Hawaiian, Other Pacific Islander, Guamanian or Chamorro, Samoan
- **Updates to Ethnicity:** Sub-categories for Hispanic, Latino/a, or Spanish origin:
  - Mexican, Mexican American, Chicano/a; Puerto Rican; Cuban; Another Hispanic, Latino/a, or Spanish Origin
  - Hispanic, Latino/a, Spanish Origin, Combined

Line	Patients by Race	Patients by Race and Hispanic, Latino/a, or Spanish Ethnicity								
		Yes, Mexican, Mexican American, Chicano/a (a1)	Yes, Puerto Rican (a2)	Yes, Cuban (a3)	Yes, Another Hispanic, Latino/a, or Spanish Origin (a4)	Yes, Hispanic, Latino/a, Spanish Origin, Combined (a5)	Total Hispanic, Latino/a, or Spanish Origin (a) (Sum Columns a1+a2+a3+a4 +a5)	Not Hispanic, Latino/a, or Spanish Origin (b)	Unreported / Chose Not to Disclose Ethnicity (c)	Total (d) (Sum Columns a+b+c)
1a	Asian Indian									
1b	Chinese									
1c	Filipino									
1d	Japanese									
1e	Korean									
1f	Vietnamese									
1g	Other Asian									
1	Total Asian (Sum Lines 1a+1b+1c+1d+1e+1f+1g)									
2a	Native Hawaiian									
2b	Other Pacific Islander									
2c	Guamanian or Chamorro									
2d	Samoan									
2	Total Native Hawaiian/Other Pacific Islander (Sum Lines 2a+2b+2c+2d)									
3	Black/African American									
4	American Indian/Alaska Native									
5	White									
6	More than one race									
7	Unreported/Chose not to disclose race									
8	**Total Patients** (Sum of Lines 1+2+3+4+5+6+7)									

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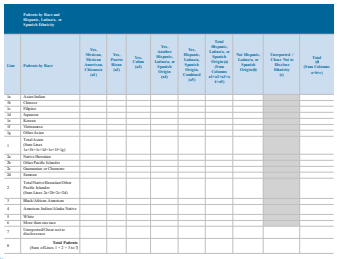
Ethnicity, Race, and Language

Table 3B, Lines 1–8



Report all patients by **ethnicity and race**.

- Rows are race categories; columns are ethnicity categories.
- If race is known but ethnicity is not, report in Column B, Not Hispanic, Latino/a, or Spanish Origin.
- If patient identifies as or selects multiple races, report on Line 6.
- **Report only patients with unknown race *and* unknown ethnicity on Line 7, Column C.**
- Line 8, Column D, equals total unduplicated patients.

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Ethnicity, Race, and Language

Table 3B, Line 12

Report patients **best served in a language other than English** on Line 12.

- If the patient's primary language is not English, then they are reported on this line.
- Line 12 is the *subset of total patients* who are best served in any language other than English.

Keys to Remember for Race and Ethnicity Reporting

1. Race, ethnicity, and language are to be self-reported by patients or caregivers (and are not to be inferred).
2. Patients should be able to select more than one race, and if they do, they are reported as more than one race (Line 6).
3. Report patients who are of Hispanic, Latino/a, or Spanish origin but for whom granularity of ethnicity is not known, and patients who select more than one listed ethnicity (e.g., Mexican and Puerto Rican), in Column A5: Hispanic, Latino/a, Spanish Origin, Combined.
4. Report patients with *known* race but *unknown* ethnicity as **Not Hispanic, Latino/a, or Spanish Origin** (Column B), as has been the guidance since inception of collection of these data for UDS.

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Sexual Orientation and Gender Identity

Table 3B, Lines 13–19 and Lines 20–26

Total patients are reported by self-reported **sexual orientation** and **gender identity**.

Line	Patients by Sexual Orientation	Number (a)
13	Lesbian or Gay	Patient selected option
14	Heterosexual (or straight)	Patient selected option
15	Bisexual	Patient selected option
16	Other	Patient selected option
17	Don't know	Patient selected option
18	Chose not to disclose	Patient selected option
18a	Unknown	No info collected
19	**Total Patients** (Sum of Lines 13 to 18a)	

Line	Patients by Gender Identity	Number (a)
20	Male	Patient selected option
21	Female	Patient selected option
22	Transgender Man/Transgender Male/Transgender Masculine	Patient selected option
23	Transgender Woman/Transgender Female/Transgender Feminine	Patient selected option
24	Other	Patient selected option
25	Chose not to disclose	Patient selected option
25a	Unknown	No info collected
26	**Total Patients** (Sum of Lines 20 to 25a)	

Lines 13–15 and Lines 20–23 may be fairly clear, while the others need more translation:

SO	**Line 16: Other:** Patient either chooses "Other" OR one of any number of other sexual orientations (asexual, pansexual, etc.) that are not listed elsewhere in these lines.	**Line 17: Don't know:** Patient reports that they do not know; unknown to the patient.	**Line 18: Chose not to disclose:** Patient actively chooses not to disclose this information, such as by selecting "Choose not to disclose" or "Prefer not to say" from a list.	**Line 18a: Unknown:** The information was not collected from the patient; unknown to the health center.
GI	**Line 24: Other:** Patients do not identify as any of the other gender identities specified on Lines 20–23, including patients who identify as genderqueer or gender nonbinary.		**Line 25: Chose not to disclose:** Patient actively chooses not to disclose this information, such as by selecting "Choose not to disclose" from a list.	**Line 25a: Unknown:** The information was not collected from the patient; unknown to the health center.

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Table 4:
Selected Patient Characteristics

2023 Changes:
- No major changes.

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Income as a Percent of Federal Poverty Guidelines

Table 4, Lines 1–6

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

Income information is important for demonstrating that HRSA's Health Center Program is meeting the mission of serving vulnerable patients, including those who have low income.

Report all **patients by income as a percent of federal poverty guidelines** on Lines 1–5.
- Report income based on federal poverty guidelines (requires information on income and household size).
- Report each patient's most recent income within 12 months prior to the last calendar year visit.
  - If income information has not been collected/confirmed in that period, report the patient's income as Unknown.
- Income for this table can be patient self-reported.
- Do not use insurance or special population status as a proxy for income.

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Primary Medical Insurance

Table 4, Lines 7–12

Line	Principal Third-Party Medical Insurance	0-17 years old (a)	18 and older (b)
7	**None/Uninsured**		
8a	Medicaid (Title XIX)		
8b	CHIP Medicaid		
8	**Total Medicaid** (Line 8a + 8b)		
	…		
12	**TOTAL** (Sum of Lines 7 + 8 + 9 +10 +11)		

Keys to Remember
- There is **no Unknown medical insurance** category. All patients need to be reported by medical insurance.
  - *This includes patients who did not receive medical services in the year.*
- Programs that cover a **limited set of services** are not considered comprehensive medical insurance.
- It is important to understand how CHIP is administered in your area to report it accurately.
- Patients by insurance and age must be equal across tables (ZIP and 3A).

Report **all patients by primary medical insurance** on Lines 7–11.
- Use **medical** insurance at the patient's last visit in the year.
- Only **comprehensive, portable medical insurance** is counted on this table.
- Dually eligible patients are those that have both Medicare and Medicaid; they are reported on both Line 9a and Line 9. (Line 9a is a subset of Line 9.)

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Primary Medical Insurance Categories

Table 4

None/Uninsured
Patient had no *medical* insurance at last visit (includes uninsured patients for whom the health center may be reimbursed through grant, contract, or uncompensated care fund).

Medicaid (Title XIX)
Medicaid and Medicaid-managed care programs, including those administered by commercial insurers.

CHIP (Medicaid *or* Other Public)
If CHIP is paid by Medicaid, report on Line 8b; if CHIP is reimbursed by another payer (e.g., a commercial carrier) outside of Medicaid, report on Line 10b.

Medicare
Include Medicare, Medicare Advantage, and Dually Eligible.

Dually Eligible (Medicare *and* Medicaid)
Subset of Medicare patients who also have Medicaid coverage.

Other Public Insurance (Non-CHIP)
State and/or local government insurance that covers a broad set of services; NOT grant programs reimbursing limited benefits (e.g., EPSDT, BCCCP).

Private Insurance
Commercial insurance such as that from an employer, insurance purchased on the federal or state exchanges, and insurance purchased for public employees or retirees.

Remember, primary medical insurance is not necessarily the entity that reimbursed or paid for the services the patient received in the year. Medical insurance is a characteristic of the patient.

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Examples: Categorizing Medical Insurance on Table 4

A patient is seen for only dental and mental health in the year, and they do not have insurance that covers those visits.

Even if the patient is seen only for dental/mental health, they **need to be reported on this table by their medical insurance**, so that information needs to be collected.

As of the last visit in the year, a patient has a commercial plan for their medical insurance.

It is important to determine whether that commercial plan is a **private commercial plan** or whether it is a **public plan (e.g., Medicaid) being administered by a commercial insurer**.

A patient is seen several times in the year. At the first two visits, they have Medicaid medical coverage; at the last visit, they have a commercial medical plan.

The medical insurance **as of the last visit** of the year is reported, so this patient is reported as privately insured.

For Table 4, it does not matter whether the health center *can* or *does* bill the patient's medical insurance.

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Managed Care

Table 4, Lines 13a–13c

Report member months for individuals assigned to the health center in medical managed care plans.

- Each month that someone is assigned to the health center by a managed care plan is one member month.
- Member months are reported by TYPE of plan: **capitated** or **fee-for-service**.
  - Capitated managed care plans pay a flat fee per member per month for a negotiated set of services.
  - Fee-for-service managed care plans pay per service rendered for assigned patients.
  - Either type of plan may also have incentives.

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)					

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Managed Care

Table 4

Keys to Remember

- Managed care organizations (MCOs) may have multiple plans with different payers (e.g., Medicaid, private).
- Health centers receive 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 are **assigned** to the health center for primary care and the health center is responsible for the patient's care.
- MCOs may include financial risk.

There must be a **reasonable relationship** between member months reported in this section and the following:

- Number of patients on Table 4
- Managed care revenue lines on Table 9D (the table that captures patient service revenue by insurance type)

Only the member months for assigned patients who have medical or comprehensive (medical plus other services) managed care are reported in the managed care section of Table 4.

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IMPORTANT KEY:

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

We will discuss Table 9D later!

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Special Populations

Table 4, Lines 14–26

All health centers report the following:

- Total Agricultural Workers or Their Family Members (Line 16)
- Total Homeless (Line 23)
- Total School-Based Service Site 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)

Health centers who have a Migrant Health Center (MHC) grant:

- Report migrant agricultural patients as Migratory (**Line 14**) or Seasonal (**Line 15**) on the Universal and Grant reports

Health centers who have a Health Care for the Homeless (HCH) grant:

- On Universal and Grant reports (**Lines 17–22**), report where patients experiencing homelessness were housed as of their ***first visit*** in the calendar year

Special Populations Resources: HRSA-funded National Training and Technical Assistance Partners (NTTAPs)

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How Special Population Status Is Identified

Table 4

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

Excerpt of Table 4

Patient-Identified Lines	Site-Based Lines
This special population is based on **characteristics of each individual patient**.	This special population is based on whether a **patient *received services* at a site that meets the definition**.
Line 16: Total Agricultural Workers or Their Family Members • Sub-lines for MHC grantees **Line 23:** Total Homeless • Sub-lines for HCH grantees **Line 25:** Total Veterans	**Line 24:** Total School-Based Service Site Patients: Total patients who received countable visits within any of the service categories at an approved school-based service site. **Line 26:** Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site: Total patients seen at a site that is in or immediately accessible to public housing (not public housing residents).

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Find Resources to Help: Patient Characteristics

HRSA BPHC UDS Resources site Patient Characteristics section includes the following resources:

- Self-Paced Learning Module: Patient Characteristics
- Fact Sheets (Patients by ZIP Code Table, Tables 3A, 3B, and 4)
- UDS Managed Care Reporting and Relationships across Tables 4 and 9D

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Tables 5, 6A, 6B, and 7

Understanding Services Provided and Their Outcomes

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Overview of Clinical Services and Clinical Quality Indicators

	Table 5	Table 6A	Table 6B	Table 7
Captures	**FTEs, visits, and patients** across seven service areas. Integrated mental health (MH) and substance use disorder (SUD).	Visits and patients who received **selected diagnoses and selected services** in the calendar year.	Fifteen **clinical quality measures**, each with a denominator, number of charts reviewed, and numerator.	Three **clinical quality outcome measures**, each reported by race and ethnicity of patients.
Purpose	Provides a profile of health center personnel, visits providers render, and the number of patients served in each of seven service areas and ancillary categories. The addendum illustrates what portion of care includes integrated behavioral health.	Provides a picture of the frequency and, when compared with other years, trends for selected diagnoses and services.	Measures selected health center processes that, through national standards, are correlated with quality of care for health center patients.	Measures selected outcomes for health center patients with certain characteristics or conditions as a proxy for quality of care, as established by national standards.

Remember, a countable visit on Table 5 is what makes someone a health center patient and therefore included in demographic tables and eligible for quality measures (based on specifications).

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Table 5: Staffing and Utilization

2023 Changes:

- Lines have been added to capture more detail on pharmacy personnel.

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Understanding the Four Columns

Table 5

Column A: Full-Time Equivalents (FTEs)

All personnel who support in-scope operations are reported by FTE in the area in which they provide services.

Columns B and B2: Clinic and Virtual Visits

Encounters that meet the definition of a UDS countable visit are reported as visits in Column B or B2 (based on how the visit was done), on the line with the FTE who conducted the visit.

Column C: Patients

All patients for whom visits are reported in the service area are counted in the patient count cell for that service area.

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Understanding the Service Categories

Table 5

FTEs, visits, and patients on Table 5 are reported across categories that reflect function and services provided.

- Medical Care Services (Lines 1–15)
- Dental Services (Lines 16–19)
- Mental Health Services (Lines 20a–20)
- Substance Use Disorder Services (Line 21)
- Other Professional Services (Line 22)
- Vision Services (Lines 22a–22d)
- Pharmacy Services (Lines 23a–23)
- Enabling Services (Lines 24–29)
- Other Programs and Related Services (Line 29a)
- Quality Improvement Personnel (Line 29b)
- Non-Clinical Support Services (Lines 30a–33)

- FTEs are reported in **each service category** for which your health center provided services.
- Service categories that can generate **countable visits and patients** on Table 5 are:
  - Medical
  - Dental
  - Mental Health
  - Substance Use Disorder
  - Other Professional
  - Vision
  - Enabling
- Patients can have visits in one or more service areas in the year.

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Patients and Visits by *Service* and *Provider Type*

Table 5

FTEs (Column A)	Visits (Columns B and B2)	Patients (Column C)	Key Reminders
All personnel who support in-scope operation are reported. Includes employees, interns, volunteers, residents, contracted personnel; NOT contractors paid fee-for-service (FFS). *Reported by credentials/ licensure **and** duties/function.* 1 FTE = 1 person full-time for entire year. "Full-time" is defined by the health center.	Clinic (in-person) and virtual visits that meet the definition are counted. Visits must be *on the same line* with the FTE of the provider who conducted the visit (e.g., rendering provider). If a visit is counted in either of these columns, the **patient MUST be reported in Column C *and* be included in the *unduplicated* patient count on all demographic tables.**	This is an unduplicated count of patients *by service category*. A patient may have visits in multiple service categories, such as having medical, dental, and vision visits in the year. Patients for whom that is true are *counted in each of those service categories in Column C.* As a result, the total number of patients reported across Column C is generally larger than the unduplicated patient count.	• Not all personnel generate visits. **See Appendix A in the UDS Manual.** • 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.

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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.
  - Personnel FTE can exceed 1.0 FTE, if paid overtime.

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

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New Lines for Reporting Pharmacy FTE

Table 5

- **Lines 23a–23d** have been added to capture more detailed data on pharmacy personnel:
  - **23a:** Pharmacists
  - **23b:** Clinical Pharmacists
  - **23c:** Pharmacy Technicians
  - **23d**: Other Pharmacy Personnel

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
22a	Ophthalmologists				
22b	Optometrists				
22c	Other Vision Care Personnel				
22d	**Total Vision Services** (Lines 22a–c)				
23a	Pharmacists				
23b	Clinical Pharmacists				
23c	Pharmacist Technicians				
23d	Other Pharmacy Personnel				
23	**Pharmacy Personnel** (Lines 23a-d)				

Note that pharmacy personnel are still *NOT providers on the UDS* and therefore *cannot* generate UDS countable visits.

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Reporting Personnel FTEs

Table 5

- Personnel are reported by position and service category.
- To determine where given personnel are 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.
- ONLY personnel reported on certain lines can generate visits—those lines are noted as Providers in Appendix A.

Keys to Remember

→ Appendix A in the 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. Contacts with non-providers are not countable visits.

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Example: Calculate FTE

Employees with full benefits*

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

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

Employees with no or reduced benefits*

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

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

*Benefits defined as vacation/holidays/sick benefits

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

We will discuss Table 8A later!

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A *patient* on the UDS is someone who has a *countable visit* in any service category on Table 5.

Remember, this definition and its relationship across tables is **central** to accurate reporting.

- Licensed or credentialed provider
- \+ Independent professional judgment
- \+ Services documented in the individual patient chart
- \+ Individualized care
- \+ Real-time in-person or virtual engagement
- = **Countable UDS Visit**

Resource: UDS Countable Visit Guidance and Frequently Asked Questions

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Counting Multiple Visits

On any given day, a patient may have only one visit per service category per provider counted on the UDS.

- Reminder: Service categories include Medical, Dental, Mental Health, Substance Use Disorder, Other Professional, Vision, and Enabling.

If multiple providers in a single service category (e.g., two medical providers) 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 at two different sites and may both be counted as visits, even when they occur on the same day.

Page 21 of the 2023 UDS Manual has additional information.

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Contacts That Do Not, *ALONE*, Count as Visits

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

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Examples: Are These Countable Visits on Table 5?

1. Charles sees 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.

2. 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.

3. A nurse practitioner (NP) sees a patient for a well visit. In the visit, the patient discloses alcohol and substance use disorder, so the NP does a warm handoff to a clinical social worker to get the patient started with SUD care.

4. A health center patient meets with a clinical pharmacist to review the patient's medication history and active prescriptions.

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Examples: Are These Countable Visits on Table 5?, cont.

1. Charles sees 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.**

2. 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.**

3. A nurse practitioner (NP) sees a patient for a well visit. In the visit, the patient discloses alcohol and substance use disorder, so the NP does a warm handoff to a clinical social worker to get the patient started with SUD care. **The warm handoff is NOT its own visit, but the medical visit is countable *and* is counted on the addendum for the integrated behavioral health care provided.**

4. A health center patient meets with a clinical pharmacist to review the patient's medication history and active prescriptions. **NOT a visit. Clinical pharmacists cannot generate countable visits on the UDS.**

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Reporting Visits

Table 5

- Visits must be provided at the health center site or at another approved location (or via telehealth).
- Count visits provided by paid, contracted, AND volunteer providers.
- 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 a location NOT listed on Form 5B as part of your health center scope of project or Form 5C: Other Activities/Locations.

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

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Location of Visits: Clinic or Virtual

Table 5, Columns B and B2

Clinic Visits (Column B)

Report *in-person contact* between a provider and a patients that meets all the requirements discussed earlier for countable visits.

Virtual Visits (Column B2)

Report documented *virtual (telemedicine) contact* between a patient and provider that meets 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.

Use codes that will result in the accurate identification of virtual visits, including CPT and HCPCS codes that include the appropriate modifiers and POS codes.

View the Virtual Visits guidance file.

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Are These Telehealth Services Countable Visits?

Remote Patient Monitoring

- Is for new and established patients
- Is used to monitor acute and chronic conditions
- Can be provided to a patient with one or more diagnoses

Example coding:

- CPT 99453—Device education and training (one-time fee)
- CPT 99454—Device/transmission reimbursement (monthly fee)
- CPT 99473—Self-measure blood pressure patient education

Not a countable visit!

Distant Site Audio-Only

Telephone evaluation and management (E&M) Service

- Is a provider visit
- Is an audio-only E&M service
- Is for new and established patients
- May be provided to a patient, parent, or guardian
- Is used for a patient visit when video technology is not available

Example coding:

- CPT 99441—5–10-minute medical discussion;
- CPT 99442—11–20-minute medical discussion

Can be a countable visit!

E-Visit

- Must be patient-initiated
- Is for established patients
- May occur over 7-day period
- Is conducted via patient portal, not face to face
- Is asynchronous (store-and-forward, not real time)

Example coding:

- CPT 99421—Cumulative time 5–10 minutes
- CPT 99422—Cumulative 11–20 minutes

Not a countable visit!

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Table 5:
Selected Service Detail Addendum

2023 Changes:
- No major changes.

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Addendum Captures *Integrated Behavioral Health*

Integrated Mental Health Services

Captures the number of **medical visits** that *included* **MH services** provided by medical providers.

Integrated Substance Use Disorder Services

Captures the number of **medical and MH visits** that *included* **SUD services** provided by medical and MH providers.

Remember, everything on the Addendum is part of what is already reported elsewhere on Table 5. This is behavioral health care integrated into certain types of visits.

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Determining Visits to Include in Addendum

Include, at minimum, all countable visits with specified providers that included the ICD-10-CM codes specified on Table 6A:
- SUD: Table 6A, Lines 18–19a
- MH: Table 6A, Lines 20a–20d

Then, you will report the **number of providers of each type** listed on the addendum that provided those visits and the number of **patients who made up those visits**.

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
	Selected Mental Health Conditions, Substance Use Disorders, and Exploitations			
18	Alcohol-related disorders	F10-, G62.1, O99.31-		
19	Other substance-related disorders (excluding tobacco use disorders)	F11- through F19- (exclude F17-), G62.0, O99.32-		
19a	Tobacco use disorder	F17-, O99.33-, Z72.0		
20a	Depression and other mood disorders	F30- through F39-		
20b	Anxiety disorders, including post-traumatic stress disorder (PTSD)	F06.4, F40- through F42-, F43.0, F43.1-, F93.0		
20c	Attention deficit and disruptive behavior disorders	F90- through F91-		
20d	Other mental disorders, excluding drug or alcohol dependence	F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0- and F43.1-), F50- through F99- (exclude F55-, F64-, F84.2, F90-, F91-, F93.0, F98-), O99.34-, R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0		

Excerpt of Table 6A

Visits reported on Lines 18–19a that were with **medical** or **mental health** providers are reported on SUD detail section of the Table 5 addendum.

Visits reported on Lines 20a–20d that were with **medical providers** are reported on MH detail section of the Table 5 addendum.

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Reporting Personnel in Addendum

In Column A1, report the ***number*** of providers in each section who provided integrated services.

- **Medical** providers can be counted once in each section if they provide both **MH *and* SUD services**.
- **MH** providers can only be counted once in the addendum, in the SUD section.

Keys to Remember:

- The *number of personnel* on the addendum is *unlikely* to equal the FTE reported in the corresponding line on the main part of Table 5.
  - Look at the number of personnel per FTE for reasonableness.
    - For example, if there are 11.5 physician FTEs on the main part of Table 5 and 119 physician personnel in the MH section of the addendum, then the average FTE per physician is *less than 0.1*.

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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Addendum: Reporting MH/SUD Services Provided as Part of Medical Visits

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

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				

Medical FTEs, visits, and patients are reported in the medical section of the main part of Table 5 (shown above left). Those same providers, visits, and patients ***may also*** be reported on the MH/SUD addendum ***if/when*** MH and/or SUD services were provided during those medical visits (shown above right).

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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*** they also included SUD services.

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

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

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

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Example: Integrated MH in a Medical Visit

A family physician sees a patient in person. The patient has a diagnosis of depression, and the physician manages the patient's depression medication during the medical visit.

This visit is counted twice across the two sections in Table 5: *once* in the medical section of the main part of Table 5 and *once* in the MH portion of the addendum.

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

In no case is a visit to be reported twice on the main part of Table 5. The visit and patient need to also be reported on the relevant lines in Table 6A.

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Example: Integrated MH and SUD in a Medical Visit

An NP sees a patient for a routine visit and during that visit addresses the patient's anxiety diagnosis and tobacco use disorder.

This visit is counted three times across the two sections in Table 5: *once* in the medical section of the main part of Table 5, *once* in the MH portion of the addendum, and *once* in the SUD portion of the addendum.

- **Table 5, Staffing and Utilization:** The NP FTE is reported in Line 9a, Column A of the main part of Table 5. The visit is reported on Line 9a, Column B, and the patient is included in Line 15, Column C.
- **Table 5, Selected Service Detail Addendum:** Due to the integrated MH and SUD treatment, the provider, patient, and visit are reported on both the NP line of the MH portion of the addendum and the NP line of the SUD portion of the addendum.

In no case is a visit to be reported twice on the main part of Table 5. The visit and patient need to also be reported on the relevant lines in Table 6A.

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Example: Integrated SUD in MH Visit

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

This visit is counted twice across the two sections in Table 5: *once* in the MH section of the main part of Table 5 and *once* in the SUD portion of the addendum.

- **Table 5, Staffing and Utilization:** Report the depression treatment services visit and clinical psychologist FTE on Line 20a1, and report 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, and patient) on Line 21f. The visit would be in Column B2, because it's a virtual visit.

In no case is a visit to be reported twice on the main part of Table 5. The visit and patient need to also be reported on the relevant lines in Table 6A.

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Find Resources to Help: Staffing and Utilization

HRSA's BPHC UDS Resources site Staffing and Utilization section includes the following resources:

- Table 5 Fact Sheet
- Countable Visit Guidance
- Countable Visit Decision Tree
- Virtual Visit Guidance
- Nurse Visit Guidance
- Selected Service Detail Addendum Guidance

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Table 6A: Selected Diagnoses and Services Rendered

2023 Changes:

- One line added for Childhood Development Screening.
- Value sets have been added, where applicable.
- Codes have been updated on a number of lines, as part of annual update.

In addition to submitting this table within the EHBs, health centers may voluntarily submit de-identified patient-level report data using HL7® FHIR® R4 standards. Visit the UDS Modernization FAQ for more on that process.

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Table 6A

Captures selected diagnoses and services provided to health center patients (those reported on patient demographic tables), not to the general public.

Report all visits and patients meeting the specified criteria (diagnosis or service, and codes).

- **Diagnoses** are reported where the indicated diagnosis is listed as part of a countable visit.
  - Diagnoses are Lines 1 through 20f.
- **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.*
  - Services and procedures are Lines 21 through 34.

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Selected Diagnoses and Services

Table 6A

Line	Diagnostic Category	Applicable ICD-10-CM Code or Value Set Object Identifier (OID)	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
	Selected Infectious and Parasitic Diseases			
1-2	Symptomatic/Asymptomatic human immunodeficiency virus (HIV)	B20, B97.35, O98.7-, Z21 **OID:** 2.16.840.1.113883.3.464.1003.120.12.1003		
3	Tuberculosis	A15- through A19-, O98.0-, Z86.15, Z22.7 **OID:** 2.16.840.1.113762.1.4.1151.56 (O98.0- is not in value set)		
4	Sexually transmitted infections (gonococcal infections and venereal diseases)	A50- through A64-, Z22.4 **OID:** 2.16.840.1.113883.3.464.1003.112.11.1003		
4a	Hepatitis B	B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.1-, O98.4- **OID:** 2.16.840.1.113883.3.464.1003.110.12.1025 (B19.1- and O98.4- are not in value set)		
4b	Hepatitis C	B17.1-, B18.2, B19.2- **OID:** 2.16.840.1.113762.1.4.1222.30		
4c	Novel coronavirus (SARS-CoV-2) disease	U07.1 **OID:** 2.16.840.1.113762.1.4.1248.139, 2.16.840.1.113762.1.4.1200.151		
4d	Post COVID-19 condition	U09.9 **OID:** 2.16.840.1.113762.1.4.1222.1391		

- **Column A:** Report the number of *visits* with the selected diagnosis or service.
  - 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 (i.e., that would be on the same line) at one visit.
- **Column B:** Report the number of unduplicated patients with the selected diagnosis or service.

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PrEP Management Reporting on Table 6A

Pre-exposure prophylaxis (PrEP) management visits and patients are reported on Table 6A, Line 21e.

- New code available toward the end of 2023: Z29.81, Encounter for HIV pre-exposure prophylaxis.

In addition to using the codes listed on Table 6A to help identify relevant visits, health centers may consider the following to ensure that only PrEP for HIV prevention is included:

- No HIV diagnosis in problem list.
- Prescription instructions should not mention oPEP (occupational), nPEP (non-occupational), or post-exposure prophylaxis.
- Related summary should only mention nPEP if PrEP is also mentioned, indicating transition from nPEP to PrEP.
- Prescription instructions likely mention it is for PrEP.
- No concurrent antiretroviral medication (ART).

Validating PrEP Reporting

In reviewing PrEP management visits and patients on Table 6A, compare to related information to determine if numbers are reasonable:

- Unlikely to have more PrEP management patients than HIV tests, as an HIV test (Line 21) is needed to start PrEP (Line 21e).
- Review PrEP prescriptions in your state on the AHEAD dashboards, as any single health center is unlikely to have more PrEP visits/patients than the state as a whole.

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Table 6A: Updated Codes

Selected Diagnoses and Services Rendered

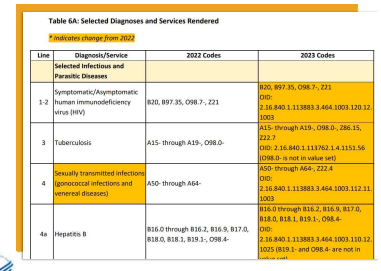

Table 6A: Selected Diagnoses and Services Rendered

** Indicates change from 2022*

Line	Diagnosis/Service	2022 Codes	2023 Codes
	Selected Infectious and Parasitic Diseases		
1-2	Symptomatic/Asymptomatic human immunodeficiency virus (HIV)	B20, B97.35, O98.7-, Z21	B20, B97.35, O98.7-, Z21 OID: 2.16.840.1.113883.3.464.1003.120.12.1003
3	Tuberculosis	A15- through A19-, O98.0-	A15- through A19-, O98.0-, Z86.15, Z22.7 OID: 2.16.840.1.113762.1.4.1151.56 (O98.0- is not in value set)
4	Sexually transmitted infections (gonococcal infections and venereal diseases)	A50- through A64-	A50- through A64-, Z22.4 OID: 2.16.840.1.113883.3.464.1003.112.11.1003
4a	Hepatitis B	B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.1-, O98.4-	B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.1-, O98.4- OID: 2.16.840.1.113883.3.464.1003.110.12.1025 (B19.1- and O98.4- are not in

- Applicable ICD-10-CM, CPT4/I/II/PLA, and HCPCS codes are updated for 2023.
- 2023 Table 6A code changes are available for download (shown in screenshot to the left).
  - **Value sets have been added where they apply.**
  - Other codes have been updated where appropriate.
- Specifications and codes are up to date as of April 2023.

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Key Notes for Table 6A

Column A describes the total number of visits at which the service/test/diagnosis was present and coded to the patients in Column B.

Only report tests or procedures that are:

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

Remember that all reporting on Table 6A is limited to health center patients.

- Patients must have a *countable* visit on Table 5 and be included in unduplicated patients on patient demographic tables in order to be counted on Table 6A.
- Mass testing/screening, tests done for the community, etc. are not counted on Table 6A, unless for a health center patient and documented in that health center patient's record.

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

2023 Changes:

- Measure denominator eligibility now defined by electronic-specified clinical quality measure (eCQM) qualifying visit specifications.
- Measures aligned with updated eCQMs, wherever available.
  - Age "as of" for several CQMs has been revised to align with Clinical Quality Language (CQL) criteria.
  - In alignment with those updated eCQMs, several existing measures have major modifications.
- Sub-categories for race and ethnicity added to Table 7, in alignment with Table 3B.

In addition to submitting this table within the EHBs, health centers may voluntarily submit de-identified patient-level report data using HL7® FHIR® R4 standards. Visit the UDS Modernization FAQ for more on that process.

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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/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		

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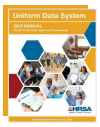
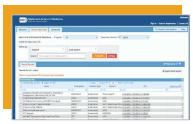
CQM Specifications



The UDS Manual provides an overview of the UDS, covers UDS-specific considerations, and links to measure specifications.

The manual links to the eCQI Resource Center, where measure information, specifications, data elements, and value sets are found.



The codes that make up each value set are available from the Value Set Authority Center (VSAC) site.

Remember, HRSA is not the measure steward and therefore does not design specific measures. Measures are nationally defined.

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Components of Each Clinical Measure

Denominator	Numerator	Exclusions and Exceptions
• Identifies the group of patients that the measure looks at for whether they have received the service, test, or outcome. • Equal to the initial population identified in the CQM. • Reported in Column A.	• Measures whether the service, event, or outcome requirements were met. • Each patient in the denominator is assessed to determine if they meet the numerator. • Reported in Column C.	• **EXCLUSIONS:** Patients who meet exclusion criteria are not to be considered for the measure. They are removed from the denominator before determining if numerator criteria are met. • **EXCEPTIONS:** Patients who do meet denominator criteria but do not meet numerator criteria and meet any of the exceptions criteria are removed from the denominator.

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2023 CQM Tables

Tables 6B and 7

Updates

- There are several updates to how data can be collected and reported.
- There are similarly several clarifications for specific measures and requirements.
- There are updates on the impact of telehealth on CQM reporting.

Changes

- Seven eCQMs have changes to their specifications.
- Table 7 now has additional race and ethnicity categories.

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Measures Updated to Align with eCQMs

Tables 6B and 7 were updated to align with the latest Centers for Medicare & Medicaid Services (CMS) eCQMs. Review Clinical Quality Measures handout for 2023 updates.

Table	Line/Columns	Quality Care Measure	Updated eCQM
6B	10	Childhood Immunization Status	CMS117v11
6B	11	Cervical Cancer Screening	CMS124v11
6B	11a	Breast Cancer Screening	CMS125v11
6B	12	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	CMS155v11
6B	13	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	CMS69v11
6B	14a	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS138v11
6B	17a	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS347v6
6B	19	Colorectal Cancer Screening	CMS130v11
6B	20a	HIV Screening	CMS349v5
6B	21	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	CMS2v12
6B	21a	Depression Remission at Twelve Months	CMS159v11
7	2a–2c	Controlling High Blood Pressure	CMS165v11
7	3a–3f	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	CMS122v11

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Birthdate Updates to Tables 6B and 7 Measures

- Age "as of" for several CQMs have been updated to reflect age as of the end of the measurement period (instead of beginning), in alignment with CQL:
  - Cervical Cancer Screening *(Table 6B)*
  - Breast Cancer Screening *(Table 6B)*
  - Colorectal Cancer Screening *(Table 6B)*
  - Controlling High Blood Pressure *(Table 7)*
  - Diabetes: Hemoglobin A1c (HbA1c) Poor Control *(Table 7)*
- For these measures, a patient must be the age specified as of Dec. 31.
- For these and all measures, it's critically important to refer to the birthdates listed in the manual and/or the CQL in the specifications for the eCQM, rather than trying to interpret from the name or description of the measure.

EXAMPLE:

Cervical Cancer Screening (CMS124v11)

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

- Women age 21–64 who had cervical cytology performed within the last 3 years
- Women age 30–64 who had cervical human papillomavirus (HPV) testing performed within the last 5 years

Initial population assessed: Women 24–64 years of age by the end of the measurement period with a visit during the measurement period (*meaning, aged 24 as of Dec. 31 of the year*).

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Modification to Tables 6B and 7 Reporting

UDS-Specific Medical Visit Requirement Removed

Patients **with qualifying encounters, as defined by the measure steward and associated value sets for each selected measure**, are to be considered for the denominator:

2022 UDS Guidance	NEW 2023 UDS Guidance
Include and evaluate patients for the denominator who had **at least one medical visit** during the measurement period as specified in the measure (dental visits are used for the dental sealant measure), even though some eCQMs may specify a broader range of service codes.	Include and evaluate patients for the denominator who had **at least one eligible countable visit (as defined by the measure steward for the selected eCQM)** during the measurement period as specified in the measure.

Now, to be eligible for clinical measure denominator reporting on the UDS:

- The person must be a health center patient on the UDS (meaning, included in the demographic tables, have a countable visit *anywhere on Table 5*) **AND**
- Have a visit (or visits) that meet the individual eCQM's specified qualifying encounters.

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Did the patient have a countable UDS visit during the year?

No

Patient is not eligible to be reported anywhere on the UDS, including the CQMs on Tables 6B and 7.

Yes

Access eCQM specifications for an individual measure.

Review denominator criteria to determine visit types eligible for inclusion.

Download the associated codes from the VSAC.

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CQM Eligibility Is Now Defined by eCQM Specifications.

In the specifications for **each measure**, the initial population and denominator are defined, and the qualifying visits for that measure are defined therein. Remember, these specifications are defined by the measure steward, not by HRSA.

Qualifying visits for each measure are defined by value sets.

As a reminder, a value set is a list of specific values, terms, and their codes, used to describe clinical and administrative concepts in quality measures. These include CPT, ICD-10, SNOMED, LOINC, and RxNorm.

For example, the value set Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001) is used as part of qualifying visit definition for many measures:

CMS117v11 - Childhood Immunization Status
CMS122v11 - Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)
CMS124v11 - Cervical Cancer Screening
CMS125v11 - Breast Cancer Screening
CMS130v11 - Colorectal Cancer Screening
CMS138v11 - Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
CMS155v11 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
CMS165v11 - Controlling High Blood Pressure
CMS347v6 - Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
CMS349v5 - HIV Screening

Other value sets are also specified in the qualifying encounters for each measure. It's not just this one, and it's not the same for all measures!

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Eligible Visits for CQMs

- Accessing and Reading Electronic Clinical Quality Measures (eCQMs) for UDS
- Accessing Value Set Codes for Clinical Quality Measures
- Clinical Quality Measures Criteria

Does this mean that *all* patients with countable visits are now included in the denominator for CQMs?

No! It means that those patients who meet the measure specifications are included in each measure's denominator. Each measure steward identifies the population or denominator for the measures that they develop.

Does this mean we need to be doing pap tests or colorectal cancer screenings for our dental patients or case management patients?

Dental visit types are not specified in the denominator for cervical cancer screening or colorectal cancer screening measures. If the patient had other visits, they could be eligible. Again, the visit types/codes are specified for each measure and can be seen in the measure specifications in the eCQI Resource Center.

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Table 6B: Change to Existing Measure

BMI Screening and Follow-Up Plan (CMS69v11)

- The Body Mass Index (BMI) Screening and Follow-Up Plan measure numerator changed:
  - From 12-month requirement for the documented BMI to a requirement during the measurement period.
  - To allow for follow-up plan to be documented **during the measurement period**, rather than on or after the most recent documented BMI.

2022 Numerator	**2023 Numerator**
Patients with a documented BMI **during the most recent visit or during the 12 months preceding that visit**, and when the BMI is outside of normal parameters, a **follow-up plan is documented on or after the most recent documented BMI**	Patients with a documented BMI **during the most recent visit or during the measurement period**, and when the BMI is outside of normal parameters, a **follow-up plan is documented during the measurement period**

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Table 6B: Change to Existing Measure

Tobacco Use: Screening and Cessation Intervention (CMS138v11)

- The Tobacco Screening measure numerator changed to allow for tobacco cessation intervention during the measurement period or in the 6 months prior to the measurement period if the patient is identified as a tobacco user.
- Use of e-cigarettes and other electronic nicotine delivery systems is now considered to be tobacco use.
- Hospice care has been added as a denominator exclusion.
- Denominator exceptions (i.e., documented medical reasons for not screening or providing cessation intervention) have been removed.

2022 Measure	**2023 Measure**
Percentage of patients aged 18 years and older who were screened for tobacco use one or more times during the measurement period and **who received tobacco cessation intervention if identified as a tobacco user**	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times during the measurement period and **who received tobacco cessation intervention during the measurement period or in the 6 months prior to the measurement period if identified as a tobacco user**

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Table 6B: Change to Existing Measure

Colorectal Cancer Screening (CMS130v11)

- The Colorectal Cancer Screening measure changed the denominator age from 50–75 to 45–75.

2022 Measure	2023 Measure
Percentage of adults **50–75 years of age** who had appropriate screening for colorectal cancer	Percentage of adults **45*–75 years of age** who had appropriate screening for colorectal cancer

*Use 46 on or after December 31 as the initial age to include in assessment.

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Table 6B: Change to Existing Measure

Screening for Depression and Follow-Up Plan (CMS2v12)

- The Depression Screening measure changed from follow-up, if needed, on the date of the visit to follow-up on the date of or up to 2 days after the date of the visit.
- The denominator exclusion for patients diagnosed with depression or bipolar disorder has been updated to include diagnosis of depression or bipolar disorder *at any time prior to the qualifying visit, regardless of whether the diagnosis is active or not.*

2022 Measure	2023 Measure
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 screening was positive, had a follow-up plan documented **on the date of the visit**	Percentage of patients aged 12 years and older screened for depression on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized depression screening tool and, if screening was positive, a follow-up plan is documented **on the date of or up to 2 days after the date of the qualifying visit**

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Table 6B: Change to Existing Measure

Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (CMS347v6)

2022 Denominator	2023 Denominator
• All patients **who were previously diagnosed with or currently have an active diagnosis of ASCVD**, including an ASCVD procedure, or	• All patients **with an active diagnosis of ASCVD**, or who ever had an ASCVD procedure, or
• Patients 20 years of age or older who have ever had a low-density lipoprotein cholesterol (LDL-C) laboratory result level greater than or equal to 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia, or	• Patients 20 years of age or older who have ever had a low-density lipoprotein cholesterol (LDL-C) laboratory result level greater than or equal to 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia, or
• Patients 40 through 75 years of age with a diagnosis of diabetes	• Patients 40 through 75 years of age with a diagnosis of diabetes

- The Statin Therapy measure denominator changed from current *or prior* diagnosis of atherosclerotic cardiovascular disease (ASCVD) to now requiring *active* diagnosis of ASCVD.
- Patients with a telephone-only visit during the year are excluded from the denominator.
- Patients with diagnosis of pregnancy are no longer excluded from the denominator.
- Added the following denominator exception:
  - Patients with a documented medical reason for not being prescribed statin therapy.

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Table 6B: Change to Existing Measure

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (CMS155v11)

- The final age to include in assessment for the Weight Assessment and Counseling measure has been changed from 16 to 17.

2022 Denominator	2023 Denominator
• **Patients 3 through 16 years of age** with at least one outpatient medical visit during the measurement period	• **Patients 3 through 17 years of age** with at least one outpatient medical visit by the end of the measurement period, as specified in the measure criteria

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Table 7: Change to Existing Measure

Controlling High Blood Pressure (CMS165v11)

The following denominator **exclusion** has been added to the hypertension measure:

- Patients 81 and older by the end of the measurement period with an indication of frailty for any part of the measurement period.

2023 Measure
• Percentage of patients 18–85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first 6 months of the measurement period, and whose most recent blood pressure (BP) was adequately controlled (less than 140/90 mmHg) during measurement period

Remember, frailty is defined by data elements and value sets in the measure specifications. For example:

- Diagnosis: Frailty Diagnosis value set (2.16.840.1.113883.3.464.1003.113.12.1074)
- Encounter, Performed: Frailty Encounter value set (2.16.840.1.113883.3.464.1003.101.12.1088)
- Symptom: Frailty Symptom value set (2.16.840.1.113883.3.464.1003.113.12.1075)

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Table 7: Clarification to Existing Measure

Controlling High Blood Pressure (CMS165v11)

In recent years, there have been many questions about what can be used for remote blood pressure and how it needs to be conveyed.

The following clarification has been provided:

- The measure **allows** patient-reported data using most methods of digital collection/reporting and **prohibits** patient-reported data taken with non-digital devices, such as with a manual blood pressure cuff and stethoscope.
- Valid readings may be transmitted directly by the device to the clinician, conveyed to the clinician by the patient, or read from the device by the clinician during an in-person/virtual encounter.
- There is not a list of valid remote monitoring devices for this measure.
- It would be up to the clinician to determine that the reading came from a digital device before documenting it.

The following are related questions and answers in ONC's JIRA eCQM Issue Tracker:

- https://oncprojectracking.healthit.gov/support/browse/CQM-5309
- https://oncprojectracking.healthit.gov/support/browse/CQM-4787
- https://oncprojectracking.healthit.gov/support/browse/CQM-5435
- https://oncprojectracking.healthit.gov/support/browse/CQM-5053
- https://oncprojectracking.healthit.gov/support/browse/CQM-5322

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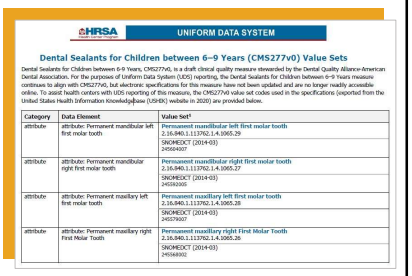
Table 6B: Dental Sealants

- Dental Sealants (CMS277v0) electronic specifications have not been updated and are no longer readily accessible from the eCQI Resource Center or VSAC.
- Find the value sets used in the specifications on the BPHC UDS Resources Clinical Care page.



HRSA UNIFORM DATA SYSTEM

Dental Sealants for Children between 6–9 Years (CMS277v0) Value Sets

Dental Sealants for Children between 6-9 Years, CMS277v0, is a draft clinical quality measure stewarded by the Dental Quality Alliance-American Dental Association. For the purposes of Uniform Data System (UDS) reporting, the Dental Sealants for Children between 6–9 Years measure continues to align with CMS277v0, but electronic specifications for this measure have not been updated and are no longer readily accessible online. To assist health centers with UDS reporting of this measure, the CMS277v0 value set codes used in the specifications (exported from the United States Health Information Knowledgebase (USHIK) website in 2020) are provided below.

Category	Data Element	Value Set[1]
attribute	attribute: Permanent mandibular left first molar tooth	Permanent mandibular left first molar tooth 2.16.840.1.113762.1.4.1065.29 SNOMEDCT (2014-03) 245664007
attribute	attribute: Permanent mandibular right first molar tooth	Permanent mandibular right first molar tooth 2.16.840.1.113762.1.4.1065.27 SNOMEDCT (2014-03) 245592005
attribute	attribute: Permanent maxillary left first molar tooth	Permanent maxillary left first molar tooth 2.16.840.1.113762.1.4.1065.28 SNOMEDCT (2014-03) 245579007
attribute	attribute: Permanent maxillary right First Molar Tooth	Permanent maxillary right First Molar Tooth 2.16.840.1.113762.1.4.1065.26 SNOMEDCT (2014-03) 245568902

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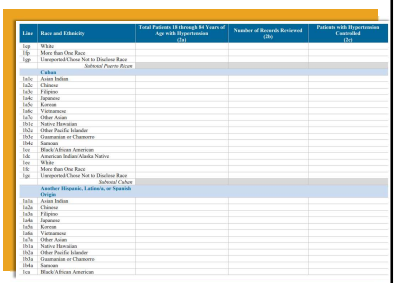
Table 7: Additional Race and Ethnicity Sub-Categories

Race/ethnicity categories here on Table 7 have been updated to align with Table 3B.

- Guidance for where to report patients by race/ethnicity is the same as Table 3B. Consistency is key!

All three measures on Table 7 are now reported with more granular race and ethnicity categories:

- Birth Outcomes
- Controlling High Blood Pressure
- Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)



Line	Race and Ethnicity	Total Patients 18 through 84 Years of Age with Hypertension (3a)	Number of Records Reviewed (3b)	Patients with Hypertension Controlled (3c)
1up	White			
1bp	More than One Race			
1gp	Unreported/Chose Not to Disclose Race			
	Subtotal Puerto Rican			
	Cuban			
1a1c	Asian Indian			
1a2c	Chinese			
1a3c	Filipino			
1a4c	Japanese			
1a5c	Korean			
1a6c	Vietnamese			
1a7c	Other Asian			
1b1c	Native Hawaiian			
1b2c	Other Pacific Islander			
1b3c	Guamanian or Chamorro			
1b4c	Samoan			
1cc	Black/African American			
1dc	American Indian/Alaska Native			
1ec	White			
1fc	More than One Race			
1gc	Unreported/Chose Not to Disclose Race			
	Subtotal Cuban			
	Another Hispanic, Latino/a, or Spanish Origin			
1a1a	Asian Indian			
1a2a	Chinese			
1a3a	Filipino			
1a4a	Japanese			
1a5a	Korean			
1a6a	Vietnamese			
1a7a	Other Asian			
1b1a	Native Hawaiian			
1b2a	Other Pacific Islander			
1b3a	Guamanian or Chamorro			
1b4a	Samoan			
1ca	Black/African American			

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Sampling Not an Option for CQMs

- Health centers may NOT use chart sampling for reporting CQMs.
- Column B must equal Column A OR be 80% or more of Column A.
  - You'll report all patients who fit the criteria (same as Column A), or a number equal to or greater than 80% of Column A.

If your health center does not have an EHR in use, contact the UDS Support Center to discuss options for reporting.

Line	Example: Childhood Immunization Status	Total Patients with 2nd Birthday (a)	Number of Records Reviewed (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	250	139

Line	Example: Childhood Immunization Status	Total Patients with 2nd Birthday (a)	Number of Records Reviewed (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

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CQMs Resources

- BPHC UDS Clinical Care Reporting Resources
  - Fact Sheets: Tables 6A, 6B, and 7
  - Table 6A Code Changes Handout
  - Clinical Measures Exclusions and Exceptions
  - Helpful Codes for HIV and PrEP
  - Clinical Quality Measures Criteria
  - Dental Sealants Value Sets
  - Telehealth Impact on Clinical Measure Reporting
  - Self-Paced Learning Module: Clinical Services and Performance
- eCQI Resource Center: Eligible Professional/Eligible Clinician eCQMs
- Health Information Technology, Evaluation, and Quality (HITEQ) Center
  - A HRSA-funded National Training and Technical Assistance Partner (NTTAP)
- Office of the National Coordinator for Health Information Technology (ONC) Issue Tracking System (OITS) JIRA project eCQM Issue Tracker
  - Sign up for an OITS account.
  - Post questions in the eCQM Issue Tracker.

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

2023 Changes:
- No major changes.

In addition to submitting this table within the EHBs, health centers may voluntarily submit de-identified patient-level report data using HL7® FHIR® R4 standards. Visit the UDS Modernization FAQ for more on that process.

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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 the **Delivery and Birth Outcomes section of Table 7**.

- Portions beginning on pages 93 and 126 of the 2023 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 a provider/entity with which the health center has *formal referral **contractual** agreements* (as indicated in Column II of Form 5A) *OR*
- Prenatal care initiated with a provider/entity with which the health center has *formal written **referral** arrangements* (as indicated in Column III of Form 5A).

Prenatal care and related delivery and birth weight outcomes are reported on the UDS regardless of how or by whom the care was provided, therefore *tracking systems must be in place for all that apply.*

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Maternal Care: Prenatal and Birth Outcome Measures

Table 6B Prenatal Care Patients	Table 7: Deliveries	Table 7: Birth Outcomes
• Report ALL prenatal care patients who received prenatal care services (either from the health center directly or by referral from the health center) during the calendar year. • Report prenatal patients **by age as of Dec. 31** and **by trimester of entry**.	• Report all **prenatal care patients who delivered** during the calendar year by **race and ethnicity of the patient delivering**. • Include stillbirths and multiple births, each as one delivery. • Miscarriages are not considered deliveries.	• Report **babies** according to their birth weight in grams by **race and ethnicity of baby**. • If multiple births, report each baby separately by birth weight as well as race and ethnicity. • If stillbirth, do not report the baby in the birth outcome section.

The numbers in these three sections will NOT equal each other.

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Prenatal Patients by Age and Entry into Prenatal Care

Table 6B

- **Line 0:** Mark the check box if your health center provides prenatal care through direct *referral only*.
- Lines 1–6: Report all prenatal care patients by their age *as of Dec. 31*.
- Lines 7–9: Report all prenatal care patients by the 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 into your health center's care.

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

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

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

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

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Deliveries and Birth Outcomes

Table 7

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

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: <1500 grams (1b)	Live Births: 1500–2499 grams (1c)	Live Births: ≥2500 grams (1d)
	Mexican, Mexican American, Chicano/a				
1a1m	Asian Indian				
1a2m	Chinese				
1a3m	Filipino				
1a4m	Japanese				
1a5m	Korean				
1a6m	Vietnamese				
1a7m	Other Asian				
1b1m	Native Hawaiian				
1b2m	Other Pacific Islander				
1b3m	Guamanian or Chamorro				
1b4m	Samoan				
1cm	Black/African American				
1dm	American Indian/Alaska Native				
1em	White				
1fm	More than One Race				
1gm	Unreported/Chose Not to Disclose Race				
	Subtotal Mexican, Mexican American, Chicano/a				

Excerpt of Table 7

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Deliveries and Birth Outcomes

Table 7, Lines 0 and 2

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.

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How Are These Scenarios Reported in Prenatal, Delivery, and Birth Weight Sections?

The health center provides prenatal care for and transfers some patients (depending on patient preference or medical need). Some of these babies become our patients.

- Is the health center obligated to find out the delivery and birth weight data for patients who transfer out and are not delivered by us?
- If yes, for all babies, or just the ones that come to the health center for pediatric care?

If the health center does delivery only for prenatal patients of other CHCs (e.g., depending on the labor and delivery [L&D] call schedule), does the health center report those deliveries and birth weights?

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Responses - How Are These Scenarios Reported in Prenatal, Delivery, and Birth Weight Sections?

The health center provides prenatal care for and transfers some patients (depending on patient preference or medical need). Some of these babies become our patients.

- Is the health center obligated to find out the delivery and birth weight data for patients who transfer out and are not delivered by us?
- If yes, for all babies, or just the ones that come to the health center for pediatric care?

Yes, the health center is expected to find out delivery and birth weight and report it for all prenatal patients, including those who transfer care.

It does not matter whether the babies come to the health center for pediatric care; all babies delivered to prenatal patients are reported by their birth weight on Table 7.

Report prenatal care patient (Table 6B), delivery (Table 7), and birth weight (Table 7) if a delivery has occurred.

If the health center does delivery only for prenatal patients of other CHCs (e.g., depending on the L&D call schedule), does the health center report those deliveries and birth weights?

Delivery is considered a visit, *if the delivery occurred within the health center's scope of project.*

- If a person is first encountered at a location NOT listed on Form 5B as part of your health center scope of project, or Form 5C: Other Locations and Activities, then it's not a countable visit. If the hospital is not part of the health center's scope, then this single contact isn't a countable visit, therefore the person doesn't become a patient.
- If the delivery is a visit, report the patient as a prenatal care patient, and report the delivery and birth weight on Table 7.

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Find Resources to Help: Clinical Care

HRSA's BPHC UDS Resources site Clinical Care section includes the following resources:

- Tables 6B and 7: Prenatal Care Fact Sheet
- UDS Clinical Quality Measures (CQM) Criteria
- UDS Clinical Measures Exclusions and Exceptions
- Telehealth Impact on UDS Clinical Measure Reporting

And much more!

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Tables 8A, 9D, and 9E

Understanding Costs and Revenues for Health Center Scope

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Overview of Financial Tables

	Table 8A	Table 9D	Table 9E
Captures	**Costs**, both direct and overhead, incurred in the year for the health center scope of project.	Patient-related **charges and adjustments** from the calendar year; patient-related revenue received in the year.	**Other revenue** (non-patient-service generated) by the entity from which the revenue was received in the year.
Purpose	Describes how the health center's resources are expended both overall and by service area.	Provides a picture of health center patient service revenue by payer and type of payment. Combined with Table 9E, it provides information on how health center costs are covered.	Provides an overview of grant and other funding by source, which, along with Table 9D, illustrates how health center operations are funded.

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Table 8A: Financial Costs

2023 Changes:
- No major changes.

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Financial Costs

Table 8A Columns

Financial costs are reported across **3 columns**, in Columns A–C, and **11 cost centers**, captured in Lines 1–15.

Cost Center (Lines 1–15)	Accrued Cost (Column A)	Allocation of Facility and Non-Clinical Support Services (Column B)	Total Cost After Allocation of Facility and Non-Clinical Support Services (Column C)

• Medical
• Dental
• Mental Health
• Substance Use Disorder
• Pharmacy and Pharmaceuticals
• Other Professional
• Vision
• Enabling
• Other Program-Related Services
• Non-Clinical Support (Admin)
• Facility
	• Report **accrued** direct costs
	• Include costs of:
	  ▪ Personnel (both staff and contracted)
	  ▪ Fringe benefits
	  ▪ Supplies
	  ▪ Equipment
	  ▪ Depreciation
	  ▪ Related travel
	• Do not include bad debt costs
		• Allocate Facility and Non-Clinical Support Services costs to all other cost centers (Lines) as overhead
		• Must equal Line 16, Column A, representing overhead costs incurred by all cost centers
			• Sum of Columns A + B (calculated automatically in EHBs)
			• Represents cost to operate service by cost center
			• Used to calculate cost per visit and cost per patient

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Tables 5 and 8A Crosswalk

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

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

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

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

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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 health IT/EHR, supplies, CMEs, and travel
- **Lines 8a–8b:** Separate drug (8b) from other pharmacy costs (8a)
- **Lines 5–13 (excluding 8a–8b):** Direct expenses including personnel (employed and contracted), benefits, contracted services, supplies, and equipment
  - **Line 12:** Other Program-Related Services includes space within health center rented out, WIC, retail pharmacy to non-patients, etc.
  - **Line 12a:** Personnel who support use of EHR and QI

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

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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 the clinic's in-house 340B manager or contract manager, are to be allocated to Line 8a, Pharmacy, in Column B.
- Report **pharmacy assistance program** on Line 11e, in the Enabling section, not in Pharmacy!
- **Donated drugs** are reported on Line 18, Donated Facilities, Services, and Supplies; value at 340B prices.

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Column A, Lines 14–16

Table 8A

- **Line 14:** Facility-related expenses, including direct 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)			

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Allocating Overhead Expenses to Column B

Three-Step Method

Step 1 — Allocate Facility (Line 14)
- Identify square footage used by each cost center and cost per square foot.
- Distribute square footage costs to each cost center across Column B.

Step 2 — Allocate Non-Clinical Support Services (Line 15)
- Distribute non-clinical support costs to the applicable service area/cost center.
  - Include decentralized front desk personnel, billing and collection systems and personnel, etc.
  - Consider lower allocation of overhead to contracted services.

Step 3 — Allocate Remaining Overhead Costs Using Straight-Line Method
- Straight-line method means allocating non-clinical support costs based on the proportion of net costs for 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 accurately portrays the use of facility and non-clinical support services and distribution of costs.

New resource: UDS Overhead Cost Allocation Methods

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Reporting Donations

Tables 8A and 9E

Donated Facilities, Services, and Supplies	Cash Donations
• Donations of vaccines, pharmaceuticals, tests, etc. • Volunteer time or in-kind services • Health center space that is provided at no cost; donated facilities	• Cash received from fundraising • Direct monetary donations • Revenue from fundraising programs such as Amazon Smile
Reported on Line 18, Column C of Table 8A	**Reported on Line 10 of Table 9E**

Resource: Reporting Donations on the UDS

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Table 9D: Patient Service Revenue

2023 Change:
- Line 8c, HRSA COVID-19 Uninsured Program, has been removed. The program ended in 2022, so there are no charges or collections for 2023.

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Patient Service Revenue

Table 9D

Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Retroactive Settlements, Receipts, Payback(s) (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)	Adjustments (d)	Sliding Fee Discounts (e)	Bad Debt Write-Off (f)
1	Medicaid Non-Managed Care									
2a	Medicaid Managed Care (capitated)									
2b	Medicaid Managed Care (fee-for-service)									
3	**Total Medicaid** (Sum of Lines 1 + 2a + 2b)									

Report (Columns)

- Column A: Charges (2023)
- Column B: Collections (**cash** basis)
- Columns C1–C4: Reconciliations
- Column D: Contractual adjustments
- Column E: Self-pay sliding discounts
- Column F: Self-pay bad debt

By Payer (Lines)

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

By Form of Payment

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

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Column A: Full Charges

Table 9D

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

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

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Column B: Collections

Table 9D

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

- **Column B: Collections:** Include **all payments** received in 2023 **related to services to patients**:
  - Capitation payments
  - Contracted payments
  - Payments from patients
  - Third-party insurance
  - Retroactive settlements, receipts, and payments
    - Include pay for performance (P4P), quality bonuses, and other incentive payments tied to patient care.
- P4P incentives (such as for conducting certain screenings or improving on CQMs) ARE included in the collections reported here.

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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.	• Federally Qualified Health Center (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)*	• FQHC PPS reconciliations *(based on filing of cost report)* • Wraparound payments *(additional amount per visit to bring payment up to FQHC level)*	• Managed care pool distributions • P4P • Other incentive payments • Quality bonuses • Value-based payments	Paybacks or deductions by payers because of overpayments or penalty *(report as a positive number)*

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Column D: Adjustments

Table 9D

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

- **Column D: Adjustments:** Agreed-upon reductions/write-offs in payment by a third-party payer:
  - \- Reduce by amount of retroactive payments in C1, C2, and C3.
  - \+ Add paybacks reported in C4.
- May result in a negative number (most common 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).

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Column E: Sliding Fee Discounts

Table 9D

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

Applicable ONLY 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 with income below 2X the federal poverty level.
- 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.

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Column F: Bad Debt Write-Off

Table 9D

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

- **Bad debt:** Amounts owed by patients considered to be uncollectable and formally written off during 2023, 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 are not patient bad debt (or a sliding discount).

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Payer Categories for Patient Service Revenue

Table 9D

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

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

Other Public
- CHIP, when NOT administered by Medicaid
- Public programs that pay for limited services, such as BCCCP and Title X
- State- or county-run insurance plans that are not Medicaid
- Service contracts with municipal/county jails, state prisons, public schools, or other public entities

Private
- Commercial insurance purchased by patients and/or their employers
- Tricare, Trigon, Federal Employees Benefits Program, workers' compensation
- Insurance purchased through state exchanges or provided by employers

Self-Pay
- Portion that the patient is responsible for or that is not covered by a third-party payer—includes co-pay, deductibles, or full charge
- Indigent care charge portion

Remember, reimbursement or payment may or may not be the same as the patient's primary medical insurance.
New resource: UDS Managed Care Reporting and Relationship Across Tables 4 and 9D

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Relationship Between Insurance on Table 4 and Revenue on Table 9D

- Revenue sources on Table 9D are generally aligned with patient insurance reported on Table 4.
- If there is a reason the relationship would look unusual, include an explanation in your UDS submission on Table 9D.

Primary Medical Insurance on Table 4, Line:	Have Revenue Reported on Table 9D, Line:
7: Uninsured—No medical insurance at last visit (includes patients whose service is reimbursed through grant, contract, or indigent care funds)	13: Self-Pay—Include co-pays and deductibles, state and local indigent care programs **(do not include revenues from programs with limited benefits; See Other Public, Lines 7–9)**
8a and 8b: Medicaid and Medicaid CHIP (includes Medicaid managed care programs and all forms of state-expanded Medicaid)	1–3: Medicaid (includes Medicaid expansion)
9: Medicare (includes Medicare Advantage)	4–6: Medicare
9a: Dually eligible (Medicare and Medicaid)	4–6: Medicare, initially, with balance reallocated to Medicaid
10a: Other Public non-CHIP—State and local government insurance that covers primary care	7–9: Other Public—Include patient service revenue from programs with limited benefits, such as family planning (Title X), EPSDT, BCCCP, etc.
10b: Other Public CHIP (private carrier outside Medicaid)	7–9: Other Public
11: Private—Private (commercial) insurance, including insurance purchased from state or federal exchanges (do not include workers' compensation coverage as health insurance—it is a liability insurance)	10–12: Private—Charges and collections from contracts with private carriers, private schools, private jails, Head Start, workers' compensation, and state and federal exchanges
13a: Capitated managed care enrollees	"a" lines
13b: Fee-for-service managed care enrollees	"b" lines

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There Are Three Possible Forms of Payment

For Patient Service Revenue on Table 9D

Non-Managed Care

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.

Charges and payments for services to patients who are *not assigned to the health center* through a managed care plan are always reported as *non-managed care*.

Managed Care Capitation

The health center contracts with a managed care organization for a specified set of services, and 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

The health center contracts with a managed care organization under which a set of patients is **assigned** to the health center, and the health center is responsible for their care. The health center is **reimbursed on an FFS (or encounter-rate) basis for covered services to those assigned patients**.

Remember that charges, in Column A, are reported based on the health center's fee schedule, regardless of payment type.

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Examples: Reclassifying a Portion of a Charge

Table 9D

Remember, when the responsibility for charges **changes** or **is split**, the charges in Column A **need to be reclassified** to reflect that.

A patient is seen, saying their insurance has not changed, but the claim is denied by the payer because the patient was no longer enrolled with them. The charges then need to be reclassified to their current payer or to Self-Pay.

A patient with Medicare is seen, and they have a supplemental plan that pays the 20% co-pay. That 20% of the charge needs to be reclassified to the secondary payer.

A claim is submitted to a private insurer for services to a patient. The patient has not yet met their deductible, so the insurer only pays a small portion of claim, then the remainder is billed to the patient. This deductible portion is reclassified to Self-Pay.

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Reporting: Reclassifying a Portion of a Charge

Table 9D

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

- **After reclassifying to a secondary payer, that portion of the charge:**
  - May be collected
  - May have a portion be adjusted
  - May be outstanding at the end of the year
- **After reclassifying to Self-Pay (Line 13), that portion of the charge:**
  - May be paid
  - May be written off as sliding fee if the patient has qualified
  - May be written off as bad debt
- **Must reclassify the charge first!**

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Example

How is this reported across Tables 4 and 9D?

- Naomi came to the health center seeking contraception in 2023. On the intake paperwork, Naomi notes that she does not have insurance.
- Naomi is then seen twice at the health center in 2023 for family planning services including contraception, STI testing, and follow-up.
- Her family planning services were covered by the Title X program.

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Example *(cont.)*

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

- **Recap:** Naomi is a health center patient who doesn't have medical insurance and was seen twice in the year for family planning services, which are covered by Title X.
- **Answer:**
  - Naomi is **Uninsured on Table 4**.
  - On Table 9D, the charges for the family planning services and collections received from Title X are reported as Other Public Non-Managed Care, on Line 7.
  - Any charges that were not covered by Title X are reported on Line 13: Self-Pay.

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Reporting 340B Contract Pharmacy

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

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Table 9E: Other Revenue

2023 Changes:

- Line 1p has been changed to Expanding COVID-19 Vaccination (ECV), while Line 1p2 has been added for Other COVID-19-Related Funding.

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Other Revenue

Table 9E

This table is reported on a **cash basis**—amount drawn down (not award) in the year.

Report based on the entity dollars were received from (called the last party rule).

- Report **non-patient-service receipts** or funds drawn down in 2023.
  - Include income that supported activities described in your health center scope of services.
  - Report funds by the entity from which you received them.
  - Complete "specify" fields.
- The total amount reported on Tables 9E and 9D represents total revenue supporting the health center's scope of services.
- Guidance for common health center funding awards related to the COVID-19 pandemic can be found here.

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Revenue Categories

Table 9E, Lines 1a–3b

Lines 1a–1q

- **BPHC Grants:** Funds your health center received directly from BPHC, including funds passed through to another agency.
  - Include 330 grant(s) drawn down in the year.
  - Include the amounts directly received under the various COVID funding streams. *Only report amounts drawn down in 2023.*

Lines 2–3b

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

Line	Source	Amount (a)
	BPHC Grants (Enter Amount Drawn Down—Consistent with PMS 272)	
1a	Migrant Health Center	
1b	Community Health Center	
1c	Health Care for the Homeless	
1e	Public Housing Primary Care	
1g	**Total Health Center** (Sum of Lines 1a through 1e)	
1k	**Capital Development Grants**, including School-Based Service Site Capital Grants	
1l	Coronavirus Preparedness and Response Supplemental Appropriations Act (HSC)	
1m	Coronavirus Aid, Relief, and Economic Security Act (CARES) (HRD)	
1n	Expanding Capacity for Coronavirus Testing (ECT) (HSE and LAL ECT)	
1o	American Rescue Plan (ARP) (HSF, L2C, CSE)	
1p	Expanding COVID-19 Vaccination (ECV)	
1p2	Other COVID-19-Related Funding from BPHC (specify_____)	
1q	**Total COVID-19 Supplemental** (Sum of Lines 1l through 1p2)	
1	**Total BPHC Grants** (Sum of Lines 1g + 1k + 1q)	
	Other Federal Grants	
2	Ryan White Part C HIV Early Intervention	
3	Other Federal Grants (specify_____)	
3a	Medicare and Medicaid EHR Incentive Payments for Eligible Providers	
3b	Provider Relief Fund (specify_____)	
5	**Total Other Federal Grants** (Sum of Lines 2 through 3b)	

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New Line for ECV Funding

Table 9E: Other Revenue

- **Line 1p:** Expanding COVID-19 Vaccination (ECV)
  - ECV funding was awarded in Dec. 2022. The amount drawn down in calendar year 2023 is reported on Line 1p.
  - Other COVID-19-Related Funding from BPHC, previously reported on Line 1p, is now reported on Line 1p2.

Line	Source	Amount (a)
	BPHC Grants (Enter Amount Drawn Down—Consistent with PMS 272)	
1a	Migrant Health Center	
1b	Community Health Center	
1c	Health Care for the Homeless	
1e	Public Housing Primary Care	
1g	**Total Health Center** (Sum of Lines 1a through 1e)	
1k	**Capital Development Grants**, including School-Based Service Site Capital Grants	
1l	Coronavirus Preparedness and Response Supplemental Appropriations Act (H8C)	
1m	Coronavirus Aid, Relief, and Economic Security Act (CARES) (H8D)	
1n	Expanding Capacity for Coronavirus Testing (ECT) (H8E and LAL ECT)	
1o	American Rescue Plan (ARP) (H8F, L2C, C8E)	
1p	Expanding COVID-19 Vaccination (ECV)	
1p2	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)	

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BPHC COVID-19 Funding Lines

Table 9E, Lines 1l–1q

Line	Source	Amount (a)
	BPHC Grants (Enter Amount Drawn Down—Consistent with PMS 272)	
1a	Migrant Health Center	
1b	Community Health Center	
1c	Health Care for the Homeless	
1e	Public Housing Primary Care	
1g	**Total Health Center** (Sum of Lines 1a through 1e)	
1k	**Capital Development Grants**, including School-Based Service Site Capital Grants	
1l	Coronavirus Preparedness and Response Supplemental Appropriations Act (H8C)	
1m	Coronavirus Aid, Relief, and Economic Security Act (CARES) (H8D)	
1n	Expanding Capacity for Coronavirus Testing (ECT) (H8E and LAL ECT)	
1o	American Rescue Plan (ARP) (H8F, L2C, C8E)	
1p	Expanding COVID-19 Vaccination (ECV)	
1p2	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-19-related funding *from HRSA BPHC* and should only include amounts drawn down in 2023.

- **Report the amount drawn down in the year.** Some of these funds were awarded in 2020, 2021, or 2022; if those funds were drawn down in 2023, then they're reported in the current UDS Report.
  - Lines 1l–1n were awarded in 2020.
  - Line 1o was awarded in 2021.
  - Line 1p was awarded in 2022.
- Report COVID-19 Bridge Funding on **Line 1p2**, Other COVID-19 Related Funding from BPHC.
- See detailed guidance on COVID-19 funding here.

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Non-Federal Grants Revenue Categories

Table 9E, Lines 6–10

- **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 (e.g., cash donations, medical record revenue, vending machine revenue)
  - Do not report bad debt recovery or 340B revenue here—these revenues are reported on Table 9D.

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

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Find Resources to Help: Financials

HRSA's BPHC UDS Resources site Financials section includes the following resources:

- Fact sheets
- UDS Financial Tables Guidance
- UDS Overhead Cost Allocation Methods
- Reporting Donations on the UDS
- UDS Managed Care Reporting and Relationship Across Tables 4 and 9D
- Self-Paced Learning Module: Operational Costs and Revenues

And much more!

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Other Forms

Understanding More About How and What Your Health Center Does

- Patient Demographic Profile
- Clinical Services and Outcomes
- Financial Tables
- Other Forms

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Health Center Health Information Technology (HIT) Capabilities Appendix D

2023 Changes:

- No major changes.

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Health Center 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?
  - Do you use more than one system?
- **Data exchange**
  - What other health care entities do you exchange information with?
  - What else do you use HIT/EHR for?
- **Social risk screening**
  - Do you use standardized tools?
  - If no, why not?
  - What is the total number of patients screened?
  - How many patients were identified with social risks?
- **Integration of Prescription Drug Monitoring Program (PDMP)**

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Social Risk Screening on HIT Form

Appendix D

Questions 11 and 12: Report whether the health center collects social risk data (beyond data reported elsewhere in the UDS) and, if yes, what screening tool is used.

Question 11a: Report the total number of patients screened for social risks in the year.

Question 12: Report the **number of health center patients who screened positive** in four areas:

- ❑ Food insecurity
- ❑ Housing insecurity
- ❑ Financial strain
- ❑ Lack of transportation/access to public transportation

This crosswalk identifies the relevant questions on each listed standardized screener and what constitutes a positive screen for each.

Do not use proxies (such as low income or Medicaid) to report social risks; only use screening results.

Be sure that reporting here is limited to only health center patients reported on the demographic tables.

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Other Data Elements (ODE)
Appendix E

2023 Changes:

- "MAT" has changed to "MOUD" to reflect federal changes that a Drug Addiction Treatment Act of 2000 (DATA) waiver is no longer required to treat opioid use disorder (OUD) with buprenorphine.

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Other Data Elements
Appendix E

Telemedicine
- Telemedicine used on this form is specific to remote clinical services, whereas "telehealth" may include remote non-clinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services.

Medications for Opioid Use Disorder (MOUD)
- Report the number of *providers* who prescribed MOUD and the number of *patients* who received MOUD.
  - Include if treating MOUD with drugs prescribed under Schedule III authority under the Drug Enforcement Administration (DEA).
  - Questions have been revised.
  - Check information with Table 5; providers and patients reported here must also be on Table 5.

Outreach and Enrollment Assistance
- Report number of assists.
- Outreach and enrollment assists are defined as customizable education sessions about affordable health insurance coverage options and any other assistance provided by a trained assister from the health center to facilitate enrollment.
  - Assists reported here do not count as visits on the UDS tables, only on this form.

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Appendix E: Other Data Elements
Question 1, MOUD

- Medication-assisted treatment (MAT) is now referred to as MOUD.
- The DATA waiver is no longer required to treat OUD with medications specifically approved by the U.S. Food and Drug Administration (FDA) (i.e., buprenorphine).

2022	Questions Revised for 2023
• **Question 1a:** How many **physicians, certified nurse practitioners, physician assistants, and certified nurse midwives**, on-site or with whom the health center has contracts, **have a Drug Addiction Treatment Act of 2000 (DATA) waiver** to treat opioid use disorder with medications specifically approved by the U.S. FDA (i.e., buprenorphine) for that indication during the calendar year? • **Question 1b:** During the calendar year, how many patients received **MAT** for opioid use disorder from a **physician, certified nurse practitioner, physician assistant, or certified nurse midwife**, with a DATA waiver working on behalf of the health center?	• **Question 1a:** How many **providers**, on-site or with whom the health center has contracts, treat opioid use disorder with medications specifically approved by the U.S. Food and Drug Administration (FDA) (i.e., buprenorphine) for that indication during the calendar year? • **Question 1b:** During the calendar year, how many patients received **MOUD** for opioid use disorder from a **provider** accounted for in Question 1a?

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Telemedicine Reporting
Appendix E

Do you use telemedicine?
- Meaning, do you provide clinical services via remote technology?

Who do you use telemedicine to communicate with?
- Patients?
- Specialists?

What telehealth technologies do you use?
- Real time, store-and-forward, remote patient monitoring, mobile health?

What services are provided via telemedicine?
- Primary care, oral health, MH, SUD, dermatology, etc.?

If you do not offer telemedicine services, why not?
- Policy barriers, inadequate broadband, lack of funding/training, etc.?

Keys to Remember
- Limit your responses to clinical services provided via telehealth.
- It is possible to respond **Yes** to telemedicine questions here without having virtual visits on Table 5—if you use remote patient monitoring or eConsults, for example.
- Reflect your health center's services during the year.

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Workforce
Appendix F

2023 Changes:
- No major changes.

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Workforce Form
Appendix F

Professional Education/Training
- Report health professional training/education provided by category.
- Report training whether it is pre-graduate/ certificate or post-graduate.
- Report for preceptor and support staff.
- Note that this is NOT internal staff training such as continuing education, CMEs, or first aid training, but training of the future health professional workforce.

Satisfaction Surveys
- Report provider satisfaction survey frequency.
  - Refer to Appendix A of the UDS Manual regarding who is a provider.
- Report general personnel satisfaction survey frequency.
- Note that this is satisfaction of personnel, not patient satisfaction surveys.

Purpose: To provide insight and clarity into the current state of health center workforce training and staffing.

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Wrapping Up
Setting Up for Success

Available Resources → Tips for Success → Wrapping Up

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Available Resources

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

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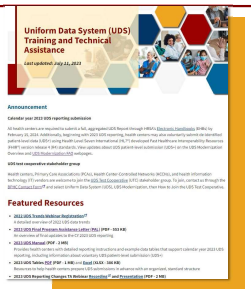
UDS Training and Technical Assistance (TTA) Resources

- **Now available: UDS reporting resources on the BPHC website**
  - Introduction
  - Reporting Training Schedule
  - Reporting Guidance
  - Patient Characteristics
  - Staffing and Utilization
  - Clinical Care
  - Financials
  - Appendices
  - Additional Reporting Topics
  - Technical Assistance Contacts
  - UDS Data
  - Archived Resources



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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 TTA site.

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Training Webinar Series for 2023 UDS Reporting

The webinar series includes:

- UDS Basics: Orientation to Terms and Resources
- Clinical Quality Measures Deep Dive
- UDS Clinical Tables Part 1: Screening and Preventive Care Measures
- UDS Clinical Tables Part 2: Maternal Care and Children's Health Measures
- UDS Clinical Tables Part 3: Chronic Disease Management Measures
- Reporting UDS Financial and Operational Tables
- Preliminary Reporting Environment
- Successful Submission Strategies

All webinars are archived on the HRSA website; watch them anytime!

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Support Available

Description	Contact	E-mail or Web Form	Phone
UDS reporting questions	UDS Support Center	udshelp330@bphcdata.net or BPHC Contact Form Select: UDS Reporting and most applicable subcategory	866-837-4357 (866-UDS-HELP)
EHBs account and user access questions	Health Center Program Support	BPHC Contact Form Select: Technical Support, EHBs Tasks/EHBs Technical Issues, EHBs Privileges	877-464-4772
EHBs technical issues with UDS Reports	Health Center Program Support	BPHC Contact Form Select: Technical Support, EHBs Tasks/EHBs Technical Issues, Other EHBs Submission Types	877-464-4772
UDS+ FHIR R4 IG and API (UDS Modernization) technical support	Health Center Program Support	BPHC Contact Form Select: UDS Modernization	877-464-4772

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Tips for Success and References

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Tips for Success

Tables are interrelated and **specific to your health center**, so get together with a team to ensure accurate reporting across:

- Sites
- Personnel, FTEs, and roles
- Patients and services
- Expenses
- Revenues

Key Examples

- Those responsible for FTEs on Table 5 and costs on Table 8A need to get together to ensure that FTEs and costs are allocated consistently across the two tables.
- Those responsible for Table 4 and those responsible for Table 9D need to be sure there is agreement about how certain insurances and programs are being classified, in terms of payer category, payment type, and whether certain plans meet the UDS definition of managed care.

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Tips for Success *(cont.)*

- Adhere to **definitions and instructions**.
  - Review how certain personnel positions or insurances were categorized for reporting last year.
- **Check your data** before submitting.
  - Refer to the questions and 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 available in the EHBs.
  - Understand and communicate system or program changes that explain the data.
- Address **edits** in the EHBs by correcting or providing explanations that demonstrate your understanding.
- Work with your **UDS Reviewer.**

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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 Program Compliance Manual

Conditions will be applied to health centers that fail to submit their UDS Report(s) by February 15.

- **February 16–April 1:** BPHC will finalize and confirm the list of *"late," "inaccurate," or "incomplete"* UDS reporters.
- **Mid-April:** BPHC will notify the respective Health Services Offices project officers of the health centers that are on the list.
- **Late April/Early May:** BPHC will issue the related Progressive Action condition.

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Thank You!

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

udshelp330@bphcdata.net *or* BPHC Contact Form

1-866-837-4357

bphc.hrsa.gov

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