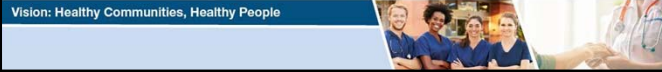


Uniform Data System (UDS) Reporting Requirements Training Calendar Year 2021

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

Vision: Healthy Communities, Healthy People



Agenda

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




Source: Adobe Stock




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Key Materials Provided with This Training





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



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Overview of the UDS

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

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



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

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

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


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

WHY: Legislatively mandated; used for program monitoring and improvement





Value of the UDS


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




1 in 3 people living in poverty



1 in 5 people who are uninsured





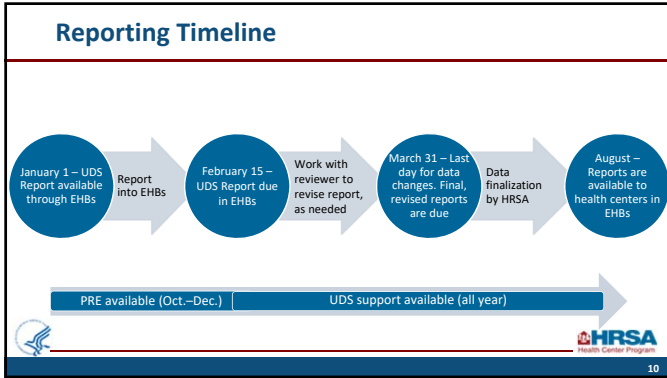
1 in 5 rural residents

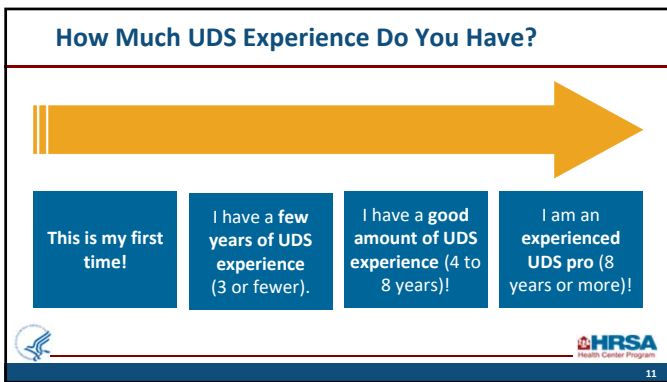


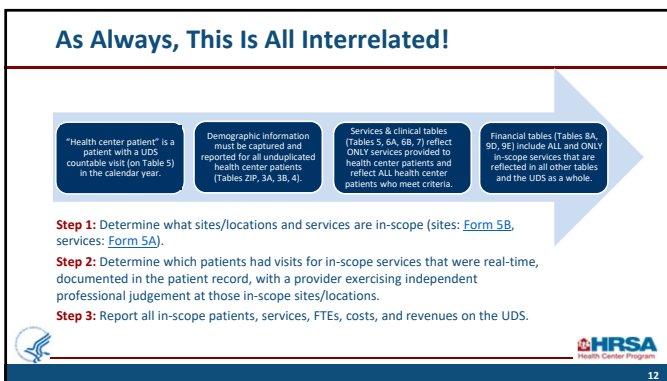
Nearly 3 million adults age 65+

FindAHealthCenter.hrsa.gov








Managed Care

Table 4

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

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

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



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Managed Care Utilization

Table 4 (and Table 9D)

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

A member month = one member enrolled for 1 month

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

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


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

There is generally a relationship between:


Member months on Table 4
Example: 36,788 Medicaid member months + 12 = 3,066

Insurance categories on Table 4
Example: 4,174 Medicaid patients

Managed care lines on Table 9D
Example: Medicaid net capitation \$1,044,850 ÷ member months 36,788 = \$28




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


We will discuss Table 9D later!



Example: Table 4

Ramy was seen by the health center twice in 2021.


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



Source: iStock

Where would this patient be reported on Table 4?

- Income
- Medical Insurance
- Special Populations



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Reporting Services and Quality of Care Indicators

Tables 5, 6A, 6B, and 7

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Table 5: Staffing and Utilization

2021 Changes: No major changes to reporting

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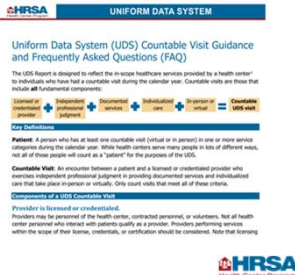
IMPORTANT KEY:
FTE reporting on Table 5 ties closely to costs on Table 8A.

We will discuss Table 8A later!



New Resource: UDS Countable Visit Guidance and Frequently Asked Questions

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



UNIFORM DATA SYSTEM

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

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

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


Key Definitions

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

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

Components of a UDS Countable Visit:

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



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Defining a Visit

Licensed or credentialed provider

+

Independent professional judgement

+

Services documented in the individual patient chart


+

Individualized care

+


Real-time in-person or virtual engagement

Countable UDS Visit




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COVID-19 Testing or Vaccination and Visits

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

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


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

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

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Counting Multiple Visits

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


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Contacts That Do Not, ALONE, Count as Visits

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


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Examples: Are These Countable Visits on Table 5?




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

Source: HRSA




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Examples: Are These Countable Visits on Table 5?



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

Source: HRSA



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Locations of Visits

Table 5

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

Line	Personnel by Major Service Category	FTEs (a)	Eligible 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 8-15)				
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				

Source: HRSA




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Example: Integrated MH in Medical Visit


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

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

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



Source: Adobe Stock



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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** SUD treatment were provided.

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

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

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




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Example: Integrated SUD in MH Visit


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

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

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



Source: iStock



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Key Notes for Table 6A

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

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

- This does not include mass testing/screening, tests done for the community, etc.
- Patient must have a countable visit on Table 5 and be included in unduplicated patients on demographic tables in order to be counted on Table 6A.
- 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 & 7: Clinical Quality Measures (CQMs)

2021 Changes:

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

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

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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 and Adolescents	Depression Remission at Twelve Months
Colorectal Cancer Screening	Dental Sealants for Children between 6-9 Years	Controlling High Blood Pressure
HIV Screening		Diabetes: Hemoglobin A1c (HbA1c) Poor Control
Screening for Depression and Follow-Up Plan		

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


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General Reminders for CQMs

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

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




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Telehealth and CQMs

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

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



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Clinical Process and Outcome Measures

Table 6B Format

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

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

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



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Table 6B CQMs

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


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Table 6B CQMs

Line	Measure	eCQM	Brief Measure Description
21	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	CMS2v10	Percentage of patients aged 12 years and older screened for depression on the date of the visit or 14 days prior to the visit using an age-appropriate standardized depression screening tool and, if positive, had a follow-up plan documented on the date of the visit
21a	Depression Remission at Twelve Months	CMS159v9	Percentage of patients aged 12 years and older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event
22	Dental Sealants for Children between 6–9 Years	CMS277v0	Percentage of children, age 6–9 years, at moderate to high risk for caries who received a sealant on a first permanent molar during the measurement period <i>Note that the Dental Sealant eCQM is has not been updated; the Version 0 specifications should continue to be used for 2021 reporting. Details can be found in the 2021 UDS Clinical Quality Measures Handout.</i>


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Table 7 Clinical Quality Outcome Measures

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


 Table 7 measures are reported by race and ethnicity. Details can be found in the 2021 UDS Clinical Quality Measures Handout. 75

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

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

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





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


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

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

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Tables 6A, 6B, and 7 Resources

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

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


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

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


2021 Changes: No major changes to reporting


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

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

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Deliveries and Birth Outcomes


Table 7

Section A

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

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

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




Source: iStock



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



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

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

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



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



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

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



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

DO

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

DON'T

- ❑ Don't report health center patients who are referred out for prenatal care in Column B for trimester of entry into prenatal care; report in Column A instead.
- ❑ Don't report patients as having delivered during the reporting period when there is no evidence of delivery.
- ❑ Don't forget to track delivery outcomes for prenatal care patients, even if they transferred out of the health center.



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

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

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




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: Two-Step Method


Facility (Line 14)

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

Non-Clinical Support Services (Line 15)

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

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



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Reporting Donations

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

Donations of Goods and Services

↓


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

Cash Donations/Fundraising Revenue

↓

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

Resource: [Reporting Donations in the UDS](#)



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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: PIP, Risk Pools, etc. (c3)	Penalty/ Payback (c4)	Adjustments (d)	Sliding Fee Discounts (e)	Bad Debt Write-Off (f)
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ONLY applicable to charges reported in Column A of Line 13, Self-Pay

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




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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: PIP, Risk Pools, etc. (c3)	Penalty/ Payback (c4)	Adjustments (d)	Sliding Fee Discounts (e)	Bad Debt Write-Off (f)
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- Bad debt:** Amounts owed by patients considered to be uncollectable and formally written off during 2021, regardless of when service was provided.
- Only report **patient bad debt** (not third-party payer bad debt):
 - ONLY related to charges reported in Column A of Line 13, Self-Pay.**
 - Third-party payer bad debt is not reported in the UDS.
- Do not change bad debt to a sliding discount.
- Discounts (e.g., to specific groups of patients, cash discounts) or forgiveness is not patient bad debt (or a sliding discount).




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Payer Categories for Patient Service Revenue

Table 9D


<p>Medicaid</p> <ul style="list-style-type: none"> Any state Medicaid program, including EPSDT, ADHC, PACE, if administered by Medicaid Medicaid MCOs or Medicaid programs administered by third-party or private payers CHIP, when administered by Medicaid <p>Medicare</p> <ul style="list-style-type: none"> Medicare managed care programs, including Medicare Advantage run by commercial insurers ADHC or PACE, if administered by Medicare 	<p>Other Public</p> <ul style="list-style-type: none"> CHIP, when NOT administered by Medicaid Public programs that pay for limited services, such as BCCCP and Title X State- or county-run insurance plans, such as the Massachusetts CommonHealth plan Service contracts with municipal/county jails, state prisons, public schools, or other public entities Testing and treatment associated with caring for uninsured patients with suspected or actual COVID-19 administered by HRSA under the COVID-19 Uninsured Program on Line 8c (more on the next slide) <p>Private</p> <ul style="list-style-type: none"> Tricare, Trigon, Federal Employees Insurance Program, workers' compensation Insurance purchased through state exchanges or provided by employers Commercial insurance purchased by patient and/or their employers <p>Self-Pay</p> <ul style="list-style-type: none"> Portion that the patient is responsible for or that is not covered by a third-party payer — includes co-pay, deductibles, or full charge for the uninsured patients when insurance does not cover (e.g., dental charges to a Medicaid patient) Indigent care charge portion
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Example

How is this reported across Tables 4 and 9D?




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




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Example

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



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




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Reporting 340B Contract Pharmacy

Table	Related Reporting/Impact
8A (Costs)	<ul style="list-style-type: none"> Report the amount the pharmacy charges for managing dispensing of drugs on Line 8a, Pharmacy. Report the full amount paid for drugs, either directly (by clinic) or indirectly (by contract pharmacy) on Line 8b, Pharmaceuticals. If the pharmacy buys prepackaged drugs and there is no reasonable way to separate the pharmaceutical costs from the dispensing/administrative costs, report all costs on Line 8b. Associated non-clinical support services (overhead) costs go on Line 8a, Column B, even though Line 8a Column A is blank. Report payments to pharmacy benefit managers on Line 8a, Pharmacy. Some pharmacies split the fee or keep a share of profit. Report this as a payment to the pharmacy on Line 8a, Pharmacy.
9D (Patient Service Revenue)	<ul style="list-style-type: none"> Charge (Column A) is the health center/contract pharmacy's full retail charge for the drugs dispensed, by 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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BPHC COVID-19 Funding Lines

Table 9E

Line	Source	Amount (a)
	BPHC Grants (Enter Amount Drawn Down—Consistent with PMS 272)	
1a	Migrant Health Center	
1b	Community Health Center	
1c	Health Care for the Homeless	
1e	Public Housing Primary Care	
1g	Total Health Center (Sum of Lines 1a through 1e)	
1k	Capital Development Grants, including School-Based Health Center Capital Grants	
1l	Coronavirus Preparedness and Response Supplemental Appropriations Act (HBC)	
1m	Coronavirus Aid, Relief, and Economic Security Act (CARES) (HRD)	
1n	Expanding Capacity for Coronavirus Testing (ECT) (HRE and L&L ECT)	
1o	American Rescue Plan	
1p	Other COVID-19-Related Funding from BPHC (specify _____)	
1q	Total COVID-19 Supplemental (Sum of Lines 1l through 1p)	
1	Total BPHC Grants (Sum of Lines 1g + 1k + 1q)	

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




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Revenue Categories

Table 9E

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


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



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



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



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Resources to Support Financial and Operational Reporting



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

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Other Forms to Complete

Health Information Technology Form
Other Data Elements Form
Workforce Form




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

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

A series of approximately 15 questions that assess:

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






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Workforce Form

Appendix F

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





Source: Stock



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Available Resources



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

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BPHC UDS Reporting Resources


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


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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 resource page](#).



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Training [Webinar Series](#) for 2021 UDS Reporting

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




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



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Support Available

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



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Tips for Success

Tips for Success

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







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Available Assistance

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

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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 Compliance Manual*

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

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



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

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

[Evaluation Link](#)

Vision: Healthy Communities, Healthy People



Contact Information


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

1-866-UDS-HELP

or

1-866-837-4357

udshelp330@bphcdata.net



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