Uniform Data System (UDS) Reporting Requirements Training
Annual State-Based Training
Calendar Year 2022

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

Overview of the UDS
The Who, What, Where, When, and Why of the UDS
Key Facts About Reporting the UDS

<table>
<thead>
<tr>
<th>WHO</th>
<th>WHAT</th>
<th>WHERE</th>
<th>WHEN</th>
<th>WHY</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHCs, HCHs, MHCs, PHPCs, LALs, and BHW primary care clinics funded or designated before Oct. 2022 all complete a UDS Report.</td>
<td>The UDS includes 11 tables and 3 forms that provide an annual snapshot of all in-scope activities: Unusual and, if applicable, Grant Reports.</td>
<td>The UDS Report is completed in the Performance Report in the Electronic Handbooks (EHBs).</td>
<td>All health centers complete their UDS Report between Jan. 1 and Feb. 15, 2023; reporting covers health center services in calendar year from Jan. 1 to Dec. 31, 2022.</td>
<td>The UDS is legislatively mandated as part of the Health Center Program; used for program monitoring and improvement.</td>
</tr>
</tbody>
</table>

For a full list of acronyms, refer to Appendix I of the UDS Manual.

Health Center Program Grants and Designations

Some health centers have a single 330 grant: CHC, HCH, MHC, PHPC—any one of these.

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

Some health centers have a Health Center Program look-alike (LAL) designation.

These health centers do not have a 330 grant.

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.
Overview of UDS Report

Four Primary Sections

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

- **Clinical Services and Outcomes**
  - Table D: Staff, visits, patients, and selected services and diagnoses
  - Table E: Clinical quality measures
  - Table F: Critical outcome measures by race & ethnicity

- **Financial Performance**
  - Table G: Financial costs
  - Table H: Financial revenue related to charges and collections
  - Table I: Other revenue

- **Other Forms**
  - Appendix J: Health Information Technology (HIT) Capabilities
  - Appendix K: Other Data Elements (ODE)
  - Appendix L: Workforce

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 330 grant, LALs, and those with multiple 330 grants).
- Grant Report(s)—completed only by awardees that receive multiple 330 grants (e.g., CHC, CMC, HCH, PHPC).

<table>
<thead>
<tr>
<th>Table</th>
<th>All reported in Universal Report</th>
<th>Table in Grant-Specific Report(s)? For those health centers with multiple 330 grants</th>
</tr>
</thead>
<tbody>
<tr>
<td>ZIP Code</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>SA, SB, SC</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>SE</td>
<td>Yes, but patients and visits only</td>
<td></td>
</tr>
<tr>
<td>EA</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>EA, SE, SB, SC, SE</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>HIT, ODE, Workforce Forms</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Reporting Timeline

- January 1: UDS Report available through Title III
- February 1: UDS Report due
- Work with reviewer to receive report as needed
- March 15: Last day for data changes, reports are due
- Data submitted by HRSA
- Late-Season Reports are not eligible for报送 due toCoder in Title III

Pre-1/30/2013: UDS support available (all year)
Where to Report: The Electronic Handbooks (EHBs)

- The UDS is the Performance Report for your HRSA 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

**Picture That These Data Paint**

Health centers provide affordable, high-quality primary health care to more than 30 million people in the U.S. each year. That includes:

- 1 in 9 children & adolescents
- 1 in 5 rural residents
- 1 in 3 senior citizens
- 63% socially or medically underserved

**Key Definitions**

**Understanding Terms Foundational to the UDS**

Health Center Patient  Countable Visit  Health Center Scope
Health Center Scope

**UDS Definition:** Health center scope of project defines 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 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 in order to report correctly.
- Sites that are part of your health center scope of project are spelled out on your Form 5A; in-scope services for your health center are on your Form 5A, and other activities and locations on Form 5C.

Patient

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

- The patient demographic tables (ZIP Code Table and Tables 5A, 5B, 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.

Visit

**UDS Definition:** Encounters between a patient and a licensed or credentialed provider who exercise 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 row 2 in Table 5) can be providers on the UDS. Page 63 spells out lines that cannot have visits.
- A countable visit in ANY service category on Table 5 makes someone a health center patient on the UDS.
- Page 51 of the 2021 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.
Remember the Big Picture

- Identify Patients Served in Your Health Center Scope
  A "health center patient" is a patient with a UDS countable visit (per Table 5) in the calendar year.

- Health Center Scope
  Determine what sites and services are within your health center scope of project.

- Report Patient Characteristics
  Demographic information must be captured and reported for all unduplicated health center patients (Tables 5, 6A, 6B, 6C).

- Report Services Patients Received
  Services & Visit tables (Tables 5, 6A, 6B, 7) reflect UDS and all services provided to health center patients.

- Report Financials
  Financial tables (Tables 6A, 6B, 6C) include CHN and all services reflected in all other tables and the UDS as a whole.

Overview of the UDS Tables and Forms

Understanding What Data Is Reported and Why

ZIP Code Table, Tables 3A, 3B, and 4

Understanding Who You Are Serving
### Overview of Patient Demographic Tables

<table>
<thead>
<tr>
<th>ZIP Code Table</th>
<th>Table 3A</th>
<th>Table 3B</th>
<th>Table 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Captures</strong></td>
<td>Patients by ZIP code and primary medical insurance</td>
<td>Patients by age and sex assigned at birth</td>
<td>Patients by primary medical insurance</td>
</tr>
<tr>
<td><strong>Purpose</strong></td>
<td>To understand the distribution of your health center’s patients and the primary medical insurance they have</td>
<td>To understand the age and sex distribution of patients and other factors to determine gaps in services for vulnerable patients (i.e., for Medicaid, CHIP, or Other)</td>
<td>To understand the reach and distribution of health center services to patients and in particular to understand and support equity of access for those served</td>
</tr>
</tbody>
</table>

Remainder: all sections of these tables (except those that are *denoted equal to each other because they describe the same group of patients, just by different characteristics.

### 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), and columns are medical insurance categories.
- List all ZIP codes to which your health center has 15 or more patients in Column 2.
- Aggregate ZIP codes with 10 or fewer patients into the Other ZIP Codes line.
- Use local address for migratory agricultural workers and people from other countries; use clinic address for patients experiencing homelessness if no other address.

**Keys to remember:**
- There is no unknown primary medical insurance: all patients must have medical insurance captured.
- On this table, Medicaid, CHIP, and Other Public are combined in Column 3 (they are separate on Table 4).
- Total patients: ZIP code by medical insurance must equal counts of patients by insurance on Table 4.

### Patients by Age and Sex Assigned at Birth

Report all patients by age and sex assigned at birth (as reported on birth certificate):
- Rows are age, columns are sex assigned at birth.
- Use age as of December 31, 2022.
- *This is an update from prior years!*

**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 must equal Table 4 insurance by age groups (0–17 years old and 18 and older).
- Information is used for cross-table comparisons.
### Ethnicity, Race, and Language

#### Table 3B, Lines 1–8

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Frequency</th>
<th>Unreported/Chose not to disclose</th>
<th>Total Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>5</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Black/African American</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Native Hawaiian/Other Pacific Islander</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Asian</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

**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.
- Only report patients with unknown race and unknown ethnicity on Line 7, Column C.
- Line 8, Column D, equals total unduplicated patients.

#### Table 3B, Line 12

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Frequency</th>
<th>Unreported/Chose not to disclose</th>
<th>Total Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>5</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Black/African American</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Native Hawaiian/Other Pacific Islander</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Asian</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

**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 a subset of total patients.

**Keys to remember**
- Race, ethnicity, and language are to be self-reported by patients or caregivers (and are not to be inferred).
- Patients should be able to select more than one race and, if they do, are reported as more than one race.

### Sexual Orientation (SO) and Gender Identity (GI)

#### Table 3B, Lines 13–19 and Lines 20–26

<table>
<thead>
<tr>
<th>GI</th>
<th>Frequency</th>
<th>Unreported/Chose not to disclose</th>
<th>Total Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>6</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Non-binary</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Transgender Man/Transgender Male/Transgender Masculine</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Transgender Woman/Transgender Female/Transgender Feminine</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

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

Lines 13–15 and Lines 20–23 may be fairly clear, while the others are more opaque. Here is a reference table:

- Line 30: "Other (please specify)." Patients should only specify if they are other than what is specified in Lines 1 through 29.
- Line 30: "Non-binary" should be reported on Line 23.
- Line 30: "Transgender Man/Transgender Male/Transgender Masculine" should be reported on Line 24.
- Line 30: "Transgender Woman/Transgender Female/Transgender Feminine" should be reported on Line 25.
- Line 30: "Unspecified" is the only available choice if the patient does not want to identify as anything on the other gender identities, including gender identity.
- Line 30: If a patient selects "Other (please specify)," they should be asked to specify in the other gender identities.
- Line 30: "Other (please specify)" should not be used to indicate gender identity or gender expression in the health center.
### Income as a Percent of Federal Poverty Guideline

**Table 4, Lines 1–6**

<table>
<thead>
<tr>
<th>Income as a Percent of Poverty Guideline</th>
<th>Number of Patients (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% and below</td>
<td>0</td>
</tr>
<tr>
<td>101–150%</td>
<td>0</td>
</tr>
<tr>
<td>151–200%</td>
<td>0</td>
</tr>
<tr>
<td>201–250%</td>
<td>0</td>
</tr>
<tr>
<td>251–300%</td>
<td>0</td>
</tr>
<tr>
<td>301–350%</td>
<td>0</td>
</tr>
<tr>
<td>351–400%</td>
<td>0</td>
</tr>
<tr>
<td>401–450%</td>
<td>0</td>
</tr>
<tr>
<td>451–500%</td>
<td>0</td>
</tr>
<tr>
<td>501–550%</td>
<td>0</td>
</tr>
<tr>
<td>551–600%</td>
<td>0</td>
</tr>
<tr>
<td>601–650%</td>
<td>0</td>
</tr>
<tr>
<td>651–700%</td>
<td>0</td>
</tr>
<tr>
<td>701–750%</td>
<td>0</td>
</tr>
<tr>
<td>751–800%</td>
<td>0</td>
</tr>
<tr>
<td>801–850%</td>
<td>0</td>
</tr>
<tr>
<td>851–900%</td>
<td>0</td>
</tr>
<tr>
<td>901–950%</td>
<td>0</td>
</tr>
<tr>
<td>951–1000%</td>
<td>0</td>
</tr>
</tbody>
</table>

**This information is important for confirming that the 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 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.

### Primary Medical Insurance

**Table 4, Lines 7–12**

<table>
<thead>
<tr>
<th>Type</th>
<th>Insurance Code</th>
<th>Number of Patients (n)</th>
<th>Income as Percent of Federal Poverty Guideline (Line 7–11)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Table 4, Lines 7–12**

**Keys to Remember:**
- There is no unknown medical insurance category. All patients need to be reported by medical insurance (excluding 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 equal detail on ZIP Code Table and Table 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 8a and Line 8b (Line 8a is a subset of Line 8b).

### Primary Medical Insurance Categories

**Table 4**

<table>
<thead>
<tr>
<th>Non-Uninsured</th>
<th>Medicaid (Title XIX)</th>
<th>CHIP (Medicaid or Other Public)</th>
<th>Medicare</th>
<th>Other Public Insurance (Non-CHIP)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medicaid and managed care programs, including those administered by commercial insurers.</td>
<td>CHIP if paid by Medicaid, report on Line 8b. If CHIP is reimbursed by another payer (e.g., a commercial carrier), it is outside of Medicaid, report on Line 10b.</td>
<td>Medicare includes Medicare, Medicare Advantage, and Dually Eligible.</td>
<td>State and/or local government insurance that covers a broad set of services, NOT a grant program reimbursing limited benefits (e.g., EPSDT, BCCCP).</td>
</tr>
<tr>
<td></td>
<td>Dually Eligible (Medicare and Medicaid)</td>
<td>Subset of Medicare patients who also have Medicaid coverage.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Remember:** 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.
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.

For this table, it does not matter whether the health center can or does bill the patient’s insurance.

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

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

A patient is seen several times in the year, and at the first two visits, they have Medicaid medical coverage and then 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.

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: Captured or Fee-for-Service.
- Captured 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.

<table>
<thead>
<tr>
<th>Line</th>
<th>Managed Care Plans</th>
<th>Medicaid</th>
<th>Medicare</th>
<th>Other Private Insurance</th>
<th>Commercial</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.a</td>
<td>Captured Member Months</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.b</td>
<td>Fee-For-Service Member Months</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.c</td>
<td>Total Member Months (Sum of Lines 1.a + 1.b)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

We will discuss Table 9D later!

Special Populations
Table 4, Lines 14–25

All health centers report the following:
- Total Agricultural Workers or Dependents (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.

How Special Population Status Is Identified
Table 4

Patient-Identified Lines
- This special population is based on characteristics of each individual patient.
- Are able to identify other patients based on the selected category.

Site-Based Lines
- This special population is based on whether a patient resided at a site that meets the definition.

Line 16: Total Agricultural Workers or Dependents
- Sub-lines for MHC grantees

Line 23: Total Homeless
- Sub-lines for HCH grantees

Line 24: Total Veterans
- Total Patients Served at a Health Center Located in an immediately accessible to a Public Housing Site.
- Total Veterans Served at a Health Center Located in an immediately accessible to a Public Housing Site (330g awardees only).
- Total Patients Served at a Health Center Located in or Immediately Accessible to a Public Housing Site.
Tables 5, 6A, 6B, and 7
Understanding Services Provided and Their Outcomes

Overview of Clinical Services and Quality Indicators

Columns 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
Those 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 is credited with 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.
Understanding the Service Categories

Table 5

- Reporting of FTEs, visits, and patients on Table 5 are split across categories that reflect function and services provided.
- Medical Care Services (Line 1–6)
- Dental Services (Lines 6–9)
- Mental Health Services (Line 10–19)
- Substance Use Disorder Services (Line 20)
- Other Professional Health Services (Line 21)
- Voice Services (Lines 22–28)
- Pharmacy Services (Line 29)
- Enabling Services (Lines 29a–29c)
- Other Programs and Related Services (Line 30)
- Quality Improvement Personnel (Line 31)
- Non-Clinical Support Services (Lines 30a–32)

Patients and Visits by Service and Provider Type

Table 5

<table>
<thead>
<tr>
<th>FTEs (Col. A)</th>
<th>Visits (Cols. B and B2)</th>
<th>Patients (Col. C)</th>
<th>Key Reminders</th>
</tr>
</thead>
<tbody>
<tr>
<td>All personnel who support in-scope operations are reported. Includes employees, interns, volunteers, residents, contracted personnel, and contractors paid FTEs. Visits must be on the same line with the FTE of the provider who conducted the visit.</td>
<td>Clinic (in-person) and virtual visits that meet the definition are counted. A visit is counted in either of these columns; the patient MUST be reported in Column C and/or included in the unduplicated patient count on all demographic tables.</td>
<td>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. Providers for whom the total is equal to the total of all service categories in Column C. As a result, the total number of patients reported across Column C generally support the unduplicated patient count.</td>
<td>Not all personnel generate visits. See Appendix A in the UDS Manual. Not all contacts are countable visits. A single visit may result in 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/or clinical care tables.</td>
</tr>
</tbody>
</table>

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

Table 5

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

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

Key Reminders:
- Appendix A in the UDS Manual outlines where (e.g., 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.

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:
     40 hours/week x 30 weeks = 1,200 hours
  2. Calculate this staff person’s paid hours:
     40 hours/week x 26 weeks = 1,040 hours
  3. Calculate FTE for this person:
     1,040 hours/1,200 hours = 0.867 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 + 3 = 30 days x 8 hours = 240 hours
     2,080 - 240 = 1,840 hours
  3. Calculate combined person hours:
     Total hours: 1,040 hours
  4. Calculate FTE:
     1,040 hours/1,840 hours = 0.578 FTE

*Benefits defined as vacation/holidays/sick benefits

**IMPORTANT KEY:**

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

We will discuss Table 8A later!
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.

**Countable UDS Visit**

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

**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 two different sites and may both be counted as visits even when they occur on the same day.

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

- Health Screenings or Outreach
  - Informationvenida for prospective patients
  - Health promotion to community group
  - Immunization driven

- Group Visits
  - Patient education classes
  - Health education sessions
  - Executive flu/influenza health group visits

- Tests/Assay Services
  - Drawing blood
  - Laboratory or diagnostic tests
  - COVID-19 testing

- Dispensing/Advising Medications
  - Dispensing controlled substances
  - Giving injections

- Health Status Checks
  - Wound care
  - STD testing

Page 19 of the 2022 UDS Manual has additional information.
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, fills out a brief form, and then a nurse administers a one-dose COVID-19 vaccine. Yvonne leaves and is not seen at the health center again.

2. 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.

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

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

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, fills out a brief form, and then a nurse administers a one-dose COVID-19 vaccine. Yvonne leaves and is not seen at the health center again. **NOT A VISIT.**

2. 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.**

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.

**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 Locations and Activities.
Location of Visits: Clinic or Virtual

Table 5, Columns B and B2

<table>
<thead>
<tr>
<th>Location of Visits: Clinic or Virtual</th>
<th>Virtual Visits (Column B2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic Visits (Column B)</td>
<td>Report documented virtual (telemedical) contact between a patient and provider that meet all the requirements discussed earlier for countable visits. Must be provided using interactive, synchronous audio and/or video telecommunication systems that permit real-time communication between the provider and a patient. Use codes that will result in accurate identification of virtual visits. These include telehealth-specific codes with the CPT or Healthcare Common Procedure Coding System (HCPCS) codes such as G0071, G0406-G0408, G0425-G0427, modifier “.95,” or Place of Service code “02” to identify virtual visits. View the Virtual Visits guidance file.</td>
</tr>
<tr>
<td>Remote Patient Monitoring (RPM)</td>
<td></td>
</tr>
<tr>
<td>RPM</td>
<td></td>
</tr>
<tr>
<td>• Is for new and established patients</td>
<td></td>
</tr>
<tr>
<td>• Is used to monitor acute and chronic conditions</td>
<td></td>
</tr>
<tr>
<td>• Can be provided to a patient with one or more diagnoses</td>
<td></td>
</tr>
<tr>
<td>Not a UDS Visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Distant Site Audio-Only Telehealth Services</td>
<td></td>
</tr>
<tr>
<td>Telephone E&amp;M Service</td>
<td></td>
</tr>
<tr>
<td>• Is a provider visit</td>
<td></td>
</tr>
<tr>
<td>• Is an audio-only E&amp;M service</td>
<td></td>
</tr>
<tr>
<td>• Is for new and established patients</td>
<td></td>
</tr>
<tr>
<td>• May be provided to a patient, parent, or guardian</td>
<td></td>
</tr>
<tr>
<td>• Is used for a patient visit when video technology is not available</td>
<td></td>
</tr>
<tr>
<td>Is a UDS Visit, reported in Column B2, by the provider who did the visit</td>
<td></td>
</tr>
</tbody>
</table>
E-Visit

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

*Not a UDS Visit*

---

Table 5: Completing the Selected Service Detail Addendum

2022 Changes: No major changes to reporting

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Addendum Captures *Integrated Behavioral Health*

Integrated Mental Health Services
Captures the number of medical visits that included mental health (MH) services provided by medical providers.

Integrated Substance Use Disorder Services
Captures the number of medical and mental health visits that included substance use disorder (SUD) services provided by medical and MH providers.
### 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 18–20
- MH: Table 6A, lines 20a–20d

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

#### 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.
- Mental health 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 addendum.
- Look at the number of personnel per FTE for reasonableness.
- For example, if there are 15 physician FTEs on the main part of TS and 100 physician personnel in the MH section of the addendum, then the average FTE per physician is less than 1/10.

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Physician</th>
<th>Nurse Practitioner</th>
<th>Physician Assistant</th>
<th>Certified Nurse Midwife</th>
<th>iatrician</th>
<th>Other Licensed Mental Health Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visits</td>
<td>10a</td>
<td>8</td>
<td>5</td>
<td>4</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Pediatricians</td>
<td>10a</td>
<td>8</td>
<td>5</td>
<td>4</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Obstetrician/Gynecologists</td>
<td>20a–20d</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Line Personnel by Major Service Category FTEs</td>
<td>19a</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Medical visits, and patients are reported in the medical section of the main part of Table 5 (shown above left). These visits, visits, and patients may also be reported as the MH/SUD addendum if they MH and/or SUD services were provided during those medical visits (shown above right).
### Reporting SUD Treatment Provided as Part of MH Visits in the Addendum

MH FTEs, visits, and patients are reported on lines 20a–20c of the main part of Table 5. These MH personnel, visits, and patients may also be reported on the addendum if they also included SUD services.

<table>
<thead>
<tr>
<th>Description</th>
<th>Number of MH Providers</th>
<th>Total MH Visits</th>
<th>Total SUD Visits</th>
<th>Total SUD Patients</th>
<th>Percent of Total SUD Visits</th>
<th>Percent of Total SUD Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>2,224,198</td>
<td>2,475,833</td>
<td>264,957</td>
<td>74,366</td>
<td>12.9%</td>
<td>26.0%</td>
</tr>
<tr>
<td>Psychologists</td>
<td>1,139,407</td>
<td>1,225,531</td>
<td>85,322</td>
<td>7,012</td>
<td>7.5%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Clinical Social Workers</td>
<td>5,188,663</td>
<td>5,305,036</td>
<td>509,426</td>
<td>45,813</td>
<td>9.8%</td>
<td>8.9%</td>
</tr>
</tbody>
</table>

### Determining Visits to Include in the Addendum

#### Table 6A

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Number of MH Providers</th>
<th>Total MH Visits</th>
<th>Total SUD Visits</th>
<th>Total SUD Patients</th>
<th>Percent of Total SUD Visits</th>
<th>Percent of Total SUD Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Psychiatrists</td>
<td>2,224,198</td>
<td>2,475,833</td>
<td>264,957</td>
<td>74,366</td>
<td>12.9%</td>
<td>26.0%</td>
</tr>
<tr>
<td>1b</td>
<td>Psychologists</td>
<td>1,139,407</td>
<td>1,225,531</td>
<td>85,322</td>
<td>7,012</td>
<td>7.5%</td>
<td>0.6%</td>
</tr>
<tr>
<td>1c</td>
<td>Clinical Social Workers</td>
<td>5,188,663</td>
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<td>45,813</td>
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<td>8.9%</td>
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</tbody>
</table>

#### Table 5: Addendum

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Number of MH Providers</th>
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<td>8.9%</td>
</tr>
</tbody>
</table>

### Calendar Year 2021 Table 5 Addendum Findings

#### Medicaid FTEs with integrated MH and SUD Services

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Number of Providers</th>
<th>Total MH Visits</th>
<th>Total SUD Visits</th>
<th>Total SUD Patients</th>
<th>Percent of Total SUD Visits</th>
<th>Percent of Total SUD Patients</th>
</tr>
</thead>
<tbody>
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<td>509,426</td>
<td>45,813</td>
<td>9.8%</td>
<td>8.9%</td>
</tr>
</tbody>
</table>

#### Medicaid FTEs with integrated SUD Services

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Number of Providers</th>
<th>Total MH Visits</th>
<th>Total SUD Visits</th>
<th>Total SUD Patients</th>
<th>Percent of Total SUD Visits</th>
<th>Percent of Total SUD Patients</th>
</tr>
</thead>
<tbody>
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<td>509,426</td>
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<td>9.8%</td>
<td>8.9%</td>
</tr>
</tbody>
</table>

* Represents 5% or more provider planning mental health services
** Represents 5% or more provider planning SUD services

---

10/4/2022
### Example: Integrated MH in 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 mental health portion of the addendum.

- **Table 5, Staffing and Utilization:** The family physician FTE is reported on Line 3, Column A of Table 5. The visit is reported on Line 3, 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 A3, 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.

---

### Example: Integrated MH and SUD in a Medical Visit

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 mental health 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 6a, Column C of the main part of Table 5. The visit is reported on Line 6a, Column B, and the patient is included in Line 15, Column C.
- **Table 5, Selected Service Detail Addendum, Substance Use Disorder Service Detail:** Due to the integrated MH and SUD treatment, the provider, patient, and visit are reported on both the MH line of the MH portion of the addendum and the NF 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.

---

### Example: Integrated SUD in MH Visit

This visit is counted twice across the two sections in Table 5: once in the mental health 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 21a1, 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, & patient) on Line 211. 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.
Find Resources to Help
HRSA BPHC UDS Resources site Staffing and Utilization section includes the following resources:
- Countable visit guidance
- Virtual visit guidance
- Nurse visit guidance
- Selected Service Detail Addendum guidance

Table 6A:
Selected Diagnoses and Services Rendered
2022 Changes:
- One line added
- Ten lines have updated codes

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 20.
- 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.
Selected Diagnoses and Services

Table 6A

<table>
<thead>
<tr>
<th>Line</th>
<th>Report Form</th>
<th>applicable ICD-10-CM</th>
<th>Number of Diagnosis</th>
<th>Line</th>
<th>Report Form</th>
<th>applicable ICD-10-CM</th>
<th>Number of Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>11</td>
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</tr>
<tr>
<td>3</td>
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<td>4</td>
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<td>6</td>
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</tr>
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<td>7</td>
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<td></td>
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<tr>
<td>8</td>
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<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td>18</td>
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</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

- **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 versions of the same type (i.e., that would be on the same line) at one visit.
- **Column B:** Report the number of unduplicated patients receiving the service.

New Line for Post COVID-19 Condition

Table 6A, Line 4d

**Line 4d: Post COVID-19 Condition (ICD-10 U09.9)**

- **Column A:** Number of visits at which the selected ICD-10 code for post COVID-19 condition has been coded.
- **Column B:** Number of patients who have had one or more visits where post COVID-19 condition has been coded.

**Keys to Remember**

- Patients and visits with this diagnosis are reported regardless of primacy.
- In other words, if a patient is treated for pneumonia and post COVID-19 condition, both pneumonia and post COVID-19 condition are documented in the patient health record and reflected in the corresponding lines of Table 6A.

Table 6A: Updated Codes

Selected Diagnoses and Services Rendered

- Applicable ICD-10-CM, CPT4/I/II/PLA, and HCPCS codes are updated for 2022.
- 2022 Table 6A code changes available for download (shown in screenshot to the left).
- 10 lines have code updates.
- Codes are updated as of April 2022.
PrEP Management Reporting on Table 6A

PrEP Management visits and patients are reported on Table 6A, Line 21a. 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 cPrEP, PPEP or post-exposure prophylaxis.
- Related summary should only mention nPrEP if PrEP is also mentioned, indicating transition from nPrEP to PrEP.
- Prescription instructions likely mention it is for PrEP.
- No concurrent antiretroviral medication.

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 21a).
- 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.

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.

- 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.

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

2022 Changes:
- Measures aligned with updated eCQMs, wherever available
- In alignment with those updated eCQMs, three existing measures have major modifications
Clinical Process and Outcome Measures

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

Clinical Quality Measure (CQM) Specifications

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

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

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

Components of Each Clinical Measure

Denominator
- Identifies the group of patients that the measure is looking at to determine compliance.
- Equal to the initial population identified in the CQM.
- Reported in Column A.

Numerator
- 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 and Exceptions
- 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 not meet denominator criteria but do not meet numerator criteria and meet any of the exceptions criteria are removed from the denominator.
There are several updates to how data can be collected and reported.

There are similarly several clarifications for specific measures and requirements.

Three eCQMs have changes to their specifications.

Measure Updated to Align with eCQMs

<table>
<thead>
<tr>
<th>Table</th>
<th>Measure Description</th>
<th>Updated eCQM</th>
</tr>
</thead>
<tbody>
<tr>
<td>6B 18</td>
<td>Childhood Immunization Status</td>
<td>CMS117v10</td>
</tr>
<tr>
<td>6B 11</td>
<td>Cervical Cancer Screening</td>
<td>CMS347v5</td>
</tr>
<tr>
<td>6B 13</td>
<td>Breast Cancer Screening</td>
<td>CMS349v4</td>
</tr>
<tr>
<td>6B 15</td>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents</td>
<td>CMS124v10</td>
</tr>
<tr>
<td>6B 16</td>
<td>Preventive Care and Screening: Tobacco Use Screening and Cessation Interventions</td>
<td>CMS125v10</td>
</tr>
<tr>
<td>6B 17</td>
<td>Mammography Screening</td>
<td>CMS155v10</td>
</tr>
<tr>
<td>6B 18</td>
<td>Colon Cancer Screening</td>
<td>CMS159v10</td>
</tr>
<tr>
<td>6B 21</td>
<td>Preventive Care and Screening: Screening for Depression and Follow-up Plan</td>
<td>CMS165v10</td>
</tr>
<tr>
<td>6B 21a</td>
<td>Depression Remission at Twelve Months</td>
<td>CMS138v10</td>
</tr>
<tr>
<td>6B 21b</td>
<td>Screening for Depression and Follow-up Plan</td>
<td>CMS130v10</td>
</tr>
<tr>
<td>6B 21c</td>
<td>Screening for Depression and Follow-up Plan</td>
<td>CMS2v11</td>
</tr>
</tbody>
</table>

Table 6B:

Dental Sealants

- Dental Sealants (CMS277v0) electronic specifications have not been updated and are no longer readily accessible online at United States Health Information Knowledgebase (USHIK).
- Find the value sets used in the specifications on the BPHC UDS Resources Clinical Care Page.

Table 6B: Dental Sealants

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>Value Sets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Sealants</td>
<td>CMS277v0</td>
</tr>
<tr>
<td></td>
<td>USHK</td>
</tr>
<tr>
<td></td>
<td>BPHC UDS</td>
</tr>
<tr>
<td></td>
<td>Resources</td>
</tr>
<tr>
<td></td>
<td>Clinical</td>
</tr>
<tr>
<td></td>
<td>Care Page</td>
</tr>
</tbody>
</table>
Clarifications to Tables 6B and 7

<table>
<thead>
<tr>
<th>Table</th>
<th>Section</th>
<th>Description of Clarification</th>
</tr>
</thead>
<tbody>
<tr>
<td>6B and 7</td>
<td>Viewable and/or accessible results</td>
<td>For clinical quality measures requiring the completion of screenings, tests, or procedures to meet the numerator criteria, the findings of the screenings, tests, or procedures must be accessible in the patient health record.</td>
</tr>
<tr>
<td>6B</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan</td>
<td>Provided clarification that the follow-up plan must be on or after the most recent documented BMI when BMI is outside of normal parameters, to align with the measure standards.</td>
</tr>
<tr>
<td>7</td>
<td>Diabetes: Hemoglobin A1c (HbA1c) Poor Control (&gt;9%)</td>
<td>Slight adjustment to wording in numerator to clarify that patients missing an HbA1c in the year are also included in numerator (as Poor Control).</td>
</tr>
</tbody>
</table>

Sampling No Longer an Option for CQMs

- Chart sampling is no longer an option for reporting CQMs.
- Now, 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.
- New title for Second Column: Number of Records Reviewed. (b).

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

Table 6B: Existing Measure Modified

**Tobacco Use: Screening and Cessation Intervention (CMS138v10)**

- The measure description and numerator have changed:
  - 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.

<table>
<thead>
<tr>
<th>2021 Measure</th>
<th>2022 Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td>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</td>
</tr>
</tbody>
</table>
Table 6B: Existing Measure Modified
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (CMS347v5)

<table>
<thead>
<tr>
<th>2021 Denominator</th>
<th>2022 Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients 21 years of age and older who have an active diagnosis of ASCVD</td>
<td>Patients 20 years of age and older who have an active diagnosis of ASCVD</td>
</tr>
</tbody>
</table>

- The population included for assessment (denominator) has changed.
- Denominator exceptions have been revised:
  - Now includes patients who received hospice care during the measurement period.
  - Removed as a denominator exception: "Patients 40 through 75 years of age with Type 1 or Type 2 Diabetes and with an LDL-C result of 70–189 mg/dL, measured as the highest fasting or direct laboratory test result in the calendar year or the 2 years prior.
- Now includes statin-associated muscle symptoms as a denominator exception.

Table 7: Existing Measure Modified
Controlling High Blood Pressure (CMS165v10)

- The population included for assessment (denominator) has changed.
- Specification guidance has been updated to further clarify blood pressure readings that meet compliance:
  - Taken in-person by a clinician
  - Measured remotely by an electronic monitoring device capable of transmitting the blood pressure data to the clinician
  - Taken by a remote monitoring device and conveyed by the patient to the clinician

<table>
<thead>
<tr>
<th>2021 Denominator</th>
<th>2022 Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients 18–85 years of age who had a visit and diagnosis of essential hypertension overlapping the measurement period or the year prior to the measurement period</td>
<td>Patients 18–85 years of age who had a visit and diagnosis of essential hypertension starting before and continuing into, or starting during the first 6 months of the measurement period</td>
</tr>
</tbody>
</table>

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

2022 Change:
Age of prenatal patients on Table 6B is now reported as of December 31.
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 (change for this year).
- Lines 7–9: Report all prenatal care patients by the trimester they began prenatal care:
  - Prenatal care begins with a comprehensive prenatal 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.

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.
- Column 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 10 (≥2,500 grams) is normal birth weight.
  - Column 11 (1,500–2,499 grams) is low birth weight.
  - Column 12 (<1,500 grams) is very low.

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.

View the Prenatal and Birth Outcomes Fact Sheet for more information.
Where Are These Patients Reported in Prenatal Section(s)?

1. A 23-year-old patient was seen in December of 2021 for prenatal care in the health center. The patient then had a 2,750-gram baby on January 13, 2022.

2. A 32-year-old patient is seen in the health center in early 2022, 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 2022 for allergies and a COVID-19 test. At that visit, the patient has the new baby in tow.

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

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

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

A 23-year-old patient was seen in December of 2021 for prenatal care in the health center. The patient then had a 2,750-gram baby on January 13, 2022.

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

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

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

A 32-year-old patient is seen in the health center in early 2022, 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 2022 for allergies and a COVID-19 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.
Find Resources to Help: Clinical Care

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

- UDS Clinical Quality Measures (CQM) Criteria
- Table 6A Codes Changes
- UDS Clinical Measures Exclusions and Exceptions
- Telehealth Impact on Uniform Data System (UDS) Clinical Measure Reporting

And much more!

Tables 8A, 9D, & 9E

Understanding Costs and Revenues for Health Center Scope

Overview of Financial Tables

<table>
<thead>
<tr>
<th></th>
<th>Table 8A</th>
<th>Table 9D</th>
<th>Table 9E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Captures</td>
<td>Costs, both direct and overhead, incurred in the year for the health center scope of project.</td>
<td>Patient-related changes and adjustments from the calendar year; patient-related revenue received in the year.</td>
<td>Other revenue (non-patient service generated) by the entity from which the revenue was received in the year.</td>
</tr>
<tr>
<td>Purpose</td>
<td>Describes how the health center's resources are expended overall and by service area.</td>
<td>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.</td>
<td>Provides an overview of grant and other funding by source, which, along with Table 9D, illustrates how health center operations are funded.</td>
</tr>
</tbody>
</table>
# Table 8A: Financial Costs

2022 Changes: No major changes

<table>
<thead>
<tr>
<th>Cost Center (Lines 1-15)</th>
<th>Accrued Cost (Column A)</th>
<th>Allocation of Facility and Non-Clinical Support Services (Column B)</th>
<th>Total Cost After Allocation of Facility and Non-Clinical Support Services (Column C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accrued direct costs</td>
<td></td>
<td>Allocate Facility and Non-Clinical Support Services to all other cost centers as overhead</td>
<td>Total equals to Line 16, Column A, representing overhead costs incurred by all cost centers</td>
</tr>
<tr>
<td>Fringe benefits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equipment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No bad debt costs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Medical**
- **Dental**
- **Mental Health**
- **Substance Use Disorder**
- **Pharmacy & Pharmaceuticals**
- **Other Professional**
- **Vision**
- **Enabling**
- **Other Program-Related Services**
- **Non-Clinical Support (Admin)**

**Financial Costs**

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

**Tables 5 and 8A Crosswalk**

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

Table 8A

<table>
<thead>
<tr>
<th>Financial Costs</th>
<th>Table 8A</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Report costs by cost center</strong></td>
<td></td>
</tr>
<tr>
<td>• Line 1: Medical personnel salary and benefits, including:</td>
<td></td>
</tr>
<tr>
<td>• FTE (full-time equivalent)</td>
<td></td>
</tr>
<tr>
<td>• Voucher medical service</td>
<td></td>
</tr>
<tr>
<td>• Line 2: Medical lab and X-ray direct expense</td>
<td></td>
</tr>
<tr>
<td>• Line 3: Non-personnel medical expenses, including</td>
<td></td>
</tr>
<tr>
<td>• health IT/EHR, supplies, CMEs, and travel</td>
<td></td>
</tr>
<tr>
<td>• Lines 8a–8b: Separate drug (8b) from other pharmacy costs (8a)</td>
<td></td>
</tr>
<tr>
<td>• Lines 5–13: Costs for contract pharmacy (8a, 340B) are reported on</td>
<td></td>
</tr>
<tr>
<td>• Line 8a, Pharmacy, separate from the cost of drugs</td>
<td></td>
</tr>
<tr>
<td>• Costs of pharmaceuticals (either in-house pharmacy or contract pharmacy) are reported on Line 8b.</td>
<td></td>
</tr>
<tr>
<td>• 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.</td>
<td></td>
</tr>
<tr>
<td>• Report pharmacy assistance program on Line 11e, in the enabling section, not in Pharmacy!</td>
<td></td>
</tr>
<tr>
<td>• Donated drugs are reported on Line 18, Donated Facilities, Services, and Supplies, value at 340B prices</td>
<td></td>
</tr>
</tbody>
</table>

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 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.

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 33.
- Line 15: Costs for all personnel whose FTEs are 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.). Includes malpractice insurance in the service categories, not here.
- Line 16: Total indirect costs to be allocated in Column B.

10/4/2022
Allocating Overhead Expenses to Column B

Three Step Method

Step 1: Allocate Facility (Line 14)
- Identify square footage utilized 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 services costs based on the proportion of net costs for each service category.

Reporting Donations

Table 8A and Table 9E

Donated Facilities, Services, and Supplies
- Donations of vaccines, pharmaceuticals, tests, etc.
- Volunteer time or in-kind services
- Health center space that is provided at no cost; donated facilities

Cash Donations
- Cash received from fundraising
- Direct monetary donations
- Revenue from fundraising programs like Amazon Smile

Table 9D: Patient Service Revenue

2022 Change: No major changes
### Patient Service Revenue

**Table 9D**

<table>
<thead>
<tr>
<th>Line</th>
<th>Payer Category</th>
<th>Full Charges (a)</th>
<th>Gross Charges (b)</th>
<th>Collections of Gross Charges During Year (c)</th>
<th>Collections of Gross Charges During Years (d)</th>
<th>Collections of Gross Charges During Years (e)</th>
<th>Adjustments (f)</th>
<th>Amount of Payment or Reconciliation (g)</th>
<th>Total Reconciliation (h)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Total Medicaid</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2a</td>
<td>Medicaid Managed Care (non-managed care)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2b</td>
<td>Medicaid Managed Care (capitated)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Other Medicaid Payer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Non-Medicaid Payer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Column A: Full Charges

**Table 9D**

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

### Column B: Collections

**Table 9D**

- **Column B: Collections**: Include all payments received in 2022 for services to patients:
  - Capitation payments
  - Contracted payments
  - Payments from patients
  - Third-party insurance
  - Retroactive settlements, receipts, and payments
  - Include pay-for-performance, quality bonuses, and other incentive payments tied to patient care
- Do not include Promoting Interoperability payments from Medicaid and Medicare here.
- Do not include pay-for-participation or pay-for-reporting incentives here (report on Table 9E). Pay-for-performance incentives (tied to patient services) ARE reported here.
## Columns C1–C4: Retroactive Settlements, Receipts, and Paybacks

**Table 9D**

<table>
<thead>
<tr>
<th>Amount Collected: This Period (a)</th>
<th>Collection of Reconciliation: Adjustments (b)</th>
<th>Collection of Reconciliation: Receipts (c)</th>
<th>Collection of Other Reconciliation: PPS, Risk Pools, etc. (d)</th>
<th>Penalty/Payback (e)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments reported in C1–C4 are part of Column B total, but do not equal Column B.</td>
<td>FQHC prospective payment updates (PPUs) reconciliation (based on eligible paid report)</td>
<td>FQHC prospective payment updates (PPUs) reconciliation (based on eligible paid report)</td>
<td>Managed care past distributions.</td>
<td>Paybacks or deductions by payers because of overpayments or errors (report as a positive number)</td>
</tr>
<tr>
<td></td>
<td>Whipped payments (additional amount paid to bring payment up to FQHC level)</td>
<td>Whipped payments (additional amount paid to bring payment up to FQHC level)</td>
<td>Pay for performance improvement.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Other incentive payments.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Quality bonuses.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Value-based payments.</td>
<td></td>
</tr>
</tbody>
</table>

---

## Column D: Adjustments

**Table 9D**

- 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).

---

## Column E: Sliding Fee Discounts

**Table 9D**

- 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 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.

---

**ONLY applicable to charges reported in Column A of Line 13, Self-Pay**
**Column F: Bad Debt Write-Off**

**Table 9D**

- **Bad debt:** Amounts owed by patients considered to be uncollectable and formally written off during 2022, 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 11, Self-Pay.**
- Third-party payer bad debt is not reported in the UDS.
- Discounts (e.g., to specific groups of patients, cash discounts) or forgiveness is not patient bad debt (or a sliding discount).

---

**Payer Categories for Patient Service Revenue**

**Table 9D**

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>Any state Medicaid program, including EPDST, ADHC, PAZ, if administered by Medicaid. Medicaid MCOs or Medicaid programs administered by third-party or private payers. CHIP, when administered by Medicaid.</td>
</tr>
<tr>
<td>Medicare</td>
<td>Medicare managed care programs, including Medicare Advantage run by commercial insurers. ADHC or PAZ, if administered by Medicare.</td>
</tr>
<tr>
<td>Other Public</td>
<td>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. Care under HRA COVID-19 Uninsured Program.</td>
</tr>
<tr>
<td>Private</td>
<td>Commercial insurance purchased by patients and/or their employers. Tricare, TRICARE, Federal Employees Insurance Program, Workers’ compensation. Insurance purchased through state exchanges or provided by employers.</td>
</tr>
<tr>
<td>Self-Pay</td>
<td>Pensions that the patient is responsible for or that is not covered by a third-party payer—includes copay, deductibles, or full charge Indigent care charge portion.</td>
</tr>
</tbody>
</table>

---

**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.
**COVID-19 Uninsured Program Reporting**

<table>
<thead>
<tr>
<th>Table 9D</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Funding</td>
<td>Other Names</td>
</tr>
<tr>
<td>Reimbursement for COVID-related costs of uninsured patients from HRSA</td>
<td>HRSA Uninsured Claims Program (administered by United Health/ Optum Pay)</td>
</tr>
</tbody>
</table>

- Only HRSA’s COVID-19 Claims Reimbursement to health care providers and facilities for testing and treatment of the uninsured patients is reported. The HRSA COVID-19 Uninsured program stopped accepting claims in early April 2022.

- Do not report write-offs or costs to treat or test uninsured patients that are not reimbursed through HRSA’s COVID-19 Claims Reimbursement program on this line.

---

**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.

- **Managed Care Capitation**
  - The revenue from health center contracts with a managed care organization for a specified set of services, for which the managed care plan pays the health center a set amount for each patient assigned to the health center. This is called a capitation fee and is typically paid per member per month.

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

---

**Examples: Reclassifying a Portion of a Charge**

*Remember, when 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.**
Reporting: Reclassifying a Portion of a Charge

<table>
<thead>
<tr>
<th>Line</th>
<th>Payer Category</th>
<th>Full Charge This Period ($)</th>
<th>Amount Collected This Period ($)</th>
<th>Reclassified Portion of Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Private Non-Managed Care</td>
<td>Total Charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11a</td>
<td>Private Managed Care (capitated)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11b</td>
<td>Private Managed Care (fee-for-service)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Total Private</td>
<td>Sum of Lines 10 + 11a + 11b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Self-Pay</td>
<td>Reclassified Portion of Charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td></td>
<td>Total</td>
<td>Sum of Lines 3 + 6 + 9 + 12 + 13</td>
<td></td>
</tr>
</tbody>
</table>

- 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 or
  - May be written off as sliding fee if the patient has qualified or
  - May be written off as bad debt.

- Must reclassify the charge first!

Example

How is this reported across Tables 4 and 9D?

- Naomi came into the health center seeking contraception in 2022. In completing intake paperwork, Naomi notes that she does not have insurance.
- Naomi is then seen twice at the health center in 2022 for family planning services including contraception, STI testing, and follow-up.
- Her family planning services were covered by the Title X program.

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 her own 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 received and collections received from Title X are reported as Other Public Non-Managed Care, on Line 7.
  - Any charges that were Naomi’s responsibility are reported on Line 13: Self Pay.
### Reporting 340B Contract Pharmacy

<table>
<thead>
<tr>
<th>Table</th>
<th>Related Reporting/Impact</th>
</tr>
</thead>
</table>
| 8A (Cost) | - Report the amount the pharmacy charges for dispensing/dispensing of drugs to 340B Pharmacy.  
- Report the amount of the drug (not drugs) for this pharmacy.  
- Indirectly by contract pharmacy (on Line B).  
- If the pharmacy has pre-packaged drugs and there is no reasonable way to report the pharmaceutical costs from the dispensing/administration costs, report all costs on Line B, associated non-clinical support services (permitted) costs go on Line B. Column B, even though Line B, Column A is blank.  
- Report payments to patient/benefit managers or Line B, Column A.  
- Report payments to patient/benefit managers on Line B, Column A.  
- Payment to patient/benefit managers (Line B, Column A).  
- Report payments to patient/benefit managers on Line B, Column A.  |
| 9D (Patient Service Revenue) | - Change (Column B) is the health center’s common pharmacy’s full retail charge for the drug dispensed.  
- Change (Column B) is the amount owed for patients’ expenses/compensation.  
- Column B (if column B) is the amount received from patients on account of the pharmacy.  
- Make sure there are no errors in the calculation (Column D).  
- Column B (if column B) is the amount received from patients on account of the pharmacy.  
- Make sure there are no errors in the calculation (Column D).  
- Column B (if column B) is the amount received from patients on account of the pharmacy.  
- Make sure there are no errors in the calculation (Column D).  |
| 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 9E.  |

**Key Takeaway:** The breaks/verticals above are needed to report correctly.

---

### Table 9E: Other Revenue

2022 Changes:
- Updated one line label, now reads Capital Development Grants, including School-Based Service Site Capital Grants.

---

### Other Revenue

**Table 9E**

- Report non-patient-service receipts or funds drawn down in 2022.
- Include income that supported activities described in your health center’s scope of services.
- Report funds by the entity from which you received them.
- Complete “specify” fields.
- The total amount reported on Tables 9E and 9O 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](#).
### Revenue Categories

**Table 9E, Lines 1a–3b**

- **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 received in 2020.
- **Other Federal Grants**: Grants you received directly from the federal government other than BPHC. Other federal grants (e.g., HHS, 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 let party rule).
  - Provider Relief Fund.

### BPHC COVID-19 Funding Lines

**Table 9E, Lines 1a–5q**

- 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 2022, then they’re reported in Calendar Year 2022 UDS.
  - Lines 1–5q were awarded in 2020.
  - Line 1a was awarded in 2021.
- At this time, there will be no reporting on Line 5p, as no other BPHC COVID-19 funding exists.
- Detailed guidance on COVID-19 funding.

### Non-Federal Grants Revenue Categories

**Table 9E, Line 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 revenue.
  - Do not report bad debt recovery or 340B revenue here—these revenues are reported on Table 9D.
Find Resources to Help: Financial

HRSA BPHC UDS Resources site financials section includes the following resources:

• Fact sheets
• COVID-19 Funding UDS Reporting Guidance
• UDS Financial Tables Guidance
• Reporting Donations on the UDS
• Costs and revenues module

And much more!

Other Forms

Understanding More About How and What Your Health Center Does

Patient Demographic Profile
Clinical Services and Outcomes
Financial Tables
Other 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 CEHRT? Did you switch?
  • 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
  • New this year: Total number of patients screened
  • Patients identified with social risks
  • If no, why not?

• Integration of Prescription Drug Monitoring Program (PDMP)
Updates to Health IT Form
Appendix D
- Clarifying questions throughout
- New question on social risk factors

<table>
<thead>
<tr>
<th>Question</th>
<th>Description of Revisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>New: Question 11a</td>
<td>Question 11a, how many health center patients were screened for social risk factors using a standardized screener during the calendar year? A new question has been added to capture the total number of patients screened for social risk factors.</td>
</tr>
<tr>
<td>Questions throughout</td>
<td>Questions throughout have been revised to provide clarity and additional selection options.</td>
</tr>
<tr>
<td>Questions 14, 15, 16, 17</td>
<td>Questions 15 and 16 have been revised to provide clarity and additional selection options. Questions 17 have been removed.</td>
</tr>
</tbody>
</table>

Positive Screens for Selected Social Risks
Appendix D
- In addition to asking whether a health center is using a standardized social risk screener, the HIT form also collects the number of health center patients who screened positive in four areas:
  - Food insecurity
  - Housing insecurity
  - Financial strain
  - Lack of transportation/access to public transportation
- This crosswalk identifies the questions on each standardized screener and what constitutes a positive screen in each of the selected areas.
- Do not use proxies (such as patients with low income) to report social risks.

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.
- **Medication-Assisted Treatment (MAT)**
  - Report number of providers who have obtained a Drug Addiction Treatment Act of 2000 (DTA) waiver to provide MAT
  - Report number of patients who received MAT from a provider with a DTA waiver working on behalf of the health center
  - Count only MAT (buprenorphine) provided by providers with a DTA waiver
  - Check information with reporting on Table 5.
- **Outreach and Enrollment Assistance**
  - Report number of assists
  - Outreach and enrollment assists are defined as customizable education sessions about affordable health insurance coverage options and any other assistance provided by a trained assister from the health center to facilitate enrollment.
  - Assists reported here do not count as visits on the UDS tables, only on this form.
**Teledicine Reporting**

**Appendix E**

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

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

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

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

**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.

---

**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 staff training like continuing education, CMEs, or first aid training, but training of the health professional workforce.

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

---

**Wrapping Up**

**Setting Up for Success**

Available Resources

Tips for Success

Wrapping Up
Available Resources

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

UDS Training and Technical Assistance Resources

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

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 site
**Training Webinar Series for 2022 UDS Reporting**

The webinar series includes:

- UDS Basics: Orientation to Terms and Resources
- The Foundation of the UDS: Counting Visits and Patients
- UDS Clinical Tables Part 1: Screening and Preventive Care Measures
- 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; watch them anytime!

---

**Support Available**

<table>
<thead>
<tr>
<th>Description</th>
<th>UDS Support Center</th>
<th>Health Center Program Support</th>
<th>HRSA Call Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>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)</td>
<td>Assistance for health centers when completing the UDS Report or the tools (e.g., report access/submission, troubleshooting system issues, technical assistance materials, training)</td>
<td>Assistance with getting an EHBs account, troubleshooting system issues, setting up the roles and privileges associated with your EHBs account, and determining whether a competing application is with Grants.gov or HRSA</td>
</tr>
<tr>
<td>Contact</td>
<td>866‐837‐4357/866‐UDS‐HELP</td>
<td>877‐864‐4772, Option 1</td>
<td>877‐864‐4772, Option 2</td>
</tr>
<tr>
<td>Website</td>
<td>UDS Support Center website: usda.gov/hrsadata/udsreporting</td>
<td>Health Center Program Support website: hrsadata.gov/udsreporting</td>
<td>HRSA Call Center website: hrsadata.gov/contact</td>
</tr>
<tr>
<td>Hours of Operation</td>
<td>8:30 a.m. to 5:00 p.m., ET, M–F</td>
<td>7:30 a.m. to 8:00 p.m., ET, M–F</td>
<td>8:00 a.m. to 8:00 p.m., ET, M–F</td>
</tr>
<tr>
<td></td>
<td>Extended hours during UDS reporting period</td>
<td>Extended hours during UDS reporting period</td>
<td></td>
</tr>
</tbody>
</table>

**Tips for Success and Resources**
**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.

---

**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 EHIs.
  - Understand and communicate system or program changes that explain the data.
- **Address edits** in the EHIs by correcting or providing explanations that demonstrate your understanding.
- Work with your UDS reviewer.

---

**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:
    - udsinfo330@bphcdata.net
    - 866-UDS-HELP (866-837-4357)
  - Health Center Program support for questions about the Health Center Program.
- **EHBs support**
  - UDS Report and Preliminary Reporting Environment access (in EHBs)
  - EHBs system issues: 877-464-4772, Option 1
  - EHBs account access and roles: 877-464-4772, Option 3
- **National Training and Technical Assistance Partners**
Administering Program Conditions

Health centers must demonstrate program compliance with these requirements:

• The health center has a system in place to collect and organize data related to the HRSA-approved scope of project, as required to meet Health and Human Services (HHS) reporting requirements, including those data elements for UDS reporting; and
• The health center submits timely, accurate, and complete UDS reports in accordance with HRSA instructions and submits any other required HHS and Health Center Program reports.

Conditions will be applied to health centers that fail to submit 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 (HSO) project officers of the health centers that are on the non-compliant list.
• Late April/Early May: BPHC will issue the related Progressive Action condition.

Source: Chapter 18: Program Monitoring and Data Reporting Systems of the Health Center Program Compliance Manual

Thank You!

Thank you for joining this UDS Training!
Bureau of Primary Health Care (BPHC)
Health Resources and Services Administration (HRSA)

udshelp330@bphcdata.net
1-866-UDS-HELP

bphc.hrsa.gov
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www.HRSA.gov

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