HRSA
Health Resources & Services Administration

Reporting Uniform Data System (UDS) Financial and Operational Tables

October 14, 2021, 1:00–2:30 p.m. ET

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Vision: Healthy Communities, Healthy People

Opening Remarks

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UDS Patient Level Submission (UDS+)

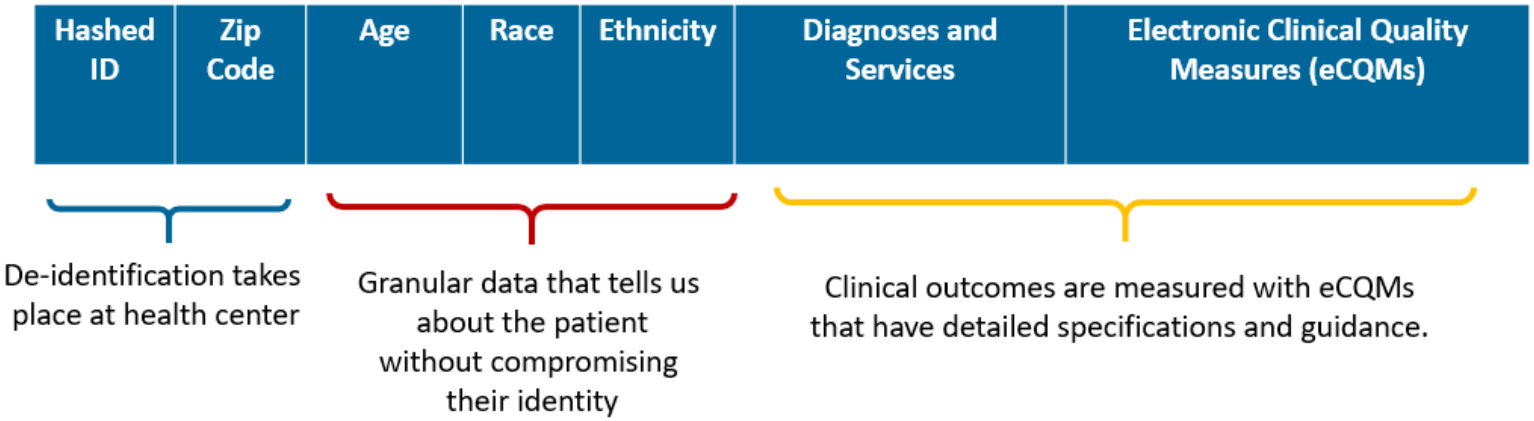
UDS+ is...

- Beginning with the 2023 UDS, BPHC will accept patient-level report data.
  - UDS Tables PBZC, 3A, 3B, 4, 6A, 6B, and 7
- HRSA plans to accept UDS+ data in two ways:
  - Manual file upload system & Fast Healthcare Interoperability Resources (FHIR)

UDS+ does not...

- Collect full copies of data directly from patients' electronic medical records.
- Collect patient identifiers.

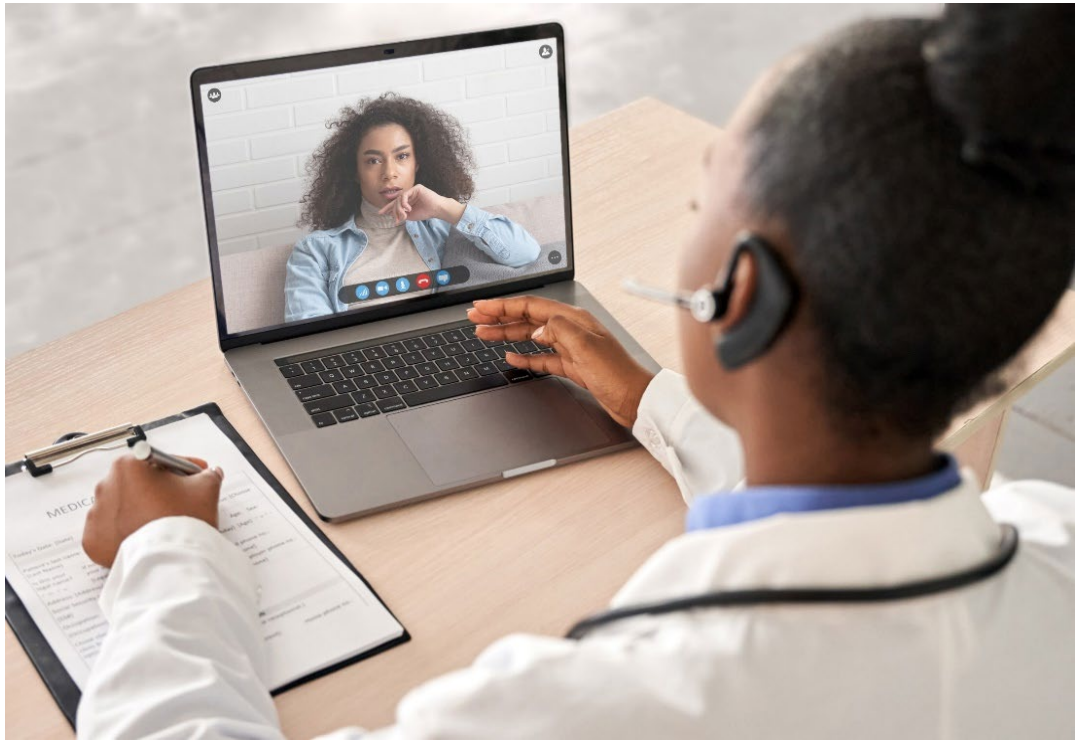
For more information, visit: Uniform Data System (UDS) Modernization Initiative



HRSA Health Center Program

Agenda

- Review reporting requirements for UDS financial tables and related operational tables.
- Review UDS terminology.
- Discuss common reporting questions.
- Review COVID-19 impacts across financial tables.



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Objectives of the Webinar

By the end of this webinar, participants will be able to:

- Understand reporting requirements for the UDS financial tables and related operational tables.
- Identify strategies to check data for accuracy.
- Identify the impact of COVID-19 on UDS reporting.
- Access additional reporting support.

Poll #1

How familiar are you with the UDS financial tables?

A. I am not familiar. The basics will be helpful to learn.
B. I am not very familiar. Gaining a better understanding will be helpful.
C. I am somewhat familiar. Learning about the tables in more detail will be helpful.
D. I am very familiar with these tables. I would like to learn about any changes this year that impact UDS reporting.

Overview of Data Collected in UDS Tables

Patient Profile	Services and Clinical Outcomes	Financial Tables
Captures the demographic information of health center patients who received in-scope services	Captures personnel, visits, services, and outcomes related to all in-scope services provided to health center patients	**Captures the costs and the revenues (both patient service generated and other) related to in-scope services**
ZIP Code Table, Table 3A, Table 3B, and Table 4	Table 5, Table 6A, Table 6B, and Table 7	**Table 8A, Table 9D, and Table 9E**

All data is reported for the *full calendar year*, Jan. 1, 2021, through Dec. 31, 2021.

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Overview of Financial Tables

Table 8A: Financial Costs	Table 9D: Patient Service Revenue	Table 9E: Other Revenue
Costs related to personnel, classified by cost center, aligned with service areas on Table 5	Charges, by payer, related to services provided to patients	Federal grant revenue, including health center funding and COVID-19 supplemental funding from HRSA BPHC
Costs related to services/contracts, by cost center aligned with service areas on Table 5	Collections, by payer, related to services provided to patients	State/local grant revenue, including indigent care program revenue
Pharmaceutical costs	Adjustments, by payer, related to services provided to patients	Private/foundation revenue
Costs for facilities and non-clinical support services	Revenue within each payer (except self-pay) is classified as capitated managed care, fee-for-service managed care, and non-managed care	Other revenue, including cash donations
Value of donated facilities, services, and supplies	Sliding fee discount for patients and bad debt for patients	Other revenue includes receipts from indigent care programs

Key Terms in UDS Financial Tables

Cost Center	A grouping of costs by service type or function aligned with classifications used in Table 5
Accrued Cost	Expenses incurred during the calendar year
Overhead	Facility and non-clinical support service expenses
Charges	The value of services rendered to patients during the calendar year based upon the center's fee schedule
Collections	Total of cash received in the calendar year for services provided to patients, regardless of when those services were rendered
Adjustments	Contractual discounts granted as part of an agreement with a third-party payer
Third-Party Payer	Any entity, other than the patient, reimbursing the health center for patient services
Managed Care	Revenue from organizations who meet the UDS definition of managed care. Payers with which the health center has a *contractual managed care agreement to provide a range of services to patients assigned to the health center*; paid fee-for-service or capitated

Table 8A: Costs

Financial Costs

Table 8A Columns

Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
Expenses incurred during the calendar year. Cost includes personnel and all costs other than personnel. Cost excludes bad debt and principal payments.	Allocation of facility and non-clinical support services (Column A, Lines 14 and 15) to each cost center. Note: Total of Column B must be equal to Column A, Line 16.	Includes all direct cost and the cost center's share of overhead cost. Represents total cost to operate services. All in-kind non-cash donations are reported on line 18. Note: Sum of Columns A + B (occurs automatically in EHBs). Can be used to calculate cost per visit and cost per patient.

Financial Costs

Table 8A Column A

Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
Expenses incurred during the calendar year. Cost includes personnel and all costs other than personnel. Cost excludes bad debt and principal payments.	Allocation of facility and non-clinical support services (Column A, Lines 14 and 15) to each cost center. Note: Total of Column B must be equal to Column A, Line 16.	Includes all direct cost and the cost center's share of overhead cost. Represents total cost to operate services. All in-kind non-cash donations are reported on line 18. Note: Sum of Columns A + B (occurs automatically in EHBs). Can be used to calculate cost per visit and cost per patient.

Accrued Costs

- Accrued costs are those costs incurred by a given cost center but not yet paid during the calendar year, including:
  - Staff costs (salary, fringe benefits, continuing medical education [CME], etc.).
  - Paid referred care.
  - Supplies.
  - Depreciation of equipment.
  - Software or systems.
  - Interest payments on any loans.
  - Costs for contracted care, etc.
- Accrued costs do not include:
  - Costs for anything incurred outside the calendar year.
  - Bad debt related to the provision of patient service.
  - Loan principal payments.
  - Costs for services the health center did not pay for directly (e.g., services that the health center referred, but were billed by the third-party provider).
  - Gross costs for capitalized expenses.

Cost Centers

Table 8A		Alignment with Table 5	
Line	**Cost Center**	**Line**	**Service Area (includes FTEs and visits)**
1	**Medical** personnel costs	1–12	Medical Providers and Clinical Support Personnel
2	Medical **Lab and X-ray** costs	13–14	Medical Lab and X-ray
5	**Dental** costs	16–18	Dentists, Dental Hygienists, etc.
6	**Mental Health** costs	20a–20c	Psychiatrists, Licensed Clinical Psychologists, LCSWs, etc.
7	**Substance Use Disorder** costs	21	Substance Use Disorder
8a	**Pharmacy** costs	23	Pharmacy
9	**Other Professional** costs	22	Other Professional (dieticians, podiatrists, community health aids and practitioners)
9a	**Vision** costs	22a–22c	Vision (ophthalmologists, optometrists)
11a–11h	**Enabling** costs	24–28	Enabling (case management, patient, community education)

Medical Cost Center
Table 8A, Lines 1–3, Column A

Line 1: Medical personnel salary and benefits

- **Includes** costs for all personnel directly attributable to medical department including medical providers, medical assistants
- **Includes** medical personnel under contract
- Does **not** include value of volunteers

Line 2: Medical **lab and X-ray** direct costs

- **Includes** medical lab and X-ray provided directly by the health center and those paid to a referred care provider
- Does **not** include costs that lab/radiology bills directly to the patient, unpaid medical lab and X-ray provided directly by a referred care provider, or dental lab and X-ray costs

Line	Cost Center	Accrued Cost (a)
	Financial Costs of Medical Care	
1	Medical Personnel	
2	Lab and X-ray	
3	Medical/Other Direct	
4	**Total Medical Care Services** (Sum of Lines 1 through 3)	

Line 3: Other than personnel direct medical costs

- **Includes** costs for anything else directly attributable to the medical department
- Does **not** include value of donated goods
- Does **not** include any pharmacy or pharmaceutical costs, such as cost of medications

Medical Cost Center
Table 8A, Lines 5–8b, Column A

Line 5: Dental

- **Includes** dental personnel costs, contracted dental care, and electronic dental record costs

Line 6: Mental Health

- **Includes** mental health personnel , supplies, and software used specifically by mental health department

Line 7: Substance Use Disorder

- **Includes** substance use disorder services health personnel, supplies, and software

Line 8a: Pharmacy

- **Includes** pharmacy personnel and the dispensing and administrative fees for 340B contractors
- Does **not** include costs of drugs

Line	Cost Center	Accrued Cost (a)
	Financial Costs of Other Clinical Services	
5	Dental	
6	Mental Health	
7	Substance Use Disorder	
8a	Pharmacy (not including pharmaceuticals)	
8b	Pharmaceuticals	

Line 8b: Pharmaceuticals

- **Includes** the cost of medications administered in-house or via contract pharmacy
- Does **not** include value of donated drugs; dispensing and administrative fees of contract pharmacy

Do not include volunteer or donated personnel or donated supplies.

Other Cost Centers

Table 8A, Lines 9 and 9a, Column A

Line 9: Other Professional

- **Includes** other professional and ancillary health care services costs like podiatry, chiropractic, acupuncture, naturopathy, speech and hearing pathology, or occupational and physical therapy
- Does **not** include other professional costs that may be included in programs reported under "Other Program Related Services" (Line 12), such as WIC, Healthy Start, fitness centers, clinical trials, etc.

Line 9a: Vision

- **Includes** vision personnel and supplies
- Does **not** include donated time of optometrists

Line	Cost Center	Accrued Cost (a)
9	Other Professional (specify___)	
9a	Vision	
10	**Total Other Clinical Services** (Sum of Lines 5 through 9a)	

Other Cost Centers

Table 8A, Lines 11-13, Column A

Lines 11a–11h, Line 11: Enabling Services

- **Includes** costs such as those for education materials, taxi vouchers, translation/interpretation services, in addition to personnel costs.

Line 12: Other Program-Related

- **Includes** costs such as WIC, child care centers, housing, clinical trials, employment training, space leased to others, and retail pharmacy services provided to non-health-center patients.
- Describe the program costs using the "specify" field.

Line 12a: Quality Improvement (QI)

- **Includes** costs of personnel dedicated to the QI program and/or HIT/EHR system development.
- Does **not** allocated portions of costs and time for QI personnel attending meetings, peer reviews, designing or interpreting QI findings to other service categories.

Line	Cost Center	Accrued Cost (a)
	Financial Costs of Enabling and Other Services	
11a	Case Management	
11b	Transportation	
11c	Outreach	
11d	Patient and Community Education	
11e	Eligibility Assistance	
11f	Interpretation Services	
11g	Other Enabling Services (specify___)	
11h	Community Health Workers	
11	**Total Enabling Services** (Sum of Lines 11a through 11h)	
12	Other Program-Related Services (specify___)	
12a	Quality Improvement	
13	**Total Enabling and Other Services** (Sum of Lines 11, 12, and 12a)	

Poll #2: Accrued Costs

Which of these costs *will be* reported on Table 8A?

A. Health center staffing costs that occurred in federal fiscal year 2021.

B. A loan principal payment made by the health center in calendar year 2021.

C. Depreciation of the health center's medical equipment.

Answer: Accrued Costs

Which of these costs *will be* reported on Table 8A?

A. Costs for colorectal cancer screening tests performed by and billed for by a health center referral partner.

B. A loan principal payment made by the health center in calendar year 2021.

C. Depreciation of the health center's medical equipment.

Financial Costs

Table 8A Column B

Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
Costs attributable to the calendar year by cost center. Report costs of: • Personnel. • Fringe benefits. • Supplies. • Equipment. • Depreciation. • Interest paid. • Related travel. Exclude bad debt and repayment of principal on loans.	Allocation of facility and non-clinical support services (Column A, Lines 14 and 15) to each cost center. Note: Total of Column B must be equal to Column A, Line 16.	Represents cost to operate services. Note: Sum of Columns A + B (occurs automatically in EHBs). Represents **total cost** to operate services. Can be used to calculate cost per visit and cost per patient.

Allocating Facility and Non-Clinical Support Services (Overhead) Table 8A

Facility and non-clinical support service expenses are referred to as overhead expenses. In the UDS, these are reported on Table 8A, Column A, in Lines 14 and 15 (Line 16 is the total).

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

Line 14: Facility-related expenses

- Includes facility personnel costs, rent or depreciation, mortgage interest payments, utilities, security, grounds keeping, janitorial services, maintenance, etc.

Line 15: Non-clinical support services

- Includes personnel such as corporate administration, billing, revenue cycle, medical records and intake personnel and facility and liability insurance, legal fees, managing practice management system, and direct non-clinical support costs (travel, supplies, etc.)

Allocating Facility and Non-Clinical Support Services (Overhead) Table 8A, Column B

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

Line	Cost Center	Allocation of Facility and Non-Clinical Support Services (b)
	Financial Costs of Medical Care	
1	Medical Personnel	
2	Lab and X-ray	
3	Medical/Other Direct	
4	**Total Medical Care Services** (Sum of Lines 1 through 3)	
	Financial Costs of Other Clinical Services	
5	Dental	
6	Mental Health	
7	Substance Use Disorder	
8a	Pharmacy (not including pharmaceuticals)	
8b	Pharmaceuticals	
9	Other Professional (specify___)	
9a	Vision	
10	**Total Other Clinical Services** (Sum of Lines 5 through 9a)	
12	Other Program-Related Services (specify___)	
12a	Quality Improvement	
13	**Total Enabling and Other Services** (Sum of Lines 11, 12, and 12a)	

- All overhead costs are allocated to cost centers in Column B.
- Overhead costs that are directly associated with a cost center should be allocated first.
- The remaining overhead costs should be allocated using a proportional method, such as the proportion of square footage that each cost center uses (for facility costs) and percent of total accrued costs of each cost center (for non-clinical support costs).

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Allocating Facility and Non-Clinical Support Services (Overhead) to Cost Centers

Use the simplest allocation method that produces a result comparable to a more complex method. If possible, use at least a three-step allocation method.

Step 1: Allocate Line 14, Facility

- Allocate facility costs to each cost center based on either actual facility costs for that cost center or percentage of total square footage that the cost center uses.
- Any facility costs that are specific to non-clinical support services are allocated to Line 15 and then allocated in Step 2.

Step 2: Line 15, Non-Clinical Support Services

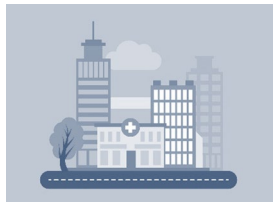
- Allocate any non-clinical support costs attributable to a specific cost center to that cost center.
  - For example, decentralized front desk personnel, billing and collection systems and personnel, etc. are allocated to the service they work in.
- Consider lower allocation of overhead to contracted services and enabling services.

Step 3: Remaining Costs

- Allocate remaining costs using a consistent approach, commonly based on the proportion of direct costs or of visits.

Overhead Allocation Example: First Step

Total Facility Costs on Line 14, Col a: $70,000



Site A
2,500 Square Feet
80% medical, 20% admin

Site B
3,500 Square Feet
57% medical, 29% mental health, 14% admin

Site C
6,500 Square Feet
31% medical, 31% dental, 15% mental health, 23% admin

	Medical	Dental	Mental Health	Admin	Total Square Feet
Site A	2,000	-	-	500	2,500
Site B	-	2,000	1,000	500	3,500
Site C	2,000	2,000	1,000	1,500	6,500
Total Square Feet (SF)	4,000	4,000	2,000	2,500	12,500
% of total SF	32%	32%	16%	20%	100%
% total SF times total facility costs	32%*$70K	32%*$70K	16%*$70K	20%*$70K	100%*$70K
Facility Allocation	$22,400	$22,400	$11,200	$14,000	$70,000

*Administration facility costs are allocated to non-clinical support and then allocated with non-clinical support services in second step.

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Overhead Allocation Example: Next Steps

Line 15: Non-Clinical Support Services are $250,000.

- **Plus** $14,000 of allocated facilities costs (as shown in last slide).
- **Total of $264,000** of non-clinical support costs to be allocated.

First, distribute non-clinical support costs to the applicable service where possible.

Cost Center	Total to be allocated to cost center in Column b
Medical (Lines 1–3)	$75,000
Dental (Line 5)	$105,000
Mental Health (Line 6)	$50,000
Total Allocated in this Step	$230,000
Remaining Non-Clinical Support Costs to be allocated	$34,000

Next, distribute remaining non-clinical support costs.

Cost Center	Percent of Costs in Column a	Allocation
Medical (Lines 1–3)	30.8%	$10,458.70
Dental (Line 5)	44.6%	$15,170.65
Mental Health (Line 6)	24.6%	$8,370.65
Total	100%	**$34,000**

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Overhead Allocation Example: Total of $320,000

Cost Center	Allocated Facility Costs	Allocated Non-Clinical Support Services	Allocation of Remaining Costs	Total Overhead Costs to be Reported in Column B for Cost Center
Medical (Lines 1–3)	$22,400	$75,000	$10,458.70	$107,858.70
Dental (Line 5)	$22,400	$105,000	$15,170.65	$142,570.65
Mental Health (Line 6)	$11,200	$50,000	$8,370.65	$69,570.65

Poll #3: Allocating Costs on Table 8A

What costs are allocated in Column B of Table 8A?

A. Column B includes allocation of facility and non-clinical support services costs (Lines 14 and 15).
B. Column B includes allocation of total accrued costs (Line 17).
C. Column B includes allocation of facility, non-clinical support services costs, and value of donated facilities, services, and supplies (Lines 14, 15, and 18).

Answer: Allocating Costs on Table 8A

What costs are allocated in Column B of Table 8A?

A. **Column B includes allocation of facility and non-clinical support services costs (Lines 14 and 15).**
B. Column B includes allocation of total accrued costs (Line 17).
C. Column B includes allocation of facility, non-clinical support services costs, and value of donated facilities, services, and supplies (Lines 14, 15, and 18).

Pharmacy Reporting on Table 8A

Health centers with pharmacy programs

- Dispensing and administrative fees for contract pharmacy (e.g., 340B) are reported on Line 8a, Pharmacy, separate from the cost of drugs.
- The cost of medications administered by in-house clinicians are reported on Line 8b, **not** in Medical.
- Administrative or overhead costs for the contract pharmacy program should be allocated to Line 8a, Pharmacy, in Column B.
- Report assistance establishing eligibility for pharmacy assistance programs on line 11e, **not** in Pharmacy.
- Donated drugs are reported on Line 18, Donated Facilities, Services, and Supplies; value at 340B prices.

Table 8A: Tips and Frequently Asked Questions

Question	Answer
How do we report costs for personnel whose FTE is split across multiple lines on Table 5?	If an individual's FTE is split across multiple lines on Table 5, the same proportional allocation must be used for that personnel cost on Table 8A.
How do we report costs for telehealth equipment (e.g., iPads) we bought to reach patients and personnel at home?	Determine which cost center(s) use the telehealth equipment. If the equipment is used by one cost center (e.g., medical), the equipment will be reported as an accrued cost for that cost center in Column A. If the equipment is used across the clinic (e.g., medical and behavioral health), allocate the cost across those cost centers.
How do we report donated services or supplies?	Donations of goods, supplies, services, or personnel time should be valued and reported on Line 18 of Table 8A in Column C. **Do not** report cash donations on Table 8A; those are reported on Table 9E.
We contract with a pharmacy for 340B. How do we report the costs of the purchased drugs?	Report the full cost of 340B drugs purchased by or on behalf of the clinic and dispensed by a contract pharmacy. This includes 340B drugs paid for in full by the health center, net payment after subtraction of revenue at the contract pharmacy, or receipt of a reduced net payment from the pharmacy. See UDS Manual page 166.

Table 9D: Patient Related Revenue

Table 9D: Patient Service Revenue

Lines 1–14

Revenue by five payer categories: Medicaid, Medicare, Other Public, Private, and Self-Pay.

All include three sub-categories:

- Non-managed care
- Capitated managed care
- Fee-for-service managed care

Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Retroactive Collection of Reconciliation/ Wraparound Current Year (c1)	Settlements, Receipts, Collection of Reconciliation/ Wraparound Previous Years (c2)	and Paybacks (c) Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty/ Payback (c4)	Adjustments (d)	Sliding Fee Discounts (e)	Bad Debt Write-Off (f)
1	Medicaid Non-Managed Care									
2a	Medicaid Managed Care (capitated)									
2b	Medicaid Managed Care (fee-for-service)									
3	**Total Medicaid** (Sum of Lines 1 + 2a + 2b)									
4	Medicare Non-Managed Care									
5a	Medicare Managed Care (capitated)									
5b	Medicare Managed Care (fee-for-service)									
6	**Total Medicare** (Sum of Lines 4 + 5a + 5b)									
7	Other Public, including Non-Medicaid CHIP, Non-Managed Care									
8a	Other Public, including Non-Medicaid CHIP, Managed Care (capitated)									
8b	Other Public, including Non-Medicaid CHIP, Managed Care (fee-for-service)									
8c	Other Public, including COVID-19 Uninsured Program									
9	**Total Other Public** (Sum of Lines 7 + 8a + 8b + 8c)									
10	Private Non-Managed Care									
11a	Private Managed Care (capitated)									
11b	Private Managed Care (fee-for-service)									
12	**Total Private** (Sum of Lines 10 + 11a + 11b)									
13	**Self-Pay**									
14	**TOTAL** (Sum of Lines 3 + 6 + 9 + 12 + 13)									

Report charges, collections, supplemental payments, contractual adjustments, and sliding discounts and bad debt for patients.

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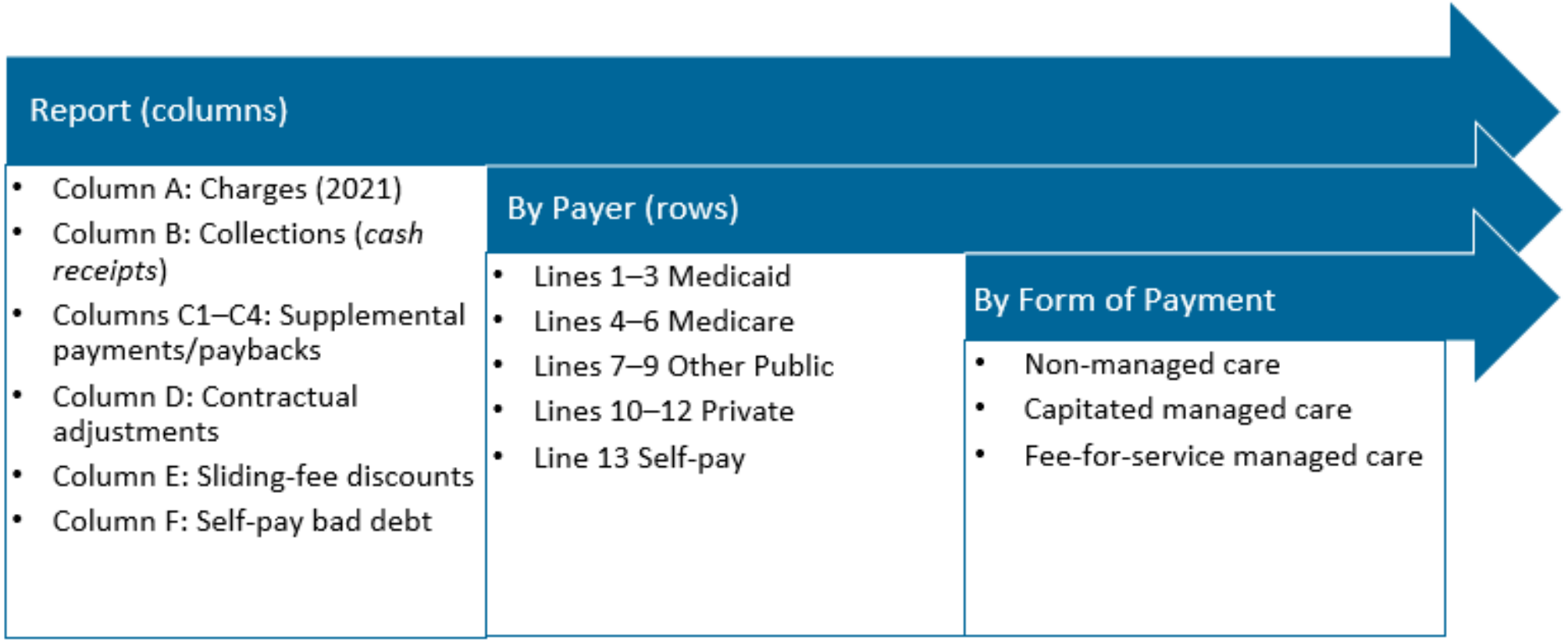
Table 9D at a Glance: Reporting Patient Service Revenue



Patient Service Revenue

Table 9D, Columns A–B

Charges (a)	Collections (b)
Charges are the amount each service rendered to patients in the calendar year is valued at, **according to the health center's fee schedule**. Charges for any given procedure are recognized and reported at the same amount across all payers. Charges are captured by third-party and self-pay payer, for all patient services rendered to health center patients in the calendar year (January 1 through December 31). Charges are reclassified in accordance with co-pay or co-insurance responsibility; for example, if a patient is responsible for 20% of the charge, then 80% of the charge is on the third-party payer line and 20% of the charge is moved to the self-pay line.	Collections are the total of cash received in the calendar year (January 1 through December 31) for services provided to patients, regardless of when those services were rendered. Collections include: • Reimbursement for services provided to patients from third-party payers and patients. • Managed care or capitation payments. • Payment for grant-covered services from public entities. • Health center reconciliation or wrap payments. • Quality bonuses or pay-for-performance bonuses.

Patient Service Revenue

Table 9D, Columns C1–C4

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

Patient Service Revenue

Table 9D, Column D

Adjustments (d)

- Adjustments are contractual discounts granted as part of an agreement with a third-party payer. Virtually all insurance companies have a maximum amount they pay for a given service, and the health center agrees to write off the difference between what they charge and that contracted amount. These are considered contractual adjustments.
- On Table 9D, adjustments have the effect of reducing the amount to be collected and are generally reported in Column D as a positive number.
- Adjustments for third-party payers are reported in Column D.

Third-Party Payers

- A third-party payer is any entity, other than the patient, reimbursing the health center for patient services. The patient and the health center are parties directly involved with the service. An outside payer is a "third-party payer." In the UDS, these categories are:
  - **Medicaid**
    - ✓ Any state Medicaid program, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Adult Day Health Care (ADHC), Program of All-inclusive Care for the Elderly (PACE), if administered by Medicaid
    - ✓ Medicaid managed care organizations (MCOs) or Medicaid programs administered by third-party or private payers
    - ✓ Children's Health Insurance Program (CHIP), when administered by Medicaid
  - **Medicare**
    - ✓ Any Medicare program or other program administered by Medicare
    - ✓ Medicare managed care programs, including Medicare Advantage run by private payers
    - ✓ ADHC or PACE if administered by Medicare
  - **Other Public**
    - ✓ CHIP, when paid for through private insurers
    - ✓ State- or county-run insurance plans
    - ✓ Service contracts with municipal or county jails, state prisons, public schools, or other public entities
    - ✓ HRSA COVID-19 Uninsured Program
  - **Private**
    - ✓ Insurance provided by employers
    - ✓ Tricare, Trigon, Federal Employees Insurance Program
    - ✓ Insurance purchased through state exchanges or by individuals
    - ✓ ***NOT*** Medicaid or Medicare programs administered by private payers

Patient Service Revenue

Forms of Payment

Managed Care	Revenue from organizations who meet the UDS definition of managed care. Payers with which the health center has a *contractual managed care agreement to provide a range of services to patients assigned to the health center*; paid fee-for-service or capitated.
Non-Managed Care	A payment model in which procedures and services are separately charged and paid. Third-party payers pay some or all of the bill, generally based on agreed-upon maximums or discounts.
Managed Care — Capitated	A managed care payment model in which a health center contracts with an MCO 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 — Fee-for-Service	A managed care payment model in which a health center contracts with an MCO, is assigned patients who must receive their primary care from the health center, and is reimbursed on a fee-for-service (or encounter-rate) basis for covered services.

Managed Care

- Managed care (either capitated or fee-for-service) refers to those payers with which the health center has a contractual managed care agreement to provide a range of services to patients assigned to the health center.
  - Typically these agreements include:
    - ✓ Responsibility for managing the care of a set of assigned patients.
    - ✓ Requirement for patients to receive all of their primary care from the health center.
- This generally requires regular review and reclassification of insurers in your system to be sure that only those with whom you have contractual managed care agreements are categorized as managed care for UDS reporting.

Managed care **does not** refer to all managed care plans from which you received payment. In other words, it is likely that you will occasionally provide services and receive payments for patients who are covered by a managed care plan but who are not assigned to you or with whose managed care plan you do not have a contract.

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Patient Service Revenue

Table 9D, Line 13

Self-Pay

- Self-pay refers to charges or the portion of charges that **are the responsibility of the patient** (rather than a third-party payer) and includes related collections and write-offs.
  - Includes charges incurred by uninsured patients, including those covered by indigent care programs, written off as sliding fee discounts, and/or written off as patient bad debt.
  - Includes co-payments, deductibles, and charges to insured individuals for uncovered services that become the patient's personal responsibility.
- **Self-pay Charges** (Column A) may then be paid by the patient and recorded as **Collections** (Column B), written off as **Sliding Fee Discounts** (Column E) based on patient income and family size, or written off as **Bad Debt** (Column F) when uncollectable (including inability to locate persons, patient's refusal, or inability to pay regardless of income).
  - Self-pay does NOT include third-party payer bad debt.
- Self-pay is reported on Line 13 of Table 9D.

Table 9D Revenue and Table 4 Insurance

Payer categories are generally aligned with patient insurance categories.

Table 4		Table 9D	
Line	**Principal Medical Insurance**	**Line**	**Revenue Source**
7	Uninsured—No medical insurance at last visit	13	Self-Pay—Include co-pays and deductibles, state and local indigent care programs
8a and 8b	Medicaid and Medicaid CHIP	1–3	Medicaid
9a and 9	Dually eligible and Medicare	4–6	Medicare
10a	Other Public non-CHIP—State and local government insurance	7–9	Other Public—Include patient service revenue from programs with limited benefits
10b	Other Public CHIP (private carrier outside Medicaid)	7–9	Other Public
11	Private	10–12	Private

Table 9E: Other Revenue

Table 9E: Other Revenues

Lines 1a–11

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

- Other revenue includes all federal, state, local, and other revenue that is **not tied to the provision of services to health center patients**.
- Includes grants, contracts, and other funds **received or drawn down** in 2021 that cover in-scope activities.
- Other revenue is reported on a **cash receipt basis**, meaning the amount actually drawn down or received in 2021, not the full award amount.
- Other revenue is reported on the line that aligns with the entity from which the funds were received.

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Revenue Sections on Table 9E

Revenue Source	Revenue Type	Line
BPHC Grants	Health Center Program Grants	1a–1e
	Capital Development Grants	1k
	COVID-19 Supplemental Funding	1l–1p
Other Federal Grants	Ryan White Part C—HIV Early Intervention Grants	2
	Other Federal Grants	3
	Medicare and Medicaid EHR Incentive Grants for Eligible Providers	3a
	Provider Relief Fund	3b
Non-Federal Grants or Contracts	State Government Grants and Contracts	6
	State/Local Indigent Care Programs	6a
	Local Government Grants and Contracts	7
	Foundation/Private Grants and Contracts	8
	Other Revenue	10

Table 9E: COVID-19 Federal Funding Reporting

Line	Source	Amount (a)
	BPHC Grants (Enter Amount Drawn Down—Consistent with PMS 272)	
1l	Coronavirus Preparedness and Response Supplemental Appropriations Act (H8C)	
1m	Coronavirus Aid, Relief, and Economic Security Act (CARES) (H8D)	
1n	Expanding Capacity for Coronavirus Testing (ECT) (H8E and LAL ECT)	
1o	American Rescue Plan	
1p	Other COVID-19-Related Funding from BPHC (specify_____)	
1q	**Total COVID-19 Supplemental** (Sum of Lines 1l through 1p)	

Resources on COVID-related funding sources administered to health centers and where they should be reported in the UDS Report are found in **COVID-19 Funding Uniform Data System (UDS) Reporting Guidance**.

Poll #4: COVID Funding

Which of the following statements is correct? HRSA BPHC COVID-related funding is reported on…

A. Table 9E, Lines 1l–1p, based on the supplemental funding code received from BPHC. This includes the total amount of awarded funding.
B. Table 9E, Lines 1l–1p, based on the supplemental funding code received from BPHC. This includes the amount drawn down.
C. Table 9E, Lines 1a–1e, based our Health Center Program Grant received from BPHC. This includes the amount drawn down.

Answer: COVID Funding

Which of the following statements is correct? HRSA BPHC COVID-related funding is reported on…

A. Table 9E, Lines 1l–1p, based on the supplemental funding code received from BPHC. This includes the total amount of awarded funding.

B. Table 9E, Lines 1l–1p, based on the supplemental funding code received from BPHC. This includes the amount drawn down.

C. Table 9E, Lines 1a–1e, based our Health Center Program Grant received from BPHC. This includes the amount drawn down.

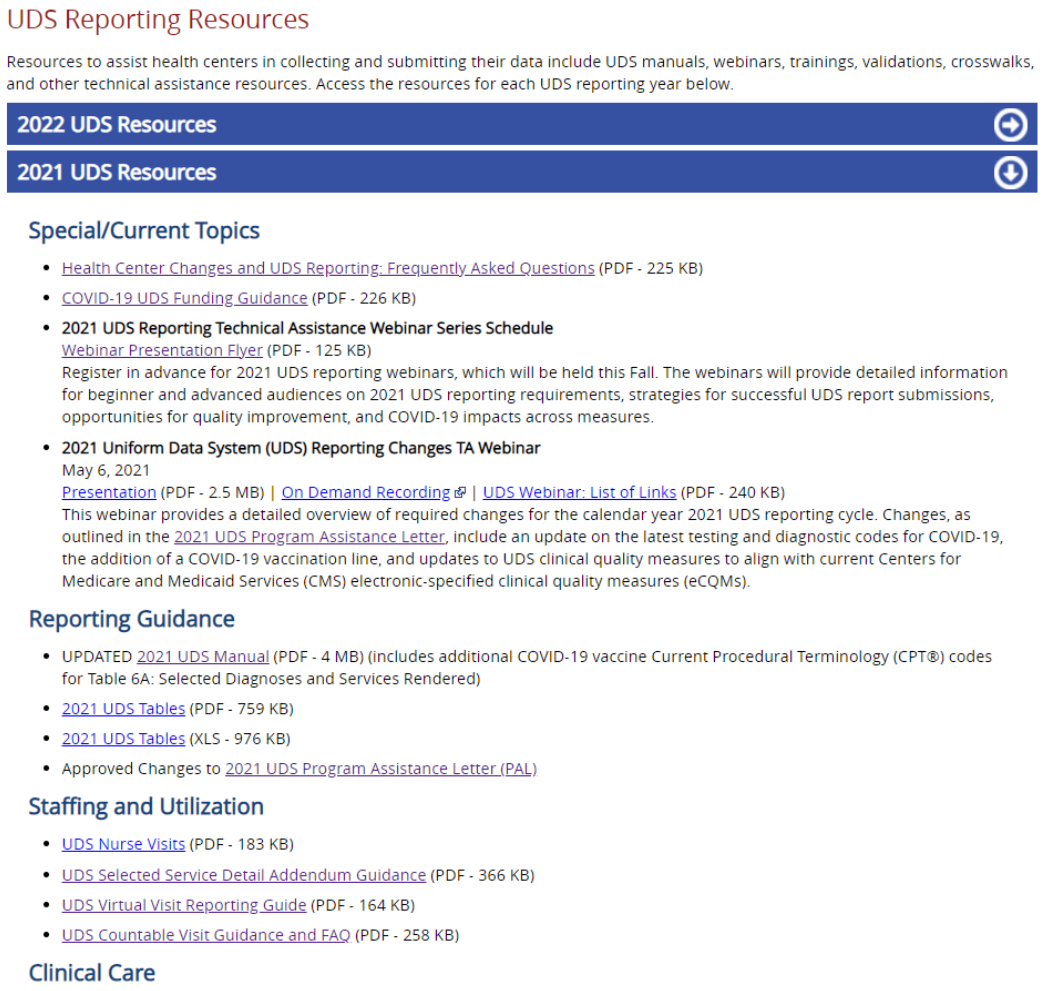
Table 9E: Tips and Frequently Asked Questions

Question	Answer
Do we report the proceeds from a loan?	Health centers do not report the proceeds of any loan received for operations, a mortgage, or other purposes in the UDS. Paycheck Protection Program receipts are initially recorded as a loan, so the proceeds are not reported on table 9E. At the time the loan is forgiven, the loan is converted to accrued income. Because that transaction does not involve a cash receipt, it is not reported on Table 9E.
How does the UDS Table 9E financial reporting differ from our health center financial statements?	Table 9E reports all non-patient-service-related revenue on a cash basis, and health centers will recognize this revenue on an accrual basis in their financial statements.
How do we report funding that we receive from an organization that received a grant, which they "pass through" to our health center?	Use the "last party rule" to classify the receipts. Grant, contract, and other funds should always be reported based on the entity from which the health center received them, regardless of the source from which they originated.
How do we report grant funds of which we have only used (or drawn down) part of the award amount?	Table 9E collects information on cash receipts for the calendar year. For a grant, report the cash amount received during the calendar year. **Do not** report the award amount (unless the full award was paid/drawn down during the year).

Resources and Updates

BPHC UDS Reporting Resources

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



UDS Reporting Resources

Resources to assist health centers in collecting and submitting their data include UDS manuals, webinars, trainings, validations, crosswalks, and other technical assistance resources. Access the resources for each UDS reporting year below.

2022 UDS Resources

2021 UDS Resources

Special/Current Topics

- Health Center Changes and UDS Reporting: Frequently Asked Questions (PDF - 225 KB)
- COVID-19 UDS Funding Guidance (PDF - 226 KB)
- **2021 UDS Reporting Technical Assistance Webinar Series Schedule**
  Webinar Presentation Flyer (PDF - 125 KB)
  Register in advance for 2021 UDS reporting webinars, which will be held this Fall. The webinars will provide detailed information for beginner and advanced audiences on 2021 UDS reporting requirements, strategies for successful UDS report submissions, opportunities for quality improvement, and COVID-19 impacts across measures.
- **2021 Uniform Data System (UDS) Reporting Changes TA Webinar**
  May 6, 2021
  Presentation (PDF - 2.5 MB) | On Demand Recording | UDS Webinar: List of Links (PDF - 240 KB)
  This webinar provides a detailed overview of required changes for the calendar year 2021 UDS reporting cycle. Changes, as outlined in the 2021 UDS Program Assistance Letter, include an update on the latest testing and diagnostic codes for COVID-19, the addition of a COVID-19 vaccination line, and updates to UDS clinical quality measures to align with current Centers for Medicare and Medicaid Services (CMS) electronic-specified clinical quality measures (eCQMs).

Reporting Guidance

- UPDATED 2021 UDS Manual (PDF - 4 MB) (includes additional COVID-19 vaccine Current Procedural Terminology (CPT®) codes for Table 6A: Selected Diagnoses and Services Rendered)
- 2021 UDS Tables (PDF - 759 KB)
- 2021 UDS Tables (XLS - 976 KB)
- Approved Changes to 2021 UDS Program Assistance Letter (PAL)

Staffing and Utilization

- UDS Nurse Visits (PDF - 183 KB)
- UDS Selected Service Detail Addendum Guidance (PDF - 366 KB)
- UDS Virtual Visit Reporting Guide (PDF - 164 KB)
- UDS Countable Visit Guidance and FAQ (PDF - 258 KB)

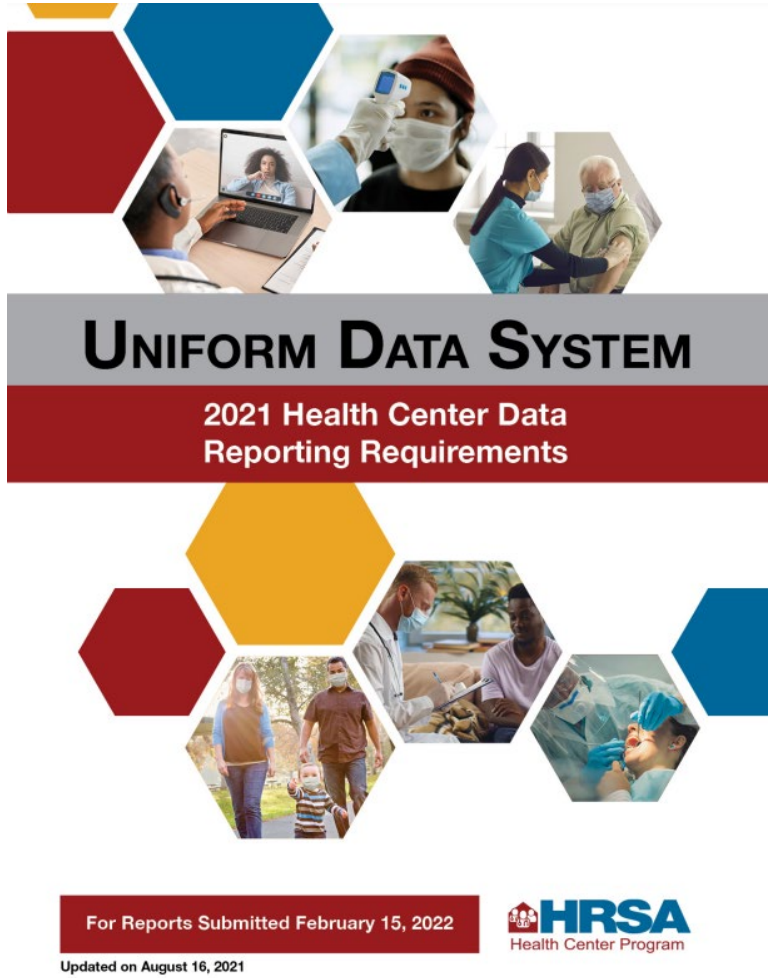
Clinical Care

UDS reporting resources are available at https://bphc.hrsa.gov/datareporting/reporting/index.html

HRSA Health Center Program

Follow UDS Guidance

- Thoroughly read definitions and instructions in the 2021 UDS Manual.
- UDS Financial Tables Reporting Guidance
  - This resource provides health centers with information about common reporting considerations and issues to consider when reporting UDS Tables 8A, 9D, and 9E.
  - Includes tips and acronyms.
- **Table-Specific Fact Sheets**
  - Table 8A Fact Sheet
  - Table 9D Fact Sheet
  - Table 9E Fact Sheet



HRSA Health Center Program

Financial Reporting Resources

COVID-19 Funding Uniform Data System (UDS) Reporting Guidance

- The resource outlines common COVID-19 funding sources administered to health centers and where they should be reported in the UDS Report.

Reporting Donations on the UDS

- The resource instructs on reporting various types of donations a health center may receive throughout the year. It clarifies where health centers are to report donated services and supplies vs. monetary donations across the UDS financial tables 8A (Financial Costs) and 9E (Other Revenue).

Available Assistance

- Technical assistance materials, including local trainings, are available online:
  - HRSA Health Center Program website
- UDS Support Center for assistance with UDS reporting questions:
  - udshelp330@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

Upcoming Webinars

- Upcoming UDS Webinars
  - UDS Successful Submission Strategies (10/20/21, 1:00–2:30 p.m. ET)
  - Preliminary Reporting Environment (PRE) (11/4/21, 2:00-3:30 pm ET)
- Past webinar presentations are archived on HRSA's UDS Resources page.
  - Counting Visits in the UDS
  - UDS Clinical Tables Part 1: Screening and Preventive Care
  - UDS Clinical Tables Part 2: Maternal Care and Children's Health
  - UDS Clinical Tables Part 3: Chronic Disease Management

Questions and Answers

Thank You!

Bureau of Primary Health Care (BPHC)

Health Resources and Services Administration (HRSA)

udshelp330@bphcdata.net or Health Center Program Support

1-866-837-4357

bphc.hrsa.gov

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