HRSA
Health Resources & Services Administration

# Uniform Data System (UDS) Reporting Requirements Training

## Annual State- and Territory-Based Training

***Calendar Year 2024***

**Bureau of Primary Health Care (BPHC)**

Vision: Healthy Communities, Healthy People

# Training Agenda

1. Welcome and Logistics
2. Overview of the Uniform Data System (UDS)
3. Reporting Patient Demographic Profile
4. Reporting Clinical Services and Quality of Care Indicators
5. Reporting Operational and Financial Tables
6. Other Required UDS Reporting Forms
7. Tips for Success

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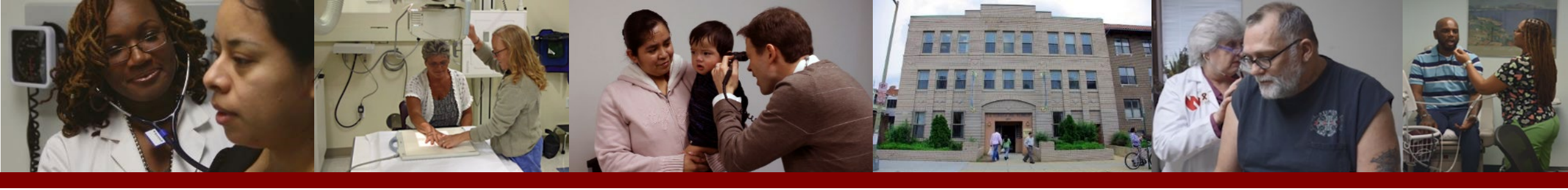

# Overview of the UDS

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

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# Key Facts About Reporting the UDS

| WHO | WHAT | WHERE | WHEN | WHY |
|---|---|---|---|---|
| CHCs, HCHs, MHCs, PHPCs, LALs, and certain BHW awardees funded or designated before Oct. 2024 all complete a UDS Report. | The UDS includes 11 tables and 3 forms that provide an annual snapshot of all in-scope activities, the Universal Report, and, if applicable, Grant Reports. | The UDS Report is completed in the Performance Report in the Electronic Handbooks (EHBs). | All health centers complete their UDS Report between Jan. 1 and Feb. 15, 2025; reporting covers health center services in the calendar year from Jan. 1 to Dec. 31, 2024. | The UDS is legislatively mandated as part of the Health Center Program and is used for program monitoring and improvement. |

BHW: Bureau of Health Workforce; CHC: Community Health Center; HCH: Health Care for the Homeless; LAL: look-alike; MHC: Migrant Health Center. PHPC: Public Housing Primary Care.
For a full list of acronyms, refer to Appendix J of the UDS Manual.

***In addition to submitting UDS within the EHBs, health centers must submit certain de-identified patient-level report data using HL7® Fast Healthcare Interoperability Resources (FHIR®) R4 standards.***
***Visit the UDS Modernization FAQ for more on that process.***

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# UDS Patient-Level Reporting: UDS+

**All health centers are required to submit an aggregate UDS Report within the Health Resources and Services Administration's (HRSA's) EHBs by Feb. 15, 2025.**

Additionally, minimum submission requirements for 2024 include de-identified patient demographics and **at least one** electronic-specified clinical quality measure (eCQM).

- Patients by ZIP Code Table
- Table 3A: Patients by Age and by Sex Assigned at Birth
- Table 3B: Demographic Characteristics
- Table 4: Selected Patient Characteristics
- Table 6A: Selected Diagnoses and Services Rendered
- Table 6B: Quality of Care Measures
- Table 7: Health Outcomes and Disparities (recommendation to submit hypertension eCQM)

**All health centers will be required to submit the above specified amount of patient-level data (UDS+) for, at minimum, medical patients, by April 30, 2025.**

**To learn more, visit the UDS Modernization Frequently Asked Questions (FAQ).**

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# Value of the UDS

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

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

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

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# Health Center Program Grants and Designations

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

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

**Some health centers have a Health Center Program LAL designation** or are **BHW awardees**. These health centers do not have a Section 330 grant.

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

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# Overview of UDS Report

## Four Primary Sections, Eleven Tables, and Three Forms

### Patient Demographic Profile

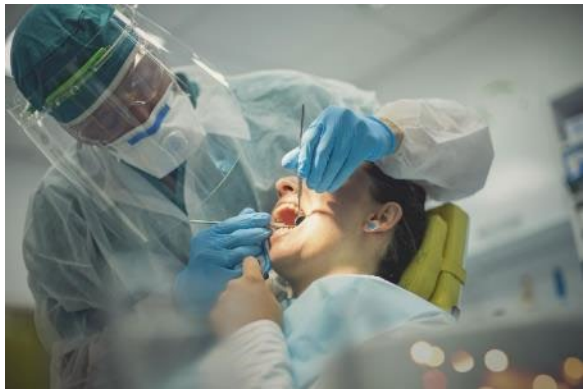
- **ZIP Code**, medical insurance
- **Table 3A:** Age, sex at birth
- **Table 3B:** Race, ethnicity, language, sexual orientation, gender identity
- **Table 4:** Income, medical insurance, special populations

### Clinical Services and Outcomes

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

### Financial Performance

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



### Other Forms

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

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# Overview of UDS Reporting Requirement

| Universal Report | Grant-Specific Report |
|---|---|
| Reported by *all* health centers. | Reported by those health centers with **additional** Health Center Program 330 grants, like MHC, HCH, or PHPC. **This is *in addition* to the Universal Report.** |
| Full UDS Report, 11 tables and 3 forms | Subset of the full UDS Report, 5 tables and no forms. |
| All patients, services, and revenues within the calendar year that are in-scope for the Health Center Program award are reported. | Tables 3A, 3B, 4, and 6A, as well as patients and visits on Table 5 are reported specific to the scope of the additional 330 grant. |
| All health centers who only have a single Health Center Program award or designation will report just a Universal Report. | Those health centers with more than one Health Center Program award (meaning, they have additional 330 funding) will report the Universal report *and* an additional grant-specific report for each additional Health Center Program grant. |

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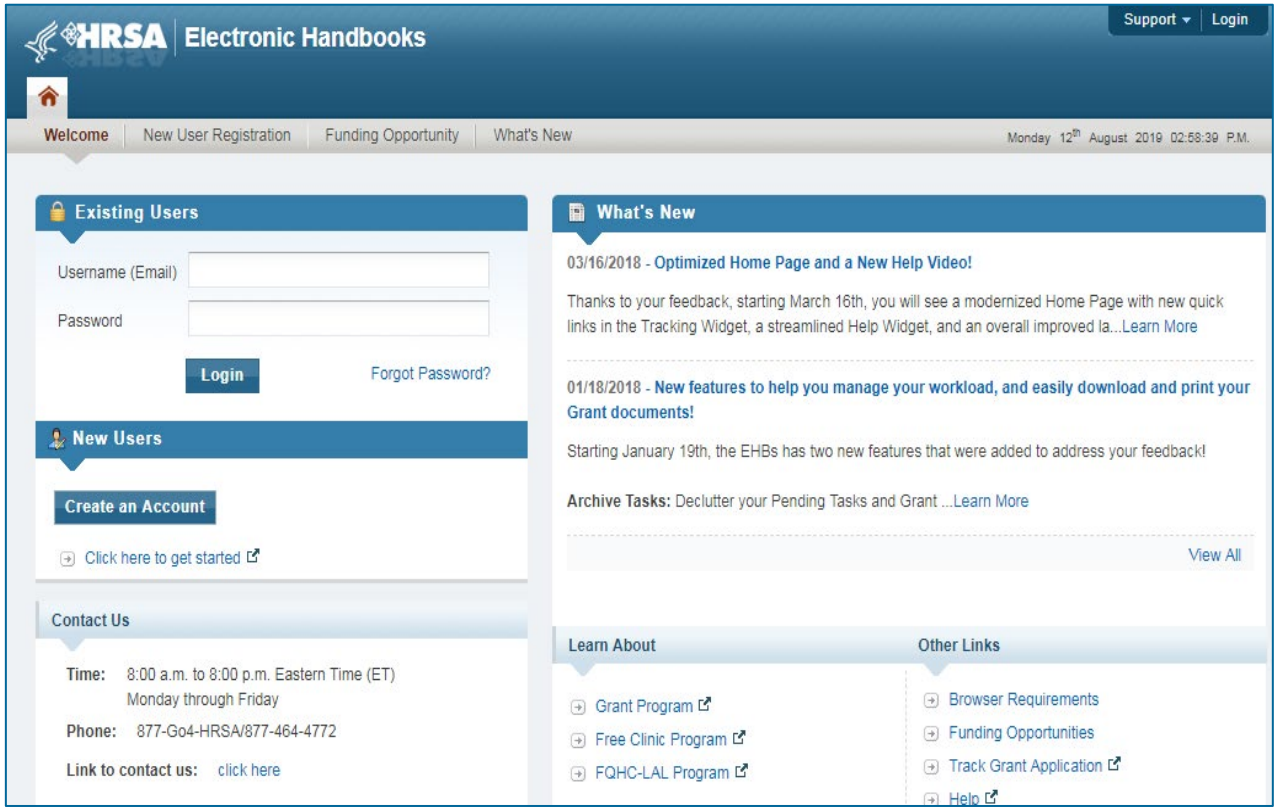
# Where to Report: the EHBs




- **The UDS is the performance report for your H80 grant (which is the activity code for Section 330 grant) or LAL designation in the EHBs.**
- Each person tasked with UDS data entry, review, or submission needs an EHBs login.
- Tools to assist with reporting:
  - Preliminary Reporting Environment (PRE) for early access beginning in late Oct.
  - Excel template (download/upload in the EHBs)
  - Comparison tool
  - Edits

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

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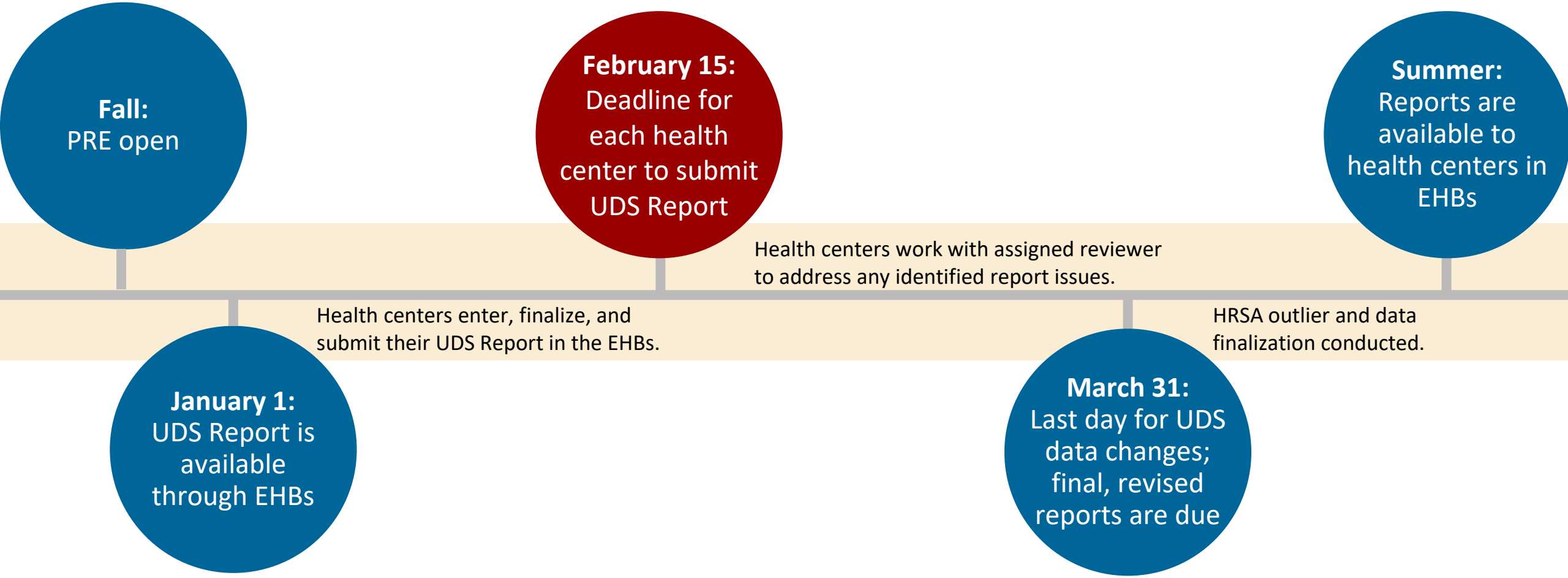
# Reporting Timeline




All health centers are required to submit an **aggregate** UDS Report within the Health Resources and Services Administration's (HRSA's) EHBs by Feb. 15, 2025. All health centers will be required to submit the above specified amount of patient-level data (UDS+) for, at minimum, medical patients, by April 30, 2025.

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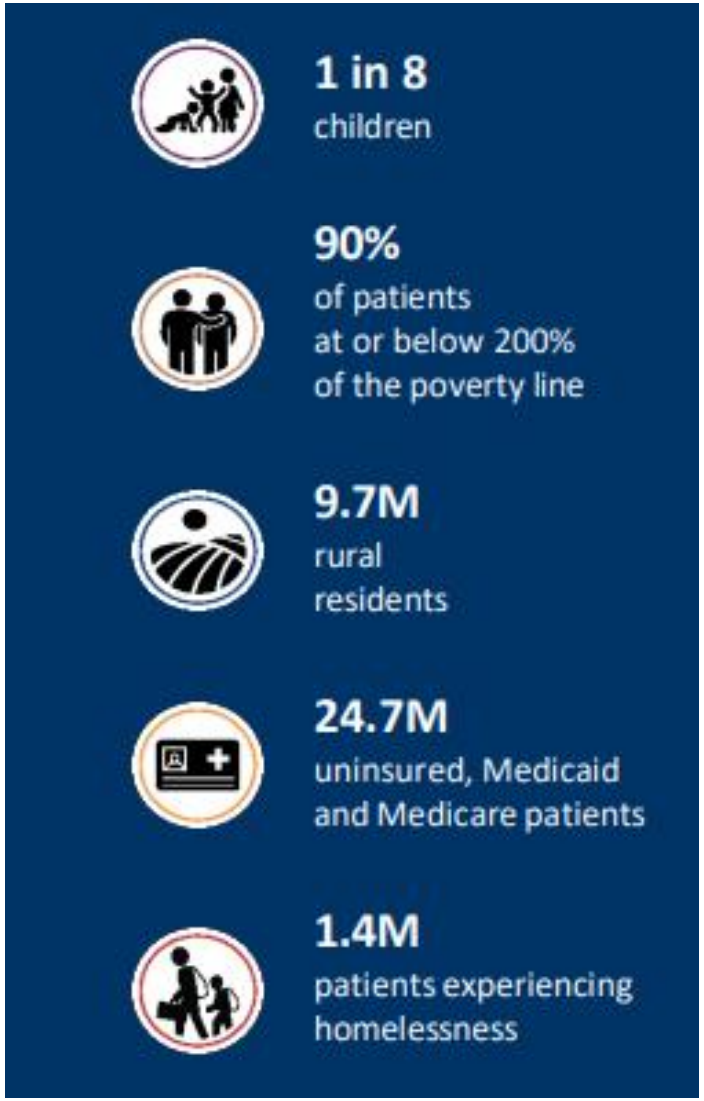
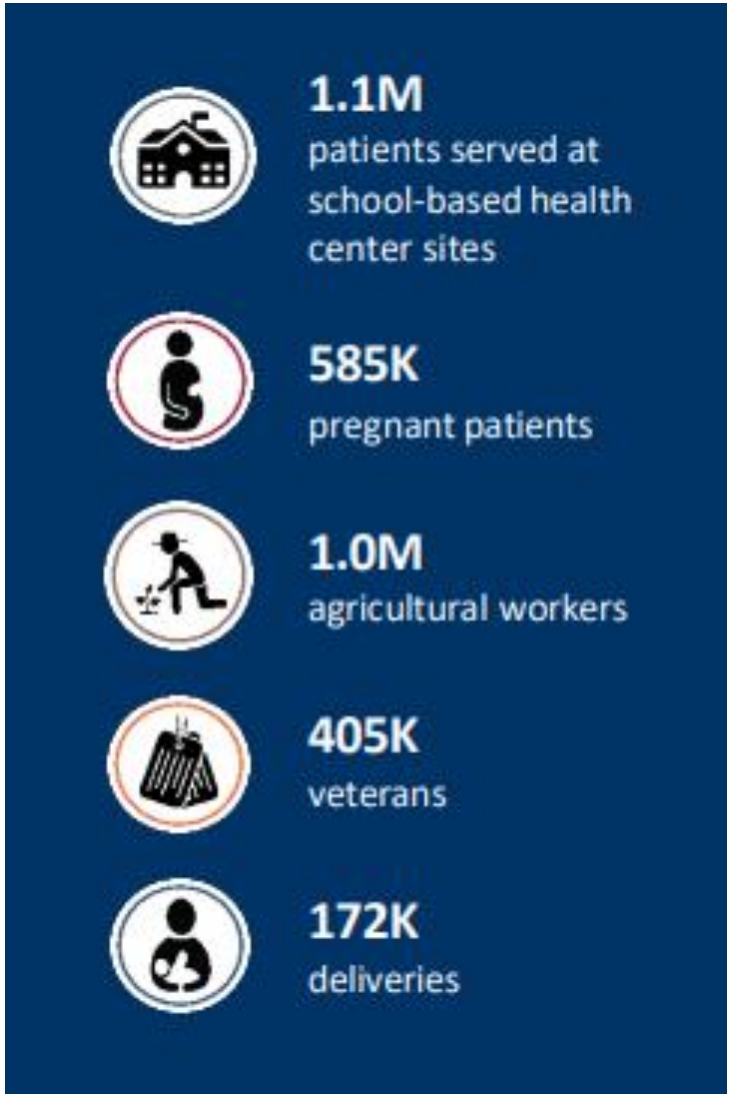
# The Picture Painted by These Data

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

Read more in the UDS Trend data brief.



# Key Definitions

## Understanding Terms Foundational to the UDS

Health Center Patient

Countable Visit

Health Center Scope

# Health Center 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 3A, 3B, and 4) provide an **unduplicated count of health center patients**.
  - In the patient demographic profile tables, **each patient is counted once** regardless of the number of visits or services received.
  - All patients must be included in the patient demographic tables by their demographic characteristics.
- Individuals with contact with the health center who **don't** meet this definition of health center patient are **not counted anywhere on the UDS**.
- Health center patients are reported on all service and clinical tables for which they meet the criteria.

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# Countable Visit

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

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

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# Health Center Scope

**UDS Definition:** Health center scope of project is a health center's approved service sites, services, providers, service area, and target populations.

- Only services in the **health center scope of project**, meaning the scope of your 330 grant (or LAL designation or BHW awardees), are reported in the health center's UDS Report.
- 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 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 5B, in-scope services for your health center are on your Form 5A, and other activities and locations are on Form 5C.

# Keep the Big Picture in Mind

## Report Patient Characteristics

Demographic information must be captured and reported for all unduplicated health center patients (Tables ZIP, 3A, 3B, 4).

## Identify Patients Served in Your Health Center Scope

A "health center patient" is a patient with a UDS countable visit (on Table 5) in the calendar year.

## Report Services Patients Received

Services and clinical tables (Tables 5, 6A, 6B, 7) reflect *only* and *all* countable services provided to health center patients. The forms are also limited to health center patients, except where specified!

## Health Center Scope

Determine what sites and services are within your health center scope of project.

## Report Financials

Financial tables (Tables 8A, 9D, 9E) include *only* and *all* costs and revenue for services reflected in all other tables and the UDS as a whole.

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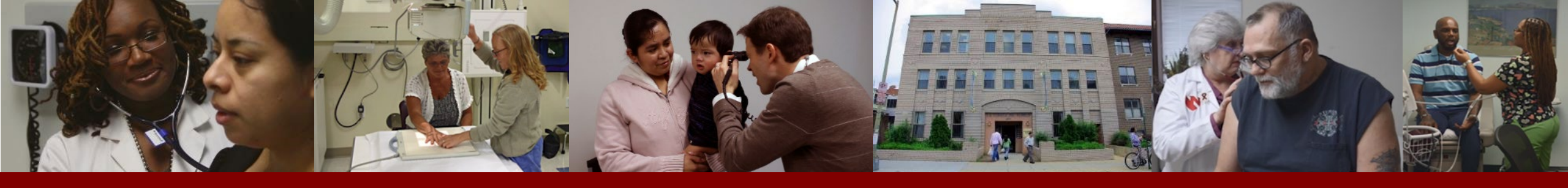

# Overview of the UDS Tables and Forms

## Understanding What Data Are Reported and Why

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# Quick Overview of 2024 UDS Changes

**Each will be reviewed in greater detail when we get to the relevant section.**

# Five Major Changes to Be Aware Of!

1. **Tobacco Screening and Cessation measure** on Table 6B now requires that patients aged 12 and up receive tobacco screening and cessation intervention.

2. **Statin measure** on Table 6B has three major changes to the denominator criteria.

3. Annual update of **Tables 6A, 6B, and 7** to align with current-year versions and codes, resulting in some changes throughout these tables.

4. In addition to aggregate UDS reporting in EHBs, **de-identified patient-level data (UDS+) submission** using FHIR will be required for certain UDS tables.

5. Additional item on ODE Form for reporting number of patients **screened for family planning needs** using a standardized tool.

*Again, each will be reviewed in greater detail when we get to the relevant section!*

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

## Understanding Who You Are Serving

**Patient Demographic Profile**

**Clinical Services and Outcomes**

**Financial Tables**

**Other Forms**

*All health centers are required to submit an aggregate UDS Report within HRSA's EHBs by Feb. 15, 2025. All health centers will be required to submit the above specified amount of patient-level data (UDS+) for, at minimum, medical patients, by April 30, 2025. Health centers who are concerned about their ability to report UDS+ should reach out via the BPHC Contact form, select UDS Modernization under Uniform Data System (UDS) heading.*

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# Overview of Patient Demographic Tables

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

*All sections of these tables except those with an asterisk (*) equal each other because they describe the same group of patients, just by different characteristics.*

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# Patients by ZIP Code Table

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

- Rows are ZIP codes (which you will enter or import); columns are primary medical insurance categories.
  - List all ZIP codes from which your health center has 11 or more patients in 2024 in Column A.
- Combine the count of all patients from ZIP codes with 10 or fewer patients into the Other ZIP Codes line.
- Use the **patient's local address** for migratory agricultural workers, people in jail or prison, and those from other countries; use **clinic address** for patients experiencing homelessness, who do not have another identified address.

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

## Keys to remember:

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

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# Patients by Age and Sex Assigned at Birth

## Table 3A

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

- Rows are age; columns are sex assigned at birth.
- Use age as of **December 31, 2024**.

### Keys to remember:

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

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

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# Table 3B:
# Demographic Characteristics

No major changes in 2024

# Ethnicity, Race, and Language

## Table 3B, Lines 1–8

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

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

- Rows are race categories; columns are ethnicity categories.
  - **All patients are reported by both race *and* ethnicity.**
- If **race is known or recorded in the record, but ethnicity is not**, report in Column B, Not Hispanic, Latino/a, or Spanish Origin.
- If a patient **identifies or selects multiple races**, report on Line 6.
- If a patient **identifies multiple ethnicities**, report in Column A5.
- **Report only patients with unknown race *and* unknown ethnicity on Line 7, Column C.**

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# Table 3B

## Subcategories for Race and Ethnicity

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

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

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# Ethnicity, Race, and Language

## Table 3B, Line 12

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

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

### Keys to Remember for Race, Ethnicity, and Language Reporting

1. Race, ethnicity, and language are to be self-reported by patients or caregivers.
2. Report patients who trace their ancestry to any of the original peoples of Europe, the Middle East, or North Africa on Line 5, White.
3. Patients can select more than one race and, if they do, are reported as More than One Race (Line 6).
4. Report patients who are of Hispanic, Latino/a, or Spanish origin but for whom granularity of ethnicity is not known, and patients who select more than one listed ethnicity (e.g., Mexican and Puerto Rican), in Column A5: "Hispanic, Latino/a, Spanish Origin, Combined."
5. Report patients with *known* race but *unknown* ethnicity as **Not Hispanic, Latino/a, or Spanish Origin** (Column B).

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

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

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

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

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

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

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

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# Table 4:
# Selected Patient Characteristics

No major changes in 2024

# Income as a Percent of Federal Poverty Guidelines

## Table 4, Lines 1–6

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

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

Report all **patients by income as a percent of federal poverty guidelines** on Lines 1–5.

- Report income based on federal poverty guidelines (requires information on income and household size).
- Report each patient's most recent income within 12 months prior to the last calendar year visit.
  - If income information has not been collected/confirmed in that period, report the patient's income as Unknown.
- Income for this section of Table 4 can be patient self-reported.
- Do not use insurance or special population status as a proxy for income.

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# Primary Medical Insurance

## Table 4, Lines 7–12

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

Report **all patients by primary medical insurance** on Lines 7–11.

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

### Keys to Remember

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

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# Primary Medical Insurance Categories

## Table 4

### None/Uninsured

Patient had no *medical* insurance at last visit (includes uninsured patients for whom the health center may be reimbursed through grant, contract, or uncompensated care fund).

### Medicaid (Title XIX)

Medicaid and Medicaid-managed care programs, including those administered by commercial insurers.

### CHIP (Medicaid *or* Other Public)

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

### Medicare

Include Medicare, Medicare Advantage, and Dually Eligible.

### Dually Eligible (Medicare *and* Medicaid)

Subset of Medicare patients who also have Medicaid coverage.

### Other Public Insurance (Non-CHIP)

State and/or local government insurance that covers a broad set of services; *not* grant programs reimbursing limited benefits (e.g., Early & Periodic Screening, Diagnosis, and Treatment [EPSDT]; Breast & Cervical Cancer Early Detection Program [BCCP or BCCEDP]).

### Private Insurance

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

*Remember, primary medical insurance is **not** necessarily the payer or payment source for the services the patient received in the year. Medical insurance is a characteristic of the patient.*

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# Examples: Categorizing Medical Insurance on Table 4

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

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

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

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

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

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

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

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# Managed Care

## Table 4, Lines 13a–13c

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

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

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

# 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 list** of patients in the managed care plan.
  - May be called an enrollment list, assignments, or attributed patients.
- 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 by insurance on Table 4
- Managed care revenue lines on Table 9D (the table that captures patient service revenue by insurance type)

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

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# IMPORTANT KEY:

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

We will discuss Table 9D later!

# Special Populations

## Table 4, Lines 14–26

**All health centers** report the following:

- Total Agricultural Workers or Their Family Members (Line 16)
- Total Homeless (Line 23)
- Total School-Based Service Site Patients (Line 24)
- Total Veterans (Line 25)
- Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site (Line 26)

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

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

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

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

*Special Populations Resources: HRSA-funded* National Training and Technical Assistance Partners

# How Special Population Status Is Identified

## Table 4

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

*Excerpt of Table 4*

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

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# Find Resources to Help

HRSA Bureau of Primary Health Care (BPHC) UDS Resources site Patient Characteristics section includes the following resources:

- Fact Sheets (Patients by ZIP Code Table, Tables 3A, 3B, and 4)
- UDS Managed Care Reporting and Relationships across Tables 4 and 9D (posted in the Financials section)

# Tables 5, 6A, 6B, and 7

## Understanding Services Provided and Their Outcomes

**Patient Demographic Profile**

**Clinical Services and Outcomes**

**Financial Tables**

**Other Forms**

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# Overview of Clinical Services and Clinical Quality Indicators

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

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

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# Table 5:
# Staffing and Utilization

No major changes in 2024

# Understanding the Service Categories

## Table 5

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

- Medical Care Services (Lines 1–15)
- Dental Services (Lines 16–19)
- Mental Health Services (Lines 20a–20c)
- Substance Use Disorder Services (Line 21)
- Other Professional Health Services (Line 22)
- Vision Services (Lines 22a–22d)
- Pharmacy Services (Line 23)
- Enabling Services (Lines 24–29)
- Other Programs and Related Services (Line 29a)
- Quality Improvement Personnel (Line 29b)
- Non-Clinical Support Services (Lines 30a–32)

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

# Understanding the Four Columns

## Table 5

### Column A: FTEs

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

### Columns B and B2: Clinic and Virtual Visits

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

### Column C: Patients

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

# Reporting Personnel on Table 5

Table 5 includes personnel FTE for all individuals who work in programs and activities that are within Form 5B of the health center's scope of project for all service delivery sites included in the UDS.

Report all personnel in terms of annualized FTEs.

# FTE by Position and Service Category

## Table 5

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

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

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# Reporting Personnel FTEs

## Table 5

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

**Keys to Remember**

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

➔ Visits, *when countable*, must be reported **on the line with the provider** who conducted the visit. Contacts with non-providers are not countable visits.

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# Example: Calculate FTE

## Employees with full benefits

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

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

## Employees with no or reduced benefits

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

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

*Benefits defined as vacation/holidays/sick benefits

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# Where do these personnel go on Table 5?

A nurse at the health center works in "Communication Triage" which includes responsibilities to contact patients as needed to schedule follow up or referrals, respond to patient messages by phone or secure messaging, and do warm handoffs via phone between primary care and behavioral health when needed.

**This nurse's FTE is reported in Column a, on either NURSE (Line 11), *if part of the medical team*, or on CASE MANAGER (Line 24) *if the nurse does this for an assigned group of patients such as patients with high risk scores or diabetic patients*.**

The health center has a staff member who tables at local events and works with organizations in the community to provide some services (like education or taking blood pressures) at community events.

**This staff person's FTE is reported on OUTREACH, Line 26, Column a.**

The health center contracts with a local organization to have someone come in 16 hours a month to assist with Medicaid and Marketplace enrollment for patients in need of insurance.

**This contracted personnel's FTE is reported on Eligibility Assistance, Line 27a, Column a based on hours paid.**

Review Appendix A of the 2024 UDS Manual for more examples of the roles reported on each line of Table 5.

# IMPORTANT KEY:

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

Determinations about where to report FTEs and visits here must *also* be reflected on Table 8A costs. The two must align!

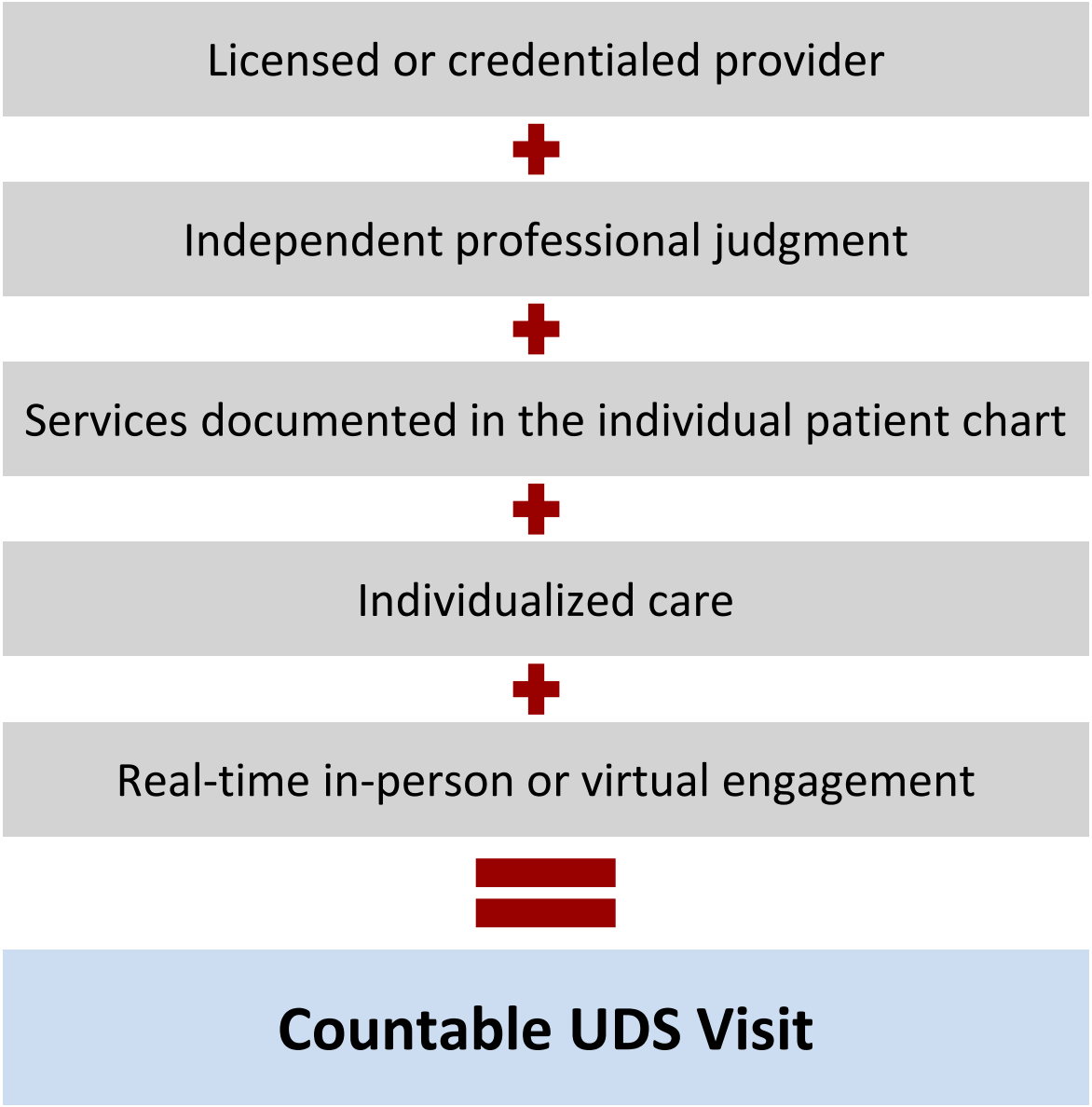
# Reporting Visits on Table 5

A visit is a documented contact between an individual and a licensed or credentialed provider who exercises their independent, professional judgment in the provision of services to that individual, either virtually or in person. This definition of visits determines who to count as a patient here on Table 5 and on all other tables that include patients.

# 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 are **central** to accurate reporting.

Only those who have had a countable visit here are reported on demographic tables!




Resource: UDS Countable Visit Guidance and Frequently Asked Questions

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# Counting Multiple Visits

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

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

If multiple providers in a single service category (e.g., two medical providers) deliver multiple services at the *same location* on a single day, count only one visit.

If services are provided by *two different providers* located at *two different sites* on the same day, count two visits.

- A virtual visit and a clinic visit are considered to be two different sites and may both be counted as visits, even when they occur on the same day.

Page 20 of the 2024 UDS Manual has additional information.

# 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, including locations on Form 5C.
- 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.

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

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# Location of Visits: Clinic or Virtual

## Table 5, Columns B and B2

### Clinic Visits (Column B)

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

### Virtual Visits (Column B2)

Report documented *virtual (telemedicine) contact* between provider and patient that meets all the requirements discussed earlier for countable visits.

Must be provided using interactive, synchronous audio and/or video telecommunication systems that permit *real-time communication* between the provider and a patient.

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

**View the Virtual Visit Reporting Guide.**

# Contacts That Do Not, *Alone*, Count as Visits

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

# Why is each of these encounters *not* a countable visit?

**Health Screening at a Community Health Fair**: A patient attends a community health fair organized by the health center and receives a blood pressure check and a glucose test.

**Medication Dispensing**: A patient visits the health center's pharmacy to pick up a prescribed medication. The pharmacist provides the medication and some brief instructions on how to take it.

**Follow-Up Lab Test**: A patient returns to the clinic for a follow-up blood test to monitor their cholesterol levels. The patient interacts only with the lab technician, who draws the blood sample.

**Group Nutrition Education Class**: A group of diabetic patients attends a nutrition education class led by a dietitian at the health center.

**Routine Blood Pressure Check**: A patient stops by the clinic for a routine blood pressure check performed by a nurse. The reading is documented, but no other assessment or intervention is conducted.

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# Why *is* each of these encounters a countable visit?

**Primary Care Consultation:** A patient visits the health center to discuss ongoing management of their hypertension. The physician assesses the patient's current condition, reviews their medication regimen, and adjusts the prescription based on the latest blood pressure readings. The visit is documented in the patient's health record.

**Behavioral Health Counseling Session:** A patient has an individual counseling session with a licensed clinical social worker to address anxiety and depression. The session involves the social worker assessing the patient's mental health, providing therapeutic interventions, and documenting the encounter in the patient's health record.

**Virtual Telehealth Consultation:** A patient has a virtual consultation with a nurse practitioner to review symptoms related to a recent infection. The nurse practitioner assesses the patient's condition via video, provides medical advice, and prescribes antibiotics. This encounter, documented in the patient's health record and involving independent professional judgment, is a countable virtual visit.

**Substance Use Disorder Treatment Session:** A patient participates in an individual therapy session with a licensed substance use counselor at the health center. The counselor assesses the patient's progress, provides counseling, and updates the treatment plan. The session is documented in the patient's health record.

**Case Management Encounter:** A patient with multiple chronic conditions, including diabetes and hypertension, meets with a case manager at the health center. The case manager conducts a comprehensive assessment of the patient's current health status, medication adherence, and social support needs. During the visit, the case manager identifies that the patient is struggling to manage their medications due to financial constraints and lack of transportation to the pharmacy and creates and documents a plan with the patient.

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# Are These Telehealth Services Countable Visits?

## Remote Patient Monitoring

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

**Example coding:**

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

**Not a countable visit!**

## Distant Site Audio-Only

Telephone evaluation and management (E&M) Service

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

**Example coding:**

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

**Can be a countable visit!**

## E-Visit

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

**Example coding:**

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

**Not a countable visit!**

# Reporting Patients on Table 5

Each individual who has a countable visit in Column B and/or Column B2 is a patient on the UDS. Only those who meet this definition are reported here on Table 5, and then only those in Column C here on Table 5 are reported on the demographic tables and clinical tables.

# Patients Are Reported in Alignment with Visits and FTEs

## Table 5

| FTEs (Column A) | Visits (Columns B and B2) | Patients (Column C) | Key Reminders |
|---|---|---|---|
| All personnel who support in-scope operation are reported.<br><br>Includes employees, interns, volunteers, residents, and contracted personnel, *not* contractors paid FFS.<br><br>Reported by credentials/ licensure **and** duties/function. | Clinic (in-person) and virtual visits that meet the definition are counted.<br><br>Visits must be *on the same line* with the FTE of the provider who conducted the visit (e.g., rendering provider).<br><br>If a visit is counted in either of these columns, the **patient *must* be reported in Column C *and* be included in the *unduplicated* patient count on all demographic tables.** | This is an unduplicated count of patients ***by service category***.<br><br>A patient may have visits in multiple service categories, such as having medical, dental, and vision visits in the year. Patients for whom that is true are *counted in **each** of those service categories in Column C*.<br><br>As a result, the total number of patients reported across Column C here is generally **larger** than the unduplicated patient count on the demographic tables. | 🔑 Not all personnel generate visits. **See Appendix A in the UDS Manual.**<br><br>🔑 Not all contacts are countable visits. And if something is not a countable visit, then the individual is not a patient!<br><br>🔑 Only those patients reported on this table are included in the unduplicated patient count on demographic tables and in clinical care tables (and vice versa!). |

# Table 5:
# Selected Service Detail Addendum

No major changes in 2024

# Addendum Captures *Integrated Behavioral Health*

## Integrated MH Services

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

## Integrated SUD Services

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

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

# Table 5 Addendum: Reporting MH/SUD Services Provided as Part of Medical Visits

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

| Line | Personnel by Major Service Category: Mental Health Service Detail | Personnel (a1) | Clinic Visits (b) | Virtual Visits (b2) | Patients (c) |
|---|---|---|---|---|---|
| 20a01 | Physicians (other than Psychiatrists) | | | | |
| 20a02 | Nurse Practitioners | | | | |
| 20a03 | Physician Assistants | | | | |
| 20a04 | Certified Nurse Midwives | | | | |

| Line | Personnel by Major Service Category: Substance Use Disorder Detail | Personnel (a1) | Clinic Visits (b) | Virtual Visits (b2) | Patients (c) |
|---|---|---|---|---|---|
| 21a | Physicians (other than Psychiatrists) | | | | |
| 21b | Nurse Practitioners (Medical) | | | | |
| 21c | Physician Assistants | | | | |
| 21d | Certified Nurse Midwives | | | | |

**Medical FTEs, visits, and patients** are reported in the medical section of the main part of Table 5 (shown above left).

Those same providers, visits, and patients ***may also*** be reported on the MH/SUD addendum ***if/when*** MH and/or SUD services were provided during those medical visits (shown above right).

# Reporting Personnel in Addendum

In Column A1 of the **Addendum of Table 5**, report the ***number*** of providers in each section who provided integrated services.

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

**Keys to Remember:**

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

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# Determining Services to Include in Addendum

Include, at minimum, all countable visits with specified providers that included the ICD-10-CM codes specified on Table 6A:

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

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

| Line | Diagnostic Category | Applicable ICD-10-CM Code or Value Set Object Identifier (OID) | Number of Visits by Diagnosis Regardless of Primacy (a) | Number of Patients with Diagnosis (b) |
|---|---|---|---|---|
| | **Selected Mental Health Conditions, Substance Use Disorders, and Exploitations** | | | |
| 18 | Alcohol-related disorders | F10-, G62.1, K70-, O99.31- | | |
| 19 | Other substance-related disorders (excluding tobacco use disorders) | F11- through F19- (exclude F17-), G62.0, O99.32- | | |
| 19a | Tobacco use disorder | F17-, O99.33-, Z72.0 | | |
| 20a | Depression and other mood disorders | F30- through F39- | | |
| 20b | Anxiety disorders, including post-traumatic stress disorder (PTSD) | F06.4, F40- through F42-, F43.0, F43.1-, F43.8-, F93.0 | | |
| 20c | Attention deficit and disruptive behavior disorders | F90- through F91- | | |
| 20d | Other mental disorders, excluding drug or alcohol dependence | F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0- and F43.1-), F50- through F99- (exclude F55-, F64-, F84.2, F90-, F91-, F93.0, F98-), O99.34-, R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0 | | |

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

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

**Excerpt of Table 6A**

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

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

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

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

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

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# Example: Integrated MH in a Medical Visit

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

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

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

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

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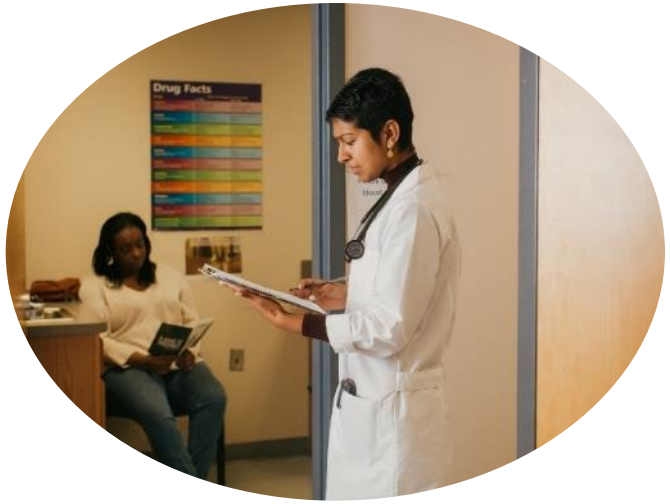
# Example: Integrated MH and SUD in a Medical Visit




A nurse practitioner (NP) sees a patient for a routine visit and during that visit addresses the patient's anxiety diagnosis and tobacco use disorder.

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

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

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

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# Example: Integrated SUD in MH Visit

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

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

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

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

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# Find Resources to Help

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

- Table 5 fact sheet
- Countable visit guidance
- Virtual visit guidance
- Nurse visit guidance
- Selected Service Detail Addendum guidance

# Table 6A:
# Selected Diagnoses and Services Rendered

## No major changes in 2024

*All health centers are required to submit an aggregate UDS Report within HRSA's EHBs by Feb. 15, 2025. All health centers will be required to submit the above specified amount of patient-level data (UDS+) for, at minimum, medical patients, by April 30, 2025. Health centers who are concerned about their ability to report UDS+ should reach out via the BPHC Contact form, select UDS Modernization under Uniform Data System (UDS) heading.*

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# Table 6A

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

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

- **Diagnoses** are reported where the indicated diagnosis is listed as part of a countable visit.
  - Diagnoses are Lines 1 through 20f.
- **Services and procedures** are counted when *provided at any point during the year to a health center patient and documented in that patient's chart*.
  - Services and procedures are Lines 21 through 34.

# Selected Diagnoses and Services

## Table 6A

| Line | Diagnostic Category | Applicable ICD-10-CM Code or Value Set Object Identifier (OID) | Number of Visits by Diagnosis Regardless of Primacy (a) | Number of Patients with Diagnosis (b) |
|---|---|---|---|---|
| | **Selected Infectious and Parasitic Diseases** | | | |
| 1–2 | Symptomatic/Asymptomatic human immunodeficiency virus (HIV) | B20, B97.35, O98.7-, Z21<br><br>**OID**: 2.16.840.1.113883.3.464.1003.120.12.1003 | | |
| 3 | Tuberculosis | A15- through A19-, O98.0-, Z86.15, Z22.7<br><br>**OID**: 2.16.840.1.113762.1.4.1146.451 | | |
| 4 | Sexually transmitted infections (gonococcal infections and venereal diseases) | A50- through A64-, A69.0, A69.1, A69.8, A69.9<br><br>**OID**: 2.16.840.1.113883.3.464.1003.112.11.1003 | | |
| 4a | Hepatitis B | B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.1-<br><br>**OID**: 2.16.840.1.113883.3.464.1003.110.12.1025 | | |
| 4b | Hepatitis C | B17.1-, B18.2, B19.2-<br><br>**OID**: 2.16.840.1.113762.1.4.1146.153 | | |
| 4c | Novel coronavirus (SARS-CoV-2) disease | U07.1<br><br>**OID**: 2.16.840.1.113762.1.4.1248.139, 2.16.840.1.113762.1.4.1200.151 | | |
| 4d | Long COVID | U09.9<br><br>**OID**: 2.16.840.1.113762.1.4.1222.1391 | | |

- **Column A:** Report the number of *visits* with the selected diagnosis or service.
  - If a patient has more than one category of reportable service or diagnosis during a visit, count each.
  - Do not count multiple services of the same type (i.e., that would be on the same line) at one visit.
- **Column B:** Report the number of unduplicated patients receiving the service.

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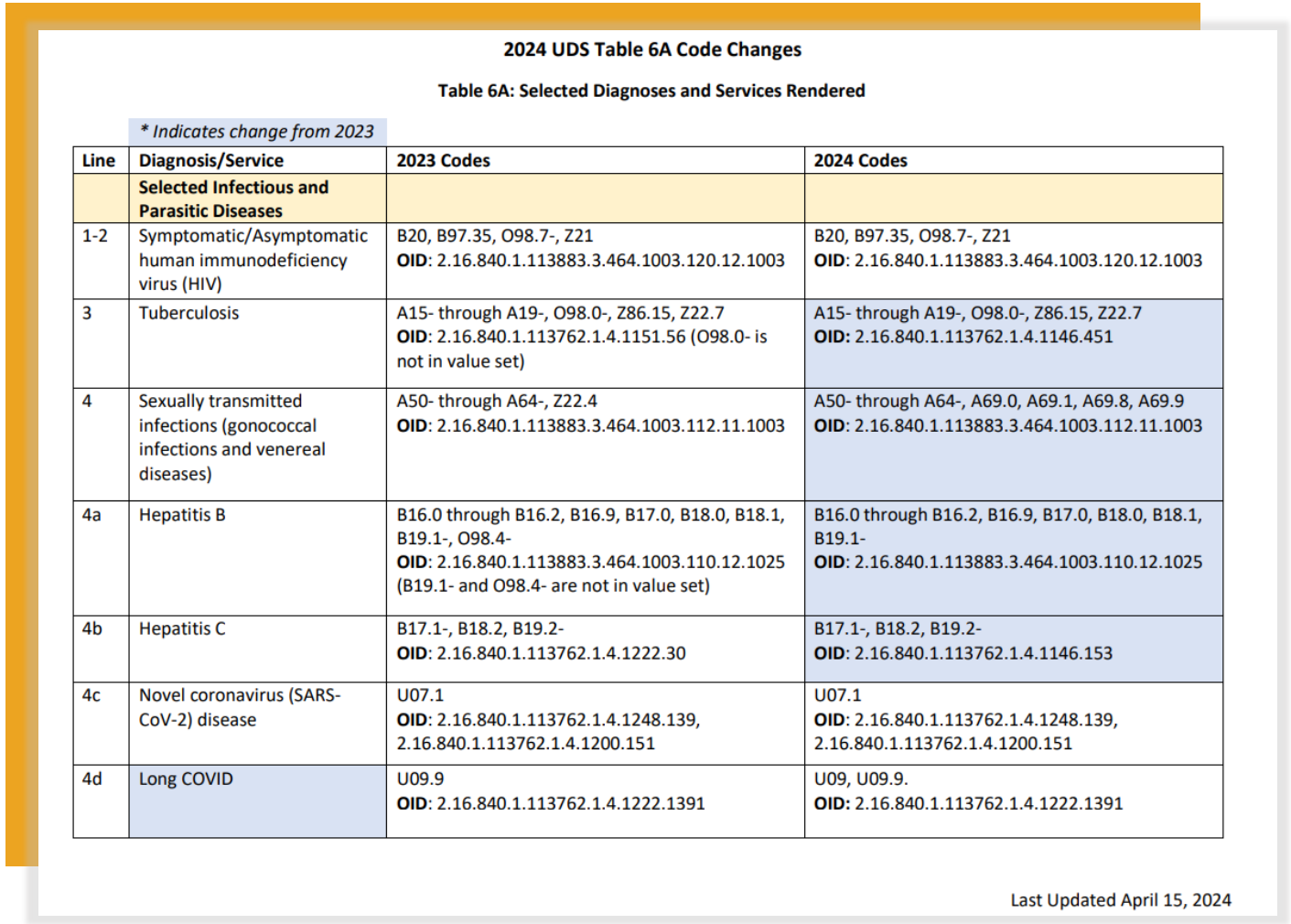
# Table 6A: Updated Codes

## Selected Diagnoses and Services Rendered



**2024 UDS Table 6A Code Changes**

**Table 6A: Selected Diagnoses and Services Rendered**

** Indicates change from 2023*

| Line | Diagnosis/Service | 2023 Codes | 2024 Codes |
|---|---|---|---|
| | **Selected Infectious and Parasitic Diseases** | | |
| 1-2 | Symptomatic/Asymptomatic human immunodeficiency virus (HIV) | B20, B97.35, O98.7-, Z21<br>**OID**: 2.16.840.1.113883.3.464.1003.120.12.1003 | B20, B97.35, O98.7-, Z21<br>**OID**: 2.16.840.1.113883.3.464.1003.120.12.1003 |
| 3 | Tuberculosis | A15- through A19-, O98.0-, Z86.15, Z22.7<br>**OID**: 2.16.840.1.113762.1.4.1151.56 (O98.0- is not in value set) | A15- through A19-, O98.0-, Z86.15, Z22.7<br>**OID:** 2.16.840.1.113762.1.4.1146.451 |
| 4 | Sexually transmitted infections (gonococcal infections and venereal diseases) | A50- through A64-, Z22.4<br>**OID**: 2.16.840.1.113883.3.464.1003.112.11.1003 | A50- through A64-, A69.0, A69.1, A69.8, A69.9<br>**OID**: 2.16.840.1.113883.3.464.1003.112.11.1003 |
| 4a | Hepatitis B | B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.1-, O98.4-<br>**OID**: 2.16.840.1.113883.3.464.1003.110.12.1025 (B19.1- and O98.4- are not in value set) | B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.1-<br>**OID**: 2.16.840.1.113883.3.464.1003.110.12.1025 |
| 4b | Hepatitis C | B17.1-, B18.2, B19.2-<br>**OID**: 2.16.840.1.113762.1.4.1222.30 | B17.1-, B18.2, B19.2-<br>**OID**: 2.16.840.1.113762.1.4.1146.153 |
| 4c | Novel coronavirus (SARS-CoV-2) disease | U07.1<br>**OID**: 2.16.840.1.113762.1.4.1248.139, 2.16.840.1.113762.1.4.1200.151 | U07.1<br>**OID**: 2.16.840.1.113762.1.4.1248.139, 2.16.840.1.113762.1.4.1200.151 |
| 4d | Long COVID | U09.9<br>**OID**: 2.16.840.1.113762.1.4.1222.1391 | U09, U09.9.<br>**OID:** 2.16.840.1.113762.1.4.1222.1391 |

Last Updated April 15, 2024

- Applicable ICD-10-CM, CPT-4/I/PLA, or HCPCS codes are updated for the year.
- Annual Table 6A code changes are available for download (shown in screenshot to the left).
  - **Value sets are included where they apply.**
  - Other codes have been updated where appropriate.
- Specifications and codes are updated as of spring of this year.

# Key Notes for Table 6A

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

Only report **tests** or **procedures** that are:

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

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

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

# PrEP Management Reporting on Table 6A

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

- **New code available: Z29.81, Encounter for HIV pre-exposure prophylaxis**

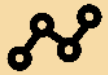
Health centers report based on the code provided or the equivalent. This guidance is further tailored from prior years in order to prevent overcounting.

Health centers must confirm that *only* PrEP prescribed and/or managed **in the year** for HIV prevention is included.

## Validating PrEP Reporting

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

Unlikely to have more PrEP management patients than HIV tests, as an HIV test (Line 21) is needed to start PrEP (Line 21e).



Review PrEP prescriptions in your state on the AHEAD dashboards, as any single health center is unlikely to have more PrEP visits/patients than the state as a whole.

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# Tables 6B and 7: CQMs

2024 Changes:

- Measures updated to align with updated eCQMs, wherever available.
- In this alignment with those updated eCQMs, several existing measures have notable modifications.

*All health centers are required to submit an aggregate UDS Report within HRSA's EHBs by Feb. 15, 2025. All health centers will be required to submit the above specified amount of patient-level data (UDS+) for, at minimum, medical patients, by April 30, 2025. Health centers who are concerned about their ability to report UDS+ should reach out via the BPHC Contact form, select UDS Modernization under Uniform Data System (UDS) heading.*

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# Understanding CQM Reporting in the UDS

Key considerations and structures must be understood in order to accurately report measures in the UDS specifically.

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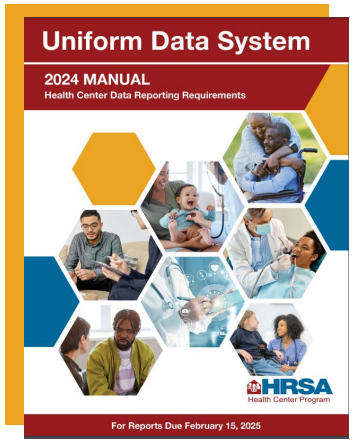
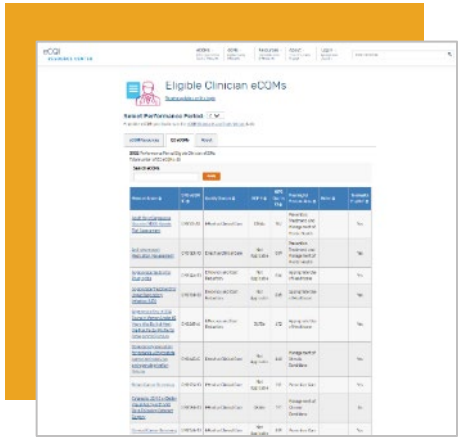
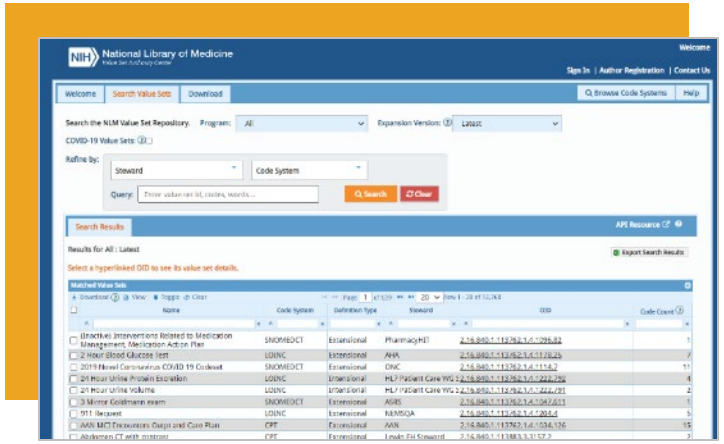
# CQM Specifications




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




The manual links to the Electronic Clinical Quality Improvement (eCQI) Resource Center, where measure information, specifications, data elements, and value sets are found.




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

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

# eCQM issues that have been identified can be reviewed in the Office of the National Coordinator for Health Information Technology (ONC) Issue Tracking System (OITS) JIRA project eCQM Issue Tracker.

Responses and guidance from the measure stewards about questions can be found here.

Sign up for an OITS account.

Post questions in the eCQM Issue Tracker.

# Components of Each Clinical Measure

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

# Understanding Columns of Table 6B

- Health centers report the full denominator for the CQM in **Column A**.
  - Note: Don't be misled by the heading! This is where you will report the denominator as defined by the measure specifications, not the total patients in the age group.
- **Column B** must equal Column A *or* be 80% or more of Column A. In Column B:
  - Report all patients who meet the specifications (same as Column A) as shown to the top right, **or**,
  - In those limited instances where a health center doesn't have access to the full set of data needed to assess numerator compliance, a number equal to or greater than 80% of Column A (*shown to the bottom right*).
    - Health centers may NOT use chart sampling for reporting CQMs. If your health center does not use an electronic health record (EHR), contact the UDS Support Center to discuss options.
- **Column C** is the number of patients in the denominator, from Column B, who meet the numerator requirements.

| Line | Example: Childhood Immunization Status | Total Patients with 2nd Birthday (a) | Number of Records Reviewed (b) | Number of Patients Immunized (c) |
|---|---|---|---|---|
| 10 | MEASURE: Percentage of children 2 years of age who received age-appropriate vaccines by their 2nd birthday | 250 | 250 | 139 |

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

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# Denominators: Qualifying Encounters

**Clinical measure guidance for the UDS specifies that to be included in any given CQM denominator, patients must have:**

- A **countable UDS visit** during the calendar year reported on Table 5, **and**

- A **visit that meets the qualifying encounter definitions** for that particular eCQM's measure criteria and specifications.
- Each measure defines its own qualifying encounters in its specifications.

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# Understanding Eligible Visits for CQMs

- Accessing and Reading eCQMs for UDS
- Accessing Value Set Codes for CQMs

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

No! It means that those patients who meet the measure specifications are included in each measure's denominator. For some measures, this is *a lot* of visit types; in others, it's fairly narrow. Each measure steward identifies the population or denominator for the measures that they develop.

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

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

# Clinical Process and Outcome Measures

## Tables 6B and 7

| Screening and Preventive Care |
| --- |
| Cervical Cancer Screening |
| Breast Cancer Screening |
| Body Mass Index (BMI) Screening and Follow-Up Plan |
| Tobacco Use: Screening and Cessation Intervention |
| Colorectal Cancer Screening |
| HIV Screening |
| Screening for Depression and Follow-Up Plan |

| Maternal Care and Children's Health |
| --- |
| Early Entry into Prenatal Care |
| Low Birth Weight |
| Childhood Immunization Status |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents |
| Dental Sealants for Children between 6-9 Years |

| Chronic Disease Management |
| --- |
| Statin Therapy for the Prevention and Treatment of Cardiovascular Disease |
| Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet |
| HIV Linkage to Care |
| Depression Remission at Twelve Months |
| Controlling High Blood Pressure |
| Diabetes: Hemoglobin A1c (HbA1c) Poor Control |

Each measure that is an eCQM has been updated to the 2024 version. The link to each of these measures in the eCQI Resource Center is in the UDS Manual.

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# Tables 6B and 7:

## Measures That Are Not Electronically Specified

**Not all Table 6B and 7 measures are currently eCQMs.**

Electronic specifications have **not** been updated for these measures:

- Dental Sealants (CMS277v0)
- Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet (CMS164v7)

As a result, these are no longer readily accessible from the eCQI Resource Center or VSAC.

Some measures have never been electronically specified:

- Early Entry into Prenatal Care
- HIV Linkage to Care
- Deliveries and Low Birth Weight

Additional resources for measures that are not electronically specified can be found:

- In the UDS Manual
- On the BPHC UDS Resources Clinical Care page

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# Table 7:
# Race and Ethnicity Subcategories

Race/ethnicity categories and subcategories here on Table 7 align with Table 3B.

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

All three measures on Table 7 are reported with granular race and ethnicity subcategories.

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

| Line | Race and Ethnicity | Prenatal Ca… Delivered I… |
|---|---|---|
| | **Mexican, Mexican American, Chicano/a** | |
| 1a1m | Asian Indian | |
| 1a2m | Chinese | |
| 1a3m | Filipino | |
| 1a4m | Japanese | |
| 1a5m | Korean | |
| 1a6m | Vietnamese | |
| 1a7m | Other Asian | |
| 1b1m | Native Hawaiian | |
| 1b2m | Other Pacific Islander | |
| 1b3m | Guamanian or Chamorro | |
| 1b4m | Samoan | |
| 1cm | Black or African American | |
| 1dm | American Indian/Alaska Native | |
| 1em | White | |
| 1fm | More than One Race | |
| 1gm | Unreported/Chose Not to Disclose Race | |
| | *Subtotal Mexican, Mexican American, Chicano/a* | |

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# Understanding Specifications of CQMs

Most CQMs are nationally specified, meaning their requirements are set at the national level by measure stewards. So, understanding the measure specifications is critical for accurate workflow and documentation, which will drive reporting and outcomes.

# 2024 CQM Tables

## Tables 6B and 7

### Updates

- Updates to how data can be collected and reported.
- Clarifications for specific measures and requirements.

### Changes

- Several eCQMs have material changes to their specifications.

We will not review *all* the clinical measures; join or watch the three clinical deep dive webinars for more details!

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# Table 6B: Existing Measure Modified

## Tobacco Use: Screening and Cessation Intervention (CMS138v12)

The Tobacco Screening measure denominator age has changed from patients aged 18 and older to those aged 12 and older.

| 2023 Measure Description | 2024 Measure Description |
|---|---|
| Percentage of patients aged **18 years and older** who were screened for tobacco use one or more times during the measurement period and who received tobacco cessation intervention during the measurement period or in the 6 months prior to the measurement period if identified as a tobacco user | Percentage of patients aged **12 years and older** who were screened for tobacco use one or more times during the measurement period and who received tobacco cessation intervention during the measurement period or in the 6 months prior to the measurement period if identified as a tobacco user |

**Known Issue:** The "Preventive Care Services, Initial Office Visit, 0 to 17" and "Preventive Care, Established Office Visit, 0 to 17" value sets are not currently included in the measure. (Related ONC Jira tickets are here and here.)

**Solution from the measure steward:** Clinically equivalent codes can be used for mapping if your organization elects to include additional values for 2024 reporting. If mapping is done, you should maintain documentation in the event of a Centers for Medicare & Medicaid Services (CMS) audit.

# Table 6B: Existing Measure Modified

## Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (CMS347v7)

- The Statin Therapy measure now includes:
  - Patients who were previously diagnosed with or currently have a diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD)
  - Patients 40 through 75 years of age with a 10-year ASCVD risk score ≥ 20%

| 2023 Denominator | 2024 Denominator |
|---|---|
| • All patients **who have an active diagnosis of ASCVD**, or have ever had an ASCVD procedure *and* | • All patients **who were previously diagnosed with or currently have a diagnosis of ASCVD**, including an ASCVD procedure *and* |
| • Patients who were **20 years of age and older** who ever had a laboratory result of LDL-C greater than or equal to 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia *and* | • Patients who were **20 through 75** years of age who ever had a laboratory result of LDL-C greater than or equal to 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia *and* |
| • Patients 40 through 75 years of age with type 1 or type 2 diabetes | • Patients 40 through 75 years of age with type 1 or type 2 diabetes *and* |
| | • **Patients 40 through 75 years of age with a 10-year ASCVD risk score of greater than or equal to 20% during the measurement period** |

# Table 6B: Existing Measure Modified

## HIV Screening (CMS349v6)

- The HIV Screening measure has added a denominator exception for patients who died on or before the end of the measurement period.

| 2023 Denominator Exceptions | 2024 Denominator Exceptions |
|---|---|
| *Not applicable* | **Patients who died on or before the end of the measurement period** |

# Table 6B: Existing Measure Modified

## Screening for Depression and Follow-Up Plan (CMS2v13)

The Depression Screening measure has removed diagnosis of depression as a denominator exclusion. This change is based on updated clinical guidance. Denominator exception language has been updated to include patient refusal to participate in or complete screening.

| 2023 Denominator Exclusions | 2024 Denominator Exclusions |
|---|---|
| Patients who have been **diagnosed with depression or bipolar disorder** at any time prior to the qualifying encounter, regardless of whether the diagnosis is active or not | Patients who have been **diagnosed with bipolar disorder** at any time prior to the qualifying encounter, regardless of whether the diagnosis is active or not |
| **2023 Denominator Exceptions** | **2024 Denominator Exceptions** |
| Patient Reasons: Patient refuses to participate | Patient Reasons: Patient refuses to participate in **or complete the depression screening** |

**Known Issue:** Patients with an active depression diagnosis who are currently receiving treatment might not meet numerator criteria. (See eCQM Known Issue details here.)

**Guidance:** Follow current measure logic, as specified, for CMS2v13. For patients that are advised to continue their depression care plan, clinicians can consider mapping to the following codes: SNOMED CT 410234004 (Management of mental health treatment (procedure)) or SNOMED CT 410232000 (Mental health treatment assessment (procedure)).

# Table 6B: Existing Measure Modified

## Depression Remission at Twelve Months (CMS159v12)

- The Depression Remission measure no longer excludes permanent nursing home residents from the denominator.

| 2023 Denominator Exclusions | 2024 Denominator Exclusions |
|---|---|
| • Patients with a diagnosis of bipolar disorder, personality disorder emotionally labile, schizophrenia, psychotic disorder, or pervasive developmental disorder | • Patients with a diagnosis of bipolar disorder, personality disorder emotionally labile, schizophrenia, psychotic disorder, or pervasive developmental disorder |
| • Patients who died or who received hospice or palliative care services | • Patients who died or who received hospice or palliative care services |
| • Patients who were permanent nursing home residents | • ~~**Patients who were permanent nursing home residents**~~ |

# Table 6B: Existing Measure Modified

## Childhood Immunization Status (CMS117v12)

- The Childhood Immunization Status measure numerator expands criteria for anaphylaxis due to vaccine.

| 2023 Numerator Criteria | 2024 Numerator Criteria |
|---|---|
| Demonstrated vaccinations for diphtheria, tetanus, and pertussis (DTaP); poliovirus (IPV); measles, mumps, and rubella (MMR); haemophilus influenzae type B (Hib); hepatitis B; varicella (VZV); pneumococcal conjugate; hepatitis A; rotavirus; and influenza<br><br>Or anaphylaxis due to DTaP, Hib, hepatitis B, or rotavirus | Demonstrated vaccinations for diphtheria, tetanus, and pertussis (DTaP); poliovirus (IPV); measles, mumps, and rubella (MMR); haemophilus influenzae type B (Hib); hepatitis B; varicella (VZV); pneumococcal conjugate; hepatitis A; rotavirus; and influenza<br><br>Or anaphylaxis due to DTaP, **IPV, MMR,** Hib, hepatitis B, **VZV, pneumococcal conjugate, hepatitis A,** rotavirus, or **influenza** |

# Table 6B: Existing Measure Modified

## Cervical Cancer Screening (CMS124v12)

- The Cervical Cancer Screening measure includes language to capture screenings performed outside of the measurement period.

| 2023 Guidance | 2024 Guidance |
|---|---|
| *Not applicable* | **Please note the measure may include screenings performed outside the age range of patients referenced in the initial population. Screenings that occur prior to the measurement period are valid to meet measure criteria.** |

# Table 6B: Existing Measure Modified

## Breast Cancer Screening (CMS125v12)

- The Breast Cancer Screening measure includes additional denominator exclusion language to confirm timing for bilateral mastectomy "on or before the end of the measurement period."
- Includes added guidance to capture screenings performed outside of the measurement period.

| 2023 Denominator Exclusions | 2024 Denominator Exclusions |
|---|---|
| Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy. | Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy **on or before the end of the measurement period.** |
| **2023 Guidance** | **2024 Guidance** |
| *Not applicable* | **Please note the measure may include screenings performed outside the age range of patients referenced in the initial population. Screenings that occur prior to the measurement period are valid to meet measure criteria.** |

# Table 6B: Existing Measure Modified

## Colorectal Cancer Screening (CMS130v12)

- The Colorectal Cancer Screening measure's numerator terminology has changed to refer to "Stool deoxyribonucleic acid (sDNA) with FIT test" in place of "FIT-DNA."
- Includes language to capture screenings performed outside of the measurement period.

| 2023 Numerator Terminology | 2024 Numerator Terminology |
|---|---|
| FIT-DNA during the measurement period or the two years prior to the measurement period | **Stool DNA (sDNA) with FIT test** during the measurement period or the two years prior to the measurement period |
| **2023 Guidance** | **2024 Guidance** |
| *Not applicable* | **Please note the measure may include screenings performed outside the age range of patients referenced in the initial population. Screenings that occur prior to the measurement period are valid to meet measure criteria.** |

FIT = fecal immunochemical test

# Table 7: Existing Measure Modified

## Controlling High Blood Pressure (CMS165v12)

The Controlling High Blood Pressure measure guidance language changed from "remote monitoring device" to "automated blood pressure monitor or device."

| 2023 Numerator Criteria | 2024 Numerator Criteria |
|---|---|
| Only blood pressure readings performed by a clinician or a remote monitoring device are acceptable for numerator compliance with this measure. | Only blood pressure readings performed by a clinician or **an automated blood pressure monitor or** device are acceptable for numerator compliance with this measure. |

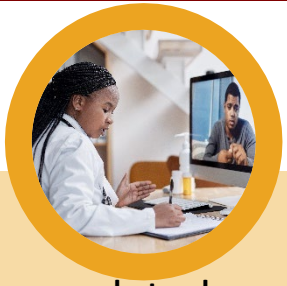
# Unpacking the Change

## Controlling High Blood Pressure (CMS165v12)

**The addition of "automated blood pressure monitor" to the measure has generated lots of questions!**

Clarifications:

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



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

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

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

No major changes in 2024

*All health centers are required to submit an aggregate UDS Report within HRSA's EHBs by Feb. 15, 2025. All health centers will be required to submit the above specified amount of patient-level data (UDS+) for, at minimum, medical patients, by April 30, 2025. Health centers who are concerned about their ability to report UDS+ should reach out via the BPHC Contact form, select UDS Modernization under Uniform Data System (UDS) heading.*

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

Health center patients who **initiate prenatal care with the health center or its referral network** are included in the **Prenatal section of Table 6B** *and* tracked and reported in the **Delivery and Birth Outcomes section of Table 7**.

- Portions beginning on pages 93 and 127 of the UDS Manual detail the health center UDS reporting requirements for prenatal care and related delivery and birth outcomes.

**Prenatal care initiated with "the health center or its referral network" refers to:**

- Prenatal care initiated with the health center directly *or*
- Prenatal care initiated with a provider/entity with which the health center has *formal referral* ***contractual*** *agreements* (as indicated in Column II of Form 5A) *or*
- Prenatal care initiated with a provider/entity with which the health center has *formal written* ***referral*** *arrangements* (as indicated in Column III of Form 5A).

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# Maternal Care: Prenatal and Birth Outcome Measures

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

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

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# Prenatal Patients by Age and Entry into Prenatal Care

## Table 6B

- **Line 0:** Mark the check box if your health center provides prenatal care through direct *referral only*.
- Lines 1–6: Report all prenatal care patients by their age *as of Dec. 31*.
- Lines 7–9: Report all prenatal care patients by the trimester they began prenatal care:
  - **Prenatal care begins with a comprehensive prenatal care physical exam.**
  - Report in Column A if care *began at your health center* (including any patient you may have referred out for care).
  - Report in Column B if care *began with another provider* and was then transferred into your health center's care.

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

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

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

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

# Deliveries and Birth Outcomes

## Table 7

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

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

*Excerpt of Table 7.*

# Deliveries and Birth Outcomes

## Table 7, Lines 0 and 2

### Section A

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

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

**View the Prenatal and Birth Outcomes Fact Sheet for more information.**

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

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

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

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

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

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

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

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

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

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

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

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

- If someone is first encountered at a location NOT listed on Form 5B as part of your health center scope of project, then it's not a countable visit.
- If the hospital is **not** part of the health center's scope, then this single contact isn't a countable visit, therefore the person doesn't become a patient.
- If the delivery **is a visit**, report the patient as a prenatal care patient on Table 6B by age and trimester of entry, and report the delivery and birth weight on Table 7.

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# Find Resources to Help

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

- UDS CQM Criteria
- Table 6A Code Changes
- UDS Clinical Measures Exclusions and Exceptions
- Telehealth Impact on UDS Clinical Measure Reporting

And much more!

# Tables 8A, 9D, and 9E

## Understanding Costs and Revenues for Health Center Scope

Patient Demographic Profile

Clinical Services and Outcomes

**Financial Tables**

Other Forms

# Overview of Financial Tables

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

# Table 8A: Financial Costs

No major changes in 2024

# Financial Costs

## Table 8A Columns

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

| Cost Center (Lines 1–15) | Accrued Cost (Column A) | Allocation of Facility and Non-Clinical Support Services (Column B) | Total Cost After Allocation of Facility and Non-Clinical Support Services (Column C) |
|---|---|---|---|
| • Medical<br>• Dental<br>• Mental Health<br>• Substance Use Disorder<br>• Pharmacy and Pharmaceuticals<br>• Other Professional<br>• Vision<br>• Enabling<br>• Other Program-Related Services<br>• Non-Clinical Support (Admin)<br>• Facility | • Report **accrued** direct costs<br>• Include costs of:<br>▪ Personnel (both staff and contracted)<br>▪ Fringe benefits<br>▪ Supplies<br>▪ Equipment<br>▪ Depreciation<br>▪ Related travel<br>• Do not include bad debt costs | • Allocate Facility and Non-Clinical Support Services costs to all other cost centers (Lines 1-13) as overhead<br>• Must equal Line 16, Column A, representing overhead costs incurred by all cost centers | • Sum of Columns A + B (calculated automatically in EHBs)<br>• Represents cost to operate service by cost center<br>• Used to calculate cost per visit and cost per patient |

# Tables 5 and 8A Crosswalk

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

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

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

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

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# Financial Costs

## Table 8A

**Report costs by cost center:**

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

| Line | Cost Center | Accrued Cost (a) |
|---|---|---|
| | **Financial Costs of Medical Care** | |
| 1 | Medical Personnel | |
| 2 | Lab and X-ray | |
| 3 | Medical/Other Direct | |
| 4 | **Total Medical Care Services** (Sum of Lines 1 through 3) | |
| | **Financial Costs of Other Clinical Services** | |
| 5 | Dental | |
| 6 | Mental Health | |
| 7 | Substance Use Disorder | |
| 8a | Pharmacy (not including pharmaceuticals) | |
| 8b | Pharmaceuticals | |
| 9 | Other Professional (specify___) | |
| 9a | Vision | |
| 10 | **Total Other Clinical Services** (Sum of Lines 5 through 9a) | |
| | **Financial Costs of Enabling and Other Services** | |
| 11a | Case Management | |
| 11b | Transportation | |
| 11c | Outreach | |
| 11d | 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) | |

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# Pharmacy Reporting on Table 8A

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

- **Dispensing fees** for contract pharmacy (e.g., 340B) are reported on Line 8a, Pharmacy, separate from the cost of drugs.
- **Costs of pharmaceuticals** (either for in-house pharmacy or contract pharmacy) are reported on Line 8b.
- Administrative or overhead costs for the contract pharmacy program, such as the clinic's in-house 340B manager or contract manager, are to be allocated to Line 8a, Pharmacy, in Column B.
- Report **pharmacy assistance programs** 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 31.
- **Line 15:** Costs for all personnel whose FTE is reported on Table 5, Lines 30a–30c and 32, including corporate administration, billing collections, medical records and intake personnel; facility and liability insurance; legal fees; practice management system; and direct non-clinical support costs (travel, supplies, etc.).
  - Include malpractice insurance in the service categories, not here.
- **Line 16:** Total indirect costs to be allocated in Column B.

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

# Allocating Overhead Expenses to Column B

## Three-Step Method

**Step 1**

### Allocate Facility (Line 14)

- Identify square footage used by each cost center and cost per square foot.
- Distribute square footage costs to each cost center across Column B.

**Step 2**

### Allocate Non-Clinical Support Services (Line 15)

- Distribute non-clinical support costs to the applicable service area/cost center.
  - Include decentralized front desk personnel, billing and collection systems and personnel, etc.
  - Consider lower allocation of overhead to contracted services.

**Step 3**

### Allocate Remaining Overhead Costs Using Straight-Line Method

- Straight-line method means allocating non-clinical support costs based on the proportion of net costs for each service category.

There are multiple ways that facility and non-clinical support services (Lines 14 and 15, Column A) may be allocated to the cost centers in Column B (Lines 1–13).

**Use the simplest method that accurately portrays the use of facility and non-clinical support services and distribution of costs.**

***Resource: UDS Overhead Cost Allocation Methods***

HRSA Health Center Program

# Reporting Donations

## Tables 8A and 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

**Reported on Line 18, Column C of Table 8A**

### Cash Donations

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

**Reported on Line 10 of Table 9E**

***Resource: Reporting Donations on the UDS***

# Table 9D: Patient Service Revenue

No major changes in 2024

# Table 9D: Reporting Patient Service Revenue

## Patient Service Revenue *(Columns)*

- **Column A:** Charges for services in the year
- **Column B:** Collections on a cash basis
- **Columns C1–C4:** Reconciliations
- **Column D:** Contractual adjustments
- **Column E:** Self-pay sliding fee discounts
- **Column F:** Self-pay bad debt

## By Payer *(Rows)*

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

## By Form of Payment *(Breakout of rows)*

- Non-managed care
- **Sub-line a:** Managed care
- **Sub-line b:** Non-managed care

# Table 9D Columns: Charges and Collections

Table 9D columns are where charges, revenue/ collections, adjustments, sliding fees, and bad debt are reported.

# Column A: Full Charges

## Table 9D

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

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

# Column B: Collections

## Table 9D

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

- **Column B: Collections:** Include **all payments** received in 2024 **related to services to patients**:
  - Capitation payments
  - Contracted payments
  - Payments from patients
  - Third-party insurance
  - Retroactive settlements, receipts, and payments
    - Include pay for performance (P4P), quality bonuses, and other incentive payments tied to patient care.
- Payer incentives (such as for conducting certain screenings or improving on CQMs) are included in the collections reported here.

# Columns C1–C4: Retroactive Settlements, Receipts, and Paybacks

## Table 9D

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

# Column D: Adjustments

## Table 9D

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

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

# Table 9D: Revenue Timing

New FAQ added to the UDS Manual in 2024 clarifies the timing for revenue reporting (charges, collections, adjustments) on Table 9D, Patient Service Revenue.

**Charges** in Column A are to be reported based on the date of service and limited to **dates of service** that occurred in 2024.

**Collections** and **adjustments** (Columns B, C1–C4, and D) are reported based on **posting date** and limited to transactions posted in 2024.

This acknowledges that there is likely to be some timing difference between these.

# Column E: Sliding Fee Discounts

## Table 9D

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

**Applicable *only* to charges reported in Column A of Line 13, Self-Pay.**

- **Column E: Sliding Fee Discounts:** Reductions in patient charges based on their ability to pay.
  - Based on the patient's documented income and family size (per federal poverty guidelines), including uninsured patients with income below 2X the federal poverty guideline.
- 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.

# Column F: Bad Debt Write-Off

## Table 9D

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

- **Bad debt:** Amounts owed by patients considered to be uncollectable and formally written off during 2024, regardless of when service was provided.
- Only report **patient bad debt** (not third-party payer bad debt):
  - ***Only*** *related to charges reported in* ***Column A*** *of* ***Line 13, Self-Pay****.*
  - Third-party payer bad debt is not reported in the UDS.
- Do not change bad debt to a sliding discount.
- Discounts (e.g., to specific groups of patients, cash discounts) or forgiveness is not patient bad debt (or a sliding discount).

# Table 9D Rows: Payer and Payment Type

Each line on Table 9D is a different payer and payment type, which needs to align with the payer the claim was submitted to and origin of the payment.

# Payer Categories for Patient Service Revenue

## Table 9D

### Medicaid

- Any state Medicaid program, including EPSDT, adult day health care (ADHC), Program of All-Inclusive Care for the Elderly (PACE), if administered by Medicaid
- Medicaid MCOs or Medicaid programs administered by third-party or private payers
- CHIP, when administered by Medicaid

### Medicare

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

### Other Public

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

### Private

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

### Self-Pay

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

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

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

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

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

# There Are Three Possible Forms of Payment

## For Patient Service Revenue on Table 9D

### Non-Managed Care

Procedures and services are **separately charged** and paid for by a third-party payer, generally based on FFS. The third-party payers pay some or all of the bill based on agreed-upon maximums or discounts.

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

### Managed Care Capitation

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

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

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# Reporting: Reclassifying a Portion of a Charge

## Table 9D

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

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

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

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# Examples: Reclassifying a Portion of a Charge

## Table 9D

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

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

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

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

# Example

## How is this reported across Tables 4 and 9D?

- Naomi came to the health center seeking contraception in 2024. On the intake paperwork, Naomi notes that she does not have insurance.
- Naomi is then seen twice at the health center in 2024 for family planning services including contraception, sexually transmitted infection 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 medical insurance and was seen twice in the year for family planning services, which are covered by Title X.
- **Answer:**
  - Naomi is **Uninsured on Table 4**.
  - On Table 9D, the charges for the family planning services and collections received from Title X are reported as Other Public Non-Managed Care, on Line 7.
  - Any charges that were not covered by Title X are reported on Line 13: Self-Pay.

# Reporting 340B Contract Pharmacy

| Table | Related Reporting/Impact |
|---|---|
| **8A (Costs)** | • Report the **amount the pharmacy charges for managing dispensing of drugs** on Line 8a, Pharmacy.<br>• Report the **full amount paid for drugs, either directly (by clinic) or indirectly (by contract pharmacy)** on Line 8b, Pharmaceuticals.<br>• If the pharmacy buys prepackaged drugs and there is no reasonable way to separate the pharmaceutical costs from the dispensing/administrative costs, report all costs on Line 8b. Associated non-clinical support services (overhead) costs go on Line 8a, Column B, even though Line 8a, Column A is blank.<br>• Report payments to pharmacy benefit managers on Line 8a, Pharmacy.<br>• Some pharmacies split the fee or keep a share of profit. Report this as a payment to the pharmacy on Line 8a, Pharmacy. |
| **9D (Patient Service Revenue)** | • **Charge (Column A) is the health center/contract pharmacy's full retail charge for the drugs dispensed, *by payer*.** If retail is unknown, ask the pharmacy for retail prices for the drugs dispensed.<br>• **Collection (Column B) is the amount received from patients or insurance companies.** Health centers must collect this information from the contract pharmacy in order to report accurately.<br>• **Adjustments (Column D) is the amount disallowed by a third party for the charge** (if on Lines 1–12).<br>• **Sliding Fee Discount (Column E) is the amount written off for eligible patients per health center policies (Line 13).** Calculate as retail charge/pharmacy charge, minus amount collected from patients (by pharmacy or health center), minus amount owed by patients. |
| **9E (Other Revenue)** | Do not report 340B or contract pharmacy revenue on Table 9E, specifically do not use Table 9E to report net revenue from the pharmacy. Report actual gross revenue on Table 9D. |

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

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# Table 9E: Other Revenue

No major changes in 2024

# Other Revenue

## Table 9E

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

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

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

# BPHC Grant Lines

## Table 9E, Lines 1a–1q

- **BPHC Grants:** Funds your health center received directly from BPHC, including funds passed through to another agency.
  - Include 330 grant(s) drawn down in the year.
  - Include the amounts directly received under the various COVID-19 awards. *Only report amounts drawn down in 2024.*

**Lines 1a–1q**

| Line | Source | Amount (a) |
|---|---|---|
| | **BPHC Grants (Enter Amount Drawn Down—Consistent with PMS 272)** | |
| 1a | Migrant Health Center | |
| 1b | Community Health Center | |
| 1c | Health Care for the Homeless | |
| 1e | Public Housing Primary Care | |
| 1g | **Total Health Center** (Sum of Lines 1a through 1e) | |
| 1k | **Capital Development Grants**, including School-Based Service Site Capital Grants | |
| 1l | Coronavirus Preparedness and Response Supplemental Appropriations Act (H8C) | |
| 1m | Coronavirus Aid, Relief, and Economic Security Act (CARES) (H8D) | |
| 1n | Expanding Capacity for Coronavirus Testing (ECT) (H8E and LAL ECT) | |
| 1o | American Rescue Plan (ARP) (H8F, L2C, C8E) | |
| 1p | Expanding COVID-19 Vaccination (ECV) | |
| 1p2 | Other COVID-19-Related Funding from BPHC (specify _____) | |
| 1q | **Total COVID-19 Supplemental** (Sum of Lines 1l through 1p2) | |
| 1 | **Total BPHC Grants** (Sum of Lines 1g + 1k + 1q) | |
| | **Other Federal Grants** | |
| 2 | Ryan White Part C HIV Early Intervention | |
| 3 | Other Federal Grants (specify _____) | |
| 3a | Medicare and Medicaid EHR Incentive Payments for Eligible Providers | |
| 3b | Provider Relief Fund (specify _____) | |
| 5 | **Total Other Federal Grants** (Sum of Lines 2 through 3b) | |

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# BPHC COVID-19 Funding Lines

## Table 9E, Lines 1l–1q

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

Lines 1l–1p2 capture COVID-19-related funding *from HRSA BPHC* and should only include amounts drawn down in 2024. Most have already been drawn down.

- **Report the amount drawn down in the year**; some of these funds were awarded in 2020, 2021, or 2022; if those funds were drawn down in 2024, then they're reported in the current UDS Report.
  - Lines 1l–1n were awarded in 2020.
  - Line 1o was awarded in 2021.
  - Line 1p was awarded in 2022.
  - **Bridge funding awarded in 2023 is to be reported on Line 1p2.**
- See detailed guidance on COVID-19 funding here.

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# Other Federal Grants

## Table 9E, Lines 2–3b

- **Other Federal Grants:** Grants you received directly from the federal government other than BPHC (e.g., Department of Housing and Urban Development, Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration).
  - Ryan White Part C.
  - EHR Incentive Payments: Include Promoting Interoperability funds, including funds paid directly to providers and turned over to the health center (exception to last party rule).
  - Provider Relief Fund.

| Line | Source | Amount (a) |
|---|---|---|
| | **BPHC Grants (Enter Amount Drawn Down—Consistent with PMS 272)** | |
| 1a | Migrant Health Center | |
| 1b | Community Health Center | |
| 1c | Health Care for the Homeless | |
| 1e | Public Housing Primary Care | |
| 1g | **Total Health Center** (Sum of Lines 1a through 1e) | |
| 1k | **Capital Development Grants**, including School-Based Service Site Capital Grants | |
| 1l | Coronavirus Preparedness and Response Supplemental Appropriations Act (H8C) | |
| 1m | Coronavirus Aid, Relief, and Economic Security Act (CARES) (H8D) | |
| 1n | Expanding Capacity for Coronavirus Testing (ECT) (H8E and LAL ECT) | |
| 1o | American Rescue Plan (ARP) (H8F, L2C, C8E) | |
| 1p | Expanding COVID-19 Vaccination (ECV) | |
| 1p2 | Other COVID-19-Related Funding from BPHC (specify _____) | |
| 1q | **Total COVID-19 Supplemental** (Sum of Lines 1l through 1p2) | |
| 1 | **Total BPHC Grants** (Sum of Lines 1g + 1k + 1q) | |
| | **Other Federal Grants** | |
| 2 | Ryan White Part C HIV Early Intervention | |
| 3 | Other Federal Grants (specify _____) | |
| 3a | Medicare and Medicaid EHR Incentive Payments for Eligible Providers | |
| 3b | Provider Relief Fund (specify _____) | |
| 5 | **Total Other Federal Grants** (Sum of Lines 2 through 3b) | |

**Lines 2–3b**

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# Non-Federal Grants Revenue Categories

## Table 9E, Lines 6–9

- **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 government grants and contracts are reported on Line 6.
  - Local (city, town, municipal) grants and contracts are reported on Line 7.
- **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)

| | 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) | |

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# Other Revenue

## Table 9E, Line 10

**Other Revenue:** Miscellaneous non-patient-related revenues (e.g., cash donations, medical record revenue, vending machine revenue).

**Other Revenue on Line 10 INCLUDES:**

- Cash donations
- Medical record revenue
- Interest income
- Rent revenue
- Public/retail pharmacy revenue (not 340B)

**Other Revenue on Line 10 does NOT include:**

- Bad debt recovery
- 340B revenue
- Payer incentives
- Investment losses
- In-kind services and goods
- Payments that belong elsewhere on Table 9E

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# Find Resources to Help

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

- Fact sheets
- UDS Financial Tables Guidance
- UDS Overhead Cost Allocation Methods
- Reporting Donations on the UDS
- UDS Managed Care Reporting and Relationship Across Tables 4 and 9D

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

HRSA Health Center Program

# Health Center Health IT Capabilities Appendix D

No major changes in 2024

# Health Center Health IT Capabilities

## Appendix D

### A series of approximately 15 questions that assess:

- **EHR adoption and use in your health center**
  - How widely is the EHR used in the organization?
  - What EHR? Is it certified EHR technology? Did you switch?
  - Do you use more than one system?
- **Data exchange**
  - What other health care entities do you exchange information with?
  - What else do you use health IT/EHR for?
- **Social risk screening**
  - Do you use standardized tools?
  - If no, why not?
  - What is the total number of patients screened?
  - How many patients were identified with social risks?
- **Integration of Prescription Drug Monitoring Program**

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# Social Risk Screening on Health IT Form

## Appendix D

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

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

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

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

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

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

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

# Other Data Elements (ODE)
# Appendix E

2024 change:

- Question 4 added to collect the number of patients screened for family planning needs with a standardized tool.

# ODE

## Appendix E: Four Sections

### Telemedicine

Telemedicine used on this form is specific to remote clinical services, whereas "telehealth" may include remote non-clinical services in addition to clinical services. The focus here is clinical services, supporting patients.

### Medications for Opioid Use Disorder (MOUD)

Report the number of *providers* who prescribed MOUD and the number of *patients* who received MOUD.

- Include if treating MOUD with buprenorphine, methadone, or naltrexone in the year.
- Check information with Table 5; providers and patients reported here must also be on Table 5.

### Outreach and Enrollment Assistance

Report number of assists.

Outreach and enrollment assists are defined as customizable education sessions about affordable health insurance coverage options and any other assistance provided by a trained assister from the health center to facilitate enrollment.

- Assists reported here do not count as visits elsewhere on the UDS.

### Family Planning Screening

Report the number of patients screened for family planning or contraception needs in the calendar year using a standardized screener.

# Telemedicine Reporting

## Appendix E

**Do you use telemedicine?**

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

**Who do you use telemedicine to communicate with?**

- Patients?
- Specialists?

**What telehealth technologies do you use?**

- Real time, store-and-forward, remote patient monitoring, mobile health?

**What services are provided via telemedicine?**

- Primary care, oral health, MH, SUD, dermatology, etc.?

**If you do not offer telemedicine services, why not?**

- Policy barriers, inadequate broadband, lack of funding/training, etc.?

### Keys to Remember

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

# Appendix E (ODE)
# Family Planning Screening

A **new question** has been added to Appendix E: ODE to capture the total number of patients screened for family planning needs.

**Note** that this is not a CQM, so there is no "denominator"—meaning there is not a specification as to who (e.g., age, gender) will be screened. This is just a count of screenings done.

"How many health center patients were screened for family planning needs, including contraceptive methods, using a standardized screener during the calendar year?"

***NEW:*** *See the FAQs added to Appendix E for answers to questions around this new data reporting element.*

***NEW:*** *See the new crosswalk resource for reporting family planning screening.*

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# Workforce Appendix F

No major changes in 2024

# Workforce Form

## Appendix F

### Professional Education/Training

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

### Satisfaction Surveys

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

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

HRSA Health Center Program

# Wrapping Up

## Setting Up for Success

Available Resources

Tips for Success

Wrapping Up

# Available Resources

Resources are available to support your UDS reporting!

# UDS Training and Technical Assistance Resources

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


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# Training Webinar Series for 2024 UDS Reporting

The webinar series includes:

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

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

# Support Available

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

# IMPORTANT KEY:
# Use these supports as you work toward submission!

- Review resources as you work on various parts of the report or as you plan changes to your data collection and reporting processes.
- Reach out to support lines as early as possible with any needs or questions you have!

# Tips for Success and References

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

# 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 HHS reporting requirements, including those data elements for [UDS] reporting; and
- "The health center submits timely, accurate, and complete UDS reports in accordance with HRSA instructions and submits any other required HHS and Health Center Program reports."

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

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

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

HRSA Health Center Program

# 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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