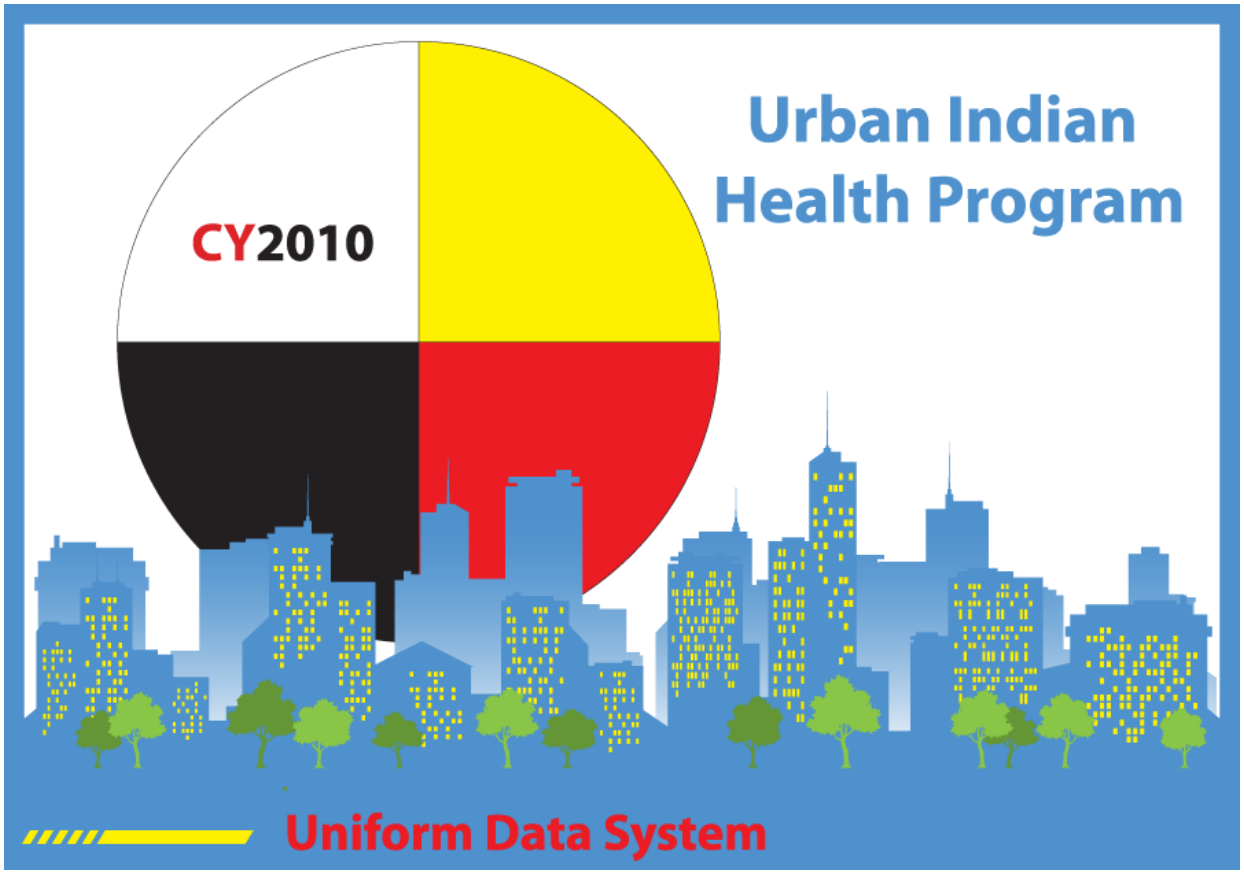
Form Approved
OMB No. 0917-0007
Exp. Date XX/XX/20XX

UDS Reporting Instructions for OUIHP Programs

UNIFORM DATA SYSTEM (UDS)
Calendar Year 2010



For help call the UDS support line at: **866-698-5976**
or email: **helpuds@uihpdata.net**

DEPARTMENT OF HEALTH & HUMAN SERVICES
INDIAN HEALTH SERVICE
OFFICE OF PROGRAM SUPPORT
801 THOMPSON AVE. TMP 450
ROCKVILLE, MD 2085

OFFICE OF URBAN INDIAN HEALTH PROGRAMS

OUIHP UNIFORM DATA SYSTEM MANUAL

For use to submit Calendar Year 2010 UDS Data

INDIAN HEALTH SERVICE

Urban Indian Health Program
801 Thompson Avenue
Rockville, Maryland 20852

2010 UNIFORM DATA SYSTEM MANUAL

CONTENTS

SECTION
PAGE

INTRODUCTION

This 3rd edition of the Office of Urban Indian Health Program (OUIHP) User's Manual: Uniform Data System (UDS) updates all instructions and modifications issued since the first OUIHP UDS reporting year (2008). **This Manual supersedes all previous manuals.**

The Uniform Data System (UDS) is a comprehensive data set reported by all organizations directly receiving Federal funds under Title V of The Indian Health Care Improvement Act, P.L. 94-437 as made permanent by the passage of P.L. 111-148, Affordable Care Act. The UDS provides an annual 'snapshot' of the activity of the funded Urban Indian Health Programs (UIHPs). This snapshot shows activity of each program including:

- The number and socio-demographic characteristics of people served
- Types and quantities of services provided
- Types of staff who provide these services
- Clinical characteristics of patients
- Cost and efficiency of delivering services
- Sources and amounts of income

In 2008, the OUIHP replaced the Urban Indian Health Common Reporting Requirements (UCRR) with the UDS currently used by the Bureau of Primary Health Care (BPHC). By replacing the UCRR with the UDS, the OUIHP retains its capability to monitor program performance and identify opportunities for strengthening service delivery while simplifying duplicate data reporting for UIHPs receiving dual funding from BPHC's Community Health Center Program and the OUIHP.

This Manual includes a brief introduction to the UDS, instructions for submitting the UDS, definitions of terms as they are used in the UDS and detailed instructions for completing each table of the 2010 UDS for UIHPs. Where relevant, the table-specific instructions also include a set of "Questions and Answers", addressing issues that are frequently raised when completing the tables. Three appendices are included which: (A) list personnel by category and designation of personnel as providers who can produce countable "visits" for the purpose of the UDS; (B) define types of service as used in the UDS; and (C) describe how to report issues which have impact on multiple tables.

The OUIHP collects data on its programs to ensure compliance with legislative mandates and to report to Congress, Office of Management and Budget and other policy makers on program accomplishments. To meet these objectives, the OUIHP requires programs to submit a core set of information annually that is appropriate for monitoring and evaluating performance and for reporting on annual trends. The UDS is the vehicle used by OUIHP to obtain this information.

The UDS is composed of 10 tables intended to yield consistent operational and financial data that can be compared with other national and State data and trended over time. A brief introduction to the UDS tables follows:

- Cover Sheet and Patient Origin form: Provides contact and general information on the program and zip codes of patients served.
- Table 2: Reports services offered and delivery method.
- Table 3A: Provides a profile of patients by age and gender.

- Table 3B: Provides a profile of patients by race, ethnicity and linguistic barriers.
- Table 4: Provides a profile of patients by income (% of poverty level), third party medical insurance source, managed care enrollment and number of Veterans.
- Table 5: Reports staffing full-time equivalents by position, and visits and patients by provider type and service type.
- Table 6A: Reports on primary diagnoses for medical visits and selected services provided
- Table 8A: Details direct and indirect expenses by cost center.
- Table 9D: Reports full charges, collections and allowances by payer as well as sliding discounts and patient bad debt.
- Table 9E: Reports non patient-service income.

GENERAL INSTRUCTIONS

This section describes submission requirements including who submits UDS reports, when and where to submit UDS data, and how data are submitted.

WHO SUBMITS REPORTS AND REPORTING PERIODS

Reports should be submitted directly by the UIHPs. The reporting period is January 1 through December 31 of each reporting year. All programs funded before October 1, 2010 are expected to report. Programs must report activity for the entire calendar year, even if they were funded, in whole or in part, for less than the full year. Agencies whose funding begins, either in whole or in part, after the beginning of the year, or whose funding is terminated, again either in whole or in part, before the end of the year, are nonetheless required to report on the entire year to the best of their ability. Programs who are funded for the first time after October 1, 2010 and who have had no other OUIHP funds during the year do not report.

DUE DATE

The Calendar Year 2010 UDS report is due **April 15, 2011.**

HOW AND WHERE TO SUBMIT DATA

- **Programs will receive custom software in March 2011 which will be used to enter UDS data. The software includes a system for submitting completed UDS reports electronically.**
- **Demonstrations on how to use the software are available by contacting the OUIHP UDS Helpline.**
- If a program does not receive the software or has difficulty in submitting the data electronically, the program will need to contact the UDS Help Line: 866-698-5976.
- Data are submitted in one of three ways. (Extensive instructions are included in the software package):
    1. Electronically: by attaching the file to an e-mail and sending it to submituihpuds@uihpdata.net
    2. Online, through the built-in File Transfer Protocol (FTP) in the UDS software (detailed instructions are provided in the software.)
    3. In rare instances, and after instructions from the UDS Support Line, data can be mailed to: **UIHP UDS Data, P.O. Box 333, Concord, NH 03302-0333**

DEFINITIONS OF VISITS, PROVIDERS, PATIENTS AND FTES

This section provides definitions which are critical for consistent reporting of UDS data across programs.

VISITS

Visit definitions are needed both to determine who is counted as a patient (Tables 3A, 3B, 4, and 6A) and to report visits by type of provider staff (Table 5). **Visits are defined as documented, face-to-face contacts between a patient and a provider who exercises independent professional judgment in the provision of services to the patient. To be included as a visit, services rendered must be documented in a chart (written or electronic) in the possession of the program.** Appendix A provides a list of UIHP personnel and the *usual* status of each as a provider or non-provider for purposes of UDS reporting. Visits which are provided by contractors **and paid for by the program,** or out-patient or in-patient specialty care associated with an at-risk managed care contract, are considered to be visits to be counted on the UDS to the extent that they meet all other criteria. In these instances, a summary of the visit may appear in the program's charts.

Further elaborations of the definitions and criteria for defining and reporting visits are included below.

1. To meet the criterion for "independent professional judgment," the provider must be acting on his/her own when serving the patient and not assisting another provider. For example, a nurse assisting a physician during a physical examination by taking vital signs, taking a history or drawing a blood sample **is not** credited with a separate visit. Independent judgment implies the use of the professional skills associated with the profession of the individual being credited with the visit and unique to that provider or other similarly or more intensively trained providers.

2. To meet the criterion for "documentation," the service (and associated patient information) must be recorded in written or electronic form. The patient record does not have to be a full and complete health record in order to meet this criterion. For example, if an individual receives services on an emergency basis and these services are documented, the documentation criterion is met even though some portions of the health record are not completed. Screenings at health fairs, immunization drives for children or the elderly and similar public health efforts do not result in visits regardless of the level of documentation.

3. When a behavioral health provider (i.e, a mental health or substance abuse provider) renders services to several patients simultaneously, the provider can be credited with a visit for each person only if the provision of services is noted in **each** person's health record. Such visits are limited to behavioral health services. Examples of such non-medical "group visits" include: family therapy or counseling sessions and group mental health counseling during which several people receive services and the services are noted in each person's health record. In such situations, **each** patient is normally billed for the service. Medical visits must be provided on an individual basis. Patient education or health education classes (e.g., smoking cessation) are not credited as visits.

4. A visit may take place in the UIHP or at any other approved site or location in

which project-supported activities are carried out. Examples of other sites and locations include mobile vans, hospitals, patients' homes, schools, nursing homes, homeless shelters, and extended care facilities. Visits also include contacts with patients who are hospitalized, where UIHP medical staff member(s) follow the patient during the hospital stay as physician of record or where they provide consultation to the physician of record provided they are being paid by the program for these services and the patient is billed either for the specific service or through a global fee. A reporting entity may not count more than one inpatient visit per patient per day regardless of how many clinic providers see the patient or how often they do so.

5. Such services as drawing blood, collecting urine specimens, performing laboratory tests (including pregnancy tests and tuberculosis skin test (PPDs)), taking X-rays, giving immunizations or other injections, and filling/dispensing prescriptions do not constitute visits, regardless of the level or quantity of supportive services.

6. Under certain circumstances a patient may have more than one visit with the UIHP in a day. The number of visits per service delivery location per day is limited as follows. Each patient may have, at a maximum:
   - One medical visit (physician, nurse practitioner, physicians assistant, certified nurse midwife, or nurse).
   - One dental visit (dentist or hygienist).
   - One "other health" visit *for each type of "other health" provider* (nutritionist, podiatrist, speech therapist, acupuncturist, optometrist, traditional healer, etc.).
   - One enabling service visit *for each type of enabling provider* (case management or health education).
   - One mental health visit.
   - One substance abuse visit.

   If multiple medical providers deliver multiple services on a single day (e.g., an Ob-Gyn provides prenatal care and an Internist treats hypertension) *only one of these visits may be counted on the UDS. While some third party payors may recognize these as billable, only one of them is* ***countable.*** *The decision as to which provider gets credit for the visit on the UDS is at the program's discretion. Internally, the program may follow any protocol it wishes in terms of crediting providers with visits.*

   An exception to this rule, allows medical services provided by two *different medical providers* located at two *different sites* to be counted on the same day.

7. A provider may be credited with no more than one visit with a given patient in a single day, regardless of the types or number of services provided.

8. The visit criteria **are not** met in the following circumstances:
   - When a provider participates in a community meeting or group session that is **not** designed to provide clinical services. Examples of such activities include information sessions for prospective patients, health presentations to community groups (high school classes, PTA, etc.), and information presentations about available health services at the center.
   - When the only health service provided is part of a large-scale effort, such as a mass immunization program, screening program, or community-wide service

program (e.g., a health fair).
- When a provider is primarily conducting outreach and/or group education sessions, not providing direct services.
- When the **only** services provided are lab tests, x-rays, immunizations or other injections, tuberculosis skin tests or readings and/or prescription refills.
- Services performed under the auspices of a Women and Infant Children (WIC) program or a WIC contract.

Further definitions of visits for different provider types follow:

PHYSICIAN VISIT – A visit between a physician and a patient.

NURSE PRACTITIONER VISIT – A visit between a Nurse Practitioner and a patient in which the practitioner acts as an independent provider.

PHYSICIAN ASSISTANT VISIT – A visit between a Physician Assistant and a patient in which the practitioner acts as an independent provider.

CERTIFIED NURSE MIDWIFE VISIT – A visit between a Certified Nurse Midwife and a patient in which the practitioner acts as an independent provider.

NURSE VISIT (Medical) – A visit between an R.N., L.V.N. or L.P.N. and a patient in which the nurse acts as an independent provider of medical services exercising independent judgment, such as in a triage visit. Services which meet this criteria may be provided under standing orders of a physician, under specific instructions from a previous visit, or under the general supervision of a physician, Nurse Practitioner, Physicians Assistant, or Certified Nurse Midwife (NP/PA/CNM) who has no direct contact with the patient during the visit, but must still meet the requirement of exercising independent professional judgment. (Note: states prohibit an LVN or an LPN to exercise independent judgment, in which case no visits would be counted for them. Also, under no circumstances are services provided by Medical Assistants or other non-nursing personnel counted as nursing visits.)

DENTAL SERVICES VISIT – A visit between a dentist or dental hygienist and a patient for the purpose of prevention, assessment, or treatment of a dental problem, including restoration. (Note: A dental hygienist is credited with a visit only when s/he provides a service independently, not jointly with a dentist. Two visits may **not** be generated during a patient's visit to the dental clinic in one day, regardless of the number of clinicians who provide services or the volume of service (number of procedures) provided.)

MENTAL HEALTH VISIT – A visit between a licensed mental health provider (psychiatrist, psychologist, LCSW, and certain other Masters Prepared mental health providers licensed by specific states,) or an unlicensed mental health provider credentialed by the center, and a patient, during which mental health services (i.e., services of a psychiatric, psychological, psychosocial, or crisis intervention nature) are provided. (Note: The term “behavioral health” is synonymous with the prevention or treatment of mental health and substance abuse disorders. All behavioral health visits, providers and costs must be parsed out into mental health or substance abuse.)

SUBSTANCE ABUSE VISIT – A visit between a substance abuse provider (e.g., a mental health provider or a credentialed substance abuse counselor, rehabilitation

therapist, psychologist) and a patient during which alcohol or drug abuse services (i.e., assessment and diagnosis, treatment, aftercare) are provided. (Note: The term “behavioral health” is synonymous with the prevention or treatment of mental health and substance abuse disorders. All behavioral health visits, providers and costs must be parsed out into mental health or substance abuse.)

VISION SERVICES VISIT – A visit between a vision service provider and a patient during which eye
exams are performed by an Ophthalmologist or an Optometrist for the purpose of early detection, care, treatment and prevention of those who suffer from eye disease and chronic diseases such as diabetes, hypertension, thyroid disease and arthritis. These exams also provide opportunities to promote behavioral changes linked to eye health (e.g., smoking, excessive use of alcohol.)

OTHER PROFESSIONAL VISIT – A visit between a provider, other than those listed above and a patient during which other forms of health services are provided. Examples are provided in Appendix A.

CASE MANAGEMENT VISIT – A visit between a case management provider and a patient during which services are provided that assist patients in the management of their health and social needs, including patient needs assessments, the establishment of service plans, and the maintenance of referral, tracking, and follow-up systems. These must be face to face with the patient. Third party interactions on behalf of a patient are not counted in case management visits.

HEALTH EDUCATION VISIT – A one-on-one visit between a health education provider and a patient in which the services rendered are of an educational nature relating to health matters and appropriate use of health services (e.g., family planning, HIV, nutrition, parenting, and specific diseases). Participants in health education classes are not considered to have had visits. Some individuals trained as pharmacists now work as health educators and perform health education work. They should be classified as health educators and have those services counted as health education visits. This *does not include* the normal education that is a required part of the dispensing of any medicine in a pharmacy.

PROVIDER

A provider is the individual who assumes primary responsibility for assessing the patient and documenting services in the patient's record. Providers include only individuals who exercise independent judgment as to the services rendered to the patient during a visit. Only one provider who exercises independent judgment is credited with the visit, even when two or more providers are present and participate. If two or more providers of the same type divide up the services for a patient (e.g., a family practitioner and a pediatrician both seeing a child) only one may be credited with a visit. Where UIHP staff are following a patient in the hospital, the primary responsible center staff person in attendance during the visit is the provider (and is credited with a visit), even if other staff from the UIHP and/or hospital are present. (Appendix A provides a listing of personnel. Only personnel designated as a “provider” can generate visits for purposes of UDS reporting.)

Providers may be employees of the UIHP, contracted staff, or volunteers. Contract providers who are part of the scope of the approved grant-funded program and who are paid by the center with grant funds or program income, serve center patients and

document their services in the UIHP's records, are considered providers. (A discharge summary or similar document in the medical record will meet this criteria.) Also, contract providers paid for specific visits or services with grant funds or program income, who report patient visits to the direct recipient of an OUIHP grant are considered providers and their activities are to be reported by the direct recipient of the OUIHP grant. Since there is no time basis in their report, no FTE is reported for such individuals. Volunteer providers who serve center patients at the program's sites or locations under the supervision of the center's staff and document their services in the center's records, are also considered providers.

PATIENT

Patients are individuals who have at least one visit during the reporting year, as defined above. The term "patient" is not limited to recipients of medical or dental services; the term is used universally to describe all persons provided UDS-countable visits.

The UDS collects information on the number of Indian and Non-Indian patients served by the UIHP. Definitions of patients are as follows:

PROGRAM PATIENT: An individual who has had at least one UDS visit during the year. An individual is to be counted only once as a program patient for the year. Total program patients equal the sum of Indian and Non-Indian patients.

INDIAN PATIENT: An Indian patient is an individual who qualifies as an American Indian/Alaska Native according to the Title XXC USC 1603 (f) definition included on the following page.

NON-INDIAN PATIENT: A Non-Indian patient is an individual who does not qualify as an Indian user.

Persons who only receive services from large-scale efforts such as immunization programs, screening programs, and health fairs are not counted as patients. Persons whose only service from the program is a part of the WIC program are not counted as patients.

UIHPs see many individuals who do not become patients as defined by and counted in the UDS process. "Patients", as defined for the UDS, never include individuals who have such limited contacts with the program, whether or not documented on an individual basis. These include, but are not limited to, persons whose only contact is:

- When a provider participates in a community meeting or group session that is **not** designed to provide clinical services. Examples of such activities include information sessions for prospective patients, health presentations to community groups (high school classes, PTA, etc.), and information presentations about available health services at the center.
- When the only health service provided is part of a large-scale effort, such as an immunization program, screening program, or community-wide service program (e.g., a health fair).
- When a provider is primarily conducting outreach and/or group education sessions, not providing direct services.
- When the **only** services provided are lab tests, x-rays, immunizations or other injections, TB tests or readings, and/or filling or refilling a prescription.

- Where the only contact with the individual is over the phone.
- Services performed under the auspices of a WIC program or a WIC contract.

FULL-TIME EQUIVALENT EMPLOYEE

A full-time equivalent (FTE) of 1.0 means that the person worked full-time for one year or 40 hours per week. The FTE is based on employment contracts for clinicians and exempt employees; FTE is calculated based on paid hours for non-exempt employees. FTEs are adjusted for part-time work or for part-year employment. In an organization that has a 40 hour work week (2080 hours/year), a person who works 20 hours per week (i.e., 50% of the time) is reported as "0.5 FTE." In some organizations different positions have different time expectations. Positions with different time expectations, especially clinicians, should be calculated on whatever they have as a base for that position. FTE is also based on the number of months the employee works. An employee who works full time for four months out of the year would be reported as "0.33 FTE" (4 months/12 months).

Staff may provide services on behalf of the program under many different arrangements including, but not limited to: salaried full-time, salaried part-time, hourly wages, National Health Service Corps (NHSC) assignment, under contract, or donated time. Interns and residents are counted consistent with their time with the program and their licensing. (See Appendix AB for further discussion.) Individuals who are paid by the program on a fee-for-service basis only and do not have specific assigned hours, are not counted in the calculation of FTEs since there is no basis for determining their hours.

Title XXV USC 1603 (f)

DEFINITIONS: **SEC. 4. For purposes of this Act--**

(a) "Secretary", unless otherwise designated, means the Secretary of Health and Human Services.

(b) "Service" means the Indian Health Service.

(c) "Indians" or "Indian", unless otherwise designated means any person who is a member of an Indian tribe, as defined in subsection (d) hereof, except that, for the purpose of section 102 and 103, such terms shall mean any individual who (1), irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member, or (2) is an Eskimo or Aleut or other Alaska Native, or (3) is considered by the Secretary of the Interior to be an Indian for any purpose, or (4) is determined to be an Indian under regulations promulgated by the secretary.

(d) "Indian tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(e) "Tribal organization" means the elected governing body of any Indian tribe or any legally established organization of Indians which is controlled by one or more such bodies or by a board of directors elected or selected by one or more such bodies (or elected by the Indian population to be served by such organization) and which includes the maximum participation of Indians in all phases of its activities.

(f) "**Urban Indian**" means any individual who resides in an urban center, as defined in subsection (g) hereof, and who meets one or more the four criteria in subsection (c)(1) through (4) of this section.

(g) "Urban center" means any community which has a sufficient Indian population with unmet health needs to warrant assistance under Title V, as determined by the Secretary.

(h) "Urban Indian organization" means a nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 503(a).

INSTRUCTIONS BY TABLE

This section provides an overview of the UDS report and detailed instructions for completing each UDS table.

OVERVIEW OF UDS REPORT

The UDS includes two components:

- The **Universal Report** reports data on services, staffing, and financing **for the entire health activity**. The Universal Report is the source of unduplicated data on UIHPs. UIHPs must report on their entire health activity even though it may be supported only in part by the Indian Health Service (IHS) contract(s) and grant(s). If the reporting program provides services through a contract with another organization that is the direct recipient of an OUIHP grant, both entities report the patients, and the utilization, costs and revenues associated with those patients. IHS funded organizations with programs that include food distribution should integrate the utilization, staffing, costs, revenues and expenditures associated with these services into what they report. However, monies received for food and associated food distribution costs should not be reported since the program is merely acting as a conduit for the funds.

- The **AI/AN Report** reports selected information on the Indian patients served by the UIHP s. The AI/AN Reports repeat all or part of the elements of five of the Universal Report tables. The table below indicates which tables are included in the Universal Report and AI/AN Reports.

TABLE		UNIVERSAL	AI/AN REPORT
SERVICE AREA			
Cover Sheet	Contact Info and Patients by Zip Code	X	
Table 2	Services Offered and Delivery Method	X	
PATIENT PROFILE			
Table 3(A)	Patients by Age and Gender	X	X
Table 3(B)	Patients by EthnicityHispanic/Latino Identity/ and Race; /Language, Patients best served in a language other than English	X	
Table 4	Selected Patient Characteristics	X	X
STAFFING AND UTILIZATION			
Table 5:	Staffing and Utilization	X	<partial>
CLINICAL			
Table 6(A)	Selected Diagnoses and Services	X	X
FINANCIAL			
Table 8A	Costs	X	
Table 9D-E	Revenues	X	

INSTRUCTIONS FOR COVER SHEET

The cover sheet provides basic identifying information about the program, its leadership and the address of its service delivery locations.

PROGRAM LEGAL NAME; ADDRESS OF PROGRAM ADMINISTRATIVE OFFICES:

- Provide the legal name and address of the UIHP. If administrative offices are located separately from the clinical service delivery locations, use the address of the administrative offices.
- Provide the 9-digit zip code. The zip code is separated into two cells. The first cell contains the first five digits and the second cell contains the last four digits. (Zip+4 information can be obtained from http://zip4.usps.com/zip4/welcome.jsp.)

CEO/EXECUTIVE DIRECTOR OR PROJECT DIRECTOR:

- Provide the name of the CEO, Executive Director, or Project Director of the UIHP.
- Provide the phone number and e-mail address of the CEO, Executive or Project Director. The OUIHP and/or its contractor may use this e-mail address to contact you during the UDS editing process and will send a copy of the feedback report to this address.

CMO/CLINICAL DIRECTOR:

- Provide the name of the Clinical Director for the program organization. Organizations with both Medical and Dental Clinical Directors should list the Medical Director.
- Provide the phone number and e-mail address of the Clinical Director. The OUIHP and/or its contractor may use this e-mail address to contact you during the UDS process and will send a copy of the feedback report to this address.

PRESIDENT OR CHAIR PERSON, BOARD OF DIRECTORS:

- Provide the name of the President or Chairperson of the UIHP's Governing Board.
- Provide the phone number and e-mail address of the President or Chair Person.

PROGRAM CONTACT PERSON:

- Provide the name of the program staff person with primary responsibility for preparing the UDS report (do not list consultants, contractors or contracted employees). Two names may be listed if they prepare separate tables, but the first name listed should be the one for whom the phone number is provided.
- Provide the address with 9-digit zip code, phone/fax numbers, including area code, and e-mail address for the Program Contact Person. The OUIHP and/or its contractor will use this e-mail address to contact you during the UDS editing process and will send a copy of the feedback report to this address.

SCHOOL HEALTH COORDINATOR:

- Provide the name of the program staff person with primary responsibility for <u>any</u> school based health center activities managed by the program.

HOMELESS PROGRAM COORDINATOR:

- Provide the name of the program staff person with primary responsibility for

any homeless program managed by the program.

MEDICAID PROVIDER BILLING NUMBER:

- *If your agency has a single billing number*, which you use for all Medicaid billing, or for all Medicaid billing other than for a pharmacy, enter it here. If you have multiple service delivery sites, with separate Medicaid billing numbers, record those numbers in the site information grids. If each provider uses their own number, report one number **only**, usually the Clinic Director's, or lead clinician's, for each service delivery site.

MEDICAID PHARMACY NUMBER:

- *If your agency has a single billing number* that you use for all Medicaid pharmacy billing, enter it here. If you do not have a separate identifier for pharmacy services, enter your Medicaid medical provider number. If you have multiple pharmacies, and each has its own billing number, record the number in the site information grids.

NUMBER OF SERVICE DELIVERY SITES:

- Report the total number of service delivery sites supported by an OUIHP grant(s) (**Include only sites in your current approved scope of project**). This ***must*** match the number of site information grids reported. Only report sites where the services delivered generate visits. Do not include administration-only or other non-service delivery locations such as warehouses or garages or WIC-only sites.

NUMBER OF NHSC ASSIGNEES*:*

- Report the total number of NHSC Assignees working at your service delivery location(s) as of December 31 of the reporting period. This is a count of individuals, and is not adjusted for FTE basis. Include all providers currently associated with the NHSC, including those fulfilling Federal NHSC scholarship or loan-repayment obligations, State loan repayment obligations under the Federal/State Student Loan Repayment Program (SLRP), Ready Responders, and members of the Public Health Service Commissioned Corps. Do not count individuals that are no longer employed by you or who are no longer serving an NHSC related obligation as of December 31, even if they had participated earlier in the year.

FEDERAL TORT CLAIMS ACT (FTCA):

- Check the box indicating whether or not you were 'deemed' under the FTCA for any portion of the reporting period. (Note: No FTCA decision is impacted by information included on the cover sheet – this is for reporting purposes only.)

DRUG PRICING PARTICIPATION:

- 340(b) Drug Pricing Participation: Indicates whether or not you participated in the 340(b) drug pricing program during the reporting period, regardless of whether or not you are reporting that you participated in an "alternative drug pricing program."
- Alternative drug discounting program: Indicate whether you participate in an alternate drug pricing program, regardless of whether or not you are reporting that you participated in a "340(b) drug pricing program." (Alternative drug pricing programs are programs, often sponsored by health care consortiums, designed to lower the cost of pharmaceuticals to members

by facilitating group purchasing activities.)

SERVICE DELIVERY SITES*:*

- A service delivery site is defined as any place where a UIHP provides clinical services to a defined geographic service area or population on a regular (e.g., daily, weekly, or monthly) scheduled basis. There is no minimum number of hours per week that services must be available. The site must, however, be operated as part of the UIHP's current approved scope of project. In order to be considered a site:
  - Visits must be generated at the site through documented face-to-face contact between patients and providers;
  - Visits are provided by health care professionals who exercise independent judgment in the provision of services to the patient; and
  - Services at the site must be provided on behalf of the UIHP which retains control and authority over the provision of services (e.g., as applicable, billing and medical records).
- **Service delivery sites may include**, but are not limited to, health care facilities, schools, homeless shelters, and mobile vans where health services are provided. Site examples include:
  - Any full-time or part-time clinic location – address of site should be listed;
  - Primary care services at a homeless shelter for 4 hours every Thursday – address of site should be listed;
  - If a UIHP provides visits at a number of similar locations (day care centers, soup kitchens, homeless shelters, migrant camps, etc.) the individual locations need not be listed, however a single "site" for "multiple (shelters, migrant camps, etc.) locations" should then be included *for each type of location*.
  - If a mobile van provides primary care services at multiple locations on a defined schedule, the locations where the van provides services do not need to be listed as sites; however the category of "mobile van" should be listed
- **Service delivery *sites* do not include other activities/locations** where the only services delivered do not generate visits (e.g. filling prescriptions, taking x-rays, giving immunizations, performing street outreach or providing health education, etc.). Examples of sites that should *not* be listed as service delivery sites include:
  - Locations for off-site activities required by the UIHP and documented as part of the employment agreement or contract between the UIHP and the provider (e.g., UIHP physicians providing coverage at the hospital emergency room or participating in hospital call for unassigned patients and nursing homes where providers follow their patients).
  - Locations where the site is administrative only, including but not limited to voucher distribution sites.
  - WIC-only sites

Report the name and physical address of each service delivery site operating at the end of the reporting year**, including the 9-digit zip code**. Do not provide the mailing address – use the physical address of the site so it can be mapped. For each service delivery site, also:

1. Indicate by checking the appropriate box whether the site operates year-

round or less than year-round.

2. Indicate by checking the appropriate box whether the service delivery location operates full-time or part-time. Full-time is defined as operational 40 or more hours per week. Part-time is operational less than 40 hours per week. If the site is part-time indicate how many hours per week it is operational.
3. Indicate the location or type(s) of facility, using codes in the drop-down menu. Each service delivery location may be described by up to two site-types. These codes (#1-15) provide information on the type of facility in which the site is located, NOT the specific services offered at the site. Examples of coding are shown below:
    - A community-based primary care service delivery location not located in a health department or substance abuse treatment clinic/facility should be coded as "1" – Community Based Primary Care Clinic.
    - A primary care service delivery location located in a health department should be coded "5" – Health Department Clinic.
    - A primary care service delivery location located in a substance abuse clinic should be coded "6" – Substance Abuse Treatment Clinic/Facility.
    - A community-based service delivery location located in a mental health clinic operated by a local health department should be coded "5" – Health Department Clinic and "8" – Mental Health Clinic.
4. If you have separate Medicaid billing numbers for each of your clinic or pharmacy sites, record those on the grid for each site as appropriate. If your agency uses a single billing number, leave these blank.

PATIENT BY ZIP CODE:

Programs must report the number of patients by zip code for all patients. To ease the burden of reporting, zip codes with three or less patients may be aggregated and reported in an “Other” category. For the small number of patients for whom residence is not known or for whom a proxy is not available, residence should be reported as “Unknown”.

QUESTIONS AND ANSWERS FOR COVER SHEET

1. Are the reporting requirements for the UDS different than for the UCRR?

The information reported in the Cover Sheet corresponds with the UCRR Face Sheet. However, the UDS requires more comprehensive contact information, service site information and information on patients by zip code.

2. Are there any changes to this table since 2009?

Yes. In CY2010 zip codes with more than 3 patients should be reported separately vs. reported in group of 'other' zip codes as was previously allowed. In CY2008 and CY2009 if a zip code had less than 10 patients, they were allowed to be grouped together into the 'other zip codes' category. In CY2010 reporting, this number has been changed to 3 or less, to provide a more accurate picture of the areas served by each program.

3. Do we need to collect information on and report on the zip code of all of our patients?

Yes. Instead of asking that individual sites be identified by area served, programs are to report on the zip codes of their patients. Although programs are expected to report residence by zip-code for all patients, it is recognized that programs may draw a small number of patients from a large number of zip-codes. To ease the burden of reporting, zip codes *with 3 or less* patients may be aggregated and reported in an "Other" category.

4. Does the number of patients reported by zip code need to equal the total number of unduplicated patients reported on Tables 3A and 3B?

Yes. The total number of patients reported by zip code on the Cover Sheet Patients by Zip Code must equal the number of total unduplicated patients reported on Tables 3A and 3B and Table 4. If zip code information is missing for a small number of patients, residence should be reported as unknown.

COVER SHEET

PROGRAM LEGAL NAME		
Address of Program Administrative Offices	Street	
	City	
	State	Zip (9-digit required)
CEO/Executive Director or Project Director	Name	
	Phone	Extension
	E-Mail	
Clinical Director	Name	
	Phone	Extension
	E-Mail	
President or Chair Person, Board of Directors	Name	
	Phone	Extension
	E-Mail	
Program Contact Person (Person completing report):	Name	
	Street	
	City	
	State	Zip -
	Phone	Extension
	Fax	
	E-mail	
School Health Coordinator		
Homeless Program Coordinator		
Medicaid Provider Billing Number: (Organization Wide Only)		
Medicaid Pharmacy Number: (Organization Wide Only)		
Number of service delivery sites supported by UIHP Grant(s)		
Number of NHSC Assignees as of 12/31		
Federal Tort Claims Act (FTCA) Deemed?	☐ Yes ☐ No	
340(b) Drug Pricing Participation?	☐ Yes ☐ No	
Alternative drug discounting program?	☐ Yes ☐ No	

COVER SHEET

NOTE: Use Location Codes listed below to describe the type of facility in which the service delivery site is located. More than one location code may apply for a given service delivery site. Use Medicaid numbers for service delivery sites only if applicable.

service delivery site	service delivery site
Year Round ☐ Less than Year Round ☐ Full-time ☐ Part-time ☐ # Hrs/Wk ___ Name: Address: Zip(9) (required) Location Code(s): Medicaid Number: Medicaid Pharmacy Number:	Year Round ☐ Less than Year Round ☐ Full-time ☐ Part-time ☐ # Hrs/Wk ___ Name: Address: Zip(9) (required) Location Code(s): Medicaid Number: Medicaid Pharmacy Number:
service delivery site	**service delivery site**
Year Round ☐ Less than Year Round ☐ Full-time ☐ Part-time ☐ # Hrs/Wk ___ Name: Address: Zip(9) (required) Location Code(s): Medicaid Number: Medicaid Pharmacy Number:	Year Round ☐ Less than Year Round ☐ Full-time ☐ Part-time ☐ # Hrs/Wk ___ Name: Address: Zip(9) (required) Location Code(s): Medicaid Number: Medicaid Pharmacy Number:

Location Codes to identify the type of facility or location:

1. Community Based Primary Care Clinic
2. Hospital or Worksite clinic
3. Fully Equipped Mobile Health Van
4. Community Based Social Service Center
5. Health Department Clinic
6. Substance Abuse Treatment Clinic/Facility
7. HIV/AIDS Medical Care Clinic/Facility
8. Mental Health Clinic
9. Public Housing
10. Migrant Camp
11. School Based Health center
12. Homeless Shelter
13. Soup Kitchen
14. Dental
15. Other (Please specify)

PATIENTS BY ZIP CODE

Zip Code	Patients
Other Zip Codes	
Unknown Residence	
TOTAL	

INSTRUCTIONS FOR TABLE 2 – SERVICES OFFERED AND DELIVERY METHOD

This table indicates the types of services provided by the program and reports whether these services are provided directly or through **formal** referral arrangements. Table 2 is included only in the Universal Report. Only services included within the scope of the Federally-approved project(s) should be reported. Individual programs will rarely provide or refer for all of the services listed in this table. Also, since more than one delivery method may apply for a given service more than one of the columns may be checked on any given line.

1. **SERVICE TYPE.** This table lists medical, dental, behavioral, and other services that may be provided by UIHPs. Service definitions appear in Appendix B.

2. **DELIVERY METHOD.** Check the delivery method(s) applicable to the particular service type. If the service is not offered, leave the row blank.

    - **PROVIDED BY PROGRAM** – Includes services rendered by salaried employees, contracted providers, NHSC Staff, volunteers and others such as out-stationed eligibility workers who render services in the program's name.

    - **BY REFERRAL – PROGRAM PAYS -** Includes services provided by another organization under a **formal** arrangement, only when the program pays for provision of the service, though the program may also bill the patient or a third party payor for all or part of the service. The arrangement may involve discounted payment (i.e., payment less than the provider's "usual, customary and reasonable" charge, but payment is generally at least equivalent to Medicaid payments). These services are generally provided off site.

    - **BY REFERRAL – PROGRAM DOES NOT PAY** – Includes services that are provided by another organization or individual under a **formal** referral arrangement where the program DOES NOT pay for or bill for the service.

A formal referral arrangement means either a written agreement or the ability to document the service in the patient record.

QUESTIONS AND ANSWERS FOR TABLE 2

1. Are the reporting requirements for the UDS different than for the UCRR?

Yes. The information reported in Table 2 is new and was not previously collected in the UCRR.

2. Are there any changes to this table since 2009?

No.

3. Does a service need to be provided full-time to all patients to be reported on Table 2?

No. There is no threshold for reporting. If the service is provided at any service location or by formal referral arrangement to any patients it is counted. This includes services which may only be available part-time.

TABLE 2 – SERVICES OFFERED AND DELIVERY METHOD (Page 1 of 3)

SERVICE TYPE **NOTE: NOT ALL CENTERS WILL PROVIDE ALL SERVICES** (See Appendix B for definitions)		DELIVERY METHOD Mark (X) if Applicable [More than one method may apply for a given service]		
		PROVIDED BY PROGRAM (A)	BY REFERRAL/ PROGRAM PAYS (B)	BY REFERRAL/ PROGRAM DOESN'T PAY (C)
PRIMARY MEDICAL CARE SERVICES				
1.	General Primary Medical Care (other than listed			
2.	Diagnostic Laboratory (technical component)			
3.	Diagnostic X-Ray Procedures (technical component)			
4.	Diagnostic Tests/Screenings (professional			
5.	Emergency medical services			
6.	Urgent medical care			
7.	24-hour coverage			
8.	Family Planning			
9.	HIV testing and counseling			
10	Testing for Blood Lead Levels			
11	Immunizations			
12	Following hospitalized patients			
OBSTETRICAL AND GYNECOLOGICAL CARE				
13	Gynecological Care			
14	Prenatal care			
15	Antepartum fetal assessment			
16	Ultrasound			
17	Genetic counseling and testing			
18	Amniocentesis			
19	Labor and delivery professional care			
20	Postpartum care			
SPECIALTY MEDICAL CARE				
21.	Directly observed TB therapy			
22.	Respite Care			
23.	Other Specialty Care			
DENTAL CARE SERVICES				
24.	Dental Care – Preventive			
25.	Dental Care – Restorative			
26.	Dental Care – Emergency			
27.	Dental Care – Rehabilitative			
MENTAL HEALTH/SUBSTANCE ABUSE SERVICES				
28.	Mental Health Treatment/Counseling			
29.	Developmental Screening			
30.	24-hour Crisis Intervention/Counseling			
31.	Other Mental Health Services			
32.	Substance Abuse Treatment/Counseling			

TABLE 2 – SERVICES OFFERED AND DELIVERY METHOD (Page 2 of 3)

	SERVICE TYPE **NOTE: NOT ALL CENTERS WILL PROVIDE ALL SERVICES** (See Appendix B for definitions)	DELIVERY METHOD Mark (X) if Applicable [More than one method may apply for a given service]		
		PROVIDED BY PROGRAM (A)	BY REFERRAL/ PROGRAM PAYS (B)	BY REFERRAL/ PROGRAM DOESN'T PAY (C)
MENTAL HEALTH/SUBSTANCE ABUSE SERVICES				
33.	Other Substance Abuse Services			
33a.	Comprehensive mental health / Substance abuse screening			
33b.	Suicide Prevention and Treatment			
33c.	Domestic Violence/Intimate Partner Violence Screening			
OTHER PROFESSIONAL SERVICES				
34.	Hearing Screening			
35.	Nutrition Services Other Than WIC			
36.	Occupational or Vocational Therapy			
37.	Physical Therapy			
38.	Pharmacy – Licensed Pharmacy staffed by Registered Pharmacist			
39.	Pharmacy – Provider Dispensing			
40.	Vision Screening			
41.	Podiatry			
42.	Optometry			
42a	Traditional Medicine			
ENABLING SERVICES				
43.	Case management			
44.	Child Care (during visit to center)			
45.	Discharge planning			
46.	Eligibility Assistance			
47.	Environmental Health Risk Reduction (via detection and/or alleviation)			
48.	Health Education			
49.	Interpretation/Translation services			
50.	Nursing home and assisted-living			
51.	Outreach			
52.	Transportation			
53.	Out Stationed Eligibility Workers			
54.	Home Visiting			
55.	Parenting Education			
56.	Special Education Program			
57.	Other (specify:_____)			

TABLE 2 – SERVICES OFFERED AND DELIVERY METHOD (Page 3 of 3)

	SERVICE TYPE **NOTE: NOT ALL CENTERS WILL PROVIDE ALL SERVICES** (See Appendix B for definitions)	DELIVERY METHOD Mark (X) if Applicable [More than one method may apply for a given service]		
		PROVIDED BY PROGRAM (A)	BY REFERRAL/ PROGRAM PAYS (B)	BY REFERRAL/ PROGRAM DOESN'T PAY (C)
PREVENTIVE SERVICES RELATED TO TARGET CLINICAL AREAS				
I. Cancer				
58.	Pap test			
59.	Fecal occult blood test			
60.	Sigmoidoscopy			
61.	Colonoscopy			
62.	Mammograms			
63.	Smoking cessation program			
II. Diabetes				
64.	Glycosylated hemoglobin measurement for people with diabetes			
65.	Urinary microalbumin measurement for people with diabetes			
66.	Foot exam for people with diabetes			
67.	Dilated eye exam for people with diabetes			
II. Cardiovascular Disease				
68.	Blood pressure monitoring			
69.	Weight reduction program			
70.	Blood cholesterol screening			
IV. HIV/AIDS - See line 9. HIV testing and counseling				
V. Infant Mortality -- Also see line 14. Prenatal Care				
71.	Follow-up testing and related health care services for abnormal newborn bloodspot screening			
VI. Immunizations -- See line 11. Immunizations				
OTHER SERVICES				
72.	WIC services			
73.	Head Start services			
74.	Food banks / Delivered meals			
75.	Employment / Educational Counseling			
76.	Assistance in obtaining housing			

INSTRUCTIONS FOR TABLES 3A AND 3B – PATIENTS BY AGE AND GENDER AND PATIENTS BY HISPANIC OR LATINO IDENTITY / RACE / LANGUAGE

Tables 3A and 3B provide demographic data on patients of the program. Table 3A is included in **both** the Universal Report and the AI/AN Report; Table 3B is included in the Universal Report, only. **NOTE: The total number of AI/AN patients reported on the AI/AN Report for Tables 3A and 3B must equal the number of AI/AN patients reported on Table 3B Line 7 Column A.**

For the **Universal Report**, include as patients all individuals receiving at least one face-to-face visit for services as described below which is within the scope of any of the programs covered by UDS. Regardless of the scope of volume of services received, each patient is to be counted only once on Table 3A and only once in **each** of the two sections of Table 3B: ethnicity and race and language, if applicable.

The **AI/AN Report** includes only individuals who qualify as American Indians/Alaska Natives according to the Title XXV USC 1603 (f) definition who received at least one face-to-face visit within the scope of the program.

The mathematical difference between the individuals reported in the Universal Report and the AI/AN Report are those individuals who are Non-Indian patients. Thus, no cell on the AI/AN Report can be greater than the corresponding cell on the Universal Report.

A visit is a face-to-face contact between a patient and a provider who exercises independent professional judgment in the provision of services to the patient, and the services rendered must be documented to be counted as a visit. See the "Definitions" of Visits, Providers, Patients and FTE section for complete definitions of patients and visits.

TABLE 3A: PATIENTS BY AGE AND GENDER

Report the number of patients by appropriate categories for age and gender. For reporting purposes, use the individual's age on June 30 of the reporting period.

TABLE 3B: PATIENTS BY HISPANIC OR LATINO IDENTITY / RACE / LANGUAGE

NOTE: Line numbers on this table have changed. Be sure you report on the correct line.

Table 3B now displays the race and ethnicity of the patient population in a matrix format. This permits the racial identification of the Hispanic/Latino population. Race and ethnicity continue to be defined as in the past:

HISPANIC/LATINO IDENTITY:

- This table collects information on whether or not patients consider themselves to be of Hispanic/Latino identity *regardless of their race*.
    - Column A (Hispanic/Latino): Report the number of persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, based on racial identification and including those Hispanics/Latinos

born in the United States. Do *not* count persons from Brazil or Haiti whose ethnicity is not tied to the Spanish language.
    - Column B (Not Hispanic/Latino) Report the number of all other patients *except* those for whom there is neither racial *nor* Hispanic/Latino identity data.
    - Column C (Unreported / Refused to Report): Only one cell is available in this column. Report only those patients who left the entire race and Hispanic/Latino Identity part of the intake form totally blank on line 7, Column C.

- Patients who self-report as Hispanic/Latino but do not separately select a race are reported on line 7, Column A as Hispanic/Latino whose race is unreported or refused to report.

RACE:

- All patients must be classified in one of the racial categories (including "Unreported / refused to report"). This includes individuals who *also* consider themselves to be "Hispanic/Latino". Patients who self-report race, but do not separately identify if Hispanic/Latino, are reported on the appropriate race line, Column B.
- Patients once categorized as "Asian / Pacific Islanders" are now divided on the Race table into three separate categories:
    - Line 2a. Native Hawaiian – Persons having origins in any of the original peoples of Hawaii.
    - Line 2b. Other Pacific Islanders – Persons having origins in any of the original peoples of Guam, Samoa, Palau, Truk, or other Pacific Islands in Micronesia, Melanesia or Polynesia.
    - Line 2. "Total Hawaiian / Pacific Islander", must equal lines 2a+2b
    - **o** Line 1. Asian – Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- American Indian/Alaska Native (Title XXV Qualified)- (line 4a) includes persons having origins in any of the original peoples of North America and Alaska, and who maintain Tribal affiliation or community attachment <u>who qualify</u> as American Indian/Alaska Native under Title XXV USC 1603. This line must equal the total of AI/AN Table 3A lines 39 columns a+b. In addition, this line must equal the total of AI/AN Table 4 line 6.
- American Indian/Alaska Native (All Others) -(line 4b) includes persons having origins in any of the original peoples of North and South America (including Central America and Canada), and who maintain tribal affiliation or community attachment, and who <u>do not qualify</u> as American Indian/Alaska Native under Title XXV USC 1603.
- American Indian/Alaska Native-(Line 4) - The total of lines 4a+4b which represents all of the AI/AN population served by the program which includes all persons having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.
- "More than one race" (line 6). Use this line *only* if your system captures multiple races (but *not* a race and an ethnicity) and the patient has chosen two or more races. This is usually done with an intake form which lists the races and tells the patient to "check one or more".

Note: Grantees are required to report race <u>*and*</u> ethnicity for all patients; however, some grantees' patient registration systems are configured to capture data for patients who were

asked to report race *or* ethnicity. Grantees who are unable to distinguish a White Hispanic/Latino patient from a Black Hispanic/Latino patient (because their system only asks patients if they are White, Black or Hispanic/Latino), are instructed to report these Hispanic/Latino patients on line 7, column A, as "unreported" race/Hispanic or Latino identity.

LANGUAGE:

- Report on line 12 the number of patients who are best served in a language other than English or with sign language.
- Include those patients who were served by a bilingual provider and those who may have brought their own interpreter.
- Include patients residing in areas where a language other than English is the dominant language such as Puerto Rico or the Pacific Islands.

NOTE: Data reported on line 12, Language, *may* be estimated if the health center does not maintain actual data in its Practice Management System (PMS). Wherever possible, the estimate should be based on a sample.

QUESTIONS AND ANSWERS FOR TABLES 3A AND 3B

1. **Are the reporting requirements for the UDS different than for the UCRR?**

   The information reported on Table 3A corresponds with the UCRR Table 1 Number of Program Users by Age and Gender. The definition of a program patient is the same for both the UCRR and UDS reports. However, age categories are more detailed in the UDS and programs are required to report total program patients and Indian patients rather than Indian and Non-Indian patients. Non-Indian patients can be calculated as the difference between Total Patients and Indian Patients.

2. **Are there any changes to this table since 2009?**
   Yes. Table 3B has changed to a matrix table that includes both Race and Ethnicity categories.

3. **Have the race data changed?**
   No. Patients will be counted in the same racial category that they were counted in last year. In 2009 an additional race category was added for "More than one race". With the addition of the race classification, the UDS classifications are now consistent with those used by the Census Bureau as per the October 30, 1997, Federal Register Notice entitled, ''Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity,'' issued by the OMB. These standards govern the categories used to collect and present federal data on race and ethnicity. The OMB requires five minimum categories (White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander) for race. In addition to the five race groups, OMB also states that respondents should be offered the option of selecting more than one race. The addition of Line 6 permits reporting of those people who have chosen to report two or more races.

4. **How should patients of Hispanic/Latino ethnicity now be reported?**
   In 2009, we divided the table into two sections. In 2010, the table has been revised to show race and ethnicity data in a matrix. Patients who were once reported as Hispanic / Latino independent of race will now be reported in Column A as Hispanic/Latino. Patients are to be reported on lines 1 through 7 depending on their race. If "Hispanic/Latino" is the only identity recorded in the center's files, these patients will be reported in Column B on line 7 as having an "Unreported" racial identification.

5. **How are individuals who receive different types of services or use more than one of the program's service delivery sites reported? For example, a person who receives both medical and dental services or a woman who receives primary care from one clinic, but gets prenatal care at another.**
   UDS Tables 3A and 3B provide unduplicated counts of patients. Programs are required to report each patient once and only once on Table 3A and on Table 3B, regardless of the type or number of services they receive or where they receive them. Each person who has at least one visit reported on Table 5 is to be counted once and only once on Table 3A and on Table 3B. Visits are defined in detail in the "Definitions of Visits, Providers, Patients, and FTE" section. Note the following:
   - Persons who receive WIC services and no other services at the agency are not to be counted as patients or reported on Table 3A or 3B (or anywhere on the UDS).
   - Persons who only receive lab services or whose only service was an immunization or screening test are not to be counted as patients or reported

on Table 3A or 3B.

6. **Do the numbers on Tables 3A and 3B tie to UDS data reported on other tables?**

Yes. The sum of Table 3A, Line 39, Column A + B (total patients by age and gender) must equal Table 3B, Line 8 Column D (total patients by Hispanic/Latino Identity and Race); Total Patients by Zip Code; Table 4, Line 6 (total patients by income); and Table 4 Line 12, Columns A + B (total patients by insurance status). The sum of Table 3A, Lines 1-20, Column A + B (total patients age 0-19 years) must equal Table 4, Line 12, Column A (total patients age 0-19 years).

Also, the number of American Indian/Alaska Native patients on Table 3B line 4a Column D must equal the number of American Indian/Alaska Native patients reported on the AI/AN Table by Age and Gender (AI/AN Table 3A Line 39 Columns A + B).

7. **Does race ***and*** ethnicity of all our patients need to be collected and reported?**

The UDS requires the classification of race and ethnicity information in order to assess health disparities across sub-populations. The format for the classification of this information has been stipulated by OMB, and the UDS manual follows the standards established by OMB.

8. **Does the number of AI/AN patients reported on the AI/AN Tables have to equal the total number of AI/AN patients reported on Table 3B Line 4a?**

Yes. The total number of AI/AN patients reported on the AI/AN Report for Tables 3A and 4 must equal the number of AI/AN patients reported on Table 3B Line 4a Column D (AI/AN who are qualified under Title XXV).

TABLE 3A – PATIENTS BY AGE AND GENDER

	AGE GROUPS	MALE PATIENTS (A)	FEMALE PATIENTS (B)
NUMBER OF PATIENTS			
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		
12	Age 11		
13	Age 12		
14	Age 13		
15	Age 14		
16	Age 15		
17	Age 16		
18	Age 17		
19	Age 18		
20	Age 19		
21	Age 20		
22	Age 21		
23	Age 22		
24	Age 23		
25	Age 24		
26	Ages 25 – 29		
27	Ages 30 – 34		
28	Ages 35 – 39		
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 LINES 1-38)		

TABLE 3B – TABLE 3B –PATIENTS BY HISPANIC OR LATINO IDENTITY / RACE / LANGUAGE

		PATIENTS BY HISPANIC OR LATINO IDENTITY			
PATIENTS BY RACE		HISPANIC/ LATINO (A)	NOT HISPANIC/ LATINO (B)	UNREPORTED / REFUSED TO REPORT (C)	TOTAL (D)
NUMBER OF PATIENTS					
1.	Asian				
2a.	Native Hawaiian				
2b.	Other Pacific Islander				
2.	**T**otal **H**awaiian/**P**acific **I**slander (SUM LINES 2A + 2B)				
3.	Black / African American				
4a	American Indian/Alaska Native (Title XXV Qualified)				
4b	American Indian/Alaska Native (All Others)				
4.	**Total American Indian / Alaska Native (Sum Lines 4a +4b)**				
5.	White				
6.	More than one race				
7.	Unreported / Refused to report				
8.	**TOTAL PATIENTS** (SUM LINES 1+2 + 3 TO 7)				

PATIENTS BY LANGUAGE		NUMBER (A)
NUMBER OF PATIENTS		
12.	**PATIENTS BEST SERVED IN A LANGUAGE OTHER THAN ENGLISH**	

INSTRUCTIONS FOR TABLE 4 – SELECTED PATIENT CHARACTERISTICS

Table 4 provides descriptive data on selected patient characteristics of UIHP patients. The table is included in **both** the Universal Report and the AI/AN Report.

For the **Universal Report**, include all individuals receiving at least one face-to-face visit for services as described below which is within the scope of any of the programs covered by UDS. Regardless of the number or types of services received, each patient is to be counted only once per section.

The **AI/AN Report** includes only individuals who qualify as American Indians/Alaska Natives according to the Title XXV USC 1603 (f) definition who received at least one face-to-face visit within the scope of the program.

The difference between the individuals reported in the Universal Report and the AI/AN Report are those individuals who are Non-Indian patients. Thus, no cell on the AI/AN Report can be greater than the corresponding cell on the Universal Report.

NOTE: The sum of Table 3A, Line 39, Columns A + B (total patients by age and gender) must equal Table 3B, Line 8 Column D (total patients by race/ethnicity; Table 4, Line 6 (total patients by income); and Table 4 Line 12, Columns A + B (total patients by medical insurance status). The sum of Table 3A, Lines 1-20, Columns A + B (total patients age 0-19 years) must equal Table 4, Line 12, Column A (total patients age 0-19 years).

INCOME AS PERCENT OF POVERTY LEVEL, LINES 1 - 6

Programs are expected to collect income data on all patients, but are not required to collect this information more frequently than once during the year. If income information is updated during the year, report the most current information available. Patients for whom the information was not collected within the last year ***must*** be reported on line 5 as unknown. Do not attempt to allocate patients with unknown income. Knowing that a patient is on Medicaid is not adequate to classify that patient as having an income below the poverty level; similarly, do not assume a patient with private insurance has an income above 200% of poverty.

Income is defined in ranges relative to the Federal poverty guidelines (e.g., less than 100 percent of the Federal poverty level). In determining a patient's income relative to the poverty level, programs should use official poverty guidelines defined and revised annually. The official Poverty Guidelines are published in the Federal Register during the first quarter of each year. (The 2010 poverty guidelines are available at: http://aspe.hhs.gov/poverty/10fedreg.pdf.)

Every patient reported on Table 3A must be reported once (and only once) on Table 4 Lines 1 through 5. The sum of Table 3A, Line 39, Column A + B (total patients by age and gender) must equal Table 4, Line 6 (patients by income). The same is true for the AI/AN Report.

PRINCIPAL THIRD PARTY INSURANCE SOURCE, LINES 7 - 12

This portion of the table provides data on patients by principal source of insurance for primary medical care services. A patient's health insurance is likely to change throughout the year. Report on this table the primary health insurance the patient had at the time of their last visit *regardless of whether or not that insurance was billed for or paid for the visit.* (Other forms of insurance, such as dental or vision coverage, are not reported.) Patients are divided into two age groups in Column A (0 – 19) and Column B (age 20+). Primary patient medical insurance is divided into seven types as follows:

- S-CHIP (Line 8b or 10b) – The State Child Health Insurance Program (also known as S-CHIP or Title XXI) provides primary health care coverage for children and, on a state by state basis, others – especially parents of these children and pregnant women. S-CHIP coverage can be provided through the state's Medicaid program and/or through contracts with private insurance plans. In some states that make use of Medicaid, it is difficult or even impossible to distinguish between regular Medicaid and S-CHIP-Medicaid. In other states the distinction is readily apparent (e.g., they may have different cards or the programs may have different names). Where it is not obvious, S-CHIP may often still be identifiable from a "plan" code or some other embedded code in the membership number. This may also vary from county to county within a state. Obtain information from the state and/or county on their coding practice. *If there is no way to distinguish between regular Medicaid and S-CHIP Medicaid, classify all covered patients as "regular" Medicaid.* In those states where S-CHIP is contracted through a private third party payor, participants are to be classified as "other public-CHIP" (Line 10b) *not* as private.

- Medicaid (Line 8a, 8b and 8) – State-run programs operating under the guidelines of Titles XIX (and XXI as appropriate) of the Social Security Act. Medicaid includes programs called by State-specific names (e.g., California's Medi-Cal program). In some states, the State Children's Health Insurance Program (S-CHIP) is also included in the Medicaid program (see above). While Medicaid coverage is generally funded by Federal and State funds, some states also have "State-only" programs covering individuals ineligible for Federal matching funds (e.g., general assistance recipients) and these individuals are also included on Lines 8a, 8b and 8. NOTE: Individuals who are enrolled in Medicaid, but receive services through a private managed care plan that contracts with the State Medicaid agency, should be reported as "Medicaid", not as privately insured.

- Medicare (Line 9) – Federal insurance program for the aged, blind and disabled (Title XVIII of the Social Security Act).

- Other Public Insurance (Line 10a) –State and/or local government programs, such as Washington's Basic Health Plan or Massachusetts' Commonwealth Plan, providing a broad set of benefits for eligible individuals. Include public paid or subsidized private insurance not listed elsewhere. Do not include any S-CHIP, Medicaid or Medicare patients on this line. Do not include uninsured individuals whose visit may be covered by a public source with limited benefits such as the Early Prevention, Screening, Detection and Treatment (EPSDT) program or the Breast and Cervical Cancer Control Program, (BCCCP), etc. ALSO DO NOT INCLUDE persons covered by workers' compensation, as this is not health insurance for the patient, it is liability insurance for the employer.

- Other Public (S-CHIP) (Line 10b) – S-CHIP programs which are run through the private sector, often through HMOs. The coverage may appear to be a private insurance plan (such as Blue Cross/Blue Shield) but is funded through S-CHIP and reported as S-CHIP.

- Private Insurance (Line 11) – Health insurance provided by commercial and non-profit companies. Individuals may obtain insurance through employers or on their own. Private insurance includes insurance purchased for public employees or retirees such as Tricare, Trigon, Veterans Administration, the Federal Employees Benefits Program, etc.

One additional category is included on Table 4 for patients who are uninsured (line 7).

Every patient reported on Table 3A must be reported once (and only once) on lines 7 through 11. Note that there is no "unknown" insurance classification on this table – programs should obtain medical coverage (if any) from all patients in order to maximize first and third party payments. The sum of Table 3A, Line 39, Columns A + B (total patients by age and gender) must equal Table 4, Line 12 Column A + B (total patients by insurance status.) The same is true for the AI/AN Report.

PATIENTS BY SOURCE OF INSURANCE

Programs should report the patient's **primary health insurance covering medical care**, if any, **as of the last visit** during the reporting period. Primary insurance is defined as the insurance plan/ program that the program would normally **bill first** for services rendered. NOTE: Patients who have both Medicare and Medicaid would be reported as Medicare patients because Medicare is billed before Medicaid. The exception to the Medicare first rule is the Medicare-enrolled patient who is still working and insured by both an employer-based plan and Medicare. In this case, the principal health insurance is the employer-based plan, which is billed first.

UIHPs should collect information on primary medical insurance on all patients regardless of whether the program intends to bill for services provided to the individual. Even if the program does not bill for services, the program will *still* report the patient as being insured and report the type of insurance.
Patients *for whom no other information is available*, whose services are paid for by grant programs, including family planning, Breast Care Early Detection program, immunizations, TB control, as well as patients served in correctional facilities, should be classified as uninsured.

Similarly, patients whose services are subsidized through State/local government "indigent care programs" are considered to be uninsured.
Examples of state government "indigent care programs" include New Jersey Uncompensated Care Program, NY Public Goods Pool Funding, California's Expanded Assistance for Primary Care, and Colorado Indigent Care Program.

For both Medicaid and Other Public Insurance, the table distinguishes between "regular" enrollees and enrollees in S-CHIP.

> **MEDICAID =** Line 8b includes Medicaid-S-CHIP enrollees only; Line 8a includes all other enrollees; and Line 8 is the sum of 8a + 8b.

OTHER PUBLIC = Line 10b includes S-CHIP enrollees who are covered by a plan other than Medicaid; Line 10a includes all other persons with other public insurance (Programs are asked to describe the programs so the UDS editor can make sure that the classification of the program as other public is appropriate.); and Line 10 is the sum of 10a + 10b.

MANAGED CARE UTILIZATION, LINES 13a – 13c

This section on "Managed Care Utilization" is to report patient Member Months in managed care plans. Do not report in this section enrollees in Primary Care Case Management (PCCM) programs which pay a small monthly fee (e.g., usually less than $10 per member per month) to "manage" patient care. Do not include managed care enrollee whose capitation or enrollment is limited to behavioral health or dental services only, though an enrollee who has medical *and* dental (for example) *is* counted.

MEMBER MONTHS: A member month is defined as 1 member being enrolled for 1 month. An individual who is a member of a plan for a full year generates 12 member months; a family of 5 enrolled for 6 months generates (5 X 6) 30 member months, etc. Member month information can often be obtained from monthly enrollment lists generally supplied by managed care companies to their providers.

MEMBER MONTHS FOR MANAGED CARE (CAPITATED) (Line 13a) – Enter the total capitated member months by source of payment. This is derived by adding the total enrollment reported from each capitated plan for each month. A patient is in a capitated plan if the contract between the program and the Health Maintenance Organization (HMO) stipulates that for a flat payment per month, the program will perform all of the services on a negotiated list. This usually includes, at a minimum, all office visits. Payments are received regardless of whether any service is rendered to the patient in that particular month. In the case of Medicaid and Medicare it is usual for there to be a second "wrap-around" payment for managed care visits to adjust total payment to FQHC rates.

.

MEMBER MONTHS FOR MANAGED CARE (FEE-FOR-SERVICE) (Line 13b) – Enter the total fee-for-service member months by source of payment. A fee-for-service member month is defined as one patient being assigned to a service delivery location for one month during which time the patient may use <u>only</u> that center's services, but for whom the services are paid on a fee-for-service basis. NOTE: Do <u>not</u> include individuals who receive "carved-out" services under a fee-for-service arrangement if those individuals have already been counted for the same month as a capitated member month.

TOTAL MEMBER MONTHS. (Line 13c) – Enter the total of lines 13a + 13b

VETERANS, LINE 25

All programs report the total number of patients served who have been discharged from the uniformed services of the United States. It is expected that this element will be included in the patient information/intake form at each center. Report only those who affirmatively indicate they are veterans. Persons who do not respond or who have

no information are not counted, regardless of other indicators. Persons who are *still in* the uniform services, including soldiers on leave, National Guard members not on active duty, are not considered Veterans, Veterans of other nation's military are not counted here, even if they served in wars in which the United States was also involved.

QUESTIONS AND ANSWERS FOR TABLE 4

1. **Are the reporting requirements for the UDS different than for the UCRR?**

   Table 4 is a new reporting requirement for UIHP programs with no corresponding UCRR Table.

2. **Are there any changes to this table since 2008?**
   No.

3. **Must the number of patients by income and insurance source equal the total number of unduplicated patients reported on Tables 3A and 3B?**
   Yes.

4. **We have never collected information on whether or not a patient is a veteran. Do we have to do this now for reporting?**
   Yes. As of January 1, 2008 all programs are required to ask every patient who comes into the UIHP whether or not they are a veteran and add this to their profile.

5. **If a patient is seen only for dental care do we report the patient's dental insurance on lines 7 - 12?**
   No. Table 4 is being used to report the medical coverage that health center patients have. All programs must collect medical coverage information from all patients even if the patient is not seeking medical services. Even though it does not cover their dental care we need to get their medical insurance. Note: If a patient has Medicaid, Private or Other Public dental insurance you may presume that they have the same kind of medical insurance. It they *do not* have dental insurance you *may not* assume that they are uninsured for medical care, and must obtain this information from the patient.

6. **If we do not bill patients for medical services, do we need to collect primary medical insurance information?**
   Yes. You must collect information on primary medical insurance from all patients regardless of whether you intend to bill for medical services to complete the UDS Report.

TABLE 4 – SELECTED PATIENT CHARACTERISTICS

CHARACTERISTIC		NUMBER OF PATIENTS (a)
INCOME AS PERCENT OF POVERTY LEVEL		
1.	100% and below	
2.	101 – 150%	
3.	151 – 200%	
4.	Over 200%	
5.	Unknown	
6.	**TOTAL** (SUM LINES 1 – 5)	

PRINCIPAL THIRD PARTY MEDICAL INSURANCE SOURCE		0-19 YEARS OLD (a)	20 AND OLDER (b)
7.	**N**one/ **U**ninsured		
8a.	Regular Medicaid (Title XIX)		
8b.	S-CHIP Medicaid		
8.	**TOTAL MEDICAID (LINE 8A + 8B)**		
9.	**MEDICARE** (TITLE XVIII)		
10a.	Other Public Insurance Non-S-CHIP (specify):		
10b.	Other Public Insurance S-CHIP		
10.	**TOTAL PUBLIC INSURANCE (LINE 10a + 10b)**		
11.	**PRIVATE INSURANCE**		
12.	**TOTAL (SUM LINES 7 + 8 + 9 +10 +11)**		

MANAGED CARE UTILIZATION

Payor Category		MEDICAID (a)	MEDICARE (b)	OTHER PUBLIC INCLUDING NON-MEDICAID S-CHIP (c)	PRIVATE (d)	TOTAL (e)
13a.	Capitated Member months					
13b.	Fee-for-service Member months					
13c.	**TOTAL MEMBER MONTHS (13a + 13b)**					
25.	**TOTAL VETERANS (ALL PROGRAMS REPORT THIS LINE)**					

INSTRUCTIONS FOR TABLE 5 – STAFFING AND UTILIZATION

This table provides a profile of program staff, the number of visits they render and the number of patients served by service category. Unlike Tables 3A, 3B and 4, where an unduplicated count of patients is reported, Column C of Table 5 is designed to report the number of unduplicated patients within each of six major service categories: medical, dental, mental health, substance abuse, other professional and enabling. The staffing information in Table 5 is designed to be compatible with approaches used to describe staff for financial/cost reporting, while ensuring adequate detail on staff categories for program planning and evaluation purposes. (NOTE: Staffing data are not reported on the AI/AN Report.)

For the **Universal Report**, all staff, all visits and all patients are reported in Columns A, B and C. For the **AI/AN Report, *only Columns B and C are to be completed***. (Column A will appear "grayed out" in the computer version and printouts of the AI/AN Report tables.) Every eligible visit must be counted on the Universal Report including all those reported in the AI/AN Report.

The **AI/AN Report** includes only patients who qualify as American Indians/Alaska Natives according to the Title XXV USC 1603 (f) definition and visits provided to these patients. The difference between the individuals and visits reported in the Universal Report and those reported on the AI/AN Report are those individuals who are Non-Indian patients and the visits provided to these patients. Thus, no cell on the AI/AN Report can be greater than the corresponding cell on the Universal Report.

FULL TIME EQUIVALENTS (FTEs), COLUMN A

This table includes FTE staffing information on all individuals who work in programs and activities that are within the scope of the UIHP project covered by UDS. (The FTE column is completed only on the Universal Report.) **All staff are to be reported in terms of annual Full-Time Equivalents (FTEs)**. A person who works 20 hours per week (i.e. 50 percent time) is reported as "0.5 FTE" - based on a full-time work week of 40 hours. Similarly, an employee who works 4 months out of the year would be reported as "0.33 FTE" (4 months/12 months). (See the "Definitions of Visits, Providers, Patients, and FTE" section of this Manual for detailed instructions on calculating FTEs.)

Staff may provide services on behalf of the program under many different arrangements including, but not limited to: salaried full-time, salaried part-time, hourly wages, NHSC assignment, under contract, or donated time. Thus, FTEs reported on Table 5 Column A include paid staff, volunteers, contracted personnel (paid based on worked hours or FTE), residents and preceptors. Individuals who are paid by the program on a fee-for-service basis only are not counted in the FTE column since there is no basis for determining their hours.

All staff time is to be allocated *by function* among the major service categories listed. For example, a full-time nurse who works solely in the provision of direct medical services would be counted as 1.0 FTE on Line 11 (Nurses). If that nurse provided case management services during 10 dedicated hours per week, and provided medical care services for the other 30 hours per week, time would be allocated 0.25 FTE case manager (Line 24) and 0.75 FTE nurse (Line 11). Do not, however, attempt to parse out

the components of an interaction. The nurse who handles a referral after a visit as a part of that visit would *not* be allocated out of nursing. For example, a nurse who takes a patient's vitals, places the patient in an exam room, and later provides instructions on wound care - would not have a portion of the time counted as "health education" – it is all a part of nursing.

An individual who is hired as a full-time clinician must be counted as 1.0 FTE regardless of the number of "direct patient care" or "face-to-face hours" they provide. Providers who have released time to compensate for on-call hours or who receive leave for continuing education or other reasons are still considered full-time if this is how they were hired. The time spent by providers doing "administrative" work such as charting, reviewing labs, filling or renewing prescriptions, returning phone calls, arranging for referrals, participating in QI activities, supervising nurses etc. is counted as part of their overall medical care services time. The one exception to this rule is when a Medical Director is engaged in *corporate* administrative activities, in which case time can be allocated to administration. Corporate administration does not, however, include clinical administrative activities such as supervising the clinical staff, chairing or attending clinical meetings, writing clinical protocols, etc.

PERSONNEL BY MAJOR SERVICE CATEGORY – Staff are distributed into categories that reflect the types of services they provide. Major service categories include: medical services, dental services, mental health services, substance abuse services, other professional services, pharmacy services, enabling services, other program related services, and administration and facility. Whenever possible, the contents of major service categories have been defined to be consistent with definitions used by Medicare. The following summarizes the personnel categories; a more detailed list appears in Appendix A.

- **MEDICAL CARE SERVICES (Lines 1 – 15)**
  - **Physicians** - M.D.s and D.O.s, except psychiatrists, pathologists and radiologists. Naturopaths and Chiropractors are *not* counted here.
  - **Nurse Practitioners**
  - **Physician Assistants**
  - **Certified Nurse Midwives**
  - **Nurses** - registered nurses, licensed practical and vocational nurses, home health and visiting nurses, clinical nurse specialists, and public health nurses
  - **Laboratory Personnel** - pathologists, medical technologists, laboratory technicians and assistants, phlebotomists
  - **X-ray Personnel** - radiologists, X-ray technologists, and X-ray technicians
  - **Other Medical Personnel** - medical assistants, nurses aides, and all other personnel providing services in conjunction with services provided by a physician, nurse practitioner, physician assistant, certified nurse midwife, or nurse. Staff who support quality assurance/ Electronic Health Records (EHR) program are included. Medical records and patient support staff are *not* reported here.

Note: Quality Assurance Personnel – Individuals in any or all of the above positions may be involved in Quality Assurance and EHR activities. They will be classified on the line that describes their main responsibility.

- **DENTAL SERVICES (Lines 16 – 19)**
  - **Dentists** - general practitioners, oral surgeons, periodontists, and pediodontists
  - **Dental Hygienists**
  - **Other Dental Personnel** - dental assistants, aides, and technicians

- **MENTAL HEALTH SERVICES (Lines 20a, a1, a2, b, c and 20) -** (Note: Behavioral health services include both mental health and substance abuse services. Centers using the "Behavioral Health" designation need to divide their staff between lines 20 and 21 as appropriate.)
  - **Psychiatrists (Line 20a)**
  - **Licensed Clinical Psychologists (Line 20a-1)**
  - **Licensed Clinical Social Workers (Line 20a-2)**
  - **Other licensed mental health providers (Line 20b)**, including psychiatric social workers, psychiatric nurse practitioners, family therapists, and other licensed Masters Degree prepared clinicians.
  - **Other mental health staff, including (Line 20c)** unlicensed individuals providing counseling, treatment or support services related to mental health professionals.

- **SUBSTANCE ABUSE SERVICES (Line 21)** - Psychiatric nurses, psychiatric social workers, mental health nurses, clinical psychologists, clinical social workers, and family therapists and other individuals providing counseling and/or treatment services related to substance abuse. **-** (Note: Behavioral health services include both mental health and substance abuse services. Centers using the "Behavioral Health" designation need to divide their staff between lines 20 and 21 as appropriate.)

- **ALL OTHER PROFESSIONAL HEALTH SERVICES (Line 22)** - Occupational and physical therapists, nutritionists, podiatrists, optometrists, naturopaths, chiropractors, acupuncturists and other staff professionals providing health services. Include **Traditional Medicine Staff** as Other Professionals. Traditional medicine staff are staff using traditional American Indian/Alaska Native practices from rituals to physiological interventions - drawing upon spiritual and non-biological forces in their application of healing arts. Note: WIC nutritionists and other professionals working in WIC programs are reported on Line 29a, "Other Programs and Services Staff". (A more complete list is included in Appendix A.) There is a "specify" box that must be completed. Explain the specific other professional health services included.

- **VISION SERVICES (Lines 22a – 22d) –** Persons working in the area of eye care, specifically
  - **Ophthalmologist (Line 22a)** – Medical doctors specializing in medical and surgical eye problems.
  - **Optometrist (Line 22b)** – Optometrists (O.D.) – not physicians
  - **Optometric Assistant** (Line 22c)

- **PHARMACY SERVICES (Line 23)** Pharmacists (including clinical pharmacists), pharmacist assistants and others supporting pharmaceutical services. Do not include staff who spend all or part of their time in assisting patients to

apply for free drugs from pharmaceutical companies. These staff are classified as "Eligibility Assistance Workers", on line 27a.

- **ENABLING SERVICES (Lines 24 - 29)**
  - **Case Managers (Line 24)** - staff who provide services to aid patients in the management of their health and social needs, including assessment of patient medical and/or social services needs, and maintenance of referral, tracking and follow-up systems. Case managers may provide eligibility assistance, if performed in the context of other case management functions. Staff may include nurses, social workers and other professional staff who are specifically allocated to this task during assigned hours, but not when it is an integral part of their other function. Care / Referral Coordinators are considered Case Managers.
  - **Patient and Community Education Specialists (Line 25)**- health educators, family planning specialists, HIV specialists, and others who provide information about health conditions and guidance about appropriate use of health services that are not otherwise classified under outreach.
  - **Outreach Workers (Line 26)** - individuals conducting case finding, education or other services to identify potential clients and/or facilitate access/referral of clients to available services.
  - **Eligibility Assistance Workers (Line 27a)**- all staff providing assistance in securing access to available health, social service, pharmacy and other assistance programs, including Medicaid, WIC, Supplemental Security Income (SSI), food stamps, Temporary Assistance for Needy Families, and related assistance programs.
  - **Personnel Performing Other Enabling Service Activities** (Line 28)- all other staff performing services as enabling services, not described above. There is a "specify" field that must be used to describe what these staff are doing.
  - **Interpretation Staff (Line 27b)-** Staff whose full time or dedicated time is devoted to translation and/or interpretation services. ***DO NOT INCLUDE*** that portion of the time of a nurse, medical assistant or other support staff who provides interpretation or translation during the course of their other activities.

- **OTHER PROGRAMS AND RELATED SERVICES STAFF (Line 29a)**

  Some programs, especially "umbrella agencies," operate programs which, while within their scope of service, are not directly a part of the listed medical, dental, behavioral or other health services. These include WIC programs, job training programs, head start or early head start programs, food programs, shelters, housing programs, child care, etc. The staff for these programs are reported under Other Programs and Related Services. The cost of these programs are reported on Table 8A on line 12. There is a "specify" field that must be used to describe what these staff are doing.

- **ADMINISTRATION AND FACILITY (Lines 30 - 33)**
  - **Management and Support Staff – (Line 30a) –** Management team including Chief Executive Officer, Chief Financial Officer, Chief Information Officer and Chief Medical Officer, other administrative

staff and administrative office support (secretaries, administrative assistants, file clerks, etc.) for UIHP operations within the scope of the grant. Report only that portion of the management team's full-time equivalent corresponding to the management function.

- **Fiscal and Billing Staff – (Line 30b) -** Staff performing accounting and billing functions in support of UIHP operations for services performed within the scope of the grant, excluding the Chief Financial Officer.
- **IT Staff** – **(Line 30c)** - Technical information technology and information systems staff supporting the maintenance and operation of the computing systems that support clinical and administrative functions performed within the scope of the grant. Staff managing an EHR/EMR system are reported on line 30c, but design of medical forms, data entry and analysis of EHR data are part of the medical functions reported on lines 1 – 15
- **Facility** – **(Line 31)** - Staff with facility support and maintenance responsibilities, including custodians, housekeeping staff, security staff, and other maintenance staff.
- **Patient Services Support Staff – (Line 32)** - Intake staff and medical/patient records. Eligibility assistance workers are reported on line 27a, not here!

NOTE: The Administration and Facility category for this report is more comprehensive than that used in some other program definitions and includes **all** personnel working in a UIHP, whether that individual's salary was supported by the OUIHP grant or other funds included in the scope of project.

NOTE ALSO: Tables 8A has data relating to cost centers. Staff classifications should be consistent with cost classifications. The staffing on Table 5 is routinely compared to the costs on Table 8A during the editing process. If there is a reason why such a comparison would look strange (e.g., volunteers on Table 5 resulting in no cost on Table 8A) be sure to include an explanatory note on Table 8A. The chart below illustrates the relationship between the two tables.

FTE's reported on Table 5, Line:	Have costs reported on Table 8A, Line:
1-12: Medical (physicians, mid-level providers, nurses)	1: Medical staff
13-14: Lab and X-ray	2: Lab and X-ray
16-18: Dental (e.g., dentists, dental hygienists, etc.)	5: Dental
20a- 20: Mental Health	6: Mental Health
21: Substance Abuse	7: Substance Abuse
22: Other Professional (e.g. nutritionists, podiatrists, etc.)	9: Other Professional
22a-22d: Vision (Ophthalmologist, Optometrist, Optometric Assistant	9: Other Professional
23: Pharmacy	8a: Pharmacy
24-28: Enabling (e.g., case management, outreach, eligibility, etc.)	11a-11g: Enabling

29a: Other programs / services (non-health related services including WIC, job training, housing, child care, etc.)	12: Other related services
30a-30c: and 32: Administration and Patient Support (e.g., corporate, intake, medical records, billing, fiscal and IT staff)	15: Administration
31: Facility (e.g., janitorial staff, etc.)	14: Facility

CLINIC VISITS, COLUMN B

VISITS (Column B) – A visit is a documented, face-to-face contact between a patient and a provider who exercises independent professional judgment in the provision of services to the individual. (See "Definitions of Visits, Providers, Patients, and FTE" section for further details on the definition of visits.) Programs are to report visits during the reporting period which were rendered by staff identified in column A, regardless of whether the staff are salaried or contracted based on time worked. ***No*** visits are reported for personnel who are not "providers who exercise independent professional judgment" within the meaning of the definition above. Programs are not required to report visits for certain other classes of staff, even if they *do* exercise professional judgment including laboratory, transportation, outreach, pharmacy, etc. These cells are blocked out.

Visits that are purchased from non-staff providers on a fee-for-service basis are also counted in this column, even though no corresponding FTEs are included in Column A. To be counted, the service must meet the following criteria:

- the service was provided to a patient of the program by a provider that is not part of the program's staff (neither salaried nor contracted on the basis of time worked),
- the service was paid for in full by the program, and
- the service otherwise meets the above definition of a visit.

This category ***does not include unpaid referrals, or referrals where only nominal amounts are paid,*** or referrals for services that would otherwise not be counted as visits.

PATIENTS, COLUMN C

PATIENTS (Column C) – A patient is an individual who has at least one visit during the reporting year. (See "Definitions of Visits, Providers, Patients, and FTE" section for further details.) Report the number of patients for **each** of the six separate services listed below. **Within each category, an individual can only be counted once as a patient. A person who receives multiple types of services should be counted once (and *only once) for each service*.**

For example, a person receiving only medical services is reported once (as a medical patient) regardless of the number of medical visits. A person receiving medical, dental and enabling services is reported once as a medical patient (Line 15), once as a dental patient (Line 19) and once as an enabling patient (Line 29), but is counted *only* once on each appropriate line in column C, regardless of the number of visits reported in column

B. An individual patient may be counted once (and **only** once) in each of the following categories:

- Medical care services patients (Line 15)
- Dental services patients (Line 19)
- Mental health services patients (Line 20)
- Substance abuse services patients (Line 21)
- Patients of other professional services (Line 22)
- Enabling services patients (Line 29)

If you show visits in Column B for any of these six categories, you are required to show the unduplicated number of persons who received these visits. Since patients must have at least one documented visit, it is not possible for the number of patients to exceed the number of visits. Also, individuals who only receive services for which no visits are generated (e.g., laboratory, transportation, outreach) are not included in the patient count reported in Column C. For example, individuals who receive outreach or transportation services are not included in the total number of patients receiving enabling services in Column C; individuals who received flu shots but no other service are not counted as medical patients, etc.

QUESTIONS AND ANSWERS FOR TABLE 5

1. Are the reporting requirements for the UDS different than for the UCRR?

The information reported on Table 5 corresponds with the UCRR Table 2 Number of Program Users by Service Group, Table 3 Staff and Visits by Service Group and Table 4 Hospital Inpatient Visits by Type of Admission. The UDS combines the reporting of staff, patients and visits into a single report. Service Groups for the UCRR and UDS are similar although reported in a different order. Definitions for staff, patients and visits are the same for both the UCRR and UDS reports. Again, programs are required to report total program patients and Indian patients rather than Indian and Non-Indian patients. The difference between total program patients and Indian patients equals Non-Indian patients. Like the UCRR, the UDS reports staff FTEs, total visits and Indian visits. However, the UDS does not report referrals separately. Programs should report all visits that meet the UDS definition in Column B including hospital visits and visits provided by contractors and paid for by the program (see Definitions for a complete list of UDS visits.) **Do not count referral visits that are not paid for by the program.**

2. Are there any changes to this table since 2009?

Yes. Four lines have been added to capture Vision Care services. They have been added because vision care is associated with reduced disabilities and costs associated with a number of chronic illnesses as well as with eye diseases and disorders associated with normal aging. To capture this data, several lines have been added to capture FTEs, visits and patients:

a. Line 22a, Ophthalmologists and associated visits
b. Line 22b, Optometrists and associated visits
c. Line 22c, Optometric Assistants
d. Line 22d, Total Vision Services (total of lines 22a-c) and Vision Services patients

3. How do I count participants in a group session?

If you have group treatment sessions (e.g., for substance abuse, mental health or behavioral health) you must record the visit in each participant's chart. If a visit is not recorded in a participant's chart, that participant may not be counted as a patient. No ***group medical visits*** are counted on the UDS. Though in some instances they may be billable as counseling services, the UDS specifically does not count group medical activities as visits activities in such sessions.

4. How do I report the FTEs for a clinician who regularly sees patients 75 percent of the time and covers after-hours call the remaining 25 percent of his/her time?

An individual who is hired as a full-time clinician must be counted as 1.0 FTE regardless of the number of "direct patient care" or "face-to-face hours" they provide. Providers who have released time to compensate for on-call hours or hours spent on clinical committees, or who receive leave for continuing education or other reasons are still considered full-time if this is how they were hired. The time spent by providers doing administrative work such as charting, reviewing labs, filling prescriptions, returning phone calls, arranging for referrals, etc. is not to be adjusted. The one exception to this rule is when a Medical Director is engaged in *corporate* administrative activities, in which case time can be allocated to

administration. This does not, however, include *clinical* administrative activities including chairing or attending meetings, supervising staff, and writing clinical protocols. Note that the FQHC Medicare intermediary has different definitions for full time providers. These definitions are ***not*** to be used in reporting on the UDS,

5. **Is it appropriate for the total number of patients reported on Table 3A to be equal to the sum of the several types of service patients on Table 5?**
   Unless the UIHP only provides one type of service (e.g., medical, mental health, etc.), the total number of patients on Table 5 should not equal the total number on Table 3A. On Table 5, the program reports **patients for each type of service, with the patient counted once for each type of service received.** Thus a person who receives both medical and dental services would be counted once as a medical patient on Line 15 and once as a dental patient on Line 19. Because there are six different types of patients identified on Table 5, a patient who is counted only once on Table 3A may be counted up to six different places on Table 5. Thus, the sum of patients on Table 5 usually is greater than the total number of patients reported on Table 3A.

6. **If I report costs for case management services on Table 8A, do I have to report case managers on Table 5?**
   Yes. There should be a logical consistency between Table 5 and 8A. If a program reports that costs for case management services one would expect to see case managers reported on Table 5. Similarly, if there is staff on Table 5 we would expect costs on Table 8A unless all of the staff are volunteers.

7. **How are contracted providers and their activities reported on Table 5?**
   If the contracted provider is paid on the basis of time worked, the FTE is reported on Table 5 Column A as well as the visits and patients receiving services from this provider. If the contracted provider is paid on a fee-for-service basis, no FTE is reported on Table 5 Column A but visits and patients are reported.

8. **Where does Behavioral Health get reported?.**
   Behavioral Health in some systems is just another name for mental health, and the staff and visits are reported on line 20. But some programs have merged the roles of “Mental Health Provider” and “Substance Abuse Provider” into a single role which they call “Behavioral Health Provider.” In this instance, the program has two choices. The first (and probably easiest) is to assert that substance abuse problems are, indeed, mental health problems, and classify their Behavioral Health staff as Mental Health staff on the lines 20a, a1, a2, b or c. In this case the visits will be mental health visits and the patients will be mental health patients. Not as easy, but perhaps more accurate, would be to carefully record the time and activities of these dual function providers. In this case they will need to identify *each and every visit* as either a mental health visits or a substance abuse visit so that the patients and visits can be correctly classified. They also must also keep track of their time so that their FTEs on Table 5 (and associated costs on table 8A) can be accurately recorded.

9. **If a clinician provides mental health and substance abuse (behavioral health) services to the same patient during a visit, how should this be counted?**
   Because “substance abuse” is also seen as a mental health diagnosis, it is permissible to count the visit as mental health. Under no circumstances would it be

counted as “one of each.” The provider will also need to be classified as mental health for this visit as must be the cost of the provider on Table 8A.

10. Do I count the time of residents?

Yes. Residents are licensed practitioners and their time is counted just like any other practitioner. Note, however, that most work shorter days because they are in educational sessions and often have more vacation time or other time off than a normal practitioner. This would make them less than full time. See also the discussion in Appendix B

11. Where do I report Traditional Medicine staff?

Traditional medicine staff are reported as Other Professionals on line 22. Traditional medicine staff are staff using traditional American Indian/Alaska Native practices from shamanistic rituals to physiological interventions - drawing upon spiritual and non-biological forces in their application of healing arts.

TABLE 5 – STAFFING AND UTILIZATION

Personnel by Major Service Category		FTEs (A)	Clinic Visits (B)	Patients (C)
1	Family Physicians			
2	General Practitioners			
3	Internists			
4	Obstetrician/Gynecologists			
5	Pediatricians			
6				
7	Other Specialty Physicians			
8	**Total Physicians (Lines 1 – 7)**			
9a	Nurse Practitioners			
9b	Physician Assistants			
10	Certified Nurse Midwives			
10a	**Total "Mid-Levels" (Lines 9a - 10)**			
11	Nurses			
12	Other Medical personnel			
13	Laboratory personnel			
14	X-ray personnel			
15	**Total Medical (Lines 8 + 10a through 14)**			
16	Dentists			
17	Dental Hygienists			
18	Dental Assistants, Aides, Techs			
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 Staff			
20	**Mental Health (Lines 20a-c)**			
21	**Substance Abuse Services**			
22	**Other Professional Services (specify___)**			
22a	Ophthalmologist			
22b	Optometrist			
22c	Optometric Assistant			
22d	**Total Vision Services (Lines 22a-c)**			
23	**Pharmacy Personnel**			
24	Case Managers			
25	Patient / Community Education Specialists			
26	Outreach Workers			
27	Transportation Staff			
27a	Eligibility Assistance Workers			
27b	Interpretation Staff			
28	Other Enabling Services (specify___)			
29	**Total Enabling Services (Lines 24-28)**			
29a	**Other Programs / Services (specify___)**			
30a	Management and Support Staff			
30b	Fiscal and Billing Staff			
30c	IT Staff			
30	**Total Administrative Staff (Lines 30a-30c)**			
31	Facility Staff			
32	Patient Support Staff			
33	**Total Admin** & **Facility (Lines 30 – 32)**			
34	**Total (Lines 15+19+20+21+22+23+29+29a+33)**			

INSTRUCTIONS FOR TABLE 6A - SELECTED PRIMARY DIAGNOSES AND SERVICES RENDERED

The table is included in **both** the **Universal Report** and **AI/AN Report**.

This table reports data on selected ***primary*** diagnoses and services rendered. It is designed to provide information on primary diagnoses and services of greatest interest to the UIHP using data maintained for billing purposes. As a *subset* of diagnoses and services, Table 6A is not expected to reflect the full range of diagnoses and services rendered by a program. The selected conditions seen and services provided represent those that are prevalent among UIHP patients or a sub-group of patients *or* are generally regarded as sentinel indicators of access to primary care. Diagnoses reported on this table are those made by a medical, dental mental health or substance abuse provider, *only* and are only the *primary diagnosis* provided at any given visit. Thus, if a case manager sees a diabetic patient, the visit is *not* to be reported on Table 6A; if a physician shows the primary diagnosis as hypertension and the secondary diagnosis as diabetes, the diabetes diagnosis is *not* reported on Table 6A.

For the **Universal Report**, report visits in the indicated diagnostic or service categories and a count of all individuals who had at least one visit in the indicated diagnostic or service category. Regardless of the number or types of services received, each patient is to be counted only once per row. The same patient may, however, be reported on more than one row if they had multiple primary diagnosis or services.

The **AI/AN Report** includes only individuals who qualify as American Indians/Alaska Natives according to the Title XXV USC 1603 (f) definition and their corresponding visits.

The difference between the individuals and visits reported in the Universal Report and the AI/AN Report are those individuals who are Non-Indian patients and their visits. Thus, no cell on the AI/AN Report can be greater than the corresponding cell on the Universal Report.

Selected Primary Diagnoses – Lines 1 through 20 present the name and applicable ICD-9CM codes for the diagnosis or diagnostic range/group. Wherever possible, diagnoses have been grouped into code ranges. Where a range of ICD-9CM codes is shown, programs should report on all visits where the *primary diagnostic code* is included in the range/group.

Selected Tests/Screenings/Preventive Services – Lines 21 through 26 present the name and applicable ICD-9CM diagnostic and visit codes and/or CPT procedure codes for selected tests, screenings, and preventive services which are particularly important to the populations served. On several lines both CPT codes and IC9 codes are provided. Programs should use *either* the CPT codes *or* the ICD9 codes for any given line, not both. Note that for these lines, the concept of a "primary" code is neither relevant nor used. *All* services are reported. A reported *service* may be in addition to a reported primary *diagnosis* or may stem from a visit where there was no UDS-reportable diagnosis code.

Selected Dental Services – Lines 27 through 34 present the name and applicable ADA procedure codes for selected dental services. These services may be performed *only by a dental provider who is reported on lines 16 – 18.* Wherever appropriate, services have been grouped into code ranges. Some codes are included on more than one line. In these cases the service would be counted on *each* line. Note that for these lines, the concept of a "primary" code is neither relevant nor used. *All* services are reported.

PLEASE NOTE: Only services which are provided at a "countable" visit are reported on table 6A,

Included in these would be services "attendant to" a countable visit. Thus, if a provider asks that a patient come back in 30 days for a flu shot, when that patient presents, the shot is counted because it is considered legally to be a part of the initial visit. Another person, walking in off the street for the same flu shot but without a specific referral from a prior visit would not have the interaction reported on Table 6A.

NUMBER OF VISITS, COLUMN A

LINES 1 – 20e: Diagnostic Data.

Visits by Selected Primary Diagnoses (Lines 1-20e). Report the total number of visits during the reporting period where the indicated diagnosis is listed on the visit/billing records as the **primary** diagnosis **only**. If a visit has a primary diagnosis which is one of the many diagnoses not listed on Table 6, it is not reported. Note: while most visits are **not** reported on this table, those which *are* counted, are reported for only the primary diagnosis on lines 1 through 20e. All visits entered into clinic practice management / billing systems, with one diagnosis listed as primary and successive diagnoses listed as secondary, tertiary, etc. Any single visit may be counted a maximum of one time on lines 1 – 20 regardless of the number of diagnoses listed for the visit.

LINES 21 – 34: Service Data.

Visits by Selected Tests/Screenings/Preventive and Dental Services (Lines 21-34). Report the total number of visits at which one or more of the listed diagnostic tests, screenings, and/or preventive services were provided. Note that codes for these services may either be diagnostic (ICD-9) codes or procedure (ADA or CPT-4) codes. During one visit more than one test, screening or preventive service may be provided, in which case, each would be counted.

- One visit may involve more than one of the identified services in which case each should be reported. For example, if during a visit both a Pap test and an HIV test were provided then a visit would be reported on both lines 21 and 23.
- If a patient receives multiple immunizations at one visit, only one visit should be reported.
- Services may be reported ***in addition to*** diagnoses. A hypertensive patient who also receives an HIV test would be counted once on the hypertension line 11 and once on line 21, HIV test.
- If a patient had more than one tooth filled, only one visit for restorative services should be reported, not one per tooth.

NUMBER OF PATIENTS, COLUMN B

LINES 1 – 20e: Diagnostic Data.

Patients by Primary Diagnosis (Lines 1-20e). For Column B report each individual who had one or more visit during the year where the primary diagnosis was the indicated diagnosis. A patient is counted once and only once regardless of the number of visits made for that specific diagnosis. Any patient may have visits with different primary diagnoses, for example, one for hypertension and one for diabetes, on different days. In this case, the patient would be reported once for each primary diagnosis used during the year. A patient with one or more visits with a primary diagnosis of hypertension and one or more encounter with a primary diagnosis of diabetes is counted *once and only once* as a patient on lines 9 and 11 regardless of how many times they were seen.

LINES 21 – 26: Services Data.

Patients by Selected Diagnostic Tests/Screenings/Preventive Services (Lines 21-26c). Report

patients who have had at least one visit during the reporting period where the selected diagnostic tests, screenings, and/or preventive services listed on Lines 21-26c was provided. If a patient had a Pap test and contraceptive management during the same visit, this patient would be counted on both Lines 23 and 25 in Column B. Regardless of the number of times a patient receives a given service, they are counted once and only once on that line in Column B. For example, an infant who has an immunization at each of several well child visits in the year has each visit reported in column A, but is counted only once in column B.

LINES 27 – 34: Dental Services Data.

Patients by Selected Dental Services (Lines 27-34). Report patients who have had at least one visit during the reporting period for each of the selected dental services listed on Lines 27-34. If a patient had two teeth repaired and sealants applied during one visit, this patient would be counted once (only) on both Lines 30 and 32 in Column B. Note that some ADA codes are listed twice. For example, the code for “fluoride treatment and prophylaxis” is listed once under fluoride treatments and once under prophylaxis. In these cases the service would be counted on *each* line.

QUESTIONS AND ANSWERS FOR TABLE 6A

1. **Are the reporting requirements for the UDS different than for the UCRR?**
   The information reported on Table 6A corresponds with the UCRR Table 3A Visits by Selected Diagnostics. The definition for visits by primary diagnosis is the same for the UCRR and UDS. The reporting categories are different for the UCRR. The UDS requires reporting of visits for selected services as well as primary diagnoses. In addition to reporting visits for total program patients and Indian patients, the UDS requires that the number of patients be reported for each diagnostic category. Programs are required to report total program patients and Indian patients rather than Indian and Non-Indian patients. The difference between total program patients and Indian patients equals Non-Indian patients.

2. **Are there changes to this table from 2009?**
   Yes. Lines 1 and 2, (symptomatic and asymptomatic HIV) have been combined. In addition, several new lines have been added including two new diagnoses and four new services. Specifically:
   a. 4a. Hepatitis B
   b. 4b. Hepatitis C
   c. 21a. Hepatitis B test
   d. 21b. Hepatitis C test
   e. 26c. Smoking and tobacco use cessation counseling
   f. 26d. Comprehensive and intermediate eye exams

3. **If a case manager or health educator serves a patient who is, for example, a diabetic, we often show that diagnostic code for the visit. Should this be reported on Table 6A?**
   No. Report only visits with medical, dental, mental health and substance providers on Table 6A.

4. **The instructions call for diagnoses or services as visits. If we provide the service, but it is not counted as a visit (such as immunizations given at a health fair) should it be reported on this table?**
   Services given at health fairs are not counted, regardless of who provides the service and the level of documentation that is done. If a service is provided *as a result of a prescription or plan from an earlier visit* **it *is* counted.** For example, if a provider asked a woman to come back in four months for a Pap test, it would be counted. But if the service is a self-referral where no clinical visit is necessary or provided (such as a blood pressure check at a health fair or a senior citizen coming in for a flu shot,) **it *is not* counted.**

5. **Some diagnostic and/or procedure codes in my system are different from the codes listed. What do I do?**
   It is possible that information for Table 6A is not available using the codes shown because of idiosyncrasies in state or clinic billing systems. Generally, these involve situations where (a) the state uses unique billing codes, other than the normal CPT code, for state billing purposes (e.g., EPSDT) or (b) internal or state confidentiality rules mask certain diagnostic data. The following provides examples of problems and solutions.

Line #	Problem	Potential Solution
1 and 2	HIV diagnoses are kept confidential and alternative diagnostic codes are used.	Include the alternative codes used at your center on these lines as well.
23	Pap tests are charged to state BCCP program using a special code	Add these special codes to the other codes listed.

26	Well child visits are charged to the state EPSDT program using a special code (often starting with W, X, Y or Z).	Add these special codes to the other codes listed and count all such visits as well. Do not count EPSDT follow-up visits in this category.

6. The instructions specifically say that the source of information for Table 6A is "billing systems." There are some services for which I do not pay and there are no visits in my system. What do I do?

Referrals for which you do not pay (e.g., sending women to the County Health Department for a mammogram) are *not to be counted.* While programs are only required to report data derived from billing systems, the reported data will understate services in the circumstances described. In order to more accurately reflect your level of service, programs are encouraged to use other codes in their system to enable the tracking. For example, if a child is given a vaccination which the clinic does not charge for because they received it free from the VFC program, the regular code with an extension may be used to indicate that it is not to be billed or have a zero charge attached to it.

Line #	Problem	Potential Solution
21	HIV Tests are processed and paid for by the State and do not show on the visit form or in the billing system.	Use other data sources such as logs of HIV tests conducted or reports to Ryan White programs and use this number of tests.
22	Mammograms are paid for, but are conducted by a contractor and do not show in the billing system for individual patients.	Use the bills from the independent contractor to identify the total number of mammograms conducted during the course of the year and report this number.
23	Pap tests are processed and paid for by the State and do not show on the visit form or in the billing system.	Use other data sources such as logs of Pap tests conducted and use this number of tests.
24	Flu shots are not counted because they are obtained at no cost by the center.	Use the Medicare cost report data on influenza vaccination reimbursements as an estimate for the number of actual visits where flu shots were administered.
25	Contraceptive management is funded under Title X or a state family planning program and does not have a V-25 diagnosis attached to it.	Use records developed for the Title X or state family planning program to count the number of family planning visits. Take care not to count the same visit twice.

TABLE 6A – SELECTED DIAGNOSES AND SERVICES RENDERED

	Diagnostic Category	Applicable ICD-9-CM Code	Number of Visits by Primary Diagnosis (A)	Number of Patients with Primary Diagnosis (B)
Selected Infectious and Parasitic Diseases				
1-2.	Symptomatic HIV , Asymptomatic HIV	042 , 079.53, V08		
3.	Tuberculosis	010.xx – 018.xx		
4.	Syphilis and other sexually transmitted diseases	090.xx – 099.xx		
4a.	Hepatitis B	070.20, 070.22, 070.30, 070.32		
4b.	Hepatitis C	070.41, 070.44, 070.51, 070.54, 070.70, 070.71		
Selected Diseases of the Respiratory System				
5.	Asthma	493.xx		
6.	Chronic bronchitis and emphysema	490.xx – 492.xx		
Selected Other Medical Conditions				
7.	Abnormal breast findings, female	174.xx; 198.81; 233.0x; 238.3 793.8x		
8.	Abnormal cervical findings	180.xx; 198.82; 233.1x; 795.0x		
9.	Diabetes mellitus	250.xx; 648.0x; 775.1x		
10.	Heart disease (selected)	391.xx – 392.0x 410.xx – 429.xx		
11.	Hypertension	401.xx – 405.xx;		
12.	Contact dermatitis and other eczema	692.xx		
13.	Dehydration	276.5x		
14.	Exposure to heat or cold	991.xx – 992.xx		
14a.	Overweight and obesity	ICD-9 : 278.0 – 278.02 or V85.xx excluding V85.0, V85.1, V85.51 V85.52		
Selected Childhood Conditions				
15.	Otitis media and eustachian tube disorders	381.xx – 382.xx		
16.	Selected perinatal medical conditions	770.xx; 771.xx; 773.xx; 774.xx – 779.xx (excluding 779.3x)		
17.	Lack of expected normal physiological development (such as delayed milestone; failure to gain weight; failure to thrive)--does not include sexual or	260.xx – 269.xx; 779.3x; 783.3x – 783.4x;		

	mental development; Nutritional deficiencies			

TABLE 6A – SELECTED DIAGNOSES AND SERVICES RENDERED

Diagnostic Category		Applicable ICD-9-CM Code	Number of Visits by Primary Diagnosis (A)	Number of Patients with Primary Diagnosis (B)
Selected Mental Health and Substance Abuse Conditions				
18.	Alcohol related disorders	291.xx, 303.xx; 305.0x 357.5x		
19.	Other substance related disorders (excluding tobacco use disorders)	292.1x – 292.8x 304.xx, 305.2x – 305.9x 357.6x, 648.3x		
19a	Tobacco use disorder	305.1		
20a.	Depression and other mood disorders	296.xx, 300.4 301.13, 311.xx		
20b.	Anxiety disorders including PTSD	300.0x, 300.2x, 300.3, 308.3,309.81		
20c.	Attention deficit and disruptive behavior disorders	312.8x, 312.9x, 313.81, 314.xx		
20d.	Other mental disorders, excluding drug or alcohol dependence (includes mental retardation)	290.xx 293.xx – 302.xx (excluding 296.xx, 300.0x, 300.2x, 300.3, 300.4, 301.13); 306.xx - 319.xx (excluding 308.3, 309.81, 311.xx, 312.8x, 312.9x,313.81,314.xx)		

TABLE 6A – SELECTED SERVICES RENDERED

Service Category		Applicable ICD-9-CM or CPT-4 Code	Number of Visits (A)	Number of Patients (B)
Selected Diagnostic Tests/Screening/Preventive Services				
21.	HIV test	**CPT-4:** 86689; 86701-86703; 87390-87391		
21a.	Hepatitis B test	**CPT-4:** 86704, 86706, 87515-17		
21b.	Hepatitis C test	**CPT-4:** 86803-04, 87520-22		
22.	Mammogram	**CPT-4:** 77052, 77057 OR **ICD-9:** V76.11; V76.12		
23.	Pap test	**CPT-4:** 88141-88155; 88164-88167, 88174-88175 OR **ICD-9:** V72.3; V72.31; V76.2		
24.	Selected Immunizations: Hepatitis A, Hemophilus Influenza B (HiB), Pneumococcal, Diptheria, Tetanus, Pertussis (DTaP) (DTP) (DT), Mumps, Measles, Rubella, Poliovirus, Varicella, Hepatitis B Child)	**CPT-4:** 90633-90634, 90645 – 90648; 90669; 90696 – 90702; 90704 – 90716; 90718 - 90723; 90743 – 90744; 90748		
24a	Seasonal Flu vaccine	**CPT-4:** 90655 - 90662		
24b	H1N1 Flu vaccine	**CPT-4:** 90663; 90470		
25.	Contraceptive management	**ICD-9:** V25.xx		
26.	Health supervision of infant or child (ages 0 through 11)	**CPT-4:** 99391-99393; 99381-99383;		
26a	Childhood lead test screening (9 to 72 months)	**CPT-4:** 83655		
26b	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	**CPT-4:** 99408-99409		
26c	Smoke and tobacco use cessation counseling	CPT-4: 99406 and 99407; S9075		
26d	Comprehensive and intermediate eye exams	CPT-4: 92002, 92004, 92012, 92014		
Service Category		Applicable ADA Code	Number of Visits (A)	Number of Patients (B)
Selected Dental Services				
27.	I. Emergency Services	**ADA :** D9110		

28.	II. Oral Exams	**ADA :** D0120, D0140, DO145, D0150, D0160, D0170, D0180		
29.	Prophylaxis – adult or child	**ADA :** D1110, D1120,		
30.	Sealants	**ADA :** D1351		
31.	Fluoride treatment – adult or child	**ADA :** D1203, D1204, D1206		
32.	III. Restorative Services	**ADA :** D21xx – D29xx		
33.	IV. Oral Surgery (extractions and other surgical procedures)	**ADA :** D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7260, D7261, D7270, D7272, D7280		
34.	V. Rehabilitative services (Endo, Perio, Prostho, Ortho)	**ADA :** D3xxx, D4xxx, D5xxx , D6xxx, D8xxx		

Sources of codes:

International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Volumes 1 and 2, 2009 / 2010. American Medical Association.

Current Procedural Terminology, (CPT) 2009 / 2010. American Medical Association.

Current Dental Terminology, (CDT) 2009 / 2010. American Dental Association.

Note: x in a code denotes any number including the absence of a number in that place

INSTRUCTIONS FOR TABLE 8A - FINANCIAL COSTS

Table 8A must be completed by all UIHPs. It is included only in the Universal Report. The table covers the **total cost** of all activities which are within the scope of the project(s) supported, in whole or in part, by the UIHP. All costs are to be reported on an accrual basis. These are the costs attributable to the period, including depreciation, regardless of when actual payments were made. Do not report the repayment of the principle of a loan on the UDS.

DIRECT AND LOADED COSTS (COLUMN DEFINITIONS)

Column A: This column reports the accrued direct costs associated with each of the cost centers / services listed. See Line Definitions for costs to be included in each category. Column A also reports the total cost of overhead (administration and facility) separately on Lines 14 and 15.

Column B: This column shows the allocation of overhead costs (from lines 14 and 15, Column A) to each of the direct cost centers.

- The total of facility and administration costs, reported in Column A, lines 14 and 15, are to be distributed in Column B. The total amounts entered in Column B will thus equal the amount reported on Line 16, Column A. Lines 1 and 3 refer to aspects of the medical practice. It is acceptable to report all medical overhead on Line 1 if a more appropriate allocation between lines 1 and 3 is not available.
- *All* pharmacy overhead is to be allocated to the non-supply line (Line 8a). No overhead costs are reported on the pharmaceutical supplies line (line 8b) which is blacked out in the

reporting software.

The allocation of administration and facility costs should be done as follows, unless your program has a more accurate system:

FACILITY COSTS should be allocated based on the amount of square footage utilized for Medical, Dental, Mental Health, Substance Abuse, Pharmacy, Other Professional, Enabling, Other Program Related Services and Administration. Square Footage refers to the portion of the program's facility space used in the operation of the organization, not including common spaces such as hallways, rest rooms, and utility closets. For reporting purposes, the square footage associated with space owned by the program and leased or rented to other parties should not be included if it is considered to be outside of the scope of the project. If it has been included inside the scope of project, it should be allocated to Other Related Services (Row 12) and the rent received should be included on Table 9E under Other Revenue (Line 10).

ADMINISTRATIVE COSTS should be allocated after facility costs have been allocated, and should include the facility costs allocated to it. Administrative cost is allocated based on a straight line allocation method. The proportion of total cost (excluding administrative cost) that is attributable to each service category should be used to allocate administrative cost. For example, if medical staff accounts for 50 percent of total cost (excluding administration) then 50 percent of administrative cost is allocated to medical staff. If you have an alternative method that provides more accurate allocations, it may be used, but save your paperwork for review and explain the methods used in the table note.

Column C: This column shows the "fully loaded" cost of each of the cost centers listed on Lines 1 - 13. The loaded cost is the sum of the direct cost, reported in Column A, plus the allocation of overhead, reported in Column B. Column C also shows the value of any donated facilities, services and supplies on Line 18. These non-cash donations should be reflected as a positive number, and are not included in any of the lines above. Note that this is the only place that the value of non-cash donations are shown. Non-cash donations are never reported on Table 9E. Line 19, Column C is the total cost including the value of donations. All UDS calculations which are based on “cost” are calculated based on costs without the value of donated services supplies or facilities calculated in.

UIHP MAJOR SERVICE CATEGORIES (LINE DEFINITIONS)

MEDICAL CARE SERVICES (Lines 1 - 4) – This category includes costs for medical care personnel; services provided under agreement; X-ray and laboratory; and other direct costs wholly attributable to medical care (e.g., staff recruitment, equipment depreciation, supplies, or professional dues and subscriptions). It does not include costs associated with pharmacy, dental care, substance abuse specialists, or mental health (psychiatrists, clinical psychologists, clinical social workers, etc.) services.

STAFF COSTS (Line 1) – Include all staff costs, including salaries and fringe benefits for personnel supported directly or under contract, for medical care staff *except lab and x-ray staff.* The accrued cost (if any) of interns and residents who were paid or paid for, either directly or through a contract with their teaching institution, are reported on line 1. The costs of intake, medical records and billing and collections are considered administrative and should be included on Line 15 and allocated in Column B. Include the cost for vouchered or contracted medical services on line 1.

LAB AND X-RAY COSTS (Line 2) – Include all costs for lab and x-ray, including salaries and fringe benefits for personnel supported directly or under contract, for lab and x-ray staff; and all other direct costs including, but not limited to, supplies, equipment depreciation, related travel, contracted or vouchered lab and x-ray services, etc. The costs of intake, medical records, billing and collections are considered administrative and should be included on Line 15 and allocated in Column B. Note that dental lab and x-ray costs are reported on the dental line, line 5.

OTHER DIRECT COSTS (Line 3) – Include all other direct costs for medical care including, but not limited to, supplies, equipment depreciation, related travel, Continuing Medical Education, laundering of uniforms, recruitment, membership in professional societies, books and journal subscriptions, etc.

TOTAL MEDICAL (Line 4) – The sum of lines 1 + 2 + 3.

OTHER CLINICAL SERVICES (Lines 5 - 10) – This category includes staff and related costs for dental, mental health, substance abuse services, pharmacy, and services rendered by other professional personnel (e.g., optometrists, occupational and physical therapists, traditional healer and podiatrists).

DENTAL (Line 5) – Report all costs for the provision of dental services including but not limited to staff, fringe benefits, supplies, equipment depreciation, related travel, dental lab services and dental x-ray. Corporate administrative and facility costs should be included on Line 15 Column A and allocated in Column B.

MENTAL HEALTH (Line 6) – Report all direct costs for the provision of mental health services, *other than substance abuse services,* including but not limited to staff, fringe benefits, supplies, equipment depreciation, and related travel. If a "behavioral health" program provides both mental health and substance abuse services, the cost should be allocated between the two programs. Allocations may be based on staffing or visits (from Table 5) or any other appropriate methodology. Corporate administrative and facility costs should be included on Line 15 Column A and allocated in Column B. (See also Q & A discussion for Table 5.)

SUBSTANCE ABUSE (Line 7) – Report all direct costs for the provision of substance abuse services including but not limited to staff, fringe benefits, supplies, equipment depreciation, and related travel. If a "behavioral health" program provides both mental health and substance abuse services, the cost should be allocated between the two programs, as should associated staff on Table 5. . (See also Q & A discussion for Table 5.)

Allocations may be based on staffing or visits (from Table 5) or any other appropriate methodology. Corporate administrative and facility costs should be included on Line 15 Column A and allocated in Column B.

PHARMACY (NOT INCLUDING PHARMACEUTICALS) (Line 8a) – Report all direct costs for the provision of pharmacy services including but not limited to staff, fringe benefits, non-pharmaceutical supplies, equipment depreciation, related travel, contracted purchasing services, etc. Corporate administrative and facility costs should be included on Line 15 Column A and allocated in Column B. Include 100 percent of the cost of clinical pharmacists on this line.

PHARMACEUTICALS (Line 8b) — Report all direct costs for the purchase of pharmaceuticals, including the cost of vaccines and other injectable drugs. Do not include other supplies. Do **not** include the value of donated pharmaceutical supplies (these are recorded on Line 18, Column C.)

OTHER PROFESSIONAL (Line 9) — Report all direct costs for the provision of other professional and ancillary health care services including, but not limited to: optometry, podiatry, chiropractic, acupuncture, naturopathy, speech, occupational and physical therapy, traditional medicine, etc. (A more complete list appears at Appendix A.) Included in direct costs are staff, fringe benefits, supplies, equipment depreciation, related travel, and contracted services. Corporate administrative and facility costs should be included on Line 15 Column A and allocated in Column B. Do not include the costs of contracted services such as audit, legal, and grant writing. These costs are reported on Line 15 as administrative. Note that there is a cell to "specify" the other professional costs reported on for this line.

TOTAL OTHER CLINICAL (Line 10) — The sum of lines 5 + 6 + 7 + 8a + 8b + 9.

ENABLING AND OTHER PROGRAM RELATED SERVICES (Lines 11 - 13) – This category includes enabling staff and related costs for case management, outreach, transportation, translation and interpretation, education, eligibility assistance — including pharmacy assistance program eligibility, environmental risk reduction and other services that support and assist in the delivery of primary medical services and facilitate patient access to care. It also includes the cost of staff and related costs for other program related services such as WIC, day care, job training, food, delinquency prevention and other activities not included in other UIHP categories.

ENABLING (Line 11) — Enabling services include a wide range of services which support and assist primary medical care and facilitate patient access to care. It includes all direct costs for the provision of enabling services including, but not limited to costs such as staff, fringe benefits, supplies, equipment depreciation, related travel, and contracted services. Corporate administrative and facility costs should be included on Line 15 Column A and allocated in Column B.

Lines 11a — 11g provide room to detail seven specific types of enabling services as well as an "other" category for all other forms of enabling services:

- Case Management (11a)
- Transportation (11 b)
- Outreach (11c)
- Patient and community education (11d)
- Eligibility assistance (11e)
- Translation / Interpretation Services (11f)
- Other (11g) - If the "other" category is used, there is room to “specify” the other forms of enabling services included on this line.

OTHER PROGRAM RELATED (Line 12) – Report all direct costs for the provision of services not included in any other category here. This includes services such as WIC, childcare centers, food, and training programs. Report all direct costs for staff, fringe benefits, supplies, equipment depreciation, related travel and contracted services. (Staff for these programs are reported on line 29a of Table 5.) Corporate administrative and facility costs should be included on Line 15 Column A and allocated in Column B. Programs are

asked to describe the program costs so the UDS editor can make sure that the classification of the program as an "other related program" in the “specify” field provided.

TOTAL ENABLING AND OTHER PROGRAM RELATED SERVICES (Line 13) — The sum of lines 11 + 12.

FACILITY AND ADMINISTRATIVE COSTS (Lines 14 - 16) — This includes all traditional overhead costs that are later allocated to other cost centers. Specifically:

FACILITY COSTS (Line 14) – Facility costs include rent or depreciation, interest payments, utilities, security, grounds keeping, facility maintenance, janitorial services, and all other related costs.

ADMINISTRATIVE COSTS (Line 15) – Administrative costs include the cost of all corporate administrative staff, billing and collections staff, medical records and intake staff, and the costs associated with them including, but not limited to, supplies, equipment depreciation, travel, etc. In addition, include other corporate costs (e.g., purchase of insurance, audits, legal fees, interest payments on non-facility loans, Board of Directors' costs, etc.) The cost of all patient support services (e.g., medical records and intake) should be included in Administrative Costs. Costs for contracted services such as audit, legal and grant writing are included on Line 15. Note that the "cost" of bad debts is **NOT** to be included in administrative costs or shown on this table in any way. Instead, the UDS reduces gross income by the amount of patient bad debt on table 9D.

NOTE: Some grant programs have limitations on the proportion of **grant funds** that may be used for administration. **Limits on administrative costs for those programs is not to be considered in completing lines 14 and 15.** The Administration and Facility categories for this report includes **all** administrative costs and personnel working in a UIHP-supported program, whether or not that cost was identified as administrative in any specific grant application.

TOTAL OVERHEAD (Line 16) – The sum of lines 14 + 15.
TOTAL ACCRUED COST (Line 17) – It is the sum of lines 4 + 10 +13 + 16

VALUE OF DONATED FACILITIES, SERVICES AND SUPPLIES (Line 18) - Include the total imputed value of all in-kind and donated services, facilities and supplies applicable to the reporting period that are within your scope of project, using the methodology discussed below. In-kind services and donations include all services (generally volunteers, but sometimes paid staff donated to the program by another organization), supplies, equipment, space, etc. that are necessary and prudent to the operation of your program that you do not pay for directly and which you included in your budget as donated. Line 18 reports the estimated reasonable acquisition cost of donated personnel, supplies, services, space rental, and depreciation for the use of donated facilities and equipment. The value of these services should not be included in the lines above.

The estimated reasonable acquisition cost should be calculated according to the cost that would be required to obtain similar services, supplies, equipment or facilities within the immediate area at the time of the donation. Donated pharmaceuticals, for example, would be shown at the price that would be paid under the federal drug pricing program, not the manufacturer's suggested retail price. Donated value should only be recognized when the intent of the donating parties is explicit and when the services, supplies, etc., are both prudent and necessary to the program's operation.

If the program is not paying NHSC for assignees, the full market value of NHSC Federal assignee(s), including "ready responders", should also be included in this category. NHSC-furnished equipment, including dental operatories, should be capitalized at the amount shown on the NHSC Equipment Inventory Document, and the appropriate depreciation expense should be shown in this category for the reporting period.

Programs are asked to describe the items included so the UDS editor can make sure that the classification of donated items is appropriate.

TOTAL WITH DONATIONS (LINE 19) – It is the sum of lines 17 and 18, Column C.

NOTE: Inasmuch as staff makes up 70 percent+ of the cost of most health centers, there is a direct relationship between the staffing included on Table 5 and expenses on Table 8A. Report as follows:

FTE's reported on Table 5, Line:	Have costs reported on Table 8A, Line:
1 – 12: Medical (physicians, mid-level providers, nurses)	1: Medical staff
13-14: Lab and X-ray	2: Lab and X-ray
16 – 18: Dental (e.g., dentists, dental hygienists, etc.)	5: Dental
20a – 20: Mental Health	6: Mental Health
21: Substance Abuse	7: Substance Abuse
22: Other Professional (e.g. nutritionists, podiatrists, etc.)	9: Other Professional
22a-22d: Vision Services (ophthalmologist, optometrist, optometric assistant	9: Other Professional
23: Pharmacy	8a: Pharmacy
24 – 28: Enabling (e.g., case management, outreach, eligibility, etc.)	11a – 11g: Enabling
29a: Other programs / services (e.g., non-health related services including WIC, job training, housing, child care, etc.)	12: Other related services
30a – 30c and 32: Administration and Patient Support (e.g., corporate, intake, medical records, billing, fiscal and IT staff)	15: Administration
31: Facility (e.g., janitorial staff, etc.)	14: Facility

CONVERSION FROM FISCAL TO CALENDAR YEAR

Programs whose cost allocation system permits them to provide accurate accrued cost data should use that system. Programs whose fiscal year does not correspond to the calendar year and whose accounting system is unable to provide accurate accrued cost data may calculate calendar year costs, using the following straight-line allocation methodology:

Step 1: Calculate the proportion of the calendar reporting period covered by the cost report and use that ratio to calculate the proportion of cost in each category attributable to the calendar year. Example: A program whose fiscal year ends March 31, 2010, allocates 25

percent of costs in each cost category to the 2010 calendar year.

Step 2: Using the trial balance for the end of December, determine the total cost for the remainder of the calendar year for each column. For example, a program whose fiscal year ends March 31, 2010 would use the nine-month trial balance for December 31. **(Note:** Programs who do not accrue depreciation monthly should adjust depreciation to an annual total.)

Step 3: Sum results of Steps 1 and 2 and enter the total in Column A.

QUESTIONS AND ANSWERS FOR TABLE 8A.

1. **Are the reporting requirements for the UDS different than for the UCRR?**
   The information reported on Table 8A corresponds with the UCRR Table 6 Costs by Service Group. Like the UCRR, the UDS reports on an accrual basis and reporting of personnel costs by service group on Table 8A should be consistent with the allocation of staff full-time equivalents on Table 5. While the service groups are similar, they are organized differently. Unlike the UCRR, the UDS reports total accrued costs for most service groups; total personnel salary and other costs are not reported separately except for medical services on Table 8A (Lines 1 and 3). The UDS does not provide worksheets to allocate overhead to service categories; recommended methods for allocation overhead to service categories are described in the manual and are similar to those used in reporting the UCRR.

2. **Are there any changes to this table?**
   No.

3. **Do we report the costs reimbursed to outside providers for paid referral visits on Table 8A?**
   Yes. Report all costs paid for services to outside providers on Table 8A in the category corresponding with the service. For example, paid referral costs for primary care services are reported on Line 1 and paid referral costs for mental health visits are reported on Line 6. Be sure to report these visits on Table 5 although no FTE will be reported for outside providers on Table 5.

4. **My auditor says that the cost of bad debts must be reflected in my financial statement as a cost. Where do I show it on Table 8A?**
   The UDS report does not follow all Financial Accounting Standards Board and Generally Accepted Accounting Principles accounting rules and this is one of those rules. Bad debt is not shown as a cost. Instead, it is shown (accounted for) on Table 9D where it is viewed by the UIHP as an adjustment to income.

5. **How are donated services accounted for?**
   If an individual comes to your UIHP and provides a service to your patients, you show both the FTE (on table 5) and the value, which is determined by "what a reasonable person would pay for" the time – *(not the service),* on Table 8A, Line 18. For example, if an optometrist sees five patients in a two hour period, the amount shown is what you would pay an optometrist for two hours of work, not the total charges for the five visits. *However,* if you refer a patient for a service to a provider outside of your site who donates these services *neither the charge nor the value of the time or service is reported on the UDS.* For example, if you refer a patient to the county hospital for a hip replacement which is provided to your patient at no cost to you or the patient, neither the time of the surgical team nor the UCR charge for the service is reported on the UDS. The same would be true of mammograms done at the County Health Department.

6. **How are donated drugs accounted for?**
   If drugs are donated directly to the UIHP which then dispenses them to a patient, the value of the drugs is *calculated at what a reasonable payor would pay for them* and is reported on Table 8A, Line 18. This is NOT the retail cost of the drug, it is the 340(b) price of the drug – an amount which is generally 40 – 60 percent of the average wholesale price (AWP). *Technically,* if the drug is donated directly to the patient, even though it may be sent to the UIHP, this is not a donation to the center and need not be accounted for or reported. But since we are

interested in knowing the total value of supplies provided to you *directly or indirectly,* programs are encouraged to include the value of such drugs on line 18 as well.

7. **We get most of our vaccines through the Vaccines For Children (VFC) program. Are these considered to be donated drugs and accounted for here?**
   Yes. The value of donated drugs that are used in the clinic, such as vaccines, should also be reported on Table 8A, Line 18, at the reasonable cost.

TABLE 8A – FINANCIAL COSTS

		Accrued Cost (A)	Allocation of Facility and Administration (B)	Total Cost After Allocation of Facility and Administration (C)
Financial Costs for Medical Care				
1.	Medical Staff			
2.	Lab and X-ray			
3.	Medical/Other Direct			
4.	**TOTAL MEDICAL CARE SERVICES** (Sum Lines 1 Through 3)			
Financial Costs for Other Clinical Services				
5.	Dental			
6.	Mental Health			
7.	Substance Abuse			
8a.	Pharmacy not including pharmaceuticals			
8b	Pharmaceuticals			
9.	Other Professional (specify: _____)			
10.	**TOTAL OTHER CLINICAL SERVICES** (Sum Lines 5 through 9)			
Financial Costs of Enabling and Other Program Related Services				
11a	Case Management			
11b	Transportation			
11c	Outreach			
11d	Patient and Community Education			
11e	Eligibility Assistance			
11 f	Interpretation Services			
11g	Other Enabling Services (specify: _____)			
11.	Total Enabling Services Cost (Sum lines 11a – 11g)			
12.	Other Related Services (specify: _____)			
13.	**TOTAL ENABLING AND OTHER SERVICES (Sum Lines 11 and 12)**			
Overhead and Totals				
14.	Facility			
15.	Administration			
16.	**TOTAL OVERHEAD** (Sum lines 14 and 15)			
17.	**TOTAL ACCRUED COSTS** (Sum Lines 4 + 10 + 13 + 16)			
18.	Value of Donated Facilities, Services and Supplies (specify: _____)			
19.	**TOTAL WITH DONATIONS** (Sum Lines 17 and 18)			

INSTRUCTIONS FOR TABLE 9D - PATIENT- RELATED REVENUE

Table 9D must be completed by all UIHPs who bill for patient services covered by the UDS. It is included only in the Universal Report. This table collects information on charges, collections, retroactive settlements, allowances, self-pay sliding discounts, and self-pay bad debt write-off.

ROWS: PAYOR CATEGORIES AND FORM OF PAYMENT

Five payor categories are listed: Medicaid, Medicare, Other Public, Private, and Self Pay. Except for Self Pay, each category has three sub-groupings: non-managed care, capitated managed care, and fee-for-service managed care.

MEDICAID - LINES 1 - 3. Programs should report as **"Medicaid"** all services billed to and paid for by Medicaid (Title XIX) regardless of whether they are paid directly or through a fiscal intermediary or an HMO. For example, in states with a capitated Medicaid program, where the program has a contract with a private plan like Blue Cross, the payor is Medicaid, even though the actual payment may have come from Blue Cross. Note that the childhood Early and Periodic Screening, Diagnosis and Treatment program which has various names in different states, is a part of Title XIX and is included in the numbers reported here — almost always on line 1. Note also that S-CHIP, which also has many different names in different states, is sometimes paid through Medicaid. If this is the case, it should be included in the numbers reported here. Also included here will be a portion of the charges for "cross-over" services that are reclassified to Medicaid after being initially submitted to Medicare

MEDICARE - LINES 4 - 6. Programs should report as **"Medicare"** all services billed to and paid for by Medicare (Title XVIII) regardless of whether they are paid directly or through a fiscal intermediary or an HMO. Specifically, for patients enrolled in a capitated Medicare program, where the program has a contract with a private plan like Blue Cross, the payor is Medicare, even though the actual payment may have come from Blue Cross. If a patient is covered by both Medicare and Medicaid, or by Medicare and a private payor, some portion of the charge will be reclassified to these other payment sources.

OTHER PUBLIC - LINES 7 - 9. Programs should report as **"Other Public"** all services billed to and paid for by State or local governments through programs *other than indigent care programs.* The most common of these would be S-CHIP, t*when it is paid for through commercial carriers.* (See above if S-CHIP is paid through Medicaid.) Other Public also includes family planning programs, BCCCP contracts with correctional facilities, and other dedicated state or local programs as well as state insurance plans, such as Washington's Basic Health Plan or Massachusetts' Commonwealth Plan. **Other Public does not include state or local indigent care programs.** Patients whose only payment source is one of these other public programs are reported as "uninsured" on Table 4. For reporting purposes, billings made to tribal entities are considered “other public” inasmuch as such entities are sovereign nations.

NOTE. Reporting on state or local indigent care programs that subsidize services rendered to the uninsured is as follows:

- Report all charges for these services and collections from patients as "self-pay" (line 13 of this table);
- Report all amounts not collected from the patients as sliding discounts or bad debt write-off, as appropriate, on line 13 of this table; and

- Report collections from the associated state and local indigent care programs on Table 9E. State/local indigent care programs are reported on a separate line (line 6a – "state/local indigent care programs") on that table.

Do not classify anything as an indigent care program without first reviewing this in a UDS Training Program or with the UDS editor or the UDS Help line.

PRIVATE- LINES 10 - 12. Programs should report as **"Private"** all services billed to and paid for by commercial or private insurance companies. Specifically, *do not* include any services that fall into one of the other categories. As noted above, charges etc. for Medicaid, Medicare and S-CHIP programs which use commercial programs as intermediaries are classified elsewhere. Private insurance *includes* insurance purchased for public employees or retirees such as Tricare, Trigon, the Federal Employees Insurance Program, Workers Compensation, etc. Private may also include contract payments from other organizations who engage the clinic on a fee-for-service or other reimbursement basis such as a Head Start program that pays for annual physical exams at a contracted rate or a school, jail or large company that pays for provision of medical care at a per-session or negotiated rate.

SELF PAY - LINE 13. Programs should report as **"Self Pay"** all services and charges where the responsible party is the patient, including charges for indigent care programs as discussed above. **NOTE: This includes the reclassified co-payments, deductibles, and charges for uncovered services for otherwise insured individuals which become the patient's personal responsibility as well as the charges associated with state and local indigent care programs discussed above.**

COLUMNS: CHARGES, PAYMENTS, AND ADJUSTMENTS RELATED TO SERVICES DELIVERED (REPORTED ON A CASH BASIS.)

FULL CHARGES THIS PERIOD (Column A) – Record in Column A the total charges for each payor source. This should always reflect the full charge (per the fee schedule) for services rendered to patients in that payor category. Charges should only be recorded for services that are billed to **AND** covered in whole or in part by a payor, the patient, or written off to sliding fee discounts. Full gross charges should always be reported and the difference between these and contracted payments are then adjusted as "contractual allowances" (see below.) Some patients have more than one source of payment for their services. In some instances, a charge will initially be made to one carrier, only to be denied or paid only in part. It will then be moved to the secondary payor.

> Example: Optometry charges should not be included in Medicare charges, since Medicare provides no coverage for these services. If a patient has both Medicare and Medicaid coverage, charges for optometry which might initially have been charged to Medicare, would then be moved and included in "Medicaid charges." If a patient has only Medicare coverage, charges for optometry would be moved and entered under "self-pay."

Charges that are generally not billable or covered by traditional third-party payors should not be included on this table. For example, a charge for parking or for job training would not normally be included. WIC services are not billable charges. Charges for transportation and similar enabling services would not generally be included in Column A, except where the payor (e.g., Medicaid) accepts billing and **pays** for these services.

Charges for eyeglasses, pharmaceuticals, durable medical equipment and dother similar supply items must be included. Charges for pharmaceuticals donated to the clinic or directly to a patient through the clinic should not be included since the clinic may not legally charge for these drugs. Charges for the dispensing of these pharmaceuticals, however, may be included.

Charges which are not accepted by a payor and which need to be reclassified (including deductibles and co-insurance) should be reversed as negative charges if your MIS system does not reclassify them automatically. Reclassifying these charges by utilizing an adjustment and rebilling to the proper category is an incorrect procedure since it will result in overstatement by including both charges and the adjustments.

NOTE: Under no circumstances should the actual amount paid by Medicaid or Medicare (such as FQHC rates) or the amount paid by any other payor be used as the actual charges. Charges *must* come from the program's CPT based fee schedule.

AMOUNT COLLECTED THIS PERIOD (Column B) — Record in Column B the amount of net receipts for the year on a cash basis, regardless of the period in which the paid for services were rendered. *This includes the FQHC reconciliations, managed care pool distributions and other payments recorded in the Columns C1, C2, C3,and/or C4.* Note: Charges and collections for deductibles and co-payments which are charged to and due from patients are recorded as "self pay" on Line 13.

RETROACTIVE SETTLEMENTS, RECEIPTS, OR PAYBACKS (Column C) — *IN ADDITION TO INCLUDING THEM IN COLUMN b***,** details on cash receipts or payments for FQHC reconciliation, managed care pool distributions, payments from managed care withholds, and paybacks to FQHC or HMOs are reported in Columns C1-C4.

COLLECTION OF RECONCILIATION/WRAP AROUND, CURRENT YEAR (Column C1l) Enter FQHC cash receipts from Medicare and Medicaid that cover services provided during the current reporting period.

COLLECTION OF RECONCILIATION/WRAP AROUND, PREVIOUS YEARS (Column C2) Enter FQHC cash receipts from Medicare and Medicaid that cover services provided during previous reporting periods.

COLLECTION OF OTHER RETROACTIVE PAYMENTS INCLUDING RISK POOL/INCENTIVE/WITHHOLD (Column C3) Enter other cash payments including managed care risk pool redistribution, incentives, and withholds, from any payor. These payments are only applicable to managed care plans

PENALTY/PAYBACK (Column C4) – Enter payments made to FQHC payors because of overpayments collected earlier. Also enter payments made to managed care plans (e.g., for over-utilization of the inpatient or specialty pool funds).

NOTE: If a program arranges to have their "repayment" deducted from their monthly payment checks, the amount deducted should be shown in Column (C4) *as if it had actually been paid.*

ALLOWANCES (Column D) – Allowances are granted as part of an agreement with a third-party payor. Medicare and Medicaid, for example, may have a maximum amount they pay, and

the center agrees to write off the difference between what they charge and what they receive. *Allowances must be reduced by the net amount of retroactive settlements and receipts reported in the Columns C1. C2, C3, C4, including current and prior year FQHC reconciliations, managed care pool distributions and other payments. This will often result in a negative number being reported as the allowance in Column D.*

If Medicaid, Medicare, other third-party, and other public payors reimburse less than the program's full charge, and the program cannot bill the patient for the remainder, enter the remainder or reduction on the appropriate payor line in Column d at the time the Explanation of Benefits (EOB) is received and the amount is written off.

> Example: The State Title XIX Agency has paid $40 for an office visit that was billed at a full charge of $75. The $75 should be reported on Line 1 Column A as a full charge to Medicaid. After payment was made, the $40 payment is recorded on Line 1 Column B. The $35 reduction is reported as a positive allowance (+$35) on Line 1 Column D.

Under FQHC, where the program is paid based on cost, it is possible that the cash payment will be greater than the charge. In this case, the adjustment recorded in Column D would be a negative adjustment. (Financial adjustments received under FQHC are reported in Columns C1 and C2.)

> Example: The State Title XIX Agency has paid program's negotiated FQHC rate of $113 for an office visit that was billed at a full charge of $75. The $75 should be reported on Line 1 Column A as a full charge to Medicaid. After payment was made, the $113 payment is recorded on Line 1 Column B. The $38 payment over the actual charge is reported as a negative allowance (-$38) on Line 1 Column D.

NOTE: Amounts for which another third party or a private individual can be billed (e.g., amounts due from patients or "Medigap" payors for co-payments) are not considered adjustments and should be recorded or reclassified as full charges due from the secondary source of payment. These amounts will only be classified as adjustments when all sources of payment have been exhausted and further collection is not anticipated and/or possible.

Because capitated plans typically pay on a per-member per-month basis only, and make this payment in the current month of enrollment, these plans typically don't carry any receivables. For Capitated Plans (lines 2a, 5a, 8a, and 11a, ONLY**)** the allowance column should be the arithmetic difference between the charge recorded in Column a and the collection in Column B unless there were early or late capitation payments (received in a month other than when they were earned) and which span the beginning or end of the calendar year.

> Also note that Line 13 Column D is blanked out because up-front allowances given to self-pay patients are recorded as sliding fee discounts and valid self-pay receivables that are not paid should be recorded as self pay bad debt.

SLIDING DISCOUNTS (Column E) – In this column, enter reductions to patient charges based on the patient's ability to pay, as determined by the program's sliding discount schedule. This would include discounts to required co-payments, as applicable.

> NOTE: Only self-pay patients may be granted a sliding discount based on their ability to pay. Column e is blanked out on all other lines. When a charge originally made to a third party such as Medicare or a private insurance company has a co-payment or deductible written

off, THE Charge must first be reclassified to self-pay. To reclassify, first reduce the third-party charge by the amount due from the patient and increase the self-pay charges by this same amount.

BAD DEBT WRITE OFF (Column f) – Any payor responsible for a bill may default on a payment due from it. In the UDS, only self pay bad debts are recorded**.** In order to keep responsible financial records, programs are required to write off bad debts on a routine basis. (It is recommended that this be done no less than annually.) In some systems this is accomplished by posting an allowance for bad debts rather than actually writing off specific named accounts. Amounts removed from the center's self-pay receivables through either (but not both) mechanism are recorded here.

Reductions of the net collectable amount for the Self-Pay category should be made on Line 13 Column F. Bad debt write off may occur due to the program's inability to locate persons, a patient's refusal to pay, or a patient's inability to pay even after the sliding fee discount is granted.

Under no circumstances are bad debts to be reclassified as sliding discounts, even if the write off to bad debt is occasioned by a patient's inability to pay the remaining amount due. For example, a patient eligible for a sliding discount is supposed to pay 50 percent of full charges for a visit. If the patient does not pay, even if he or she later qualifies for a 100 percent discount, the amount written off must still be reported as bad debt, not sliding discount. At the time of the visit, it was a valid collectable from the patient.

Only bad-debts from patients are recorded on this table. While some insurance companies do, in fact, default on legitimate debts as they go bankrupt, programs are not asked to report these data.

TOTAL PATIENT RELATED INCOME (Line 14) — Enter the sum of Lines 3, 6, 9, 12, and 13. Be sure to include only these "subtotal" lines and not the detail for each of the subtotals.

QUESTIONS AND ANSWERS FOR TABLE 9D

1. **Are the reporting requirements for the UDS different than for the UCRR?**
   The information reported on Table 9D corresponds with the UCRR Table 7 Accounts Receivable, Charges and Collections by Source of Funds. Like the UCRR, the UDS reports on a cash basis. Definitions for full charges, collections, and adjustments are the same for the UCRR and UDS. However, the UCRR permitted programs to use the FQHC negotiated rate as the full charge which is NOT permitted by the UDS. Programs should report full charges based on the fee schedule. FQHC reimbursement is reported in Columns C1 and C2. Bad debt is reported for self pay patients ONLY. The column is blanked out for all other payors. The categories for Sources of Funds are similar for the UCRR and UDS although the UDS reports non-managed care and managed care revenues separately. In addition, the UDS does not report accounts receivable at the beginning and end of the reporting period.

2. **Are there any changes to this table?**
   There are no changes to Table 9D for reporting year 2010. However, in reporting year 2010, as a result of the Children's Health Insurance Program Reauthorization Act (CHIPRA), which added requirements for managed care programs to reconcile payments to cost similar to FQHC for Medicaid, columns c1 and c2 will be opened up on lines 7, 8a, 8b and 9. These cells will be used for CHIPRA adjustments only.

3. **If we are an Outreach and Referral program and do not bill for medical services do we need to complete Table 9D?**
   No. Table 9D will be blank if you do not bill for medical services. However, if you bill for any services such as mental health or substance abuse services, you should report charges and revenues for these services on Table 9D.

4. **Are there any important issues to keep in mind for this table?**
   Payments received from state or local indigent care programs subsidizing services rendered to the uninsured are not reported on this table. **All** such payments, whether made on a per visit basis or as a lump sum for services rendered, shall be recorded on Table 9E, Line 6a. See Table 9E for specific instructions. Programs receiving payments from state/local indigent care programs that subsidize services rendered to the uninsured should:

   - Report all charges for these services and collections <u>from patients</u> as "self-pay" (Line 13);
   - Report all amounts not collected from the patient as sliding discounts or bad debt, as appropriate, on Line 13 of this table;
   - Report collections from the state/local indigent care programs on <u>Table 9E, Line 6a.</u>

5. **Are the data on this table cash or accrual based?**
   Table 9D is a 'cash' table in as much as all entries represent charges, collections, and adjustments recognized in the current year. All entries represent actual charges and adjustments for the calendar year and actual cash receipts for the year.

6. **Should the lines of the table "balance"?**
   No. Because the table is on a 'cash' basis, the columns for amount collected and for allowances will include payments and adjustments for services rendered in the prior year. Conversely, some of the charges for the current year will be remaining in accounts receivable at the end of the year. The one exception is on the capitated lines (lines 2a, 5a, 8a, and 11a) where allowances are the difference between charges and collections by definition, provided there are no early or late capitation payments that cross the calendar year change.

7. **If we have not received any reconciliation payments for the reporting period what do we show in Column c1 (current year reconciliations)?**
   If you have not received a check during this reporting period for current year services, enter zero (0) in Column C1.

8. **We regularly apply our sliding discount program to write off the deductible portion of the Medicare charge for our certified low-income patients. The sliding discount column (Column e) is blanked out for Medicare. How do we record this write off?**
   The amount of the deductible needs to be removed from the charge column of the Medicare line (Lines 4 - 6 as appropriate) and then added into the self-pay line (Line 13). It can then be written off on Line 13. The same process would be used for any other co-payment or deductible write-off.

9. **Our system does not automatically reclassify amounts due from other carriers or from the patient. Must we, for example, reclassify Medicare charges that become co-payments or Medicaid charges?**
   Yes – regardless of whether or not it is done automatically by your PMS the UDS report must reflect this reclassification of all charges that end up being the responsibility of a party other than the initial party.

Reporting Period: January 1, 2010 through December 31, 2010 OMB No. 0917-0007 Expiration Date: TBD

TABLE 9D (Part I of II) –PATIENT RELATED REVENUE (Scope of Project Only)

PAYOR CATEGORY		FULL CHARGES THIS PERIOD (A)	AMOUNT COLLECTED THIS PERIOD (B)	RETROACTIVE SETTLEMENTS, RECEIPTS, AND PAYBACKS (C)				ALLOWANCES (D)	SLIDING DISCOUNTS (E)	BAD DEBT WRITE OFF (F)
				COLLECTION OF RECONCILIATION/WRAP AROUND CURRENT YEAR (C1)	COLLECTION OF RECONCILIATION/ WRAP AROUND PREVIOUS YEARS (C2)	COLLECTION OF OTHER RETROACTIVE PAYMENTS INCLUDING RISK POOL/ INCENTIVE/ WITHHOLD (C3)	PENALTY/ PAYBACK (C4)			
1.	Medicaid Non-Managed Care									
2a.	Medicaid Managed Care (capitated)									
2b.	Medicaid Managed Care (fee-for-service)									
3.	**TOTAL MEDICAID** (LINES 1+ 2A + 2B)									
4.	Medicare Non-Managed Care									
5a.	Medicare Managed Care (capitated)									
5b.	Medicare Managed Care (fee-for-service)									
6.	**TOTAL MEDICARE** (LINES 4 + 5A+ 5B)									
7.	Other Public including Non-Medicaid CHIP (Non Managed Care)									
8a.	Other Public including Non-Medicaid CHIP (Managed Care Capitated)									

TABLE 9D (Part II of II) –PATIENT RELATED REVENUE (Scope of Project Only)

	Payor Category	Full Charges This Period (A)	Amount Collected This Period (B)	Retroactive Settlements, Receipts, and Paybacks (C)				Allowances (D)	Sliding Discounts (E)	Bad Debt Write Off (F)
				Collection of reconciliation/wrap around Current Year (C1)	Collection of Reconciliation/wrap around Previous Years (C2)	Collection of other retroactive payments including risk pool/ incentive/ withhold (C3)	Penalty/ Payback (C4)			
8b.	Other Public including Non-Medicaid CHIP (Managed Care fee-for-service)									
9.	**Total Other Public** (Lines 7+ 8a +8b)									
10.	Private Non-Managed Care									
11a.	Private Managed Care (capitated)									
11b.	Private Managed Care (fee-for-service)									
12.	**Total Private** (Lines 10 + 11a + 11b)									
13.	Self Pay									
14.	**TOTAL** (Lines 3 + 6 + 9 + 12 + 13)									

INSTRUCTIONS FOR TABLE 9E - OTHER REVENUE

Table 9E must be completed by all UIHPs covered by the UDS. It is included only in the Universal Report. This table collects information on cash receipts for the reporting period that supported activities described in the scope of project(s). Income received during the reporting period means cash receipts received during the calendar year for a Federally-approved project even if the revenue was accrued during the previous year or was received in advance and considered "unearned revenue" in the center's books on December 31.

The UDS uses the **"last party rule"** to report grant revenues. The "last party rule" means that GRANT AND CONTRACT FUNDS SHOULD ALWAYS BE REPORTED BASED ON THE ENTITY FROM WHICH THE PROGRAM RECEIVED THEM, REGARDLESS OF THEIR ORIGINAL ORIGIN. For example, funds awarded by the state for maternal and child health services usually include a mixture of Federal funds such as Title V and State funds. These should be reported as State grants because they are awarded by the state. Similarly, WIC funds are totally provided by the Federal Department of Agricultural, but are always passed through the State and, thus, are reported on Line 6 as State funds.

IHS FUNDING

LINES 1a THROUGH LINE 1d – Enter draw-downs during the reporting period for all IHS grants.

TOTAL IHS GRANTS/CONTRACTS (Line 1) — Enter the total of Lines 1a through 1d. The amounts shown on the IHS Grant Lines should reflect **direct funding** only. They should not include IHS funds passed through to you from another IHS program nor should they be reduced by money that you passed through to other centers.

OTHER FEDERAL GRANTS

RYAN WHITE Part C HIV EARLY INTERVENTION (Line 2) — Enter the amount of the Ryan White Part C funds drawn down in the reporting period. (NOTE: Ryan White Part A, Impacted Area, grants come from County or City governments and are reported on Line 7 (unless they are first sent to a third party in which case the funds are reported on Line 8). Part B grants come from the state and are reported on Line 6, unless they are first sent to a County or City government (in which case they are reported on Line 7) or to a third party (in which case the funds are reported on Line 8.) Special Projects of Regional and National Significance grants are generally direct Federal grants, and are reported on line 3.

OTHER FEDERAL GRANTS (Line 3) – Enter the amount and source of any other Federal grant revenue received during the reporting period which falls within the scope of the project(s). These grants include only those funds received directly by the center from the U.S. Treasury. Do not include Federal funds which are first received by a State or Local government or other agency and then passed on to the program such as WIC or Title II Ryan White funds. These are included below on Lines 6 through 8. Programs are asked to describe the programs so the UDS editor can make sure that the classification of the program as a federal grant is appropriate.

SECTION 329, 330 and 340 (PUBLIC HEALTH SERVICE ACT GRANTS (Line 4) – Enter

the amount of Section 329, 330 and 340 (Public Health Service Act) funds drawn down in the reporting period. The amounts shown on the BPHC Grant Lines should reflect direct funding only. They should not include BPHC funds passed through to you from another BPHC program nor should they be reduced by money that you passed through to other centers. Note again that American Recovery and Reinvestment Act of 2009 (ARRA) funds are *not* 330 funds are included only on line 4a.

ARRA IDS GRANT FUNDS. (Line 4a) – Enter the amount of American Recovery and Reinvestment Act (ARRA) Increased Demand for Services (IDS) grant funds drawn down in 2010. Note that ARRA grants were given for a multi-year period. It is not expected that the amount reported will equal the amount awarded. Please review your PMS 272 forms to determine the draw-down amount. *Please note:* ARRA grants for capital improvements (CIP) or for facility investment (FIP) will *not* be reported on Table 9E.

TOTAL OTHER FEDERAL GRANTS (Line 5) — Enter the total of Lines 2-4a .

NON-FEDERAL GRANTS OR CONTRACTS

STATE GOVERNMENT GRANTS AND CONTRACTS (Line 6) — Enter the amount of funds received under State government grants or contracts excluding Maternal and Child Care Block Grants and Women Infants and Children (WIC) Grants (these grants are reported on Line 6a). "Grants and Contracts" are defined as amounts received on a line item or other basis which are not tied to the delivery of services. They do NOT include funds from state/local indigent care programs. When a state or local grant or contract other than an indigent care program pays a program based on the amount of health care services provided or on a negotiated fee for service or fee per visit, the charges, collections and allowances are reported on Table 9D as "Other Public" services, not here on Table 9E. Programs are asked to describe the programs so the UDS editor can make sure that the classification of the program as a state grant is appropriate.

STATE/LOCAL INDIGENT CARE PROGRAMS (Line 6a) – Enter the amount of funds received from state/local indigent care programs that subsidize services rendered to the uninsured (examples include Massachusetts Free Care Pool, New Jersey Uncompensated Care Program, NY Public Goods Pool Funding, California Expanded Access to Primary Care Program, Tobacco Tax programs in Arizona and New Mexico, and the Colorado Indigent Care Program). The UIHPs are asked to describe the programs so the UDS editor can make sure that the classification of the program as a state/local indigent care program is appropriate. For reporting purposes, lump sum grants from tribal entities for patient care are considered “state and local indigent care programs” inasmuch as such entities are sovereign nations.

NOTE: Payments received from state or local indigent care programs subsidizing services rendered to the uninsured should be reported on Line 6a of this table whether or not the actual payment to the program is made on a per visit or visit basis or as a lump sum for services rendered. **Patients covered by these programs are reported as uninsured on Table 4 and all of** their charges, sliding discounts, and bad debt write-offs are reported on the self-pay line (line 13) on Table 9D. Monies collected from the patients covered by indigent programs should be reported on 9D. However, none of the funds reported on Line 6a of Table 9E are to be reported on Table 9D.

MATERNAL AND CHILD CARE BLOCK GRANTS AND WIC GRANTS (Line 6b) – Enter the amount of funds received for Maternal and Child Care Block Grants and WIC Grants.

LOCAL GOVERNMENT GRANTS AND CONTRACTS (Line 7) — This Information was formally reported on Line 7, has been reported separately on Lines 7a and 7b since calendar year 2009. See below.

CITY OR TOWN (LOCAL) GOVERNMENT GRANTS AND CONTRACTS (Line 7a) — Report the amount received from local city or town governments during the reporting period that covers costs included in the scope of the program's project(s). The UIHPs are asked to describe the programs so the UDS editor can make sure that the classification of the program as a local grant is appropriate.

COUNTY (LOCAL) GOVERNMENT GRANTS AND CONTRACTS (Line 7b) — Report the amount received from local county governments during the reporting period that covers costs included in the scope of the program's project(s). The UIHPs are asked to describe the programs so the UDS editor can make sure that the classification of the program as a local grant is appropriate.

FOUNDATION / **PRIVATE GRANTS AND CONTRACTS** (Line 8) – Report the amount received during the reporting period that covers costs included within the scope of the project(s). Include grants from Tribal Grants on Line 8. Funds which are transferred from another program or another community service provider are considered "private grants and contracts" and included on this line. The UIHPs are asked to describe the programs so the UDS editor can make sure that the classification of the program as a foundation/private grant is appropriate.

TOTAL NON-FEDERAL GRANTS AND CONTRACTS (Line 9) – Enter the total of Lines 6, 6a, 6b, 7, and 8.

OTHER REVENUE (Line 10) – Other Revenue refers to other receipts included in the federally approved scope of project that are not related to charge-based services. This may include fund-raising, interest income, rent from tenants, etc. Programs are asked to describe these sources so the UDS editor can make sure that the classification of the program as "other revenue" is appropriate. Do not enter the value of in-kind or other donations made to the program – these are shown only on Table 8A, line 18. Also, Do not show the proceeds of any loan received, either for operations or in the form of a mortgage.

TOTAL REVENUE (Line 11) – Enter the total of Lines 1, 5, 9, and 10 for total other revenues / income.

QUESTIONS AND ANSWERS FOR TABLE 9E

1. **Are the reporting requirements for the UDS different than for the UCRR?**
   The information reported on Table 9E was partially captured in the UCRR Table 8 Summary of Fiscal Year Income and Expenses. Unlike the UCRR Table 8, the UDS Table 9E Only reports non-patient related revenues and revenues are reported on a CASH basis.

2. **Are there any changes to this table since 2009?**
   No.

3. **Are there any important issues to keep in mind for this table?**
   This Table collects information on cash receipts for the reporting period that supported activities described in the scope of project. Only cash receipts received during the calendar year should be reported. In the case of a grant, this amount equals the cash amount received during the year not the full award amount unless the full award was paid during the year.

4. **How should indigent care funds be reported on the UDS?**
   Payments received from state or local indigent care programs subsidizing services rendered to the uninsured should be reported on Line 6a of Table 9E whether on not the actual payment to the program is made on a per visit or visit basis or as a lump sum for services rendered. Patients covered by these programs are reported as uninsured on Table 4 and all of their charges, sliding discounts, and bad debt write-offs are reported on the self-pay line (line 13) on Table 9D. Monies collected from the patients covered by indigent programs should be reported on 9D. However, none of the funds reported on Line 6a of Table 9E are to be reported on Table 9D. For reporting purposes, lump sum grants from tribal entities for patient care are considered “state and local indigent care programs” inasmuch as such entities are technically sovereign nations.

5. **How do we report grants received for non-health related activities such as food, training, housing programs?**
   If you report grant funds received for basic needs services, you must also report staffing and costs associated with these programs. Staff is reported on Table 5 Line 29a and Costs are reported on Table 8A Line 12. If you report grant funds but not the staff and associated costs for these programs, your UDS report will appear lopsided with revenues far exceeding program activity. If grant funds are not reported on Table 9E, corresponding staff and costs should be excluded from the UDS report, also.

TABLE 9E –OTHER REVENUES

SOURCE		AMOUNT (A)
IHS GRANTS (ENTER AMOUNT DRAWN DOWN - CONSISTENT WITH PMS-272)		
1a.	I.H.S. – Title V Contracts	
1b.	I.H.S. – Title V Grants (ASAP/HP-DP/MHealth/Immunization)	
1c.	I.H.S. – Diabetes Grant	
1d.	I.H.S. – Other Grants (specify:_____)	
1.	**TOTAL IHS GRANTS** (SUM LINES 1A + 1B + 1C + 1D)	
OTHER FEDERAL GRANTS		
2.	Ryan White Part C HIV Early Intervention	
3.	Other Federal Grants (specify:_____)	
4.	Section 330 Community Health Center	
4a	American Recovery and Reinvestment Act (ARRA) New Access Point (NAP) and Increased Demand for Services (IDS)	
4b	American Recovery and Reinvestment Act (ARRA) Capital Improvement Project (CIP) and Facility Investments Program (FIP)	
5.	**TOTAL OTHER FEDERAL GRANTS** (SUM LINES 2 – 4B)	
NON-FEDERAL GRANTS OR CONTRACTS		
6.	State Government Grants and Contracts (specify:_____)	
6a.	State/Local Indigent Care Programs (specify:_____)	
6b.	Maternal and Child Care Block Grants and WIC Grants	
7.	Local Government Grants and Contracts (reported on 7a and 7b)	
7a.	Local Government Grants and Contracts (City/Town) (specify:_____ ___)	
7b.	Local Government Grants and Contracts (County) (specify:_____ _)	
8.	Foundation/Private Grants and Contracts(specify:_____)	
9.	**TOTAL NON-FEDERAL GRANTS AND CONTRACTS** (SUM LINES 6 + 6A+ 6B+ 7+ 8)	
10.	Other Revenue (Non-patient related revenue not reported elsewhere) (specify:_____)	
11.	**TOTAL REVENUE** (LINES 1+5+9+10)	

APPENDIX A: LISTING OF PERSONNEL

(ALL Line numbers in the following table refer to Table 5)

PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NON-PROVIDER
PHYSICIANS		
• Family Practitioners (Line 1)	X	
• General Practitioners (Line 2)	X	
• Internists (Line 3)	X	
• Obstetrician/Gynecologists (Line 4)	X	
• Pediatrician (Line 5)	X	
OTHER SPECIALIST PHYSICIANS (Line 7)		
• Allergists	X	
• Cardiologists	X	
• Dermatologists	X	
• Ophthalmologists	X	
• Orthopedists	X	
• Surgeons	X	
• Urologists	X	
• Other Specialists And Sub-Specialists	X	
NURSE PRACTITIONERS (Line 9a)	X	
PHYSICIANS ASSISTANTS (Line 9b)	X	
CERTIFIED NURSE MIDWIVES (Line 10)	X	
NURSES (Line 11)		
• Clinical Nurse Specialists	X	
• Public Health Nurses	X	
• Home Health Nurses	X	
• Visiting Nurses	X	
• Registered Nurse	X	
• Licensed Practical Or Vocational Nurse	X	
OTHER MEDICAL PERSONNEL (Line 12)		
• Nurse Aide/Assistant (Certified And Uncertified)		X
• Clinic Aide/Medical Assistant (Certified And Uncertified Medical Technologists)		X
• Quality Assurance / EHR design staff		X
LABORATORY PERSONNEL (Line 13)		
• Pathologists		X
• Medical Technologists		X
• Laboratory Technicians		X
• Laboratory Assistants		X
• Phlebotomists		X
X-RAY PERSONNEL (Line 14)		
• Radiologists		X

PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NON-PROVIDER
• X-Ray Technologists		X
• X-Ray Technician		X
DENTISTS (Line 16)		
• General Practitioners	X	
• Oral Surgeons	X	
• Periodontists	X	
• Endodontists	X	
OTHER DENTAL		
• Dental Hygienists (Line 17)	X	
• Dental Assistant (Line 18)		X
• Dental Technician (Line 18)		X
• Dental Aide (Line 18)		X
MENTAL HEALTH (Line 20) & **SUBSTANCE ABUSE** (Line 21)		
• Psychiatrists (Line 20a)	X	
• Psychologists (Line 20a1)	X	
• Social Workers - Clinical (Line 20a2 or 21)	X	
• Social Workers - Psychiatric (Line 20b or 21)	X	
• Family Therapists (Line 20b or 21)	X	
• Nurses - Psychiatric And Mental Health (Line 20b)	X	
• Alcohol And Drug Abuse Counselors (Line 21)	X	
• Nurse Counselor (Line 20b)	X	
ALL OTHER PROFESSIONAL PERSONNEL (Line 22)		
• Audiologists	X	
• Acupuncturists	X	
• Chiropractors	X	
• Herbalists	X	
• Massage Therapists	X	
• Naturopaths	X	
• Occupational Therapists	X	
• Optometrists	X	
• Podiatrists	X	
• Physical Therapists	X	
• Respiratory Therapists	X	
• Speech Therapists / Pathologists	X	
• Traditional Healers	X	
• Nutritionists/Dietitians	X	
VISION SERVICES PERSONNEL (Line 22a-22d)		
• Ophthalmologists (line 22a)	X	

PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NON-PROVIDER
•Optometrists (line 22b)	X	
•Optometric Assistant (line 22c)		X
PHARMACY PERSONNEL (Line 23)		
• Pharmacist, Clinical Pharmacist		X
• Pharmacist Assistant		X
• Pharmacy Clerk		X
ENABLING SERVICES		
CASE MANAGERS (Line 24)		
•Case Managers	X	
• Care / Referral Coordinators	X	
•Social Workers	X	
•Public Health Nurses	X	
•Home Health Nurses	X	
•Visiting Nurses	X	
•Registered Nurses	X	
•Licensed Practical Nurses	X	
HEALTH EDUCATORS (Line 25)		
•Family Planning Counselors	X	
•Health Educators	X	
•Social Workers	X	
•Public Health Nurses	X	
•Home Health Nurses	X	
•Visiting Nurses	X	
•Registered Nurses	X	
•Licensed Practical Nurses	X	
OUTREACH WORKERS (Line 26)		X
PATIENT TRANSPORTATION WORKERS (Line 27)		
• Patient Transportation Coordinator		X
• Driver		X
E LIGIBLITY ASSISTANCE WORKERS (Line 27a)		
• Benefits Assistance Workers		X
• Eligibility Workers		X
• Registration Clerks		X
INTERPRETATION (Line 27b)		
• Interpreters		X
• Translators		X
OTHER ENABLING SERVICES PERSONNEL (LINE 28)		X

OTHER RELATED SERVICES STAFF (Line 29a)		
• WIC Workers		X
• Head Start Workers		X
• Housing Assistance Workers		X
• Child Care Workers		X
• Food Bank / Meal Delivery Workers		X
• Employment / Educational Counselors		X
MANAGEMENT AND SUPPORT STAFF (Line 30a)		
• Project Director		X
• Chief Executive Officer/ Executive Director		X
• Chief Financial Officer		X
• Chief Information Officer		X
• Chief Medical Officer		X
• Secretary		X
• Administrator		X
• Director of Planning And Evaluation		X
• Clerk Typist		X
• Personnel Director		X
• Receptionist		X
• Director of Marketing		X
• Marketing Representative		X
• Enrollment/Service Representative		X
FISCAL AND BILLING STAFF (Line 30b)		
• Finance Director		X
• Accountant		X
• Bookkeeper		X
• Billing Clerk		X
• Cashier		X
• Data Entry Clerk		X
IT STAFF (Line 30c)		
• Director of Data Processing		X
• Programmer		X
• IT Help Technician		X
• Data Entry Clerk		X

FACILITY (Line 31)		
• Janitor/Custodian		X
• Security Guard		X
• Groundskeeper		X
• Equipment Maintenance Personnel		X
• Housekeeping Personnel		X
PATIENT SERVICES SUPPORT STAFF (Line 32)		
• Medical And Dental Team Clerks		X
• Medical And Dental Team Secretaries		X
• Medical And Dental Appointment Clerks		X
• Medical And Dental Patient Records Clerks		X
• Patient Records Supervisor		X
• Patient Records Technician		X
• Patient Records Clerk		X
• Patient Records Transcriptionist		X
• Registration Clerk		X
• Appointments Clerk		X

APPENDIX B: SERVICE DEFINITIONS

(All line numbers in the following table refer to Table 2)

SERVICE CATEGORY	DEFINITIONS
PRIMARY MEDICAL CARE SERVICES	
General Primary Medical Care (Line 1)	Provision of basic preventive and curative medical services.
Diagnostic Laboratory (Technical Component) (Line 2)	Technical component of laboratory procedures. Does not include services of a physician to order or to analyze/interpret results from these procedures.
X-Ray Procedures (Technical Component) (Line 3)	Technical component of diagnostic X-ray procedures. Does not include services of a physician to order or to analyze/interpret results from these procedures.
Diagnostic Tests/Screenings (Professional Component) (Line 4)	Professional services to order and analyze/interpret results from diagnostic tests and screenings. Includes services of a physician to order or to analyze/interpret results from these procedures.
Emergency Medical Services (Line 5)	Provision of emergency services on a regular basis to meet life, limb or function-threatening conditions. Nearly all centers will provide EMS via referral arrangements.
Urgent Medical Care (Line 6)	Provision of medical care of an urgent or immediate nature on a routine or regular basis.
24-Hour Coverage (Line 7)	The availability of services on a 24-hour basis.
Family Planning Services (Contraceptive Management) (Line 8)	Provision of contraceptive/birth control or infertility treatment. Counseling and education by providers are included here; when provided by other staff, include under enabling services.
HIV Testing and counseling (Line 9)	Testing and counseling for HIV. Counseling and education by providers included here; when provided by other staff, include under enabling services.
Testing Blood Lead Levels (Line 10)	Testing to ensure that levels of lead in blood are below critical levels. Tests are generally conducted for at risk children.
Immunizations (Line 11)	Provision of the following preventive vaccines: Diphtheria, Pertussis, Tetanus, Measles, Mumps, Rubella, Poliovirus, Influenza virus, Hepatitis B, Hemophilus influenza B.
Following Hospitalized Patients (Line 12)	Visits to Urban Indian Health Program patients during hospitalizations.
OBSTETRICAL AND GYNECOLOGICAL CARE	
Gynecological Care (Line 13)	Gynecological services provided by a nurse, nurse practitioner, nurse midwife or physician, including annual pelvic exams and Pap tests, follow-up of abnormal findings, and diagnosis and treatment of sexually transmitted diseases/infections. This category does not include family planning services.
Obstetrical Care (Lines 14 through 20)	Provision of listed services (i.e., prenatal care, antepartum fetal assessment, ultrasound, genetic counseling and testing, amniocentesis, labor and delivery professional care, postpartum care) related to pregnancy, delivery and postpartum care.

Service Category	Definitions
Specialty medical care	
Directly observed TB therapy (Line 21)	Delivery of therapeutic TB medication under direct observation of center staff.
Respite Care (Line 22)	Recuperative or convalescent services used by homeless people with medical problems who are too ill to recover on the streets or in a shelter. It includes the provision of shelter and medical care with linkages to other health care services such as mental health, oral health, substance abuse treatment and social services.
Other specialty care (Line 23)	Services provided by medical professionals trained in any of the following specialty areas: Allergy; Dermatology; Gastroenterology; General Surgery; Neurology; Optometry/Ophthalmology; Otolaryngology; Pediatric Specialties; Anesthesiology.
Dental Care	
Dental Care (Lines 24 through 27)	Provision by a dentist or dental hygienist of the listed services: preventive, restorative, emergency, and rehabilitative.
Mental health/substance abuse services	
Mental Health Treatment/ Counseling (Lines 28 & 31) Developmental Screening (Line 29) 24-Hour Crisis Intervention/ Counseling (Line 30)	Mental health therapy, counseling, or other treatment provided by a mental health professional.
Substance Abuse Treatment/ Counseling (Lines 32 & 33)	Counseling and other medical and/or psychosocial treatment services provided to individuals with substance abuse (i.e., alcohol and/or other drug) problems. May include screening and diagnosis, detoxification, individual and group counseling, self-help support groups, alcohol and drug education, rehabilitation, remedial education and vocational training services, and aftercare.
Comprehensive Mental Health / Substance Abuse Screening. (Line 33a)	Comprehensive mental health / substance abuse screening is a tool used to identify individuals / clients / patients with emotional problems, mental illness, and /or addictive disorders who may desire or benefit from behavioral health and recovery services designed to promote mental health and wellness. The screening is conducted by or under the direction of the following licensed behavioral health providers: clinical or counseling psychologist, psychiatrist, clinical social worker, marriage/family therapist, psychiatric nurse specialist or professional counselor.
Other Professional Services	
Hearing Screening (Line 34)	Diagnostic services to identify potential hearing problems.
Nutrition Services Other Than WIC (Line 35)	Advice and consultation appropriate to individual nutrition needs.

SERVICE CATEGORY	DEFINITIONS
Occupational Or Vocational Therapy (Line 36)	Therapy designed to improve or maintain an individual's employment/career skills and involvement.
Physical Therapy (Line 37)	Assistance designed to improve or maintain an individual's physical capabilities.
Pharmacy (Line 38)	Dispensing of prescription drugs and other pharmaceutical products.
Pharmacy – Physician Dispensing (Line 39)	Operation of a dispensary at a clinic service delivery location where the clinicians are responsible for doing the actual dispensing of the drugs.
Vision Screening (Line 40)	Diagnostic services to identify potential vision problems.
Podiatry (Line 41)	Services provided by a medical professional licensed to diagnose and treat conditions affecting the human foot, ankle, and their governing and related structures, including the local manifestations of systemic conditions.
Optometry (Line 42)	Services provided by a medical professional licensed or certified to diagnose, treat and manage diseases and disorders of the visual system, the eye and associated structures as well as diagnosis of related systemic conditions.
Traditional Medicine (Line 42a)	Traditional American Indian/Alaska Native practices from shamanistic rituals to physiological interventions - drawing upon spiritual and non-biological forces in their application of healing arts.
ENABLING SERVICES	
Case Management (Line 43)	Client-centered service that links clients with health care and psychosocial services to ensure timely, coordinated access to medically appropriate levels of health and support services and continuity of care. Key activities include: 1)assessment of the client's needs and personal support systems; 2) development of a comprehensive, individualized service plan; 3)coordination of services required to implement the plan; client monitoring to assess the efficacy of the plan; and 4) periodic re-evaluation and adaptation of the plan as necessary.
Child Care (Line 44)	Assistance in caring for a patient’s young children during medical and other health care visits.
Discharge Planning (Line 45)	Services related to arranging an individual's discharge from the hospital (e.g., home health care).
Eligibility Assistance (Line 46)	Assistance in securing access to available health, social service, pharmacy and other assistance programs, including Medicaid, WIC, SSI, food stamps, TANF, and related assistance programs. Does not include eligibility assistance provided by program or government staff under arrangements for Out-stationed Eligibility Workers, as mandated by law; report the latter on line 51.
Environmental Health Risk Reduction (Line 47)	Includes the detection and alleviation of unhealthful conditions associated with water supplies, sewage treatment, solid waste disposal, rodent and parasitic infestation, field sanitation, housing, and other environmental factors related to health (e.g., lead paint abatement and pesticide management).

SERVICE CATEGORY	DEFINITIONS
Health Education (Line 48)	Personal assistance provided to promote knowledge regarding health and healthy behaviors, including knowledge concerning sexually transmitted diseases, family planning, prevention of fetal alcohol syndrome, smoking cessation, reduction in misuse of alcohol and drugs, improvement in physical fitness, control of stress, nutrition, and other topics. Included are services provided to the client's family and/or friends by non-licensed mental health staff which may include psychosocial, caregiver support, bereavement counseling, drop-in counseling, and other support groups activities.
Interpretation/Translation Services (Line 49)	Services to assist individuals with language/communication barriers in obtaining and understanding needed services.
Nursing Home and Assisted-Living Placement (Line 50)	Assistance in locating and obtaining nursing home and assisted-living placements.
Outreach (Line 51)	Case finding, education or other services to identify potential clients and/or facilitate access/referral of clients to services.
Transportation (Line 52)	Transportation, including tokens and vouchers, provided by the program for patients.
Out-stationed Eligibility Workers (line 53)	Provision of assistance to individuals to enable them to quality for Medicaid, under provisions of Federal law requiring Out-Stationed Eligibility Workers.
Home Visiting (Line 54)	Provision of services in the client's home. Not inclusive of services such as medical, home nursing, case management etc. which have their own categories.
Parenting Education (Line 55)	Individual or group sessions designed to enhance the child-rearing skills of parents/caregivers.
Special Education Program (Line 56)	Educational programs designed for children with a disability.
Other (Line 57)	This line provides the opportunity to identify an enabling service you are providing that is otherwise not listed. Please specify the service provided.
PREVENTIVE SERVICES RELATED TO TARGET CLINICAL AREAS	
Pap test (Line 58)	Microscopic examination of cells collected from the cervix to detect cancer, changes in cervix, or non-cancerous conditions such as infection or inflammation.
Fecal Occult Blood Test (Line 59	Test to check for small amounts of hidden blood in stool.
Sigmoidoscopy (Line 60)	An examination of the rectum and lower part of the colon through a tube which contains a light source and a camera lens.
Colonoscopy (Line 61)	An examination of the rectum and entire colon using a colonoscope. Procedure can be used to remove polyps or other abnormal tissue.
Mammograms (Line 62)	An x-ray of the breast.
Smoking Cessation Program (Line 63)	A clinical and public-health intervention program for smoking cessation which may involve identification of smokers, diagnosis of nicotine dependence, and self-help products and counseling.
Glycosylated Hemoglobin Measurement For People With	A test that assesses the average blood glucose level during several months.

SERVICE CATEGORY	DEFINITIONS
Diabetes (Line 64)	
Urinary Microalbumin Measurement For People With Diabetes (Line 65)	A laboratory procedure to detect very small quantities of protein in the urine indicating kidney damage.
Foot Exam For People With Diabetes (Line 66)	A foot examination using monofilaments to test for sensation from pressure that identifies those patients who have lost protective sensation in their feet.
Dilated Eye Exam For People With Diabetes (Line 67)	An examination in which the pupils are dilated in order to check for diabetic eye disease.
Blood Pressure Monitoring (Line 68)	Tracking blood pressure through regular measurement of blood pressure.
Weight Reduction Program (Line 69)	A program in which patients are taught to eat healthy foods, engage in exercise, and monitor caloric intake in order to lose weight and improve their health.
Blood Cholesterol Screening (Line 70)	A blood test that will detect the levels of cholesterol and triglycerides in the body in order to discover if there are abnormal or unhealthy levels of cholesterol in the blood.
Follow-up testing and related health care services for abnormal newborn bloodspot screening (Line 71)	Conducting additional newborn screening (using the bloodspot screening or other methods) to assess for common and/or serious health conditions of newborn infants.
OTHER SERVICES	
WIC Services (Line 72)	Nutrition and health counseling services provided through the Special Supplemental Food Program for Women, Infants and Children
Head Start (Line 73)	Comprehensive developmental services for low-income, preschool children less than 5 years of age
Food Banks / Delivered Meals (Line 74)	Provision of food or meals, not the finances to purchase food or meals.
Employment/ Educational Counseling (Line 75)	Counseling services to assist an individual in defining career/employment/educational interests, and in identifying employment opportunities and/or education options
Assistance in Obtaining Housing (Line 76)	Assistance in locating and obtaining suitable shelter, either temporary or permanent. May include locating costs, moving costs, and/or rent subsidies.

APPENDIX C: SPECIAL MULTI-TABLE SITUATIONS

Several conditions require special consideration in the UDS because they impact multiple tables which must then be reconciled to each other. Beginning with this first edition of the UDS manual, we will be presenting some of these special situations along with instructions on how to deal with them. In this edition, we deal with the following issues:

- Contracted care (specialty, dental, mental health, etc.) which is paid for by the reporting program
- Services provided by a volunteer provider
- Interns and Residents
- WIC
- In-house pharmacy or dispensary services for program's patients
- In-house pharmacy for community (i.e., for non-patients)
- Contract pharmacies
- Donated drugs
- Clinical dispensing of drugs
- Adult Day Health Care (ADHC)
- Medi-Medi cross-overs
- Certain grant supported clinical care programs (BCCCP, Title X, etc.)
- State or local safety net programs
- Workers Compensation
- Tricare, Trigon, Public Employees Insurance, etc.
- Contract sites
- S-CHIP
- Carved-out services
- Migrant voucher programs and other voucher programs
- Incarcerated patients

ISSUE	TABLES AFFECTED	TREATMENT
Contracted Care (Specialty, dental, mental health, etc.) *(Service must be paid for by program!)*	5	**Providers (Column A)** are counted if the contract is for a portion of an FTE (e.g., one day a week OB = 0.20 FTE). Providers are *not* counted if contract is for a service (e.g., $X per visit or $55 per RBRVU). **Visits (Column B)** are *always* counted, regardless of method of provider payment or location of service (program's site or contract provider's office.)
	6	Program receives visit form or equivalent from contract provider, counts primary diagnosis and/or services provided as applicable.
	8A	**Column A: Net Cost.** Cost of provider/service is reported on applicable line. **Column B: Overhead.** Program will generally use a lower "overhead rate" for off-site services.
	9D	**Charge (Column A)** is program's UCR charge if on-site; as contractor's UCR charge if off site. **Collection (Column B)** is the amount received by *either* program *or* contractor from first or third parties. **Allowance (Column D)** is amount disallowed by a third party for the charge (if on lines 1 – 12) **Sliding Discount (Column E)** is amount written off if the patient is uninsured (line 13). Calculated as UCR charge minus amount collected from patient, minus amount owed by patient as their share of payment.

Services provided by a volunteer provider *(Service <u>are not</u> paid for by program!)*	description	Volunteer staff (including AmeriCorps/HealthCorps, but not National Health Service Corps) who provide services on behalf of the program on a regularly scheduled basis where there is a basis for determining their hours can be included in the UDS report.
	5	**Providers (Column A)** are counted if the service is provided on site at programs clinic. Hours volunteered are used to calculate FTE as with any other part time provider , however because volunteers are not paid the denominator in the equation to calculate FTEs is the number of hours that a comparable *employee* spends performing their job. This means, most specifically, that a full time of 2080 hours (for example) will be reduced by vacation, sick leave, holidays and continuing education normally provided to employees. As a rule, the equation will be hours worked divided by a number somewhere around 1800. Providers *<u>are not counted</u>* if their services are provided at their own offices. **Visits (Column B)** are counted only if the service is provided at the site in the contractor's scope of service and under the program's control.
	6	Program counts primary diagnosis and/or services provided on site, as applicable.
	9D	If the provider is on-site, the charges for their services are treated exactly the same as for staff. Do not include charges for volunteer providers who are if off-site.
Interns and Residents	description	Health Centers often make use of individuals who are in training, referred to variously as interns or residents, depending on their field and their licensing. Medical Residents and some mental health interns are generally licensed practitioners who are training for a higher level of certification or licensing,

	Table 5	Column A: Residents are counted in the category of credentialing that the provider is *working toward*. Thus, a family practice resident is shown on line 1 as Family Physician, etc. Depending on the arrangement, FTEs may be calculated like any other employee (if they are being paid by the program) or like a volunteer (if they are *not* being paid). See volunteer providers, immediately above. Column B: Visits between a medical resident and a patient are recorded as visits *to that resident or intern. Under no circumstances are the visits credited to the supervisor of the resident of intern*. Visits of a *licensed* mental health provider will be counted on lines 20a, 20a1, 20a2 or 20b. if the provider is not licensed, they will be counted on line 20c.
	Table 8A	*If the intern or resident is paid by the program **or*** their cost is being paid through a contract which pays a third party for the interns or residents, the cost is shown in column a on the appropriate line (line 1 for medical, line 5 for dental, etc.) If the intern or resident *is not being paid by the program* and the program is not paying a third party, then the *value of the donated time* is reported on line 17. Be sure to describe the nature of the donation on the table at this line.
WIC	Cover Sheets	Do not list WIC-only sites on the cover pages.
	3A, 3B, 4	Clients whose only contact with the program is for WIC services and who do not receive another form of service counted on Table 5 from providers outside of the WIC program *are not counted as patients on any of these tables.* Do not count as patients because of health education or enabling services provided by WIC.
	5	**Staff (Column A)** are counted on line 29a. **Visits and patients (Columns B and C)** are *never* reported unless otherwise justified.

	8A	**Column A: Net costs.** Total cost of program reported on Line 12 in column a. **Column B: Overhead.** Since much of the administrative cost of the program will be included in the direct costs, it is presumed that overhead will be at a significantly lower rate.
	9D	Nothing associated with the WIC program is to be reported on this table.
	9E	Income for WIC programs, though originally federal, comes to programs from the State. Unless the program *is* a state government, the grant/contract funds received are reported on line 6b.
In-house pharmacy or dispensary services for program's patients [see below for other situations]. *(including only that part of pharmacy that is paid for by the program and dispensed by in-house staff.)*	5	**Column A: Staff.** Pharmacy staff are normally reported on line 23. To the extent that the pharmacy staff have an incidental responsibility to provide assistance in enrolling patients in Pharmaceutical Assistance Programs, they are included on line 23. Staff (generally not including pharmacists) who spend a readily identifiable portion of their time with PAP programs should be counted on line 27a, Eligibility Assistance. **Column B: Visits.** The UDS does not require the counting or reporting of visits with pharmacy whether it is for filling prescriptions or associated education or other patient / provider support.
	8A	**Line 8b, Column A: Pharmaceutical Direct Costs.** The actual cost of drugs purchased by the pharmacy is placed on line 8b. (The value of donated drugs (generally calculated at 340(b) rates) is reported on line 18 in column c.) **Line 8a, column A: Other Pharmacy Direct Costs.** All other operating costs of the pharmacy are shown on line 8a. Include salaries, benefits, pharmacy computers, supplies, etc. **Line 11, column A: Enabling Direct Costs.** Show the staff and other costs of staff (full- time, part-time or allocated time) spent assisting patients to become eligible for PAPs. **Column B: Facility and Administration.** All overhead costs associated with line 8a and 8b are reported on line 8a. While there may be some overhead cost associated with the actual purchase of the drugs, these costs are generally minimal when compared to the total cost of the drugs. **Column C, Line 18:** Show the value of donated drugs here *only.*

	9D	**Charge (Column A)** is program's full retail charge for the drugs dispensed. **Collection (Column B)** is the amount received from patients or insurance companies. **Allowance (Column D)** is amount disallowed by a third party for the charge (if on lines 1 – 12) **Sliding Discount (Column E)** is amount written off if the patient is uninsured (line 13). Calculated as retail charge minus amount collected from patient, minus amount owed by patient as their share of payment.
	9E	The value of donated drugs is ***not*** reported on this table – it is reported on Table 8A. (See above)
In-house pharmacy for community (i.e., for non-patients)	description	Many UIHP's which own licensed pharmacies which also provide services to members of the community at large who are *not* UIHP patients. Careful records are required to be kept at these pharmacies to ensure that drugs purchased under section 340(b) provisions are not dispensed to patients. Some of these pharmacies are totally in-scope, while others have their "public" portion out of scope. If the public aspect is "out of scope", none of its activities are reported on the UDS. If it is in scope, the public portion should be considered an "other activity" and treated as follows:
	5	**Column A: Staff.** Report allocated public portion of staff on line 29a: Other Programs and Services.
	8A	Report all related costs, including cost of pharmaceuticals, on line 12: Other Related Services.
	9E	Report all income from public pharmacy on line 10: Other, and specify that it is from "Public Pharmacy."
Contract	5	No staff, visits or patients are reported. PAP staff all go to enabling services.

Pharmacy **Dispensing to clinic patients, generally using 340(b) purchased drugs**	8A	If the pharmacy is charging one amount for "managing" the program and/or an amount for "dispensing" the drugs; and another amount for the drugs themselves, the former charge is reported on line 8a, the latter on line 8b. If the UIHP is purchasing the drugs directly [because of 340(b) regulations] the amount it spends on purchasing goes on line 8b, and any administrative or dispensing costs charged by the pharmacy go on line 8a. If the pharmacy is reporting a flat amount for services including both pharmaceuticals and their services, *and there is no reasonable way to separate the amounts* report all costs on line 8b. Associated administrative costs will go on line 8a in column B, even though line 8a column A is blank. If prepackaged drugs are being purchased, *and there is no reasonable way to separate the pharmaceutical costs from the dispensing / administrative costs* report all costs on line 8b. Associated administrative costs will go on line 8a in column B, even though line 8a column A is blank.
	9D	**Charge (Column A)** is program's full retail charge for the drugs dispensed or the amount charged by the pharmacy / pre-packager if retail is not known. **Collection (Column B)** is the amount received from patients or insurance companies or, under certain circumstances, the pharmacy. (Note: most UIHP's have this arrangement only for their uninsured patients.) **Allowance (Column D)** is amount disallowed by a third party for the charge (if on lines 1 – 12) **Sliding Discount (Column E)** is amount written off if the patient is uninsured (line 13). Calculated as retail charge (or pharmacy charge) minus amount collected from patient (by pharmacy or UIHP), minus amount owed by patient as their share of payment.
	9E	No income would be reported on Table 9E.
Donated Drugs	8A	*If the drugs are donated to the UIHP and then dispensed to patients* show their value [generally calculated at 340(b) rates] on line 18, column C. *If the drugs are donated directly to the patient* no accounting for the value of the drugs is made in the UDS, even if the UIHP receives and holds the drugs for the patient.
	9D	If a dispensing fee is charged to the patient, show this amount (only) and its collection / write-off.

	9E	Do not show any amount, even though GAAP might suggest another treatment for the value.
Clinical dispensing of drugs	description	Many pharmaceuticals, ranging from vaccines to allergy shots to family planning shots or pills, are dispensed in the clinic area of the UIHP. This dispensing is considered to be a service attendant to the visit where it was ordered or, in the case of vaccinations, to be a community service. In most instances it is appropriate to charge for these services, though they are not considered to be visits.
	3A/3B/4	If this is the only service the individual has received during the year, they are not counted as patients.
	5	These services are not counted as separate visits.
	6	Because these are not visits, they are not counted on Table 6.
	8A	Costs are reported on line 8b – pharmaceuticals. In the case of vaccines obtained at no cost through the Vaccines For Children program, the value may be reported on line 18 – donated services and supplies.
	9D	Full charges, collections, allowances and discounts are reported as appropriate. Note that it is *not appropriate* to charge for a pharmaceutical that has been donated, though an administration and/or dispensing fee *is* appropriate. Note that Medicare has separate flu vaccine rules.
	9E	Do not show any amount, even though GAAP might suggest another treatment for the value.
Adult Day Health Care (ADHC)	description	ADHC programs are recognized by Medicare, Medicaid and certain other third party payors. They involve caring for an infirm, frail elderly patient during the day to permit family members to work, and to avoid the institutionalization of and preserve the health of the patient. They are quite expensive and may involve extraordinary PMPM capitation payments, though are thought to be cost effective compared to institutionalization. If patients are covered by both Medicare and Medicaid treat as in Medi-Medi, below.

	5	When a provider does a formal, separately billable, examination of a patient at the ADHC facility, it is treated as any other medical visit. The nursing, observation, monitoring, and dispensing of medication services which are bundled together to form an ADHC service are *not* counted as a visit for the purposes of reporting on this table.
	9D	ADHC charges and collections are reported. Because of Medicaid FQHC procedures it is possible that there will also be significant positive or negative allowances. See also Medi-Medi below.
Medi-Medi Cross-Over	description	Some individuals are eligible for both Medicare and Medicaid coverage. In this case, Medicare is primary and billed first. After Medicare pays its (usually FQHC) fee, the remainder is billed to Medicaid which pays the difference between its FQHC rate and what Medicare paid.
	4	Patients are reported on line 9, Medicare. *Do not* report as Medicaid!
	9D	While initially the entire charge shows as a Medicare charge, after Medicare makes its payment, the remaining amount is re-classified to Medicaid. This means that *eventually* the charges and collections will be the same, though for any given twelve month period the cash positions will probably not net out. In most cases a large portion of the total charge will transfer to Medicaid where it will be received and/or written off as an allowance.
Certain grant supported clinical care programs: BCCCP, Title X, , etc. (These are fee-for service or fee-per-visit programs only.)	description	Some programs pay providers on a fee-for-service or fee-per visit basis under a contract which may or may not also have a cap on total payments per year. They cover a very narrow range of services. Breast and Cervical Cancer Control and Family Planning programs are the most common, but there are others.
	4	These are *not* insurance programs. They pay for a service, but the patient is to be classified according to their primary health insurance carrier. Most of these programs do not serve insured patients, so most of the patients are reported on line 7 as uninsured.
	9D	While the patient is uninsured, there *is* an “other public” payor for the service. The clinic’s usual and customary charge for the service is reported on line 7 in column A, and the payment is reported in column B. Since the payment will almost always be different than the charge, the difference is shown as an allowance in column D.

	9E	The grant or contract *is not shown on Table 9E.* It is fully accounted for on Table 9D.
State or local safety net programs	description	These are programs which pay for a wide range of clinical services for uninsured patients, generally those under some income limit set by the program. They may pay based on a negotiated fee-for-service, or fee-per-visit. They may also pay "cents on the dollar" based on a cost report, in which case they are generally referred to as an "uncompensated care" program.
	4	While patients may need to qualify for eligibility, these programs are not considered to be public insurance. Patients served are almost always to be counted on line 7 as uninsured.
	9D	The charges are to be considered charges directly to the patient (reported on line 13, column A). If the patient pays any co-payment, it is reported in column B. If they are responsible for a co-payment but do not pay it, it remains a receivable until it collected or is written off as a bad-debt in column f. All the rest of the charge (or all of the charge if there is no co-payment) is reported as a sliding discount in Column E.
	9E	The total amount received during the calendar year is reported on line 6a.
Workers Compensation	4	Workers Compensation is a form of *liability insurance for employers*, not a *health insurance for employees*. Patient's whose bills are being paid by Workers Compensation should have a related insurance that is what is reported on Table 4 (even if it is not being billed or cannot be billed by the UIHP.) In general, if they had an employer paid / work-place based health insurance plan they would be reported on line 11. If they do not have *any* health insurance, they are reported on line 7.
	9D	Charges, collections and allowances for Workers Compensation covered services are reported on line 10.
Tricare, Trigon, Veterans Administration, Public Employees Insurance, etc.	4	While there are many individuals whose insurance premium is paid for by a government, ranging from military and dependents to school teachers to congressmen and HRSA staff, these are all considered to be private insurances. They are reported on line 11, *not on line 10a.*

	9D	Charges, collections and allowances are reported on lines 10 – 12, *not on lines 7 – 9.*
Contract sites *(In-scope sites in schools, workplaces, jails, etc.)*	description	Some UIHP's have included in their scope of service a site in a school a workplace, a jail, or some other location where they are contracted to provide services to (students / employees / inmates / etc.) at a flat rate per session or other similar rate *which is not based on the volume of work performed.* The agreement generally stipulates whether and under what circumstances the clinic may bill third parties.
	4	**Lines 1-6 – income:** In general, income should be obtained from the patients. In prisons, it may be assumed that all are below poverty (line 1). In schools, income should be that of the parent or unknown or, in the case of minor consent services, below poverty. In the workplace, income is the patient's family income or, if not known, "unknown" (Line 5). **Lines 7-12 – insurance:** Record the actual form of insurance the patient has. Do not consider the agency with whom the clinic is contracted to be an insurer. (Schools and jails are not "other public" insurance.)
	5	Count all visits as appropriate. Do not reduce or reclassify FTEs for travel time.
	8A	Costs will generally be considered as medical (lines 1-3) unless other services (mental health, case management, etc) are being provided. *Do not report on line 12—"other related services"*
	9D	*Unless the visit is being charged to a third party such as Medicaid* the clinic's usual and customary charges will appear on line 10, column A. The amount paid by the contractor is shown in column B. The difference (positive or negative) is reported in column D.
	9E	*Contract revenue is not reported on Table 9E.*

S-CHIP	4	**Medicaid:** If S-CHIP is handled through Medicaid and the enrollees are identifiable, they are reported on line 8b. *If it is not possible to differentiate S-CHIP from regular Medicaid,* the enrollees are reported on line 8a with all other Medicaid patients. **Non-Medicaid:** S-CHIP enrollees in states which do not use Medicaid are reported as "Other Public S-CHIP" on line 10b. Note that, even if the plan is administered through a commercial insurance plan, the enrollees are *not reported on line 11.* *For information about the type of S-CHIP Program in your state:* *http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=compare&category=Medicaid+%26+SCHIP&subcategory=SCHIP&topic=SCHIP+Program+Type*
	9D	**Medicaid:** Report on lines 1 – 3 as appropriate. **Non-Medicaid:** Report on lines 7 – 9 as appropriate. *Do not report on lines 10 – 12 even if the plan is administered by a commercial insurance company.*
Carve-outs	description	**Relevant to capitated managed care only.** Program has a capitated contract with an HMO which stipulates that one set of CPT codes will be covered by the capitation regardless of how often the service is accessed, and another set of codes which the HMO will pay for on a fee-for-service basis whenever it is appropriate. Most common carve-outs involve lab, radiology and pharmacy, but specific specialty care or diagnoses (e.g., perinatal care) may also be carved out.
	9D	**Lines 2a/b, 5a/b, 8a/b, 11a/b.** Capitation payments are reported on the "a" lines, carve out payments are reported on the "b" lines.
Incarcerated Patients	description	Some programs contract with jails and prisons to provide health services to inmates. These arrangements can vary in terms of the contractual arrangement and location for providing health services to patients.
	4	Income must be verified or reported as unknown. Individuals receiving health services under this contract is not considered to have insurance. The patient must be classified according to their primary health insurance carrier regardless of whether the services will be billed to the insurer.

	9D	The patient's services are reimbursed by the jail/prison. For purposes of reporting, there *is* an "other public" payor for the service. The clinic's usual and customary charge for the service is reported on line 7 in column A, and the payment is reported in column B. Since the payment will almost always be different than the charge, the difference is shown as an allowance in column D.
	9E	The grant or contract *is not shown on Table 9E.* It is fully accounted for on Table 9D.