Bureau of Primary Health Care

Uniform Data System Reporting Instructions for 2020 Health Center Data

Letter from the Associate Administrator

Dear Health Center Program Participant:

The Health Resources and Services Administration's (HRSA) Health Center Program has continued to thrive for over 50 years because of your dedication and efforts to deliver primary health care services to underserved and vulnerable populations. More than 28 million people received high-quality, affordable, cost-effective health care from community-based and patient-directed health centers. Over 92 percent of health centers met or exceeded at least one or more Healthy People 2020 goals, and over half (52 percent) of health centers delivered more cost-effective care compared to national benchmarks.

With nearly 1,400 health centers and over 12,000 delivery sites in the U.S., the District of Columbia, Puerto Rico, the Virgin Islands, and the Pacific Basin, collectively, your work and dedication to the communities you serve reaches far and wide. Health centers are making a significant impact on the nation's health as you deliver care to our most vulnerable populations, including 1 in 3 families living in poverty, 1 in 5 rural residents, and 1 in 9 children in the country, nearly 1.4 million people experiencing homelessness, 4.5 million patients served at health center sites that are in or immediately accessible to public housing, almost 1 million agricultural workers, and more than 385,000 veterans.

Through new and ongoing investments, an increasing number of health centers are able to deliver comprehensive health care services, including oral health, mental health, and substance use disorder services. Advances in the adoption and utilization of health information technology have increased access through telehealth, promoting the interoperability of health information, and improving the quality of care across the nation.

The data we receive through the Uniform Data System (UDS) is vital to further expand access, address health disparities, improve quality, and reduce the costs of health care. We have updated the 2020 UDS Manual in response to your input at trainings, conferences, and conversations with me and my staff. The Manual aligns with national measures and reporting standards and includes new appendices to capture the changing landscape of health care data collection, as outlined in the Program Assistance Letter 2019-05. The UDS' clinical quality measures have been revised to align with the Centers for Medicare & Medicaid Services electronic-specified Clinical Quality Measures (eCQMs), capture more detail on depression, HIV, and breast cancer, and this year we will collect information on social determinants of health and Prescription Drug Monitoring Programs.

We continue to modernize the UDS reporting process to increase data standardization across national programs, reduce reporting burden, increase data quality, and expand data use to improve clinical care and operations to benefit you and the patients you serve. Your insights are critical to further advance the Health Center Program, and I encourage you to continue providing feedback.

I would like to extend my gratitude once again for your commitment to underserved communities and vulnerable populations across our country through the Health Center Program.

Sincerely,

James Macrae
Associate Administrator, Bureau of Primary Health Care

Uniform Data System Reporting Instructions

For Calendar Year 2020 UDS Data

For help contact: 866-837-4357 (866-UDS-HELP) or udshelp330@bphcdata.net

Health Resources and Services Administration

Bureau of Primary Health Care

5600 Fishers Lane, Rockville, Maryland 20857

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PUBLIC BURDEN STATEMENT
An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0193. Public reporting burden for this collection of information is estimated to average [169] hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland, 20857.

DISCLAIMER
"This publication lists non-federal resources to provide additional information to consumers. Neither the U.S. Department of Health and Human Services (HHS) or the Health Resources and Services Administration (HRSA) has formally approved the non-federal resources in this manual. Listing these is not an endorsement by HHS or HRSA."

Introduction

This manual describes the annual Uniform Data System (UDS) reporting requirements for all health centers that receive federal award funds ("awardees") under the Health Center Program authorized by section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b) ("section 330"), as amended (including sections 330(e), (g), (h), and (i)), as well as for health centers considered Health Center Program look-alikes. Look-alikes do not receive federal funding under section 330 of the PHS Act but meet the Health Center Program requirements for designation under the program (42 U.S.C. 1395x(aa)(4)(A)(ii) and 42 U.S.C. 1396d(l)(2)(B)(ii)). Certain health centers funded under the Health Resources and Services Administration's (HRSA) Bureau of Health Workforce (BHW) are also required to complete the UDS.

These instructions detail the submission of required data and highlight changes to the tables that have been implemented for the current year. The approved UDS Changes for Calendar Year 2020 Program Assistance Letter (PAL) 2019-05 provides an overview of changes that apply to the calendar year 2020 UDS report due February 15, 2021. In addition to detailed table instructions, frequently asked questions (FAQs) are included in Appendix B1. Nine appendices are included that provide the following:

- A list of personnel by category and identification of personnel by job title who may be able to produce countable "visits" for the UDS;

- FAQs by table;

- Information addressing specific issues that affect multiple tables;

- Sampling methods for selecting patient charts for clinical reviews;

- Reporting instructions for the Health Information Technology (HIT) Capabilities Form;

- Reporting instructions for the Other Data Elements Form;

- Reporting instructions for the Workforce Form;

- A list of resources to assist health centers, including links to electronic clinical quality measures (eCQMs); and

- A glossary of terms.

About the UDS

The UDS is a standard data set that is reported annually and provides consistent information about health centers. This core set of information includes patient demographics, services provided, clinical processes and health outcomes, patients' use of services, costs, and revenues. It is the source of unduplicated data for the entire scope of services included in the grant or designation for the reporting year. If the health center brings services or sites into scope during the calendar year, data must be included for the full year, not just for the period after the date of the scope change.

HRSA routinely reports these data and related analyses, making them

available to health centers in HRSA's Electronic Handbooks (EHBs) and to the public through HRSA's Bureau of Primary Health Care (BPHC) website.

Several health centers may have "dual status," whereby the organization is both a federal awardee under section and a BHW awardee. These sites' scopes of project may overlap.

These health centers will complete both an awardee UDS Report and a BHW UDS Report), covering the approved scope of each separately. Health centers should not use section 330 grant funds for sites and services included in the BHW scope of project. However, health centers may allocate some costs—especially of corporate executives and other non-clinical support staff, their space, etc.—across the two reports. Patients who receive services at both 330 awardee and BHW) sites may appear in both reports.

Note: In this document, unless otherwise noted, the term "health center" refers to organizations that receive grants under the Health Center Program as authorized under section 330 of the Public Health Service Act, look-alike organizations that are recognized by BPHC as meeting all the Health Center Program requirements but do not receive Health Center Program grants, and primary care clinics funded under the BHW that receive funding through other HRSA programs.

General Instructions

What to Submit

The UDS includes 11 tables and three forms (in the appendices) designed to yield consistent demographic, clinical, operational, and financial data. As a requirement to participate in the Health Center Program, health centers must complete the following:

- ZIP Codes: Patients served reported by ZIP code and by primary third-party medical insurance source, if any.

- Table 3A: Patients by age and by sex assigned at birth.

- Table 3B: Patients by race, Hispanic/Latino ethnicity, language barriers, sexual orientation, and gender identity.

- Table 4: Patients by income (as measured by percentage of the federal poverty guidelines [FPG]) and primary third-party medical insurance source; the number of "special population" patients receiving services; and managed care enrollment, if any.

- Table 5: The annualized full-time equivalent (FTE) of program staff by position category; visits by provider type; patients by service type; and mental health and substance use disorder selected services detail.

- Table 6A: Visits and patients for selected medical, mental health, substance use disorder, vision, and dental diagnoses and services.

- Table 6B: Clinical quality-of-care measures.

- Table 7: Health outcome measures by race and ethnicity.

- Table 8A: Direct and indirect expenses by service categories.

- Table 9D: Full charges, collections, and allowances by payer type; sliding fee discounts; and bad debt write-offs for patients.

- Table 9E: Other, non-patient service income.

- Appendix D: Health Information Technology (HIT) Capabilities Form: HIT capabilities, including the use of electronic health record (EHR) information.

- Appendix E: Other Data Elements Form: Medication-assisted treatment (MAT), telehealth, and outreach and enrollment assists.

- Appendix F: Workforce Form: Health center workforce training and provider and staff satisfaction surveys.

Note: *Look-alikes and BHW primary care clinics are to follow the same reporting requirements provided in this manual for Health Center Program-funded awardees. Sometimes, the reporting cell details for special populations and receipt of a BPHC grant will be visible, but gray areas will show where look-alikes and BHW primary care clinics do not enter data.*

What to File

The UDS includes two parts that health centers submit through the EHBs:

- All health centers use the Universal Report, which consists of the UDS tables, the HIT Form, the Other Data

Elements Form, and the Workforce Form.

- Health Center Program awardees that receive section 330 grants under multiple program funding authorities (Community Health Center (330(e)) program, Migrant Health Center (MHC) (330(g)) program, Health Care for the Homeless (HCH) (330(h)) program, and/or Public Housing Primary Care (PHPC) (330(i))) also complete Grant Reports. The Grant Reports provide data comparable to the Universal Report for Tables 3A, 3B, 4, 6A, and part of Table 5, but for only that portion of the program that falls within the scope of a project funded under a particular funding authority. Awardees **do not** file a Grant Report for the scope of project supported under the Community Health Center (CHC) (330(e)) program.

- The Universal Report is an unduplicated count of all patients served by the health center regardless of funding source; the Grant Report is a subset of patients reported on the Universal Report served under a special population funding authority. Thus, no cell in a Grant Report may have a number larger than the same cell in the Universal Report.

- Report all the data for any patient who receives services under *sections 330(g), (h), or (i)* funding authority in the proper Grant Report. Include services provided to these patients, regardless of the funding source. For example, if patients experiencing homelessness receive medical services in the homeless medical van, and all dental services at the clinic, their dental services

and diagnoses would be reported on the Homeless Grant Report Tables 5 and 6A regardless of the dental funding source.

In summary, health centers that receive funds under only one BPHC funding authority complete the Universal Report and no Grant Reports. Health centers funded through multiple BPHC funding authorities complete a Universal Report for the combined projects and a separate Grant Report for activity covered by their MHC, HCH, and/or PHPC program grant.

Examples include the following:

- A CHC awardee (section 330(e)) that also has HCH funding (section 330(h)) completes a Universal Report and a Grant Report for the HCH program, but does not complete a Grant Report for the CHC funding.

- A CHC awardee (section 330(e)) that also has MHC (section 330(g)) and HCH (section 330(h)) funding completes a Universal Report, a Grant Report for the HCH program, and a Grant Report for the MHC program.

- An HCH awardee (section 330(h)) that also receives PHPC (section 330(i)) funding completes a Universal Report and two Grant Reports—one for the HCH program and one for the PHPC program.

- An HCH awardee (section 330(h)) that receives no other Health Center Program funding will file a Universal Report and will not file a Grant Report.

*Note: The EHBs reporting system will automatically identify the required reports and the required sections within reports. Please contact the **UDS Support Center at 866-UDS-HELP or udshelp330@bphcdata.net** if there appear to be errors.*

Tables Shown in Each Report

The table below shows which tables and data appear in the Universal Report and Grant Reports.

Table	Data Reported	Universal Report	Grant Reports
Service Area			
ZIP Code Table	Patients by ZIP Code	X	
Patient Profile			
Table 3A	Patients by Age and by Sex Assigned at Birth	X	X
Table 3B	Demographic Characteristics	X	X
Table 4	Selected Patient Characteristics	X	X
Staffing and Utilization			
Table 5	Staffing and Utilization	X	<partial>
Clinical			
Table 6A	Selected Diagnoses and Services Rendered	X	X
Table 6B	Quality of Care Measures	X	
Table 7	Health Outcomes and Disparities	X	
Financial			
Table 8A	Financial Costs	X	
Table 9D	Patient Related Revenue	X	
Table 9E	Other Revenue	X	
Other			
HIT Form	HIT Capabilities	X	
Other Form	Other Data Elements	X	
Workforce Form	Training and Satisfaction Surveys	X	

Calendar Year Reporting Period

The UDS is a calendar year report. Health centers must report on the entire calendar year, even for health centers whose designation or funding begins, either in whole or in part, after January 1. Similarly, health centers with a fiscal year or grant period other than January 1 to December 31 will still report on the calendar year, not on their fiscal or grant year. Health centers designated or funded for the first time during the calendar year or whose designation or funding ends during the year should discuss any reporting issues with their project officer.

All health centers **funded or designated in whole or in part before October 1** must report on their approved scope, even if they did not draw down grant funds for some or all of their program during the calendar year. Health centers funded or designated for the first time on or after October 1 of the reporting year will not file a 2020 UDS report.

If one or more sites of a health center designated as a look-alike received section 330 New Access Point (NAP) funding before October, exclude all the data related to those funded sites from the look-alike UDS report for 2020 **and** report the data related to the funded sites in the awardee UDS report for 2020. If the entire look-alike program became funded, report only an awardee UDS report for the year.

In Scope Reporting

All health centers must submit data that reflects activities in the HRSA health center project, as defined in approved applications and reflected in official Notice of Award/Designation.

Due Dates and Revisions to Reports

The period for submission of complete and accurate UDS Reports is January 1 through **February 15, 2021**.

From February 15 through March 31, 2021, a Health Center Program UDS reviewer will work with you, as needed, to correct data errors. Final, corrected submissions are due no later than March 31, 2021. **HRSA does not accept changes after this date.**

HRSA may grant a reporting exemption under extraordinary circumstances, such as the physical destruction of a health center. Health centers must request such exemptions directly from the BPHC Office of Quality Improvement through the **UDS Support Center**.

For help at any time, please contact the UDS Support Center at 1-866-UDS-HELP or udshelp330@bphcdata.net.

How and Where to Submit Data

Health centers report UDS data via a web-based system that is a part of the HRSA EHBs. Health center staff will use their user name and password to log into the EHBs to complete and submit their UDS Reports. The system supports the use of standard web browsers.[1] It provides electronic forms necessary to complete the reports. The Preliminary Reporting Environment (PRE) provides early access to the EHBs and is

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[1] While most browsers should work with the EHBs, it is certified to work with Internet Explorer (IE) Version 8.0 through 11.0 or Firefox 3.6 or higher. Health centers having a problem with other browsers should consider using IE-8, 9, 10, or 11 or Firefox 3.6 for this task. More information about EHBs' recommended settings are available.

available in the fall. This allows health centers to enter available UDS data, help identify potential data reporting errors, and provide additional preparation time to compile UDS data.

Health center staff with EHBs access can work on the forms in sections, saving interim or partial versions online as they work and returning to complete them later.

The system saves work in the EHBs until the health center makes a formal submission. The chief executive officer (CEO) or project director usually does this but may delegate the authority to someone else. At the time of submission, the UDS requires that the submitter acknowledge that the health center reviewed and verified the accuracy and validity of the data. Failure to submit a timely, accurate, and complete UDS report by February 15 will result in a condition being placed on your grant award. Additional restrictions, including the requirement that all drawdowns of Health Center Program grant award funds from the Payment Management System (PMS) have the prior approval of the HRSA Division of Grants Management Operations (DGMO) and/or limits on future funding (e.g., Quality Improvement Awards, base adjustments) may also be placed on your grant award.

Health centers may give data entry responsibility to several people, each using separate login and password credentials. In addition, health centers designate one person as the UDS contact. The UDS contact receives all communications about the UDS Report. This person may be asked to explain the data reported on the UDS tables during the review. Be sure the UDS contact information is updated in the EHBs. Health center staff may receive "view" or "edit" privileges. These apply to the whole report, not just specific tables.

Reports must be complete to be submitted into the EHBs. To ensure accuracy, the EHBs will check for potential inconsistencies or questionable data. It will provide a summary of which tables are complete, as well as a list of audit questions. Although based on the health center's data, audit questions are general and may not apply to some health centers' unique circumstances. Health center staff must address each of the data audit findings. If staff believe the data is correct as submitted, they should clearly explain any unique circumstances.

Please refer to Appendix G: Health Center Resources for resources which may be helpful for completing the UDS Report. Support contacts and links, such as contact information for the UDS Support Center, web links to a complete set of the UDS tables, training opportunities, and other materials, are included.

Instructions for Tables that Report Visits, Patients, and Providers

Visits

Visits determine who to count as a patient on the ZIP Code Table, Tables 3A, 3B, 4, 5, 6A, 6B, and 7; visits are reported by type of provider on Table 5 and for selected diagnoses and selected services on Table 6A.

Countable visits are documented, individual,[2] face-to-face, or virtual[3] contacts between a patient and a licensed or credentialed provider who exercises independent, professional judgment in providing services. Health centers should count only visits that meet all these criteria.

To count visits, the services must be documented in a chart that stays in the possession of the health center (see further details below). Services must be provided by an individual classified as a "provider" for purposes of providing countable visits. Please note: Not all health center staff who interact with patients qualify. Appendix A provides a list of health center personnel and the *usual* status of each as a provider or non-provider for UDS reporting purposes.

Visits provided by contractors and **paid for by the health center** are counted in the UDS if they meet all

other criteria. These include migrant voucher visits or outpatient or inpatient specialty care associated with an at-risk managed care contract. In these instances, if the visit is not documented in the patient's medical record, a summary of the visit (rather than the complete record) must appear in the patient's medical record, including all appropriate Current Procedural Terminology (CPT) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes.

Below are definitions and criteria for reporting visits. Table 5 provides further clarifications. See Clinic Visits, Column B.

Documentation

To meet the criterion for documentation, health centers must record the service (and associated patient information) in written or electronic form in a system that permits ready retrieval of current data for the patient. The patient record does not have to be complete to meet this standard.

For example, a patient receiving documented emergency services counts even if some portions of the health record are incomplete. Providers who see their established patients at a hospital or respite care facility and make a note in the institutional file can satisfy this criterion by including a summary

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[2] An exception is allowed for behavioral health visits, which may be conducted in a group setting.

[3] Only interactive, synchronous audio and/or video telecommunication systems that permit real-time communication between a distant provider and a patient may be considered and coded as telehealth services.

discharge note showing activities for each of the visit dates.

Independent Professional Judgment

To meet the criterion for independent professional judgment, providers must be acting on their own, not assisting another provider, when serving the patient.

Independent judgment implies the use of the professional skills gained through formal training and experience and unique to that provider or other similarly or more intensively trained providers.

For example, a nurse assisting a physician during a physical examination by taking vital signs, recording a history, or drawing a blood sample does not receive credit as a separate visit. Eligible medical visits usually involve one of the "Evaluation and Management" billing codes (99201–99205 or 99211–99215) or one of the health maintenance codes (99381–99387, 99391–99397).

Behavioral Health Group Visits

A behavioral health provider who provides services to several patients simultaneously receives credit for a visit for each person only if the service appears in each person's health record.

Examples of "group visits" include family therapy or counseling sessions, group mental health counseling, and group substance use disorder counseling where several people receive services that appear in each person's health record.

Other considerations:

- The health center normally bills each patient, even if another grant or contract covers the costs.
- If only one person is billed (for example, when a relative participates in a patient's counseling session), count only the billed person as a patient and count only that patient's visit.
- When a behavioral health provider conducts services via telemedicine/telehealth, the provider can be credited with a visit only if the service is noted in the patient's record. The session will normally be billed to the patient or a third-party.
- For medical visits, only individual services count.

Location of Services Provided

A visit must take place in health center approved sites (e.g., clinics, schools, homeless shelters, as listed on Form 5B) or in other locations that do not meet HRSA's site criteria but are included in the health center's scope of project, such as hospitals, nursing homes, or extended care facilities. In addition, virtual visits may occur from other locations. See instructions for Virtual Visits.

Other considerations:

- Visits also include contacts with existing hospitalized patients, when health center medical staff "follow" the patient during the hospital stay as physician of record or where they provide consultation to the physician of record. This applies when the health center pays medical staff and bills the patient either for the specific service or through a global fee.

- A health center 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.

- When a patient's first encounter is in a hospital, respite care, or a similar facility *that is not specifically approved as a service delivery site under the scope of the grant/designation by BPHC*, none of the services for that patient are counted in the UDS.

Counting Multiple Visits by Category of Service

Multiple visits occur when a patient has more than one visit with the health center in a day. On any given day, a patient may have only one visit per service category, as described in the table below.

Other considerations:

- If multiple medical providers in a single category deliver multiple

services on a single day (e.g., an obstetrician/gynecologist [OB/GYN] who provides prenatal care to a patient and an internist who treats that same patient's hypertension), count only one visit even if third-party payers may recognize these as separate billable services.

- Health centers can count medical services provided by two *different* medical providers located at two *different* sites on the same day. This is the only exception (originally developed for programs providing services to persons experiencing homelessness and agricultural workers) to this rule. This permits patients who are in challenging environments (e.g., in parks or migrant camps) to receive services from non-physician medical providers and to receive services again that day at the health center's fixed clinic site by a different, generally higher level, provider.

- A provider receives credit for no more than one visit with a given patient in a single day, regardless of the types or number of services provided or where they occur

Maximum Number of Visits per Patient per Day

# of Visits	Visit Type	Provider Examples
1	Medical	physician, nurse practitioner, physician assistant, certified nurse midwife, nurse
1	Dental	dentist, dental hygienist, dental therapist
1	Mental health	psychiatrist, licensed clinical psychologist, licensed clinical social worker, psychiatric nurse practitioner, other licensed or unlicensed mental health providers
1	Substance use disorder	alcohol and substance use disorder specialist, psychologist, social worker
1 for each provider type	Other professional	nutritionist, podiatrist, speech therapist, acupuncturist
1	Vision	ophthalmologist, optometrist
1 for each provider type	Enabling	case manager, health educator

Patient

Patients are people who have at least one reportable visit during the reporting year. The term "patient" applies to everyone who receives visits, not just medical or dental services.

The **Universal Report** includes all patients who had at least one visit during the year that is within the scope of activities supported by the grant/designation.

- Report these patients and their visits on Tables 5 and 6A for each type of service (e.g., medical, dental, enabling) received during the year.

- On the ZIP Code Table, Tables 3A and 3B, in each section of Tables 4 and 5, and for each service of Table 6A, count each patient once and only once. This applies even if they received more than one service (e.g., medical, dental, enabling) or received services supported by more than one program authority (e.g., section 330(g), section 330(h), section 330(i)).

For each **Grant Report**, patients reported are those who have at least one visit during the year within the scope of project activities supported by the specific section 330 program authority. The number of patients reported in any cell on the Universal Report includes patients reported in the same cell in the Grant Report.

Services and Persons Not Reported on the UDS Report

Some services *do not count* as a visit for UDS reporting.

Similarly, someone who only receives one of the services described below *is not a patient for purposes of UDS reporting*.

These situations include the following:

Health screenings

- Screenings frequently occur as part of community activities that involve conducting outreach or group education.

- Examples include information sessions for prospective patients; health presentations to

community groups; information presentations about available health services at the center; services conducted at health fairs or at schools; immunization drives; services provided to groups, such as dental varnishes or sealants provided at schools; hypertension or diabetes testing; or similar public health efforts.

Group visits

- Do not count visits conducted in a group setting, except for behavioral health group visits.

- The most common non-behavioral health group visits are patient education or health education classes (e.g., people with diabetes learning about nutrition).

Tests and other ancillary services

- Tests support the services of the clinical programs.

- Examples include laboratory (including purified protein derivatives [PPDs], pregnancy, Hemoglobin A1c [HbA1c], and blood pressure) and imaging (including sonography, radiology, mammography, retinography, or computerized axial tomography).

- Do not count services required to perform such tests, such as drawing blood or collecting urine.

Dispensing or administering medications

- Do not count dispensing medications, including dispensing, from a pharmacy (whether by a clinical pharmacologist or a pharmacist) or administering medications (such as buprenorphine or warfarin).

- Do not count giving any injection (including for vaccines, allergy shots, or family planning) regardless of education provided at the same time.

- Do not count providing narcotic agonists or antagonists or mixes of these, regardless of whether the patient is assessed at the time of the dispensing and regardless of whether these medications are dispensed regularly.

Health status checks

- Do not count follow-up tests or checks (such as patients returning for HbA1c tests or blood pressure checks).

- Do not count wound care (which is follow-up to the original primary care visit).

- Do not count taking health histories.

- Do not count making referrals for or following up on external referrals.

Services under the Women, Infants, and Children (WIC) Program

- Do not count a person whose only contact with a health center

is to receive services (including nutrition) under a WIC program.

Provider

A provider is someone who assumes primary responsibility for assessing the patient and documenting services in the patient's record.

- Providers include only those who exercise independent judgment for services rendered to the patient during a visit.

- Only one provider who exercises independent judgment receives credit for the visit, even when two or more providers are present and participate.

- If two or more providers of the same type share the services for a patient (e.g., a family physician and a pediatrician both see a child, or a dental hygienist and a dentist see a patient on the same day), only one provider receives credit for a visit.

- In cases where a preceptor is following and supervising a licensed resident, the resident receives credit (see Table 5 for further instruction on counting interns and residents).

- When health center staff are following a patient in the hospital, the primary health center staff person in attendance during the visit is the provider who receives credit for the visit, even if other staff are present.

- Except for physicians and dentists, allocate staff time by function among the major service categories based on time dedicated to other roles (e.g., a

nurse who dedicates 20 hours to medical care and 20 hours to providing health education each week would split the 1.0 FTE between a medical nurse and health educator).

- Appendix A provides a listing of personnel. Only personnel designated as a "provider" can generate visits for purposes of UDS reporting.

- Table 5 provides further clarifications to these definitions. See Instructions for Table 5: Staffing and Utilization.

- Providers may be employees of the health center, contracted staff, or volunteers.

- Contract providers who are paid by the health center with grant funds or program income and who are part of the scope of the approved grant/designation, serve center patients, and document their services in the center's records count as providers.

Note: *A discharge summary or similar document in the medical record will meet these criteria.*

- Contract providers paid for specific visits or services with grant funds or program income who report patient visits to the direct recipient of a BPHC or BHW grant or designation (e.g., under a migrant voucher program or of HCH awardees with sub-awardees) are providers. The direct recipient of the BPHC or BHW grant/designation reports these providers' activities. Since such providers often have no

time basis in their report, no FTE would be reported for them if time data were not collected.

- Count providers who volunteer to serve patients at the health center's sites under the supervision of the center's staff and document their services and time in the center's records.

- Individuals or groups who provide services under formal agreement or contract when the health center does not pay for the visit are not credited as providing a health center visit. This is the case even if they provide discharge summaries or report the service in the patient's medical chart, unless they are working at an approved site under the supervision of the appropriate health center staff and are credentialed by the health center.

Note: *These providers are generally providing services noted in Column III of the grant scope of project application Form 5A. See an example of* *Form 5A*.

Instructions for ZIP Code Data

The ZIP Code Table provides data on patients' origin by primary medical insurance.

Patients by ZIP Code

All health centers must report the number of patients served by ZIP code. This information enables BPHC to better identify areas served by health centers, potential service area overlaps, and possible areas of unmet need. Patients may be mobile during the reporting period; health centers report patients' most recent ZIP code on file.

ZIP Code of Specific Groups

It is possible that residence information may not be available for some patients. This is particularly true for health centers that serve transient groups. Special instructions cover the following groups:

- **Patients experiencing homelessness**: Although many patients experiencing homelessness live doubled up or in shelters, transitional housing, or other fixed locations, others—especially those living on the street—do not know or will not share an exact location. When a ZIP code location is unavailable or the location offered is questionable, health centers should use the service location ZIP code as a proxy. Similarly, if the patient has no other ZIP code and receives services in a mobile van, use the ZIP code of the van's location that day. Health centers might collect the address of a contact person to facilitate communication with the patient; however, while appropriate from a clinical and service delivery perspective, do not use the contact person's address as the patient's address.

- **Patients who are migratory agricultural workers**: Migratory agricultural workers (as opposed to seasonal workers) may have both a temporary address that reflects where they live when they are working in the community, as well as a permanent or "downstream" address that may be far from the location of their current work and the site where they are receiving care. For the UDS report, health centers are to report the ZIP code of where the patient lived when they received care from the health center. Note that migratory agricultural worker patients may also be seen by health center providers in their home, or "downstream" community. For patients whose precise ZIP code is unavailable (e.g., living in cars or on the land), the ZIP code for the location (fixed site or mobile camp outreach) where they received services should be used.

- **Patients who are foreign nationals**: Report the current ZIP codes for people from other countries who reside in the United States either permanently or temporarily. Tourists and other people who may have a permanent residence outside the country are to be reported under "other ZIP code."

Unknown ZIP Code

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."

10 or Fewer Patients in ZIP Code

Although health centers report residence by ZIP code for all patients, some health centers may have many patients from numerous ZIP codes outside their service area. To ease the burden of reporting, *combine and report patients from ZIP codes with **ten or fewer** patients in the "other" category*.

Instructions for Type of Insurance

Health centers are expected to report primary medical insurance status for all patients regardless of what services they receive. This even applies to patients who did not receive medical care. For example, health centers must determine the primary medical insurance coverage for a patient who only received case management services. Health centers may not report patients as uninsured simply because they are receiving a service that is not covered by health insurance. Children served in school-based health center settings must have complete clinic intake forms that show insurance status and family income to be reported as patients in the UDS. They must not be considered uninsured unless they are receiving minor consent services or their family is uninsured.

Insurance Categories

Health centers will report the patient's *primary health insurance covering medical care, if any, as of the last visit during the reporting period*. Primary medical insurance is the insurance plan or program that the health center would typically bill first for medical services. The categories for this table are slightly different from those on Table 4, combining Medicaid, Children's Health Insurance Program (CHIP), and Other Public into one category. Specific rules guide reporting:

- Report patients who have both Medicare and Medicaid (dually eligible) 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.

- Report Medicaid and CHIP patients enrolled in a managed care program administered by a private insurance company as "Medicaid/CHIP/Other Public."

- Report Medicare administered by a private insurance company as Medicare.

- In rare instances, a patient may have insurance that the health center cannot or does not bill. This might include patients enrolled in Medicaid but assigned to another primary care provider, or patients with private insurance for which the health centers' providers have not been credentialed. In these instances, the health center is to *report the patient as insured* and report the type of insurance the patient has, even if it does not bill to this insurance.

- Section 330 grant funds used to serve special populations (e.g., MHC, HCH, PHPC) are not a form of medical insurance. Report any third-party insurance that patients carry.

- Classify patients who are incarcerated as uninsured (whether they were seen in the correctional facility or at the health center) and at the ZIP code of the jail or prison, unless Medicaid or other insurance covers them. Do not classify patients in residential drug programs, college dorms, military barracks, etc. as uninsured. In these instances, report the patient by type of insurance and record the ZIP code of the residential program, dorm, or barrack.

- Count patients whose care is subsidized by state or local government indigent care programs as uninsured. Examples include New Jersey's Uncompensated Care Program, New York's Public Goods Pool Funding, and Colorado's Indigent Care Program.

- Affordable Care Act subsidies (i.e., cost-sharing reductions and premium tax credits) do not affect insurance categories. Classify patients by their third-party insurer. Report patients who received insurance through the Health Insurance Marketplace as Private.

Additional information is available to clarify reporting. **View FAQs for the ZIP Code Table**.

Table: Patients by ZIP Code
Reporting Period: January 1, 2020, through December 31, 2020

ZIP Code (a)	None/ Uninsured (b)	Medicaid/ CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
Other ZIP Codes					
Unknown Residence					
Total					

Note: *This is a representation of the form. The actual online input process looks significantly different and the printed output from the EHBs may be modified.*

Instructions for Tables 3A and 3B

Tables 3A and 3B provide demographic data on patients who accessed services during the calendar year. This information must be collected from patients initially as part of the patient registration or intake process and then must be updated annually thereafter.

Table 3A: Patients by Age and by Sex Assigned at Birth

Report the number of patients by appropriate categories for age and sex assigned at birth:

- Use the individual's age on June 30 of the reporting period.

- Report patients according to their sex at birth or sex reported on a birth certificate. In states that permit this to be changed, the birth certificate sex may still be used.

- Report date of birth and sex listed on the birth certificate for all patients. There is no "unknown" category on this table.

Note: *On the non-prenatal portions of Tables 6B and 7, age is generally defined as the patient's age as of January 1 except where noted. Thus, the numbers on Table 3A will not be the same as those on Tables 6B and 7 even if all the patients at a health center were medical patients, though they will usually be similar.*

Table 3B: Demographic Characteristics

Report the number of patients by their self-identified race, ethnicity, language preference, sexual orientation, and gender identity.

Patients by Hispanic or Latino Ethnicity and Race (Lines 1–8)

Table 3B displays the race and ethnicity of the patient population in a matrix format. This permits the reporting of the racial identification of all patients, including those who identify as being of Hispanic/Latino ethnicity.

Hispanic or Latino Ethnicity

Table 3B collects information on whether or not patients consider themselves to be of Hispanic/Latino ethnicity, 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, broken out by their racial identification. Include in this count Hispanic/Latino patients born in the United States.
  - o Do not count persons from Portugal, Brazil, or Haiti whose ethnicity is not tied to the Spanish language.
- Column B (Non-Hispanic/Latino): Report the number of patients who indicate that they are not Hispanic/Latino. If a patient self-reported a race (described below) but has not made a selection for the Hispanic/non-Hispanic question, presume that the patient is non-Hispanic/Latino.

- Column C (Unreported/Refused to Report Ethnicity): Only one cell is available in this column. Report on Line 7, Column C, only those patients who left the entire race and Hispanic/Latino ethnicity part of the intake form blank or those who indicated that they refuse to report this data.

- Patients who self-report as being of Hispanic/Latino ethnicity but do not separately select a race must be reported on Line 7, Column A, as Hispanic/Latino ethnicity with "Unreported/Refused to Report" race. Health centers should not default these patients to "White," "Native American," "more than one race," or any other category.

Race

All patients must be classified in one of the racial categories.

- Presume patients who self-report race but do not separately indicate if they are Hispanic or Latino are non-Hispanic/Latino and report on the appropriate race line in Column B.

- Patients sometimes categorized as "Asian/Other Pacific Islander" in other systems are reported on the UDS in one of three distinct categories:
  - o **Line 1, Asian**: Persons having origins in any of the original peoples of Asia, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the

Philippine Islands, Indonesia, Thailand, or Vietnam.

- o **Line 2a, Native Hawaiian**: Persons having origins to any of the original peoples of Hawai'i.

- o **Line 2b, Other Pacific Islander**: Persons having origins in any of the original peoples of Guam, Samoa, Tonga, Palau, Chuuk, Yap, Saipan, Kosrae, Ebeye, Pohnpei or other Pacific Islands in Micronesia, Melanesia, or Polynesia.

- **Line 4, American Indian/Alaska Native**: Persons who trace their origins to any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment.

- **Line 6, More than one race**: 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 that lists the races and tells the patient to "check one or more" or "check all that apply." "More than one race" must not appear as a selection option on your intake form.

  - o Do not use "More than one race" for Hispanics/Latino people who do not select a separate race. Report these patients on Line 7 (Unreported/Refused to Report), as noted above.

*Note: Report race and ethnicity for all patients. Some health centers' patient registration systems were originally configured to capture data for patients who were asked to report race **or** ethnicity. Health centers that 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, but to include them in the count of those with Hispanic or Latino ethnicity. Health centers must take steps to enhance their registration system to permit the capture and reporting of these data in the future.

Patients Best Served in a Language Other than English (Line 12)

This section of Table 3B identifies the patients who have linguistic barriers to care.

Report on Line 12 the number of patients who are **best served** in a language other than English, including those who are best served in sign language.

- Include those patients who were served in a second language 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, Patients Best Served in a Language Other than English, may be estimated if the health center does not maintain actual data in its HIT. If an estimate is required, the estimate should be based on a sample where possible. **This is the only place on the UDS where an estimate is accepted.***

Patients by Sexual Orientation (Lines 13–19)

Sexual orientation is how a person describes their emotional and sexual

attraction to others. Collecting sexual orientation data is an important part of identifying and reducing health disparities and promoting culturally competent care in health centers.

Health centers are encouraged to establish routine data collection systems to support patient-centered, high-quality care for patients of all sexual orientations. As with all demographic data, this information is self-reported by patients or their caregivers if the patient cannot answer the questions themselves. Collection of sexual orientation data from patients younger than 18 years of age is not mandated, but the opportunity to provide this information must be provided to all patients regardless of age. Furthermore, patients have the choice not to disclose their sexual orientation. When sexual orientation information is not collected, report the patient on Table 3B as "don't know" on Line 17. The following descriptions may assist with data collection, but it is important to note that terminology is evolving and patients may change how they identify themselves over time.

- **Line 13** – **Lesbian or Gay**: Report patients who are emotionally and sexually attracted to people of their own gender.

- **Line 14** – **Straight (not lesbian or gay)**: Report patients who are emotionally and sexually attracted to people of a different gender.

- **Line 15** – **Bisexual**: Report patients who are emotionally and sexually attracted to people of their own gender and people of other genders.

- **Line 16** – **Something else**: Report patients who are emotionally and

sexually attracted to people who identify themselves as queer, asexual, or pansexual or another sexual orientation not captured in Lines 13–15 above, or Lines 17–18 below.

- **Line 17** – **Don't know**: Report patients who self-report that they do not know their sexual orientation. Include patients for whom the health center does not know the sexual orientation (i.e., the health center did not implement systems to permit patients to state their sexual orientation).

- **Line 18** – **Chose not to disclose**: Report patients who chose not to disclose their sexual orientation.

- **Line 19** – **Total Patients**: Sum of Lines 13 through 18.

Patients by Gender Identity (Lines 20–26)

Gender identity is the internal sense of gender. A person may be a male, female, a combination of male and female, or of another gender that may not be congruent with a patient's sex assigned at birth. Collecting gender identity data is an important part of identifying and reducing health disparities and promoting culturally competent care in health centers. This section helps to characterize populations served by health centers. Note that the gender identity reported on Table 3B is the patient's *current* gender identity. A patient's sex assigned at birth is reported on Table 3A.

As with all demographic data, this information is self-reported by patients or their caregivers if the patient cannot answer the questions themselves.

Collection of gender identity data from patients younger than 18 years of age is not mandated, but the opportunity to provide this information must be provided to all patients regardless of age. Furthermore, patients have the choice not to disclose their gender identity. When gender identity information is not collected, report the patient on Table 3B as "other" on Line 24. **Do not use sex assigned at birth to identify the gender of patients.** Report sex assigned at birth on Table 3A. The following descriptions may assist with data collection, but it is important to note that terminology is evolving and patients may change how they identify themselves over time.

- **Line 20 – Male:** Report patients who identify themselves as a man/male.

- **Line 21 – Female:** Report patients who identify themselves as a woman/female.

- **Line 22 – Transgender Male/Female-to-Male:** Report transgender patients who describe their gender identity as man/male. (Some may just use the term man).

- **Line 23 – Transgender Female/Male-to-Female:** Report transgender patients who describe their gender identity as woman/female. (Some may just use the term woman).

- **Line 24 – Other:** Report patients who do not think that one of the four categories above adequately describes them. Include patients who identify themselves as genderqueer or non-binary. In addition, report patients where the health center does not know the patient's gender identity (i.e., the health center did not implement systems to permit patients to state their gender identity).

- **Line 25 – Chose not to disclose:** Report patients who chose not to disclose their gender.

- **Line 26 – Total Patients:** Sum of Lines 20 through 25.

Additional information is available to clarify reporting. **View FAQs for Tables 3A and 3B.**

Table 3A: Patients by Age and by Sex Assigned at Birth
Reporting Period: January 1, 2020, through December 31, 2020

Line	Age Groups	Male Patients (a)	Female Patients (b)
1	Under age 1		
2	Age 1		
3	Age 2		
4	Age 3		
5	Age 4		
6	Age 5		
7	Age 6		
8	Age 7		
9	Age 8		
10	Age 9		
11	Age 10		
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 of Lines 1-38)		

Table 3B: Demographic Characteristics
Reporting Period: January 1, 2020, through December 31, 2020

Patients by Race and Hispanic or Latino Ethnicity

Line	Patients by Race	Hispanic/ Latino (a)	Non-Hispanic/ Latino (b)	Unreported/ Refused to Report Ethnicity (c)	Total (d) (Sum Columns a+b+c)
1	Asian				
2a	Native Hawaiian				
2b	Other Pacific Islander				
2	Total Native Hawaiian/Other Pacific Islander (Sum Lines 2a + 2b)				
3	Black/African American				
4	American Indian/Alaska Native				
5	White				
6	More than one race				
7	Unreported/Refused to report race				
8	**Total Patients** (Sum of Lines 1 + 2 + 3 to 7)				

Line	Patients Best Served in a Language Other than English	Number (a)
12	Patients Best Served in a Language Other than English	

Line	Patients by Sexual Orientation	Number (a)
13	Lesbian or Gay	
14	Straight (not lesbian or gay)	
15	Bisexual	
16	Something else	
17	Don't know	
18	Chose not to disclose	
19	**Total Patients** (Sum of Lines 13 to 18)	

Line	Patients by Gender Identity	Number (a)
20	Male	
21	Female	
22	Transgender Male/Female-to-Male	
23	Transgender Female/Male-to-Female	
24	Other	
25	Chose not to disclose	
26	**Total Patients** (Sum of Lines 20 to 25)	

Instructions for Table 4: Selected Patient Characteristics

Table 4 provides descriptive data on selected characteristics of health center patients.

Income as a Percent of Poverty Guideline, Lines 1–6

Collect income data from all patients at least once during the year. The report should include the most current information collected during the calendar year.

- Income, as defined by board policy consistent with the Health Center Program Compliance Manual, is used. Children will always be classified in terms of their parent's income, except for minor-consent services.

- Report "unknown" income on Line 5 for patients whose information was not collected within the calendar year.

- Do not attempt to allocate patients with unknown income to income groups.

- Do not classify a patient who is experiencing homelessness, is a migratory agricultural worker, or is on Medicaid as having income below the poverty guideline based on these factors.

- Self-declaration of income from patients is acceptable, as long as it is consistent with Board-approved policies and procedures. This is particularly important for those patients whose wages are paid in cash who have no other means of proving their income. If income information consistent with Board policy is lacking, report them as having "unknown" income.

Determine a patient's income relative to the federal poverty guidelines, which are revised annually.

Principal Third-Party Medical Insurance, Lines 7–12

This portion of the table provides data on patients classified by their age and the primary source of insurance for _medical_ care. Note that there is no "unknown" insurance classification on this table. Obtain medical insurance information from all patients to maximize third-party payments.

- Report the primary **medical** insurance patients had at the time of their last visit _regardless of whether that insurance was billed or paid for any or all of the visit services_. (Do not report other forms of insurance such as dental, mental health, or vision coverage).

- Patients are divided into two age groups: 0–17 (Column A) and age 18 and older (Column B) based on their age on June 30 (consistent with ages reported on Table 3A).

- Patient primary medical insurance is classified into seven types, as shown below.

- In rare instances, a patient may have insurance that the health center cannot or does not bill. Even in these instances, report the patient as being insured and report the type of insurance.

- Be aware that states often rename federal programs, such as State Children's Health Insurance Program (CHIP) and Medicaid.

- Do not report public programs that reimburse for selected services, such as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT); Breast and Cervical Cancer Control Program (BCCCP); or Title X, as a patient's primary medical insurance.

None/Uninsured (Line 7)

Report patients who did not have *medical insurance* at the time of their last visit on Line 7. This may include patients whose visit was paid for by a third-party source that was not an insurance, such as EPSDT, BCCCP, Title X, or some state or local safety net or indigent care programs. *Do not count* patients as uninsured if their medical insurance did not pay for their visit. Some examples follow:

- Classify a patient with Medicare who was seen for a dental visit that was not paid for by Medicare as having Medicare for this table.

- Report a patient with private insurance and a $2,000 deductible who had not reached that deductible as a private insurance patient.

- Classify a Medicaid patient who is assigned to another provider such that the health center cannot bill Medicaid for the visit as having Medicaid.

- Children seen in a school-based program who do not know their parent's health insurance status must obtain that information if they are to be included in the count of patients. The only exception is for a student seeking minor-consent service permitted in the state, such as family planning or mental health services. In these cases, record the minor child's status as uninsured if they do not have access to the parent's information.

Note: A minor receiving these same services with parental consent must be reported under the family's insurance.

- Presume a patient with Medicaid, Private, or Other Public dental insurance to have the same kind of medical insurance. If a patient does not have dental insurance, you may not assume that they are uninsured for medical care. Instead, obtain this information from the patient.

- Obtain the coverage information of patients in facilities (other than correctional), such as residential drug programs, college dorms, and military barracks and do not assume them to be uninsured.

Note: Patients served in correctional facilities may be classified as uninsured unless they have some form of insurance such as Medicaid or Medicare, whether seen in the correctional facility or at the health center.

Medicaid (Line 8a)

Report patients covered by state-run programs operating under the guidelines of Titles XIX and XXI (as appropriate) of the Social Security Act as Medicaid.

- Include Medicaid programs known by state-specific names (e.g., California's "Medi-Cal" program).

- Include patients covered by "state-only" programs covering individuals who are ineligible for federal matching funds (e.g., undocumented children, pregnant women).

- Report patients enrolled in both Medicaid and Medicare as Medicare and as Dually Eligible, on Lines 9 and 9a, *but not on Line 8a.*

Note: Report patients who are enrolled in Medicaid but receive services through a private managed care plan that contracts with the state Medicaid Agency as "Medicaid", not as privately insured. This includes states that have a Medicaid waiver permitting funds to be used to purchase private insurance for services.

CHIP-Medicaid (Line 8b)

Report patients covered by the Children's Health Insurance Program Reauthorization Act (CHIP-RA) and provided through the state's Medicaid program as CHIP-Medicaid.

- In states that use Medicaid to handle the CHIP program, it is sometimes difficult or impossible to distinguish between "Medicaid" and "CHIP-Medicaid." In other states, the distinction is

readily apparent (e.g., they have different cards). Even where it is not obvious, CHIP patients may 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 on coding practice from the state and/or county.

- If there is no way to distinguish between Medicaid and CHIP administered through Medicaid, classify all covered patients as Medicaid (Line 8a).

Medicare (Line 9)

Report patients covered by the federal insurance program for the aged, blind, and disabled (Title XVIII of the Social Security Act) as Medicare.

- Report patients who have Medicare and Medicaid ("dually eligible") or Medicare and a private ("MediGap") insurance as Medicare on Line 9.

  o *In addition*, report those who have both Medicare and Medicaid (but *not* those with MediGap insurance) as Dually Eligible, on Line 9a (see below).

- Count patients enrolled in "Medicare Advantage" products as Medicare on Line 9, even though their services were paid by a private insurance company.

- For Medicare-enrolled patients who are still working and are insured by both an employer-based plan and Medicare, report them as Private on Line 11 since

the employer-based insurance plan is billed first.

Dually Eligible (Medicare and Medicaid) (Line 9a)

Report patients with both Medicare and Medicaid insurance as Dually Eligible on Line 9a.

- This line is a subset of Line 9 (Medicare). Report patients who are dually eligible on Line 9a *and* include them on Line 9, Medicare.

- Do not include MediGap enrollees on Line 9a. Report them only on Line 9.

Other Public Insurance (Non-CHIP) (Line 10a)

Report state and/or local government programs, such as Massachusetts' Common Health plan, that provide a broad set of benefits for eligible individuals. Include public paid or subsidized private insurance not listed elsewhere on Line 10a.

- Classify Medicaid expansion programs using Medicaid funds to help patients purchase their insurance through exchanges as Medicaid (Line 8a) if it is possible to identify them. Otherwise, report them as Private (Line 11).

- Do not include any CHIP, Medicaid, or Medicare patients on Line 10a.

- Do not include uninsured individuals whose visit may be covered by a public source with limited benefits, such as EPSDT, BCCCP, AIDS Drug Assistance Program (ADAP) providing

pharmaceutical coverage for HIV patients, etc.

- Do not include persons covered by workers' compensation, which is liability insurance for the employer—not health insurance for the patient.

Other Public Insurance CHIP (Line 10b)

- In states where CHIP is contracted through a private third-party payer, classify participants as Other Public Insurance CHIP (Line 10b), not as Private.

- CHIP programs that are run through the private sector are often administered through health maintenance organizations (HMOs). Coverage may appear to be a private insurance plan (such as Blue Cross/Blue Shield), but is funded through CHIP and is to be counted on Line 10b.

- Include CHIP patients who are on plans administered by Medicaid coordinated care organizations (CCOs) on Line 10b.

- Do not include patients who have insurance through federal or state insurance exchanges on Line 10b, regardless of the extent to which their premium cost is subsidized (in whole or in part).

Private Insurance (Line 11)

Report patients with health insurance provided by commercial and not-for-profit companies as Private on Line 11.

- Individuals may obtain insurance through employers or on their own.

- Include patients who purchase insurance through the federal or state exchanges on Line 11.

- In states using Medicaid expansion to support the purchase of insurance through exchanges, report patients covered under these plans as Medicaid, Line 8a. Report patients who are not identifiable as Medicaid patients as Private on Line 11.

- Private insurance includes insurance purchased for public employees or retirees, such as Tricare, Trigon, or the Federal Employees Benefits Program.

Managed Care Utilization, Lines 13a–13c

This part of Table 4 provides data on managed care enrollment during the calendar year and specifically reports on patient member months in managed care plans.

- Do not report in this section enrollees in primary care case management (PCCM) programs, the Centers for Medicare & Medicaid Services (CMS) patient-centered medical home (PCMH) demonstration grants, or other third-party plans that pay a relatively small monthly fee (usually $5 to $10 per member per month) to "manage" patient care.

- Do not include managed care enrollees whose capitation or enrollment is limited to behavioral health or dental services only. (However, an enrollee who has medical *and* dental is counted).

Member Months

A member month is defined as one member being enrolled in a managed care plan for one month. An individual who is a member of a plan for a full year generates 12 member months; a family of five enrolled for six months generates 30 member months (5 × 6). Member month information is most often obtained from monthly enrollment lists generally supplied by managed care companies to their providers. Health centers should always save these documents. In the event they have not been saved, health centers should request duplicates early to permit timely filing of the UDS report.

If patients are enrolled in a managed care program that permits them to receive care from any number of providers, including providers other than the health center and its clinicians, this is *not* to be considered managed care, and no member months are reported in this situation.

*Note: It is possible for an individual to be enrolled in a managed care plan, assigned to a health center, and yet never be seen or not seen during the calendar year. The member months for such individuals are still to be reported in this section. **This is the only place in the UDS where an individual may be reported who is not being counted as a patient.***

Capitated Member Months (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 health center and the HMO, Accountable Care Organization (ACO), or other similar plans stipulates that for a flat payment per month, the health center will provide the patient all the services on a negotiated list. (Oregon programs should include enrollees in CCOs on this line).

- This usually includes, at a minimum, all office visits.

- Payments are received (and reported on Table 9D) regardless of whether any service is rendered to the patient in that month. The capitated member months reported on Line 13a relate to the net capitated income reported on Table 9D on Lines 2a, 5a, 8a, and/or 11a.

Fee-for-Service Member Months (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 health center or health center service delivery provider for one month, during which time the patient may receive basic primary care services only from the health center but for whom the services are paid on a fee-for-service basis.

- It is common for patients to have their primary care covered by capitation, but other services, such as behavioral health or pharmacy, are paid separately on a fee-for-service basis as a "carve out" in addition to the capitation. Do not include member months for individuals who receive "carved-out" services under a fee-for-service arrangement on line 13b if those individuals have already been counted for the same month as a capitated member on line 13a.

- There is a relationship between the fee-for-service member months reported on line 13b and the income reported on Table 9D on lines 2b, 5b, 8b, and/or 11b.

Special Populations, Lines 14–26

This section asks for a count of patients from special populations, including persons who are experiencing homelessness, migratory and seasonal agricultural workers and their family members, patients who are served by school-based health centers, patients served at a health center located in or immediately accessible to a public housing site, and patients who are veterans. Awardees who receive funding for section 330 (h) - HCH and section 330(g) - MHC must provide additional information on their agricultural employment and/or housing characteristics.

- All health centers report these populations, regardless of whether they directly receive special population funding.

- Housing status must be collected by HCH awardees at the first visit of the year when the patient was identified to be experiencing homelessness.

- Migratory or seasonal agricultural workers' status must be verified at least every two years by MHC awardees.

Total Migratory and Seasonal Agricultural Workers and their Family Members, Lines 14–16

- **Total Agricultural Workers or Dependents, Line 16:** Report the number of patients seen during the reporting period who were either migratory or seasonal agricultural workers, family members of migratory or seasonal agricultural workers, or aged or disabled former migratory agricultural workers (as described in the statute section 330(g)(1)(B)).

- For both categories of workers, report patients who meet the definition of agriculture farming in all its branches, as defined by the Office of Management and Budget (OMB)-developed [North American Industry Classification System](#) (NAICS), and include seasonal workers included in the following codes and all sub-codes within 111, 112, 1151, and 1152.

Only health centers that receive section 330(g) –MHC funding, provide separate totals for migratory and for seasonal agricultural workers on Lines 14 and 15. For section 330(g) awardees, Lines 14 + 15 = Line 16.

Instructions for reporting migratory and seasonal agricultural workers:

- **Migratory Agricultural Workers, Line 14:** Report patients whose principal employment is in agriculture and who establish a temporary home for the purposes of such employment as a migratory agricultural worker, as defined by section 330(g) of the Public Health Service Act. Migratory agricultural workers are usually hired laborers who are paid piecework, hourly, or daily wages. Include patients who had such work as their principal employment within 24 months of their last visit, as well as their dependent family members who have also used the center. The family members may or may not move with the worker or establish a temporary home. Note that agricultural workers who leave a community to work elsewhere are classified as migratory workers in their home community, as are those who migrate to a community to work there.

  o Include aged and disabled former migratory agricultural workers, as defined in section 330 (g)(1)(B). Aged and disabled former agricultural workers include those who were previously migratory agricultural workers but who no longer work in agriculture because of age or disability, and their family members.

- **Seasonal Agricultural Workers, Line 15:** Report

patients whose principal employment is in agriculture on a seasonal basis (e.g., picking fruit during the limited months of a picking season) but who do not establish a temporary home for purposes of such employment. Seasonal agricultural workers are usually hired laborers who are paid piecework, hourly, or daily wages. Include patients who have been so employed within 24 months of their last visit and their family members who may be patients of the health center.

Note: Seasonal agricultural workers may be employed throughout the year for each crop season and as a result might work full-time.

Total Homeless Patients, Lines 17–23

- **Total Homeless, Line 23**: Report the total number of patients known to have experienced homelessness at the time of any service provided during the reporting period.

- Report patients who lack housing (without regard to whether the individual is a member of a family). Include patients whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and patients who reside in transitional housing or permanent supportive housing.

- May include children and youth at risk of homelessness, homeless

veterans, and veterans at risk of homelessness[4].

Only health centers receiving section 330(h)–HCH funding provide separate totals for patients by housing location on Lines 17–22. For section 330(h) awardees, Lines 17–22 = Line 23.

HCH awardees will provide separate totals for patients experiencing homelessness by the type of shelter arrangement the patients had when they were *first encountered during the reporting year*. The following applies when categorizing patients for Lines 17 through 22:

- Report the patient's shelter arrangement as of the first visit during the reporting period. This is normally assumed to be where the person was housed the prior night.

- Report persons who spent the prior night incarcerated, in an institutional treatment program (e.g., mental health, substance use disorder), or in a hospital based on where they intend to spend the night *after* their visit/release. If they do not know, report their shelter arrangement as Street, on Line 20.

- Patients currently residing in a jail or an institutional treatment program *are not considered homeless* until they are released to the street with no housing arrangement.

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[4] Health centers may use criteria as defined by the Department of Housing and Urban Development to assist in defining 'children, youth, and veterans at risk of homelessness.'

- **Line 17 – Shelter**: Report patients who are living in an organized shelter for persons experiencing homelessness at the time of their first visit. Shelters that generally provide meals as well as a place to sleep are regarded as temporary and often limit the number of days or the hours of the day that a resident may stay at the shelter.

- **Line 18 – Transitional Housing**: Transitional housing units are generally small units (six people is common) where people transition from a shelter and are provided extended, but temporary, housing stays (generally between six months and two years) in a service-rich environment. Transitional housing provides a greater level of independence than traditional shelters and may require the resident to pay some or all of the rent, participate in the maintenance of the facility, and/or cook their own meals. Count only those persons who are "transitioning" from a homeless environment. *Do not include those who are transitioning from jail, or those residing in or transitioning from an institutional treatment program, the military, schools, or other institutions.*

- **Line 19 – Doubled Up**: Count patients who are living with others as "doubled up." The arrangement is generally considered to be temporary and unstable, though a patient may live in a succession of such arrangements over a protracted period. Do not count the person who invites a person experiencing homelessness to stay in their home for the night as doubled up.

- **Line 20 – Street**: Include patients who are living outdoors, in a vehicle, in an encampment, in makeshift housing/shelter, or in other places generally not deemed safe or fit for human occupancy in this category.

- **Line 21a – Permanent Supportive Housing**[5]: Report patients who are in permanent supportive housing in this category. Permanent supportive housing usually is in service-rich environments, do not have time limits, and may be restricted to people with some type of disabling condition.

- **Line 21 – Other**: Report patients who were housed when first seen during the year but who were still eligible for the program because they previously experienced homelessness. HCH-funded programs may continue to serve patients who are no longer experience homelessness due to becoming residents of permanent housing for 12 months after their

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[5] Health centers may use criteria as defined by the Department of Housing and Urban Development to assist in defining permanent supportive housing.

last visit as homeless. Include them in this category. Also classify patients who reside in single-room-occupancy (SRO) hotels or motels, patients who reside in other day-to-day paid housing, or other housing programs that are targeted to homeless populations on this line.

- **Line 22 – Unknown**: Report patients known to be experiencing homelessness, but with no known housing arrangement in this category.

Total School-Based Health Center Patients, Line 24

All health centers that identified a school-based health center as a service delivery site in their scope of project (grant or designation [Form 5B](#)) are to report the total number of patients who received primary health care services at the approved school service delivery site(s).

- Count patients served at in-scope school-based health centers located on or near school grounds, including pre-school, kindergarten, and primary through secondary schools, that provide on-site comprehensive preventive and primary health services.

- Services are targeted to the students at the school, but may also be provided to their children, siblings, or parents and may occasionally include persons residing in the immediate vicinity of the school.

- Do not include students who receive screening services or

mass treatment, such as vaccinations or fluoride treatments at a school, as patients.

Total Veterans, Line 25

- All health centers should report the total number of patients served who have been discharged from the uniformed services of the United States, including the Air Force, Army, Coast Guard, Marines, Navy, US Public Health Service, National Guard, or Reserves. This element is to be included in the health center's patient information/intake form. Report only those who affirmatively indicate they are veterans.

- Do not count persons who do not respond, regardless of other indicators.

- Do not consider persons who are still in the uniformed services, including soldiers on leave and National Guard members not on active duty, as veterans.

- Do not count veterans of other nations' military, even if they served in wars in which the United States was also involved.

- This category is not exclusive. For example, an individual who is classified as a patient experiencing homelessness can also be classified as a veteran.

Total Patients Served at a Health Center Site Located in or Immediately Accessible to a Public Housing Site, Line 26

All health centers are to report all patients seen at a *service delivery site* located in or immediately accessible to public housing, regardless of whether the patients are residents of public housing or the health center receives funding under section 330(i) PHPC.

- Count patients on this line if they are served at health center *sites* that meet the statutory definition for the PHPC program (located in or immediately accessible to public housing) regardless of whether the health center site receives PHPC funding and regardless of whether the patients being reported actually live in public housing (location-based reporting).

- This is the only field in the UDS Report that requires you to **provide a count of all patients based on the health centers site's proximity to public housing**. You are to report all patients seen at the health center *site* if it is located in or is immediately accessible to agency-developed, owned, or assisted low-income housing, including mixed finance projects.

- Exclude from the count Section 8 housing units that receive no public housing agency support other than Section 8 housing vouchers.

Additional information is available to clarify reporting. View **FAQs for Table 4**.

Table 4: Selected Patient Characteristics

Reporting Period: January 1, 2020, through December 31, 2020

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

Line	Principal Third-Party Medical Insurance	0-17 years old (a)	18 and older (b)
7	**None/Uninsured**		
8a	Medicaid (Title XIX)		
8b	CHIP Medicaid		
8	**Total Medicaid** (Line 8a + 8b)		
9a	Dually Eligible (Medicare and Medicaid)		
9	**Medicare** (Inclusive of dually eligible and other Title XVIII beneficiaries)		
10a	Other Public Insurance (Non-CHIP) (specify)		
10b	Other Public Insurance CHIP		
10	**Total Public Insurance** (Line 10a + 10b)		
11	**Private Insurance**		
12	**TOTAL** (Sum of Lines 7 + 8 + 9 +10 +11)		

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

Table 4: Selected Patient Characteristics (continued)
Reporting Period: January 1, 2020, through December 31, 2020

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

Instructions for Table 5: Staffing and Utilization

Table 5 and the Selected Service Detail addendum provide data on services provided to patients during the calendar year.

Table 5: Staffing and Utilization

This table provides a profile of health center staff (Column A), the number of face-to-face visits they render (Column B), the number of virtual visits they render (Column B2), and the number of patients served in each service category (Column C). Column C is designed to report the number of unduplicated patients by category:

- Medical

- Dental

- Mental health

- Substance use disorder

- Vision

- Other professional

- Enabling

The patient count will often involve duplication *across* service categories, though it is always unduplicated *within* service categories. This is unlike Tables 3A, 3B, and 4 where an unduplicated count of all patients is reported.

The staffing information in Table 5 is designed to be compatible with approaches used to describe staff for financial reporting while ensuring adequate detail on staff categories for program planning and evaluation purposes.

Staffing data are reported only on the Universal table, not the Grant Report tables. Grant Reports provide data on patients served in whole or in part with section 330(h) – HCH, section 330(g) –

MHC, and/or section 330(i) – PHPC funding and the visits they had during the year. This includes all visits supported with either grant or non-grant funds.

Staff Full-Time Equivalents (FTEs), Column A

Table 5 includes FTE staffing information on all individuals who work in programs and activities that are within the scope of project for all sites covered by the UDS. Report all staff in terms of **annualized** FTEs.

FTEs reported on Table 5 Column A include all staff supporting health center operations defined by the scope of the project. Staff may provide services on behalf of the health center 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 (paid based on worked hours or FTE), interns, residents, preceptors, or donated time.

Do not count individuals who are paid by the health center on a fee-for-service basis in the FTE column since there is no basis for determining their hours. Their visits are still reported in Column B and the patients who received services are reported in Column C.

The following describes the basis for determining someone's employment

status for purposes of reporting on FTEs:

- One full-time equivalent (FTE = 1.0) describes staff who worked the equivalent of full-time for one year. Each health center defines the number of hours for "full-time" work and may define it differently for different positions.

- The FTE is based on employment contracts for clinicians and other exempt staff. For example, a physician hired as a full-time employee who is only required to work nine four-hour sessions (36 hours) per week is full-time. Similarly, clinicians may routinely stay late in the clinic or see hospitalized patients before or after normal workdays, but they would still be considered 1.0 FTE.

- In some health centers, different positions have different time expectations. Positions with different time expectations should be calculated on whatever they have as a base for that position. For example, if licensed clinical psychologists work 36 hours per week, 36 hours would be considered 1.0 FTE. An 18-hour-per-week licensed clinical psychologist would be considered 0.5 FTE regardless of whether other employees work 40-hour weeks.

- The FTE of exempt staff working fewer than 40 hours per week can often be determined by their benefits status. If they receive full-time benefits (e.g., 8 hours pay for New Year's Day), then they would be considered full-time.

- The FTE of non-exempt staff is calculated based on paid hours. FTEs are adjusted for part-time work or for part-year employment. For example, in a health center that has a 40-hour work week (2,080 hours/year), a person who works 20 hours per week (i.e., 50 percent time) is reported as 0.5 FTE; a person who works full-time for four months out of the year is reported as 0.33 FTE (4 months ÷ 12 months).

- A non-exempt staff person who works more than full-time (i.e., overtime) will have an FTE greater than 1.0. For example, a person who works 2,200 hours/2,080 full-time hours is reported as 1.06 FTE.

- For staff who are not paid for leave, the effective FTE is calculated by dividing worked hours by adjusted full-time hours (full-time hours less leave hours).

Allocate all staff time 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, the time would be allocated as 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. The nurse who collects vitals on a patient, who is then placed in the exam room, and later provides instructions on wound care,

for example, would not have a portion of the time counted as health education—it is all a part of nursing.

Count an individual who is hired as a full-time clinician as 1.0 FTE regardless of the number of direct patient care hours they provide. Providers who have released time to compensate for on-call hours, have weekly administrative sessions when they do not see patients, or who receive paid leave for continuing education or other reasons are still considered full-time if that is how they were hired. (Similarly, do not count providers who are routinely required to work more than 40 hours per week as more than 1.0 FTE). Count the time spent by providers performing tasks in what could be considered non-clinical activities, such as charting, reviewing labs, filling or renewing prescriptions, returning phone calls, arranging for referrals, participating in quality improvement (QI) activities, supervising nurses, etc., as part of their overall medical care services time and not in a non-clinical support category.

The one exception to this rule is when a chief medical officer/medical director is engaged in non-clinical activities at the corporate level (e.g., attending board of directors or senior management meetings, advocating for the health center before the city council or Congress, writing grant applications, participating in labor negotiations, negotiating fees with insurance companies), in which case time can be allocated to the non-clinical support services category. This does not, however, include non-clinical activities in the medical area, such as supervising the clinical staff, chairing or

attending clinical meetings, or writing clinical protocols.

Staff by Major Service Category

Staff members are distributed into categories that reflect the types of services they provide as independent providers. 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, though not exhaustive, list appears in Appendix A.

Medical Care Services (Lines 1–15)

- **Physicians (Lines 1–7)**: Report medical doctors (MDs) and doctors of osteopathic medicine (DOs), including licensed residents on Lines 1–7. Do not report psychiatrists, ophthalmologists, pathologists, and radiologists here. They are separately reported on Lines 20a, 22a, 13, and 14, respectively. Report licensed interns and residents on the line designated for the specialty designation they are working toward and credit them with their own visits. (Thus, count a family practice intern as a family physician on Line 1). Do not count naturopaths, acupuncturists, community health aides/practitioners, and chiropractors on these lines. Report these providers on Line 22 as Other Professionals.

- **Nurse Practitioners (Line 9a)**: Report nurse practitioners (NPs) and advanced practice nurses (APNs) on Line 9a. Do not include psychiatric nurse practitioners (included on Line 20b, Other Licensed Mental Health Providers) or certified nurse

midwives (CNMs) (reported on Line 10).

- **Physician Assistants (Line 9b)**

- **Certified Nurse Midwives (Line 10)**

- **Nurses (Line 11)**: Report licensed registered nurses, licensed practical and vocational nurses, home health and visiting nurses, clinical nurse specialists, and public health nurses.

- **Other Medical Personnel (Line 12)**: Report medical assistants, nurses' aides, and all other personnel, including unlicensed interns or residents, providing services in conjunction with services provided by a physician, NP, PA, CNM, or nurse.

  Other medical personnel considerations:

  o   Do not report staff dedicated to QI or HIT/EHR informatics here. Report them on Line 29b, Quality Improvement Staff.

  o   Do not report medical records and patient support staff here. Report them on Line 32, Patient Support Staff.

- **Laboratory Personnel (Line 13)**: Report pathologists, medical technologists, laboratory technicians and assistants, and phlebotomists. Some or all of licensed nurses' time may be in this category if they are assigned to this responsibility, but none of the time of a physician should be included on Line 13.

- **X-ray Personnel (Line 14)**: Report radiologists, X-ray technologists, and X-ray technicians. Physician time would not be included here even if

they were taking X-rays or performing sonograms.

Dental Services (Lines 16–19)

- **Dentists (Line 16)**: Report general practitioners, oral surgeons, periodontists, and endodontists providing prevention, assessment, or treatment of a dental problem, including restoration. Do not classify dental therapists here. Report them on Line 17a, Dental Therapists.

- **Dental Hygienists (Line 17)**

- **Dental Therapists (Line 17a)**: Only a few states license dental therapists. Classify staff to this line based on state licensing and function.

- **Other Dental Personnel (Line 18)**: Report dental assistants, advanced dental assistants, aides, and technicians.

Behavioral Health Services

The term "behavioral health" is synonymous with the prevention or treatment of mental health and substance use disorders. All visits, providers, and costs classified by health centers as "behavioral health" must be parsed out into mental health or substance use disorder. Centers may choose to identify all behavioral health services as Mental Health Services if there is no way to parse out these services.

Mental Health Services (Lines 20a–20c)

Mental health services include psychiatric, psychological, psychosocial or crisis intervention services.

- **Psychiatrists (Line 20a)**

- **Licensed Clinical Psychologists (Line 20a1)**

- **Licensed Clinical Social Workers (Line 20a2)**

- **Other Licensed Mental Health Providers (Line 20b):** Report other licensed mental health providers, including psychiatric social workers, psychiatric nurse practitioners, family therapists, and other licensed master's degree-prepared clinicians.

- **Other Mental Health Staff (Line 20c)**: Report unlicensed individuals and support staff, including "certified" individuals, who provide counseling, treatment, or support to mental health providers.

  Mental health service personnel considerations:

  o Unlicensed interns or residents in any of the professions listed on Lines 20a through 20b are counted on Line 20c, unless they possess a separate license under which they are practicing. Thus, a licensed clinical social worker (LCSW) doing a psychology internship may be counted on the LCSW Line 20a2 until a license is received as a psychologist.

Substance Use Disorder Services (Line 21)

Report individuals who provide substance use disorder services, including substance use disorder workers, psychiatric nurses, psychiatric social workers, mental health nurses, clinical psychologists, clinical social workers, family therapists, and other individuals providing alcohol or drug abuse counseling and/or treatment services.

Substance use disorder service personnel considerations:

o Neither licenses nor credentials are required by the UDS. Each center will credential its own providers according to its own standards.

o Report medical providers treating patients with substance use diagnoses on Lines 1 through 10, not as substance use disorder providers.

o Do not include physicians, NPs, or physician assistants (PAs) who obtained a Drug Addiction Treatment Act of 2000 (DATA) waiver to treat opioid use disorder with medications *(medication-assisted treatment [MAT])* specifically approved by the U.S. Food and Drug Administration (FDA) here. Include MAT on Lines 1–9b (if medical), Line 20a for psychiatrist, or Line 20b for psychiatric nurse practitioner.

Other Professional Health Services (Line 22)

Report individuals who provide other professional health services. Some common professions include occupational, speech, and physical therapists; registered dieticians; nutritionists; podiatrists; naturopaths; chiropractors; acupuncturists; and community health aides and practitioners. A more complete list is included in Appendix A.

Other professional health personnel considerations:

o These professionals are usually, but not always, licensed by some entity. They are also generally credentialed

and privileged by the health center's governing board.

o Report WIC nutritionists and other professionals working in WIC programs on Line 29a, Other Programs and Services Staff.

Vision Services (Lines 22a–22d)

Report providers who perform eye exams for early detection, care, treatment, and prevention for those with vision problems that relate to chronic diseases such as diabetes, hypertension, thyroid disease, and arthritis, or for the prescription of corrective lenses.

- **Ophthalmologists (Line 22a):** Report medical doctors specializing in medical and surgical eye problems.
- **Optometrists (Line 22b)**
- **Other Vision Care Staff (Line 22c):** Report ophthalmologist and optometric assistants, aides, and technicians.

Pharmacy Services (Line 23)

Report pharmacists (including clinical pharmacists), pharmacy technicians, pharmacist assistants, and others supporting pharmaceutical services.

Pharmacy services considerations:

o Do not report the time (or cost) of individuals spending all or part of their time in assisting patients to apply for free drugs from pharmaceutical companies (pharmacy assistance programs [PAP]) here. Report them under "Eligibility Assistance Workers," on Line 27a.

o Allocate an individual employee who works as a pharmacy assistant (for example) and also provides PAP enrollment assistance by time spent in each category.

o Report licensed clinical pharmacists on Line 23. Do not allocate to other clinical or non-clinical lines.

o Do not include time for individuals who work at a 340(b) contact pharmacy.

Enabling Services (Lines 24–29)

- **Case Managers (Line 24):** Report staff who assist patients in the management of their health and social needs, including assessment of patient medical and/or social service needs; establishment of service plans; and maintenance of referral, tracking, and follow-up systems. Case managers may, at times, provide health education and/or eligibility assistance in the course of their case management functions. Include individuals who are trained as, and specifically called, case managers, as well as individuals called care coordinators, referral coordinators, and other local titles.
- **Patient and Community Education Specialists (Line 25):** Report health educators, with or without specific degrees, in this area.
- **Outreach Workers (Line 26):** Report individuals conducting case finding, education, or other services to identify potential patients or clients and/or facilitate access or referral of potential health center patients to available health center services.

- **Transportation Workers (Line 27):** Report individuals who provide transportation for patients (van drivers) or arrange for transportation, including persons who provide for long-distance transportation to major cities in extremely remote clinic locations.

- **Eligibility Assistance Workers (Line 27a):** Report staff who provide assistance in securing access to available health, social service, pharmacy, and other assistance programs, including Medicaid, Medicare, WIC, Supplemental Security Income (SSI), food stamps through the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), PAPs, and related assistance programs, as well as staff hired under the HRSA Outreach and Enrollment grants.

- **Interpretation Staff (Line 27b):** Report staff whose full-time or dedicated time is devoted to translation and/or interpretation services. Do not include the portion of the time a nurse, medical assistant, or other support staff who provides interpretation or translation during his/her other activities on this line.

- **Community Health Workers (Line 27c):** Report lay members of communities who work in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve. Staff may be called community health workers, community health

advisors, lay health advocates, *promotoras*, community health representatives, peer health promoters, or peer health educators.

Community health worker considerations:

o They may perform some or all of the tasks of other enabling services workers.

o Do not include individuals better classified under other categories, such as Other Medical Personnel (Line 12) or Other Dental Personnel (Line 18).

- **Personnel Performing Other Enabling Service Activities (Line 28):** Report all other staff performing enabling services not described above.

Other enabling services considerations:

o Do not use enabling services, and especially "Other Enabling Services" (Line 28), as a catchall, all-inclusive category for services that are not included on other lines. Often, such services belong on Line 29a (Other Programs and Related Services) or are services that are not separately reported on the UDS.

o If a service does not fit the strict descriptions for Lines 24 through 27b, its inclusion on Line 28 must include a clear detailed statement of what is being reported; complete the "specify" field to describe what these staff are doing.

o Check such services with the UDS Support Center or UDS Reviewer prior to submission.

Other Programs and Related Services Staff (Line 29a)

Some health centers, especially "umbrella agencies," operate programs that although within their scope of service and often important to the overall health of their patients, are not directly a part of the listed medical, dental, behavioral, or other health services. Include WIC programs, job training programs, Head Start or Early Head Start programs, shelters, housing programs, child care, frail elderly support programs, adult day health care (ADHC) programs, fitness or exercise programs, public/retail pharmacies, etc. Use the "specify" field to describe what these staff members are doing.

Quality Improvement Staff (Line 29b)

Although quality improvement (QI) is a part of virtually all clinical and administrative roles, some individuals have specific responsibility for the design and oversight of QI systems. Report individuals that spend all or a substantial portion of their time dedicated to these activities. They may have clinical, information technology (IT), or research backgrounds, and may include QI nurses, data specialists, statisticians, and designers of HIT (including EHRs and electronic medical records (EMRs)).

QI staff considerations:

- *Do not include on this line* the time of clinicians such as physicians or dentists who are involved in the QI process. Their time is to remain on the service delivery lines.

- Report staff who support HIT to the extent that they are working with the QI system on Line 29b.

- Continue to report staff who document services in the HIT in the appropriate service category, not here.

Non-Clinical Support Services (Line 30a–32)

- **Management and Support Staff (Line 30a):** Report management team including the CEO, chief financial officer (CFO), chief information officer, chief medical officer, chief operations officer (COO), and human resources (HR) director, as well as other non-clinical support staff and office support (secretaries, administrative assistants, file clerks, etc.). For medical directors or other individuals whose time is split between clinical and non-clinical activities, report only that portion of their FTE corresponding to the corporate management function. (See limits on non-clinical time above).

- **Fiscal and Billing Staff (Line 30b):** Report staff performing accounting and billing functions in support of health center operations for services performed within the scope of the program, excluding the CFO (who is reported on Line 30a).

- **IT Staff (Line 30c):** Report technical information systems staff supporting the maintenance and operation of the computing systems that support functions performed within the scope of the program.

  IT staff considerations:

- o Report IT staff managing the hardware and software of an HIT (including EHR/EMR) system on Line 30c.

- o Do not report IT staff designing medical forms and conducting analysis of HIT data here. Report as part of the QI functions on Line 29b.

- o Include IT staff performing data entry as well as providing help-desk, training, and technical assistance functions as part of the other medical personnel or appropriate service category for which they perform these functions.

- **Facility Staff (Line 31):** Report staff with facility support and maintenance responsibilities, including custodians, housekeeping staff, security staff, and other maintenance staff. If facility functions are contracted (e.g., janitorial services), do not attempt to create an FTE, but report the costs on the facility Line 14 on Table 8A.

- **Patient Services Support Staff (Line 32):** Report intake staff, front desk staff, and medical/patient records.

*Note: The non-clinical category for this report is more comprehensive than that used in some other program definitions and includes **all** such personnel working in a health center, whether that individual's salary was supported by the BPHC grant or other funds included in the scope of project. Where appropriate, and when identifiable, report staff included in a health center's federally approved indirect cost rate here.*

Clinic Visits, Column B

Report documented face-to-face contact between a patient and a licensed or credentialed provider who exercises their independent, professional judgment in the provision of services to the patient as a **visit** in Column B. Report face-to-face visits that occurred during the reporting year rendered by salaried, contracted, or volunteer staff. Most visits reported in Column B will be provided by staff identified in Column A (see the Definitions of Visits, Patients, and Providers section, for further details on the definition of visits). Visits purchased from contracted providers on a fee-for-service basis will also be reported.

Virtual Visits, Column B2

Report documented virtual (telemedicine) contact between a patient and a licensed or credentialed provider who exercises their independent, professional judgment in the provision of services to the patient as a **visit** in Column B2. Report virtual visits that occurred during the reporting year rendered by salaried, contracted, or volunteer staff. Most visits reported in Column B2 will be provided by staff identified in Column A. Virtual visits purchased from contracted providers on a fee-for-service basis will also be reported.

Note: It is recognized that telemedicine is a growing model of care delivery. It will be important to remember that state and federal telehealth definitions and regulations regarding the acceptable modes of care delivery, types of providers, informed consent, and location of the patient and/or provider are not applicable in determining virtual visits for UDS reporting.

Virtual Visit Considerations

- Virtual visit reporting should be consistent with the health center's scope of project.

- Virtual visits must meet the countable visit definitions (see the Definitions of Visits, Patients, and Providers section, for further details on the definition of visits).

- If the health center provider virtually provided care to a patient who is elsewhere (not physically at their health center), report the visit.

- If the health center authorized patient services by a non-health center provider who provided care to a patient who is at the health center through telemedicine, and the health center paid for the services, report the visit.

- If the health center does not pay for services provided by a non-health center provider (referral), do not count it as a visit.

- Only count virtual visits provided using interactive, synchronous audio and/or video telecommunication systems that permit real-time communication between the provider and a patient. Do not count other modes of telemedicine services (e.g., store and forward, remote patient monitoring, mHealth) or provider-to-provider consultations.

- The visit must be coded and charged as telehealth services, even if third-party payers may not recognize or pay for such services. There may also be alternative data elements in the health center systems to identify virtual visits. Generally, these charges would be comparable to a face-to-face visit charge.

Note: Use telehealth specific codes with the CPT or Healthcare Common Procedure Coding System (HCPCS) code G0071, modifier ".95", or Place of Service code "50" to identify virtual visits.

- Virtual visits by a provider who is not physically present at the health center may be counted if this is consistent with their scope of project. The provider would need access to the health center's HIT/EHR to review the patient's record and to record their activities.

- All rules regarding multiple visits in the same service category in the same day apply *except* if there are two different providers at two different locations.

Visits purchased from non-staff providers on a fee-for-service basis

Count these visits in column B (face-to-face) or B2 (virtual) even though no corresponding FTEs are included in Column A. To count, the visit must meet the following criteria:

- The service was provided to a patient of the health center by a provider who is not part of the health center's staff (neither salaried nor contracted on the basis of time worked although met the center's credentialing policies),

- The service was paid for in full by the health center, and

- The service otherwise meets the definition of a visit.

Note: Do not include unpaid referrals; referrals where a third-party will make the payment (e.g., the patient's insurance company); or referrals where only nominal amounts, including facility fees, are paid although the negotiated payment may be less than the provider's "usual, customary, and reasonable" (UCR) rates.

Visit Considerations

Nurses, Line 11:

- Services may be provided under standing orders of a medical provider under specific instructions from a previous visit or under the general supervision of a physician, NP, PA, or CNM who has no direct contact with the patient during the visit. These services must meet the requirement of exercising independent professional judgment. However, do not count if the service is attendant to another visit (e.g., nurse calls to check up on how you are doing after a visit), even if it occurs on a subsequent day.

- Report nurse visits that meet all visit criteria. See Instructions for Visits.

- Report triage services provided by nurses and visiting nurse services when a nurse sees patients independently in the patients' homes to evaluate their condition.

- Do not count interactions with the nurse where the primary purpose is to conduct a lab test, give an injection, or dispense or administer a drug, regardless of the level of observation needed.

- Count visits charged and coded as CPT 99211 only when all components of visit requirements were met.

- Most states prohibit a licensed vocational nurse or a licensed practical nurse from exercising independent judgment; do not count visits for them.

Other medical personnel, Line 12:

- Do not count services provided by medical assistants, aides, or other non-nursing personnel here or as nursing visits on Line 11.

Dentists, dental hygienists, and dental therapists, Lines 16, 17, and 17a:

- Report only one visit per patient per day, regardless of the number of clinicians who provide services (e.g., dentist and dental hygienist both see the patient) or the volume of service (i.e., number of procedures) provided.

- Do not count the application of dental varnishes, fluoride treatments, and dental screenings, absent other comprehensive dental services as a visit.

- Do not credit services of dental students or anyone else other than a licensed dental provider with dental visits, even if these individuals are working under the supervision of a licensed dental provider.

- Exception: Count the visits of a supervising dentist's student (i.e., one who is overseeing dental students who are enrolled in a graduate education program leading to a license as a dentist) as long as the supervising dentist:

  o Has no other responsibilities, including the supervision of other personnel at the time services are furnished by the students,

- o Has primary responsibility for the patients,
- o Reviews the care furnished by the students during or immediately after each visit, and
- o Documents the extent of his or her participation in the review and direction of the services furnished to each patient.

- Do not count medical providers who examine a patient's dentition or provide fluoride treatments as a dental visit.

Other mental health, Line 20c:

- Credit these individuals with their own visits regardless of any billing practices at the center. No other person is to be credited with these visits.

Substance use disorder, Line 21:

- In programs that include the regular use of narcotic agonists or antagonists or other medications on a regular basis (daily, every three days, weekly, etc.), count the counseling services as visits but not the dispensing of the drugs, regardless of the level of oversight that occurs during that activity. Report counseling patients to determine or diagnose their medical needs, including medication assistance, as medical or psychiatry visits based on the provider providing these services, not on Line 21 as substance use disorder visits.

Other professional, Line 22:

- Describe all services in a clear detailed statement using the "specify" box.

- Include the services of professional health service providers included in Appendix A.

- Check the reporting of other professional services with the UDS Support Center or the UDS Reviewer.

Vision services, Lines 22a–22d:

- Do not count the services of students or anyone other than a licensed vision service provider with vision services visits.

- Do not count retinography (imaging of the retina), whether performed by a licensed vision services provider or anyone else, as a vision visit absent a comprehensive vision exam.

- Do not consider fitting glasses as a visit regardless of who performs the fitting.

Pharmacy, Line 23:

- Some states license clinical pharmacists whose scope of practice may include ordering labs and reviewing and altering medications or dosages. Despite this expanded scope of practice, do not record clinical pharmacist interactions with patients as visits.

Case managers, Line 24:

- Case managers often contact third-parties in the provision of their services. Do not count these contacts or interactions, even though they are recognized as important.

- When a case manager serves an entire family (e.g., helping with housing or Medicaid eligibility) only count one visit, generally for an adult member of the family, regardless of documentation in other charts.

- Case management is rarely the only type of service provided to a patient during the year.

Patient and community education, Line 25:

- Report only services provided one-on-one with the patient. Do not report group education classes or visits.

- Health education is provided to support the delivery of other health care services and is rarely the only type of service provided to a patient during the year.

Do not record visits and patients for services provided by the following:

- Other Medical Personnel, Line 12

- Laboratory Personnel, Line 13

- X-ray Personnel, Line 14

- Other Dental Personnel, Line 18

- Other Vision Care Staff, Line 22c

- Pharmacy Personnel, Line 23

- Outreach Workers, Line 26

- Transportation Staff, Line 27

- Eligibility Assistance Workers, Line 27a

- Interpretation Staff, Line 27b

- Community Health Workers, Line 27c

- Other Enabling Services, Line 28

- Other Programs and Services, Line 29a

- Quality Improvement Staff, Line 29b

- Management and Support Staff, Line 30a

- Fiscal and Billing Staff, Line 30b

- IT Staff, Line 30c

- Facility Staff, Line 31

- Patient Support Staff, Line 32

Additionally, some interactions cannot be reported as visits regardless of who provides them. Please review the Services and Persons Not Reported on the UDS Report section above for specifics.

Patients, Column C

A patient is an individual who has at least one reportable visit during the reporting year. For further details, see the Instructions for Tables that Report Visits, Patients, and Providers section.

- Report an unduplicated patient count in Column C for each of the seven categories of services shown below for which patients had visits reported in Column B during the reporting year.

  o Medical services (Line 15)

  o Dental services (Line 19)

  o Mental health services (Line 20)

  o Substance use disorder services (Line 21)

  o Vision services (Line 22d)

  o Other professional services (Line 22)

  o Enabling services (Line 29)

- Within each service category, count an individual only once as a patient regardless of the number of visits. A patient who receives multiple types of services will be reported once (and only once) for each service category.

- Because patients must have at least one documented visit, it is not possible for the number of patients to exceed the number of visits.

- Do not include individuals who only receive services for which no visits are generated (e.g., laboratory, imaging, pharmacy, transportation, and outreach).

- Patients counted on Table 5 must be included as patients on the demographics tables: ZIP Table and Tables 3A, 3B, and 4.

Selected Service Detail Addendum

The Table 5 addendum provides data on mental health services provided by medical providers as well as substance use disorder services provided by medical providers and mental health providers. It is reported on the Universal Report only.

The information in this section only reflects providers and their mental health and substance use disorder treatment services not already reported in the mental health and substance use disorder sections on the main part of Table 5. The sum of mental health and substance use disorder services/visits reported in the main part of Table 5 and this addendum to Table 5 provide an **unduplicated** count of mental health and substance use disorder **services** across all provider types.

To identify visits where a mental health or substance use disorder treatment service may have been rendered, include all visits for the reporting providers with ICD-10 codes specified on Table 6A, Lines 18 through 19a for substance use disorder treatment and Lines 20a through 20d for mental health treatment.

Examples of provider activity reported in the addendum are as follows:

- A physician who sees a patient for treatment of depression.

- A nurse practitioner seeing a patient for diabetes who is also showing signs of depression.

- A physician assistant providing MAT services to a patient with an opioid use disorder.

- A licensed clinical psychologist seeing a patient for mental health problems exacerbated by a substance use disorder.

Note: All activity counted in the addendum is a part of a countable visit already reported on the main section of Table 5. Unlike the general rules used for the main part of Table 5 and for Tables 3A, 3B, and 4, where an unduplicated count of patients and visits are reported, the addendum may include duplication across service categories. Some visits may include both mental health and substance use disorder treatment and will be reported as such.

Addendum Reporting

The Selected Service Details addendum is divided into two service categories: mental health and substance use disorders.

Providers, Column A1

- Report the number of individual providers (not FTE) by type who provided mental health and/or substance use disorder services. The provider can be counted once in each section if they provide both services.

Note: If the provider is a contract provider paid by the visit or service, do not count an FTE on the main part of Table 5, but count the provider in the addendum.

Clinic Visits, Column B

- Report the number of face-to-face visits, by provider type, where the service in whole or in part included treatment for mental health (on Lines 20a01 through 20a04) or substance use disorder services (Lines 21a through 21h).

Virtual Visits, Column B2

- Report the number of virtual visits, by provider type, where the service in whole or in part included treatment for mental health (on Lines 20a01 through 20a04) or a substance use disorder services (Lines 21a through 21h).

Patients, Column C

- Report the number of patients seen for a face-to-face or virtual mental health or substance use disorder service. Report patients (and their visits) for each type of provider listed that they saw during the year for these services.

Relationship between Table 5 and Table 8A

The staffing on Table 5 is routinely compared to the costs on Table 8A. See the crosswalk of comparable fields in Appendix B.

Additional information is available to clarify reporting. View **FAQs for Table 5**.

Table 5: Staffing and Utilization

Reporting Period: January 1, 2020, through December 31, 2020

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1	Family Physicians				
2	General Practitioners				
3	Internists				
4	Obstetrician/Gynecologists				
5	Pediatricians				
7	Other Specialty Physicians				
8	**Total Physicians** (Lines 1–7)				
9a	Nurse Practitioners				
9b	Physician Assistants				
10	Certified Nurse Midwives				
10a	**Total NPs, PAs, and CNMs** (Lines 9a–10)				
11	Nurses				
12	Other Medical Personnel				
13	Laboratory Personnel				
14	X-ray Personnel				
15	**Total Medical** (Lines 8 + 10a through 14)				
16	Dentists				
17	Dental Hygienists				
17a	Dental Therapists				
18	Other Dental Personnel				
19	**Total Dental Services** (Lines 16–18)				
20a	Psychiatrists				
20a1	Licensed Clinical Psychologists				
20a2	Licensed Clinical Social Workers				
20b	Other Licensed Mental Health Providers				
20c	Other Mental Health Staff				
20	**Total Mental Health** (Lines 20a–c)				
21	**Substance Use Disorder Services**				
22	**Other Professional Services** (specify___)				

Table 5: Staffing and Utilization (continued)
Reporting Period: January 1, 2020, through December 31, 2020

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
22a	Ophthalmologists				<cell not reported>
22b	Optometrists				<cell not reported>
22c	Other Vision Care Staff		<cell not reported>	<cell not reported>	<cell not reported>
22d	**Total Vision Services** (Lines 22a–c)				
23	**Pharmacy Personnel**		<cell not reported>	<cell not reported>	<cell not reported>
24	Case Managers		<blank for demonstration>		<cell not reported>
25	Patient/Community Education Specialists		<blank for demo>		<cell not reported>
26	Outreach Workers		<cell not reported>	<cell not reported>	<cell not reported>
27	Transportation Staff		<cell not reported>	<cell not reported>	<cell not reported>
27a	Eligibility Assistance Workers		<cell not reported>	<cell not reported>	<cell not reported>
27b	Interpretation Staff		<cell not reported>	<cell not reported>	<cell not reported>
27c	Community Health Workers		<cell not reported>	<cell not reported>	<cell not reported>
28	Other Enabling Services (specify___)		<cell not reported>	<cell not reported>	<cell not reported>
29	**Total Enabling Services** (Lines 24–28)		<blank for de		<blank
29a	**Other Programs/Services** (specify___)		<cell not reported>	<cell not reported>	<cell not reported>
29b	**Quality Improvement Staff**		<cell not reported>	<cell not reported>	<cell not reported>
30a	Management and Support Staff		<cell not reported>	<cell not reported>	<cell not reported>
30b	Fiscal and Billing Staff		<cell not reported>	<cell not reported>	<cell not reported>
30c	IT Staff		<cell not reported>	<cell not reported>	<cell not reported>
31	Facility Staff		<cell not reported>	<cell not reported>	<cell not reported>
32	Patient Support Staff		<cell not reported>	<cell not reported>	<cell not reported>
33	**Total Facility and Non-Clinical Support Staff** (Lines 30a–32)		<cell not reported>	<cell not reported>	
34	**Grand Total** (Lines 15+19+20+21+22+22d+23+29+29a+ 29b+33)				<cell not reported>

Table 5: Selected Service Detail Addendum
Reporting Period: January 1, 2020, through December 31, 2020

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

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

Instructions for Table 6A: Selected Diagnoses and Services Rendered

This table is designed to provide data on selected diagnosis and selected services rendered. The data source is data maintained for billing purposes and/or in HIT systems, including EHRs. Table 6A is not expected to reflect the full range of diagnoses and services rendered by a health center. The diagnoses and services selected represent those that are prevalent among Health Center Program patients or that have been regarded as sentinel indicators of access to primary care or are of special interest to HRSA.

Report diagnoses on this table that were made as part of documented visits with licensed or credentialed medical, dental, mental health, substance use disorder, or vision providers only. For example, do not count a diagnosis for diabetes if a case manager or a health educator sees the patient with diabetes or a diagnosis of hypertension is made by a mental health provider.

Report all diagnoses rendered at a specific visit. For example, if a physician shows a diagnosis of hypertension and diabetes, record the visit and the patient on both the line for hypertension and the line for diabetes. However, *do not* count "active diagnoses" present at the time of a visit but not addressed during the visit.

Note: *Use age as of June 30 for diagnoses and tests with specified age ranges.*

Visits and Patients, Columns A and B

Visits and Patients by Selected Diagnoses, Lines 1–20d

Lines 1 through 20d present the name and applicable ICD-10-CM codes for the diagnosis or diagnostic range/group. Wherever possible, diagnoses have been grouped into code ranges. Report on all visits and patients where the provider-assigned diagnostic code is included in the range/group of ICD-10-CM codes shown. Report all diagnoses for the visit if they are included in the range of codes listed.

In Column A, report the total number of visits (face-to-face and virtual) during the reporting period where the indicated diagnosis is listed in the HIT/EHR or visit/billing record. Do not report if a visit includes a diagnosis that is among the many diagnoses not listed on Table 6A. Count each included diagnosis made at a visit on Lines 1–20d, regardless of the number of diagnoses listed for the visit. For example, count a patient visit with a diagnosis of hypertension and a diagnosis of diabetes once on Line 9 and once on Line 11.

In Column B, report each individual who had one or more visits (face-to-face and virtual) during the year that was reported in the corresponding Column A. Count a patient only once on any given line, regardless of the number of visits made for that specific diagnosis or family of diagnoses. Report patients with multiple diagnoses in Column B

only once for **each** diagnosis used during the year. For example, count a patient with one or more visits with a diagnosis of hypertension and one or more visits with a diagnosis of diabetes once as a patient in Column B on *both* Lines 9 and 11.

Visits and Patients by Selected Tests/Screenings, Lines 21–26d

Lines 21 through 26d present the name and applicable ICD-10-CM diagnostic and/or CPT procedure codes for selected tests, screenings, and preventive services that are important to the populations served or are of interest to HRSA and are services performed by the health center or by contracted paid referral. On several lines, both CPT codes and ICD-10-CM codes are provided. Use **either** the CPT codes **or** the ICD-10-CM codes for any specific visit, **but not both**. Report *all visits meeting the selection criteria that are part of a reportable visit or as follow-up to a reportable visit*. A reported service may be in addition to another service and may be in addition to a reported diagnosis or may stem from a visit where there was no UDS-reportable diagnosis code.

Note: During a visit with the provider, selected screenings or tests may be ordered. Count completed services in this section even if they were done at a later date.

Note: ICD-10-CM codes for some services (such as mammography and Pap tests) are listed to ensure capture of procedures that are done by the health center but may be coded with a different CPT code for state reimbursement under Title X or BCCCP. In some instances, payers (especially governmental payers) and labs ask health centers to use different codes for services.

In these instances, health centers should add these codes to the published list for reporting purposes.

- Count a test paid for by a third-party only if the health center performed the test in its lab (e.g., point-of-care testing) or collected the sample and transferred it to a reference lab.

- Do not report referrals or orders for tests or procedures, such as mammograms, X-rays, or tomography that are not performed by or paid for by the health center. For example, do not count the referral of a woman to the local hospital or county health department for a mammogram.

- Count Pap tests performed by a health center but read by an outside pathologist who then bills a third-party.

In Column A, report the total number of visits (face-to-face and virtual) 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-10-CM) codes or procedure (CPT) codes. During one visit, more than one test, screening, or preventive service may be provided. Count each procedure or test on each applicable line. If they are on the same line, only count one visit.

In Column B, report patients who have had at least one visit (face-to-face and virtual) during the reporting period where the selected diagnostic tests, screenings, and/or preventive services listed on Lines 21–26d were provided.

- Count patients who receive more than one type of service during a single visit. For example, 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.

- Count a patient only once per service, regardless of the number of times a patient receives a given service. 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.

The following examples illustrate these rules:

- When one visit involves more than one of the listed services, report each service. For example, if during a visit both an HIV test and a Pap test were provided, then report a visit on both Line 21 (HIV test) and Line 23 (Pap test).

- If a patient receives multiple immunizations at one visit, report only one visit on Line 24.

- Report services in addition to diagnoses. For example, count a hypertensive patient who also receives an HIV test on Line 11 (hypertension) and on Line 21 (HIV test).

- Report services where no diagnosis is reported. For example, count a patient who comes in for an annual physical and a flu shot. Report this patient on Line 24a (flu shot) but not on any diagnostic line.

*Note: **Include follow-up services** related to a countable visit. Thus, if a provider asks that a patient return in 30 days for a flu shot, when that patient presents, the shot is counted because it is legally considered to be a part of the initial visit. **Do not***

*report an interaction** with another person who is not a clinic patient who comes in just for a flu shot during a health center-run flu clinic and without a specific referral from a prior visit.*

Visits and Patients by Dental Services, Lines 27–34

Lines 27 through 34 present the name and applicable American Dental Association (ADA) procedure codes for selected dental services. These services *may be performed only by a dental provider who is reported on Lines 16–17a on Table 5 or by an in-scope dental contractor paid by the health center*. Wherever appropriate, services have been grouped into code ranges. For these lines, the concept of a "primary" code is neither relevant nor used. All services are reported.

In Column A, report the total number of visits at which one or more of the listed diagnostic tests, screenings, and/or dental services were provided. During one visit, more than one test, screening, or dental service may be provided. Count each procedure, screening, or test on each applicable line. If they are on the same line, only count one visit. For example, if a patient had more than one tooth filled during a visit, report only one visit for restorative services (Line 32), not one per tooth.

In Column B, report patients who had at least one visit with a dental professional during the reporting period for each of the selected dental services listed.

- Do not report services provided by persons other than a dentist, a dental hygienist, or a dental therapist.

- Count a patient who had two teeth repaired and sealants applied during a visit once on both Lines 30 and 32.

- Report dental services provided directly by a licensed dental provider or an individual working under his/her direct supervision.

- Only report services that are provided at or as follow-up to "countable" visits (e.g., an oral exam).

Note: Do not count fluoride treatments or varnishes that are applied outside of a comprehensive treatment plan, especially when provided as part of a community service at schools, on this table or as a visit on Table 5.

Services provided by multiple entities:

Take care when multiple entities are involved with a service. Use the following general examples to guide reporting:

- Count the service if the health center provider orders and performs the service. For example, count a rapid HbA1c test ordered by a physician and performed in the clinic lab.

- Do not report vaccinations performed by the health department when children are referred to a city or county health department and the health center does not pay for the service.

- If the health center provider orders a test (e.g., HIV test) and the sample is collected at the health center and then sent to a reference lab for processing, count the test regardless of whether the test is paid for by the patient, the patient's

insurance company,[6] a government entity, or the health center.

- Count a test that a provider asks the patient to get from a third-party provider that sends the results back to the provider to be acted on *and bills the health center for it*. For example, count mammograms performed by a third-party provider that a health center contracts with and pays for the service.

- Do not count a test or service that a provider asks the patient to get from a third-party provider that *does not bill the health center*, even if the results are sent back to the provider to be acted on. For example, do not count mammograms performed by the county health department for which the county will follow up with the patient directly and the health center did not pay for the service.

- Do not count a test or service when a patient is referred (e.g., for an HIV test to a Ryan White program) where the receiving entity performs the service and follows up with the patient and the health center does not pay for the service. (These are generally noted in Column III: Formal Written Referral Arrangement [Health center does not pay] of Form 5A: Services Provided).

Additional information is available to clarify reporting. View **FAQs for Table 6A**.

_____
[6] Billing rules require that the charge for a lab test ordered by a provider be sent directly to a third-party (including Medicaid and Medicare) and not to the provider or the health center.

DRAFT

Table 6A: Selected Diagnoses and Services Rendered

Reporting Period: January 1, 2020, through December 31, 2020

Table 6A: Selected Diagnoses

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
	Selected Infectious and Parasitic Diseases			
1-2	Symptomatic/ Asymptomatic human immunodeficiency virus (HIV)	B20, B97.35, O98.7-, Z21	<blank for dental>	
2a	Pre-Exposure Prophylaxis (PrEP) Prescription	Through possible exposure risk at encounters: Z20.2, Z11.4, Z11.3, Z20.6, Z72.5, Z72.51, Z72.52, Z72.53, Z11.59, Z20.5, Z71.7, F19.20, Z70.1, Z20.82, Z77.21, Z77.9, W46, W46.0, W46.1 Through possible counseling during initiation or continuation: (CPT codes) 99201-99205, 99211-99215, 99401-99404, 99411, 99412 Through possible lab codes during initiation or surveillance: (CPT codes) 86689, 86701-86703, 87534-87539, 87389-87391, G0432, G0433, G0435 Z01.812, Z51.81, Z79.899, Z86.59, Z87.898, F11.20, F11.21, F11.10, F11.90 Through codes associated with possible PrEP prescribing: Z79.899 and (RXNorm codes) Truvada 495430, Descovy 1747692, TDF 322248, FTC 276237, TAF 1721604		
3	Tuberculosis	A15- through A19-, O98.0-		
4	Sexually transmitted infections	A50- through A64- (exclude A63.0)		
4a	Hepatitis B	B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, O98.4-		
4b	Hepatitis C	B17.10, B17.11, B18.2, B19.20, B19.21		
	Selected Diseases of the Respiratory System			
5	Asthma	J45-		

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
6	Chronic lower respiratory diseases	J40- through J44-, J47-		
	Selected Other Medical Conditions			
7	Abnormal breast findings, female	C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.81, D05-, D48.6-, D49.3, N60-, N63-, R92-		
8	Abnormal cervical findings	C53-, C79.82, D06-, R87.61-, R87.629, R87.810, R87.820		
9	Diabetes mellitus	E08- through E13-, O24- (exclude O24.41-)		
10	Heart disease (selected)	I01-, I02- (exclude I02.9), I20- through I25-, I27-, I28-, I30- through I52-		
11	Hypertension	I10- through I16-, O10-, O11-		
12	Contact dermatitis and other eczema	L23- through L25-, L30- (exclude L30.1, L30.3, L30.4, L30.5), L58-		
13	Dehydration	E86-		
14	Exposure to heat or cold	T33-, T34-, T67-, T68-, T69-, W92-, W93-		
14a	Overweight and obesity	E66-, Z68- (exclude Z68.1, Z68.20 through Z68.24, Z68.51, Z68.52)		
	Selected Childhood Conditions (limited to ages 0 through 17)			
15	Otitis media and Eustachian tube disorders	H65- through H69-		
16	Selected perinatal/neonatal medical conditions	A33-, P19-, P22- through P29- (exclude P29.3), P35- through P96- (exclude P54-, P91.6-, P92-, P96.81), R78.81, R78.89		
17	Lack of expected normal physiological development (such as delayed milestone, failure to gain weight, failure to thrive); nutritional deficiencies in children only. Does not include sexual or mental development.	E40- through E46-, E50- through E63-, P92-, R62- (exclude R62.7), R63.3		

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
	Selected Mental Health Conditions and Substance Use Disorders			
18	Alcohol-related disorders	F10-, G62.1, O99.31-		
19	Other substance-related disorders (excluding tobacco use disorders)	F11- through F19- (exclude F17-), G62.0, O99.32-		
19a	Tobacco use disorder	F17-, O99.33-		
20a	Depression and other mood disorders	F30- through F39-		
20b	Anxiety disorders, including post-traumatic stress disorder (PTSD)	F06.4, F40- through F42-, F43.0, F43.1-, F93.0		
20c	Attention deficit and disruptive behavior disorders	F90- through F91-		
20d	Other mental disorders, excluding drug or alcohol dependence	F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0- and F43.1-), F50- through F99- (exclude F55-, F84.2, F90-, F91-, F93.0, F98-), O99.34-, R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0		
20e	Human Trafficking	T74.5- through T74.6-, T76.5- through T76.6-, Z04.8-, Z62.813, Z91.42		
20f	Intimate Partner Violence	T74.11, T74.21, T74.31, Z69.11, Y07.0		

Table 6A: Selected Services Rendered

Line	Service Category	Applicable ICD-10-CM Code or CPT-4/II Code	Number of Visits (a)	Number of Patients (b)
	Selected Diagnostic Tests/ Screening/Preventive Services			
21	HIV test	**CPT-4**: 86689, 86701 through 86703, 87389 through 87391, 87534 through 87539, 87806		
21a	Hepatitis B test	**CPT-4**: 86704 through 86707, 87340, 87341, 87350		
21b	Hepatitis C test	**CPT-4**: 86803, 86804, 87520 through 87522		
22	Mammogram	**CPT-4**: 77065, 77066, 77067 OR **ICD-10**: Z12.31		
23	Pap test	**CPT-4**: 88141 through 88153, 88155, 88164 through 88167, 88174, 88175 OR **ICD-10**: Z01.41-, Z01.42, Z12.4 (exclude Z01.411 and Z01.419)		
24	Selected immunizations: hepatitis A; haemophilus influenzae B (HiB); pneumococcal, diphtheria, tetanus, pertussis (DTaP) (DTP) (DT); mumps, measles, rubella (MMR); poliovirus; varicella; hepatitis B	**CPT-4**: 90632, 90633, 90634, 90636, 90643, 90644, 90645, 90646, 90647, 90648, 90669, 90670, 90696, 90697, 90698, 90700, 90701, 90702, 90703, 90704, 90705, 90706, 90707, 90708, 90710, 90712, 90713, 90714, 90715, 90716, 90718, 90720, 90721, 90723, 90730, 90731, 90732, 90740, 90743, 90744, 90745, 90746, 90747, 90748		
24a	Seasonal flu vaccine	**CPT-4**: 90630, 90653 through 90657, 90658, 90661, 90662, 90672, 90673, 90674, 90682, 90685 through 90689, 90749, 90756		
25	Contraceptive management	**ICD-10**: Z30-		
26	Health supervision of infant or child (ages 0 through 11)	**CPT-4**: 99381 through 99383, 99391 through 99393 **ICD-10**: Z00.1-		

Line	Service Category	Applicable ICD-10-CM Code or CPT-4/II Code	Number of Visits (a)	Number of Patients (b)
26a	Childhood lead test screening (9 to 72 months)	**ICD-10:** Z13.88 **CPT-4**: 83655		
26b	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	**CPT-4**: 99408, 99409 **HCPCS**: G0396, G0397, G0443, H0050		
26c	Smoke and tobacco use cessation counseling	**CPT-4**: 99406, 99407 OR **HCPCS**: S9075 OR **CPT-II**: 4000F, 4001F, 4004F		
26d	Comprehensive and intermediate eye exams	**CPT-4**: 92002, 92004, 92012, 92014		

Line	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)
	Selected Dental Services			
27	Emergency services	**ADA:** D0140, D9110		
28	Oral exams	**ADA:** D0120, DO145, D0150, D0160, D0170, D0171, D0180		
29	Prophylaxis–adult or child	**ADA:** D1110, D1120		
30	Sealants	**ADA:** D1351		
31	Fluoride treatment–adult or child	**ADA:** D1206, D1208 **CPT-4:** 99188		
32	Restorative services	**ADA:** D21xx through D29xx		
33	Oral surgery (extractions and other surgical procedures)	**ADA:** D7xxx		
34	Rehabilitative services (Endo, Perio, Prostho, Ortho)	**ADA:** D3xxx, D4xxx, D5xxx, D6xxx, D8xxx		

Sources of Codes:

- ICD-10-CM (2019)–National Center for Health Statistics (NCHS)
- CPT (2019)–American Medical Association (AMA)
- Code on Dental Procedures and Nomenclature CDT Code (2019)–Dental Procedure Codes. American Dental Association (ADA)

Note: "X" in a code denotes any number including the absence of a number in that place. Dashes (–) in a code indicate that additional characters are required. ICD-10-CM codes all have at least four digits. These codes are not intended to reflect if a code is billable or not. Instead, they are used to point out that other codes in the series are to be considered.

Instructions for Tables 6B and 7

Tables 6B and 7 provide data on selected quality of care and clinical health outcome and disparity measures. BPHC first implemented these measures in 2008 and continues to update them. BPHC will continue to revise and expand these measures consistent with the National Quality Strategy, CMS electronic Clinical Quality Measures (eCQMs), and other national quality initiatives.

The clinical quality measures (CQMs) described in this manual must be reported by all health centers using specifications detailed in the measure definitions described below. The majority of the UDS clinical measures are aligned with CMS 2020 Performance Period Eligible Professional/Eligible Clinical eCQMs. Use the most current CMS-issued eCQM specifications for the version numbers referenced in the UDS Manual for 2020 reporting and measurement period. Although there are other updates available from CMS, *they are not to be used* for 2020 reporting.

Note: The use of the phrase "measurement year" or "measurement period" may be used interchangeably in this section. These have the same meaning and are intended to represent calendar year 2020, unless another timeframe is specifically noted. For UDS clinical measure reporting, evaluate patients who had at least one medical visit (dental for the dental sealant measure) during the measurement period.

The measure specifications can be found at the CMS' eCQI Resource Center. The eCQM measure numbers and links are provided to assist you, when applicable. For clarification or interpretation of CMS eCQMs, please contact the measure steward (listed in Appendix G). Additionally, the use of official versions of vocabulary value sets as contained in the Value Set Authority Center (VSAC)[7] is encouraged for health centers capable of appropriately using this resource as defined below to support the data reporting of these clinical measures.

Note: CMS has updated the logic statements describing the criteria for eCQM reporting using Clinical Quality Language (CQL) in an effort to standardize reporting workflows. Health centers are advised to review workflows to ensure that required data are being captured correctly to calculate measures. It is important to note that data results may be impacted by the change. In order to address the impacts of these changes, health centers should work with vendors and IT staff to understand any unexpected changes in the data results.

Column Logic Instructions

Column A (A, 2A, or 3A): Number of Patients in the Universe (Denominator)

Report the total number of patients who fit the detailed criteria described for the specified measure. *Consider patients meeting the criteria in the health*

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[7] Requires user account and login.

center's total patient population, including all sites, all programs, and by all providers.

Note: eCQM uses "initial patient population" to describe the universe (denominator).

Because the initial patient population for each measure is defined in whole or in part in terms of age (or age and sex assigned at birth), comparisons to the numbers on Table 3A, 6B, and 7 will be made when evaluating your submission. The numbers in Column A of Tables 6B and 7 will not be equal to those which might be calculated on Table 3A for the following reasons:

(1) All patients seen for all reportable services are counted on Table 3A, but the clinical measures reported on Tables 6B and 7 relate only to medical patients or dental patients (specific to one measure only) or to patients with specific conditions (which might only be listed on the patient active problem list). The more dental-, mental health-, or substance use disorder-only patients a health center has, the less comparable the data will be; and

(2) Table 3A measures age as of June 30 of the calendar year, but Tables 6B and 7 define specific time periods (e.g., as of January 1) to measure age.

Although comparisons may be made between the numbers on Table 6A and Tables 6B and 7, the numbers in Column A of Tables 6B and 7 will not be equal to those reported in Column B of Table 6A for the following reasons:

(1) All patients, regardless of age, seen for all reportable services and diagnosis count on Table 6A, but Tables 6B and 7 relate only to patients of specific age ranges; and

(2) Table 6A reflects diagnosis and services treated during the calendar year, but Tables 6B and 7 measures may require patients to be considered based on active diagnoses or look-back period of completed services.

Additionally, pregnancy outcomes on Table 7 are compared to prenatal care patients on Table 6B.

Column B (B, 2B, or 3B): Number of Charts/Records Sampled or EHR Total

Report the total number of health center patients from the universe (Column A) for whom data have been reviewed. The number will essentially become the denominator in evaluating the measurement standard and will be:

- all patients who fit the criteria (the same number as the universe reported in Column A), or

- a number equal to or greater than 80 percent[*] of all patients who fit the criteria (a value no less than 80 percent of the universe reported in Column A), or

- a scientifically drawn *sample* of 70 patients selected from all patients who fit the criteria. Please refer to Appendix C for specifics on sampling methodology.

*To streamline the process for reporting on the CQMs, and to encourage the use of HIT to report on the full universe of patients, health centers may use all of the records available in the HIT/EHR in lieu of a chart sample if at least 80 percent of all health center patient's records are included in the HIT/EHR for any given measure and patients missing from the HIT/EHR are not related to any variable involved with any given measure. For example, if the patients from a pediatric site are missing in the HIT/EHR, it cannot be used for the childhood immunization measure.

If a sample is to be used, it *must* be a random sample of 70 patient charts and *must* be drawn from the health center's entire patient population identified as the universe. Larger samples will not be accepted. Health centers may not choose to select the same number of charts from each site or the same number for each provider or use other stratification mechanisms because this will result in oversampling some group of patients.

Note: Health centers using a sample for any medical clinical quality measure will be ineligible for HRSA quality improvement awards.

Use a review of a sample of charts in lieu of full-universe reporting from an HIT/EHR if:

- The HIT/EHR system does not include a minimum of 80 percent of health center patients who meet the criteria described below for inclusion in the specific measure's universe;

- The HIT/EHR system does not exclude every health center patient who meets one or more exclusion criteria described below for exclusion from the universe;

- The HIT/EHR system has not been in place long enough to be able to find the data required in prior year's activities. Look-back period data are necessary for many of the UDS' CQMs (e.g., cervical cancer screening, colorectal cancer screening, and childhood immunizations); or

- The required data were not collected from the patient as part of the visit or searchable in discrete data fields at the time of the visit.

Records for new patients should be obtained from their former providers to document prior treatment, including data for look-back periods. Medical records obtained from other providers may be recorded in the health center's HIT/EHR system consistent with internal medical records policies, at which point they could be used in the calculated performance rate for the applicable measure.

If the HIT/EHR system is used, the number in Column B (records reviewed) must be no less than 80 percent of the number in Column A when the total universe is greater than 70. The reduced total (in Column B) may not be the result of excluding patients based on a variable related to the measure.

Note: Health centers reporting on less than 100 percent of the universe for any medical clinical quality measure will be ineligible for HRSA quality improvement awards.

Column C (C or 2C): Number of Charts/Records Meeting the Measurement Standard (Numerator)

Report the total number of records (included in the count for Column B) that meet the measurement standard for the specified measure. The number in Column C (records meeting the measurement standard) may never exceed the number in Column B (patient records reviewed).

Note: The percentage of patient records meeting the measurement standard can be calculated by dividing Column C by Column B.

Column 3F: Number of Charts/Records that Do Not Meet the Measurement Standard (Numerator)

Report the total number of records that *do not* meet the measurement standard as discussed for the specified measure (i.e., Diabetes: Hemoglobin A1c (HbA1c) Poor Control). The number in Column 3F (patients not meeting the measurement standard) may never exceed the number in Column 3B (patient records reviewed).

Note: The percentage of patient records not meeting the measurement standard can be calculated by dividing Column 3F by Column 3B.

Criteria vs. Exceptions and Exclusions in HITs/EHRs vs. Chart Reviews

Conditions may sometimes be listed as criteria and sometimes as exclusions and are used to either constrain the universe for a measure or identify charts to be replaced in a chart review process.

In the information that follows, "conditions" or "criteria" are at times interchanged with "exceptions" or "exclusions." This is partly because of the differing language and procedures in an HIT/EHR (or practice management system [PMS])-based report versus a chart audit report. In an HIT/EHR or PMS review, all criteria for a measure must be locatable in the HIT/EHR and must be in the HIT/EHR for each patient at the health center. If they cannot be found, findings will be distorted and the HIT/EHR cannot be used. If, for example, the HIT/EHR cannot differentiate between a medical patient and a dental-only patient, then the HIT/EHR cannot be used to review the immunization of 2-year old children because the universe cannot be limited to medical patients.

In a sample chart review process, items listed as "criteria" may be used as "exclusions." For example, if you are unable to use HIT/EHR, you are to randomly select 70 patient charts of all 2-year-old patients listed and, if your sample includes someone who turns out to be a dental (only) patient, you can "exclude" that chart from the sample and replace it with another chart. (In a

computer search, include as criterion that they must be medical patients for the child immunization measure).

And vs. Or

In this section, conditions linked with "*and*" mean that each of the conditions must be met. If some but not all conditions are met, the services for that patient are considered to have failed to meet the measurement standard. Conditions linked with "*or*" mean that if any of the conditions is met, the measure is satisfied.

Detailed Instructions for Clinical Measures

The clinical measures reported in the UDS relate only to medical patients (or dental patients in the case of one measure only). Health centers are to report each measure using the criteria outlined below. Each measure has been organized in the same way to assist with data collection and reporting.

- **Measure Description**: The quantifiable indicator to be evaluated.
- **Denominator (Universe)**: Patients who fit the detailed criteria described for inclusion in the specific measure to be evaluated.
- **Numerator**: Records (from the denominator) that meet the measurement standard for the specified measure.
- **Exclusions/Exceptions**: Patients not to be considered and removed from the denominator.
- **Specification Guidance**: CMS measure guidance that assists with understanding and implementing eCQMs.
- **UDS Reporting Considerations**: BPHC requirements and guidance to be applied to the specific measure and may differ from or expand on the eCQM specifications.

Instructions for Table 6B: Quality of Care Measures

The quality of care measures reported on Table 6B are "process measures." This means that they document services that have been shown to be correlated with, and serve as a proxy for, positive long-term health outcomes. Individuals who receive routine preventive care and timely chronic care are more likely to have positive outcomes.

By increasing the proportion of health center patients who receive timely preventive care and routine acute and chronic care, an improved health status of the patient population is expected in the future. Specifically:

- **Early entry into prenatal care:** The probability of adverse birth outcome will be reduced if women enter care in their first trimester.

- **Childhood immunization status:** Children will be less likely to contract vaccine-preventable diseases or to suffer from the sequelae of these diseases if they receive their vaccinations in a timely fashion.

- **Cervical cancer screening:** Early detection and treatment of cervical abnormalities can occur, and women will be less likely to suffer adverse outcomes from cervical cancer if women receive Pap tests as recommended.

- **Breast Cancer Screening:** Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period

- **Weight assessment and counseling for nutrition and physical activity for children and adolescents:** The likelihood of obesity and its sequelae will be reduced if clinicians ensure their patients' body mass index (BMI) percentile is recorded and if patients (and parents) are counseled on nutrition and physical activity (regardless of the patient's weight).

- **Preventive care and screening: Body mass index (BMI) screening and follow-up plan:** The likelihood of the debilitating sequelae of serious weight problems can be reduced if clinicians routinely calculate and record the BMI for their adult patients and if clinicians identify patients with weight problems and develop a follow-up plan for overweight and underweight patients.

- **Preventive care and screening: Tobacco use: Screening and cessation intervention:** Patients will be more likely to quit using tobacco and will therefore have a lower risk of cancer, asthma, emphysema, and other tobacco related illnesses if they are routinely queried about their tobacco use and are provided with cessation counseling and/or pharmacologic intervention if they are tobacco users.

- **Statin Therapy for the Prevention and Treatment of Cardiovascular Disease:** The likelihood of cardiovascular-related

clinical events will be reduced if clinicians ensure patients at high risk of cardiovascular events receive lipid-lowering statin therapy.

- **Ischemic vascular disease (IVD): Use of aspirin or another antiplatelet:** The likelihood of myocardial infarctions and other vascular events can be reduced if clinicians ensure patients with established IVD use aspirin or another antiplatelet drug.

- **Colorectal cancer screening:** Early intervention is possible and premature death can be averted if patients receive appropriate colorectal cancer screening.

- **HIV linkage to care:** The probability of HIV-related complications and transmission are reduced if patients found to be HIV positive are seen for follow-up care within 30 days of the initial HIV diagnosis.

- **HIV Screening:** Percentage of patients aged 15-65 at the start of the measurement period who were between 15-65 years old when tested for HIV

- **Preventive care and screening: screening for depression and follow-up plan:** Patients will be more likely to receive needed treatment and less likely to suffer from the sequelae of depression if they are routinely screened for depression and are provided with a follow-up plan when screened as positive.

- **Depression Remission at Twelve Months:** The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event

- **Dental sealants for children between 6-9 years:** Children with moderate to high risk for caries will be less likely to experience dental decay if they are provided sealants on first permanent molars.

Sections A and B: Demographic Characteristics of Prenatal Care Patients

Report on all patients who are either provided direct prenatal care or referred for prenatal care.

Report on the age and trimester of entry into prenatal care for all prenatal care patients, regardless of whether they receive all or some of their prenatal services in the health center or are referred elsewhere.

Prenatal Care by Referral Only (check box)

Check the "Prenatal Care by Referral Only" flag if you *only* provide prenatal care to patients through direct referral to another provider. Do not select this flag if your health center providers provide some or all prenatal care to patients.

Note: All health centers are required to provide prenatal care to patients, either directly or by referral. Do not include women who did not receive prenatal care from a health center provider or who were not referred by the health center to another provider for prenatal care. Do not include women who chose to go outside of the health center's referral network.

Do not include women who receive care, not related to their pregnancy, who are being seen elsewhere for prenatal care.

Section A: Age of Prenatal Care Patients (Lines 1–6)

Report the total number of patients who received or were referred for prenatal care services at any time during the reporting period by age group. Include all women receiving any prenatal care during the reporting year, including the delivery of their child, regardless of when that care was initiated. Include women who:

- Receive all their prenatal care from the health center,

- Were referred by the health center to another provider for all their prenatal care,

- Began prenatal care with another provider but transferred to the health center at some point during their prenatal care,

- Began prenatal care with the health center but were transferred to another provider at some point during their prenatal care,

- Were provided with all their prenatal care by a health center provider but were delivered by another provider,

- Began or were referred for care during the previous reporting year or in this reporting year and delivered during the reporting year, or

- Began or were referred for their care in this reporting period but will not/did not deliver until the next year.

To determine the appropriate age group, use the woman's age on June 30 of the reporting period.

Note: As many as half of all prenatal care patients reported will usually have been reported in the prior year or will be reported in the next year.

Section B: Early Entry into Prenatal Care (Lines 7–9), no eCQM

Measure Description

Percentage of prenatal care patients who entered prenatal care during their first trimester.

Note: The measure itself is not dependent on which category of performance measurement achievement a woman might fall into.

Calculate as follows:

Denominator (Universe) (Line 7 + Line 8 + Line 9, Columns A + B)

- Women seen for prenatal care during the year.

Numerator (Line 7, Columns A + B)

- Women beginning prenatal care at the health center or with a referral provider (Column A), or with another prenatal provider (Column B), during their first trimester.

Exclusions/Exceptions

- Denominator
  - o Not applicable.
- Numerator
  - o Not applicable.

Specification Guidance

- Not applicable.

UDS Reporting Considerations

- Report on Lines 7–9, all women who received prenatal care, either directly or through a referral, including but not limited to the delivery of a baby during the reporting period.

  o **First Trimester (Line 7)**: Report women who were prenatal patients during the reporting period and whose first visit occurred when they were estimated to be pregnant up through the end of the 13th week after their last menstrual period.

  o **Second Trimester (Line 8)**: Report women who were prenatal patients during the reporting period whose first visit occurred when they were estimated to be between the start of the 14th week and the end of the 27th week after their last menstrual period.

  o **Third Trimester (Line 9)**: Report women who were prenatal care patients during the reporting period and whose first visit occurred when they were estimated to be 28 weeks or more after their last menstrual period.

Note: It is unusual for the number in Column B to be very large or larger than that in Column A because it would require women to have begun care and then transferred in a very short period of time.

The sum of the numbers in the six cells of Lines 7 through 9 represents the total number of women who received prenatal care from the health center during the calendar year and is equal to the number reported on Line 6.

- Criteria used to identify how prenatal women are reported:

  o Determine the trimester by the trimester of pregnancy that the woman was in when she began prenatal care either at one of the health center's service delivery locations or with another provider, including a referral provider. For example:

    ▪ If the woman began prenatal care during the first trimester at the health center's service delivery location or from a provider she was referred to by the health center, she is reported on Line 7 in Column A.

    ▪ If the woman received prenatal care from another provider during the first trimester before coming to the health center's service delivery location, she is reported on Line 7 in Column B, regardless of when she begins care with the health center.

  o Report a woman who begins her prenatal care with the health center or is referred by the health center to another

provider only once in Column A (not in Column B).

o Report a woman who begins her prenatal care on her own with another provider and then transfers to the health center only once in Column B *and not* in Column A.

o Prenatal care is considered to have begun at the time the patient has her first visit with a physician or NP, PA, or CNM provider who initiates prenatal care with a complete prenatal exam. Consider this the first prenatal care visit for UDS purposes. Most women will have one or more interactions with the health center prior to that for their pregnancy, including pregnancy and other lab tests, dispensing vitamins, taking a health history, and/or obtaining a nutritional or psychosocial assessment. Do not count these interactions as the start of prenatal care.

o In the event a woman is referred to another provider for care by a health center that does not have its own prenatal care program, count as the first visit the visit at which they receive a complete prenatal exam from the referral provider. Do not count when she first contacts the prenatal referral provider, when they do lab tests, or when she has psychosocial or nutritional assessments done if a prenatal exam was not conducted.

o Patient self-report of trimester of entry is permitted.

o Count a woman only once, regardless of the number of trimesters during which she receives care.

o In those rare instances when a woman receives prenatal care services for two separate pregnancies in the same calendar year, count her twice as a prenatal patient. For example, this would occur if a woman delivers in January and then becomes pregnant again in October.

Sections C through N: Other Quality of Care Measures

In these sections, report on the findings of your reviews of services provided to targeted populations.

- For sections C through M, specifically assess the current medical patients (i.e., patients who had a medical visit at least once during the reporting period). Do not include patients whose *only* visits were for dental, mental health, or something other than medical care in the universe for these measures.

- For section N, assess current dental patients (i.e., patients who had a dental visit at least once during the reporting period). Do not include patients whose *only* visits were for medical, mental health, or something other than dental care in the universe for this measure.

- For these measures, base age on the patient's age before the start of January 1 of the reporting year (or patient's age during the

reporting year, as noted in specified measures).

- Using the specified measure criteria, include patients seen for medical care even if the only care provided was in an urgent care setting or if patients were seen only once for acute care.

- For measures requiring the completion of tests or procedures to meet the measurement standard, test results or procedures must be evidenced by documented results. Patient-self report is not accepted.

Note: In this section, the term "measurement period" is the same as the term "reporting period" and is intended to capture calendar year 2020 data.

Childhood Immunization Status (Line 10), CMS117v8

Measure Description

Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three or four H influenza type B (HiB); three Hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one Hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

Calculate as follows:

Denominator (Universe) (Columns A and B)

- Children who turn 2 years of age during the measurement period and who had a *medical* visit during the measurement period.

Note: Include children born on or after January 1, 2017, and on or before December 31, 2017, including children who turn 2 during the measurement period.

Numerator (Column C)

- Children who have evidence showing they received recommended vaccines, had documented history of the illness, had a seropositive test result, or had an allergic reaction to the vaccine by their second birthday.

Exclusions/Exceptions

- Denominator
  - o Patients who were in hospice care during the measurement period.

- Numerator
  - o Not applicable.

Specification Guidance

- Include patients in the numerator in these situations:
  - o MMR, Hep B, VZV, and Hep A vaccines: evidence of receipt of the recommended vaccine; documented history of the illness; or a seropositive test result for the antigen.

  - o DTaP, IPV, HiB, pneumococcal conjugate, rotavirus, and influenza vaccines: evidence of receipt of the recommended vaccine.

  - o Include patients in the numerator for a particular antigen if they had an anaphylactic reaction or adverse reaction to the vaccine.

- o DTaP vaccine: if patients have encephalopathy.

- o IPV vaccine: if patients have had an anaphylactic reaction to streptomycin, polymyxin B, or neomycin.

- o Influenza, MMR, or VZV vaccines: if patients have cancer of lymphoreticular or histiocytic tissue, multiple myeloma, or leukemia; have had an anaphylactic reaction to neomycin; have immunodeficiency or have HIV.

- o Hep B vaccine: if patients have had an anaphylactic reaction to common baker's yeast.

- The measure allows a grace period by measuring compliance with these recommendations between birth and age two.

UDS Reporting Considerations

- Include children who turned two years of age during the measurement period, regardless of when they were seen for medical care during the year. Specifically, include them in the assessment whether the medical visit in the year occurred before or after they turned two.

- Include children in the universe if they came to the health center for well-child[8] services or for any other medical services, including vaccinations or for treatment of an injury or illness.

- Include children in the universe for whom no vaccination information is available and/or who were first seen at a point when there was not enough time to fully immunize them prior to their second birthday.

- Do not include children here or anywhere on the UDS who only received a vaccination and never received other services.

- Include children who had a contraindication for a specific vaccine in the universe. Count them as being "compliant" for that specific vaccine, if the guidance (above) permits it, and then review for the administration of the rest of the vaccines.

- To count as meeting the measure, a child's medical record must be documented as being compliant for each vaccine.

- Registries can be used to fill any voids in the immunization record if the search is routinely done prior to or immediately after a visit and before the end of the measurement period. For example, you may use an immunization registry maintained by the state or other public entity that shows comparable information.

- Do not count as meeting the measurement standard charts that only state that the "patient is up to date" with all immunizations and that do not list the dates of all immunizations and the names of immunization agents.

- Do not count verbal assurance from a parent or other person that

[8] Health centers should add to their universe those patients whose only visits were well-child visits (99381, 99382, 99391, 99392) if their automated system does not include them. In addition, if your state uses different codes for EPSDT visits, those codes should be added.

a vaccine has been given toward the measurement standard.

- Good-faith efforts to get a child immunized that fail do not meet the measurement standard. These include the following:
  - o Parental failure to bring in the patient.
  - o Parents who refuse for personal or religious reasons.
  - o Patients lost to inadequate follow-up.
  - o Parents who refuse because of beliefs about vaccines.

Cervical Cancer Screening (Line 11), CMS124v8

Measure Description

Percentage of women 21*–64 years of age who were screened for cervical cancer using **either** of the following criteria:

- Women age 21*-64 who had cervical cytology performed every 3 years.
- Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.

Calculate as follows:

Denominator (Universe) (Columns A and B)

- Women 23 through 64 years of age with a *medical* visit during the measurement period.

  Note: Include women born on or after January 1, 1955, and on or before December 31, 1995.

*Note: *Use age 23 as the initial age to include in assessment. See Specification Guidance for further detail.*

Numerator (Column C)

- Women with one or more screenings for cervical cancer. Appropriate screenings are defined by any one of the following criteria:
  - o Cervical cytology performed during the measurement period or the 2 years prior to the measurement period for women who are at least 21 years old at the time of the test.
  - o Cervical cytology/HPV co-testing performed during the measurement period or the 4 years prior to the measurement period for women who are at least 30 years old at the time of the test.

Exclusions/Exceptions

- Denominator
  - o Women who had a hysterectomy with no residual cervix or a congenital absence of cervix.
  - o Patients who were in hospice care during the measurement period.
- Numerator
  - o Not applicable.

Specification Guidance

- The measure only evaluates whether tests were performed after a woman turns 21 years of age. The youngest age in the initial population is 23.

- Do not include reflex testing. In addition, if the medical record indicates the HPV test was performed only after determining the cytology result, this is considered reflex testing and does not meet measurement standard.

UDS Reporting Considerations

- Include documentation in the medical record of a cervical cytology and HPV tests performed outside of the health center, which has the date the test was performed, who performed it, and the result of the finding provided by the agency that conducted the test or a copy of the lab test.

- Do not count as compliant charts that note the refusal of the patient to have the test.

- If a system cannot determine exclusions, include them in the universe and later exclude and replace them from the sample, if identified.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (Line 12), CMS155v8

Measure Description

Percentage of patients 3–17 years of age who had an outpatient *medical* visit and who had evidence of height, weight, and body mass index (BMI)

percentile documentation **and** who had documentation of counseling for nutrition **and** who had documentation of counseling for physical activity during the measurement period.

Calculate as follows:

Denominator (Universe) (Columns A and B)

- Patients 3 through 17 years of age with at least one outpatient *medical* visit during the measurement period.

Note: Include children and adolescents who were born on or after January 1, 2002, and on or before December 31, 2015.

Numerator (Column C)

- Children and adolescents who have had:
  - Their BMI percentile (not just BMI or height and weight) recorded during the measurement period **and**
  - Counseling for nutrition during the measurement period **and**
  - Counseling for physical activity during the measurement period.

Exclusions/Exceptions

- Denominator
  - Patients who have a diagnosis of pregnancy during the measurement period.
  - Patients who were in hospice care during the measurement period.

- Numerator
  - Not applicable.

Specification Guidance

- Because BMI norms for youth vary with age and sex, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

UDS Reporting Considerations

- Include medical visits performed by any medical provider. Note that this is different from the eCQM, which requires that the visit be performed by a primary care physician or an OB/GYN. For example, include patients who had a medical visit with a nurse practitioner.

- The UDS numerator differs from the eCQM in that the eCQM requires the numerator elements to be reported separately against two age strata (age 3–11; age 12–17). For UDS purposes, the patients must have had all three numerator components completed in order to meet the measurement standard against one age strata (age 3–17).

- Do not count as meeting the performance measure charts that show only that a well-child visit was scheduled, provided, or billed. The electronic or paper well-child visit template/form must document each of the elements noted above.

Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (Line 13), CMS69v8

Measure Description

Percentage of patients aged 18 years and older with BMI documented during the most recent visit or within the previous 12 months to that visit **and** when the BMI is outside of normal parameters, a follow-up plan is documented during the visit or during the previous 12 months of that visit

Note: Normal parameters: For age 18 years and older, BMI greater than or equal to 18.5 and less than 25 kg/m2

Calculate as follows:

Denominator (Universe) (Columns A and B)

- Patients 18 years of age or older on the date of the visit with at least one *medical* visit during the measurement period.

*Note: Include patients who were born on or before December 31, 2000, **including** patients who were 18 years of age or older on the date of their last visit.*

Numerator (Column C)

- Patients with:

  o A documented BMI (not just height and weight) during their most recent visit in the measurement period **or** during the previous 12 months of that visit, **and**

  o When the BMI is outside of normal parameters, a follow-up plan is documented during the

visit or during the previous 12 months of the current visit.

*Note: Include in the numerator patients within normal parameters who had their BMI documented **and** those with a follow-up plan if BMI is outside normal parameters.*

Exclusions/Exceptions

- Denominator

  o Patients who are pregnant during the measurement period.

  o Patients receiving palliative care during or prior to the visit.

  o Patients who refuse measurement of height and/or weight or refuse follow-up during the visit.

  o Patients with a documented medical reason during the visit or within 12 months of the visit, including:

    ▪ Elderly patients (65 years or older) for whom weight reduction/weight gain would complicate other underlying health conditions such as the following examples:

      • Illness or physical disability.

      • Mental illness, dementia, confusion.

      • Nutritional deficiency, such as vitamin/mineral deficiency.

    ▪ Patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status.

- Numerator

  o Not applicable.

Specification Guidance

- Report this measure for all patients seen during the reporting period.

- An eligible professional or their staff is required to measure both height and weight. Both height and weight must be measured within 12 months of the current encounter and may be obtained from separate visits. Do not use self-reported values.

- BMI may be documented in the medical record at the health center or in outside medical records obtained by the health center.

- If more than one BMI is reported during the measurement period, use the most recent BMI to determine if the performance has been met.

- Document the follow-up plan based on the most recent documented BMI outside of normal parameters.

UDS Reporting Considerations

- Documentation in the medical record must show the actual BMI or the template normally viewed by a clinician must display BMI.

- Do not count as meeting the measurement standard charts or templates that display only height and weight. The fact that an HIT/EHR can calculate BMI does not replace the presence of the BMI itself.

Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Line 14a), CMS138v8

Measure Description

Percentage of patients aged 18 and older who were screened for tobacco use one or more times within 24 months *and* who received cessation counseling intervention if identified as a tobacco user.

Calculate as follows:

Denominator (Universe) (Columns A and B)

- Patients aged 18 years and older seen for at least two *medical* visits in the measurement period or at least one preventive *medical* visit during the measurement period.

Note: Include patients who were born on or before December 31, 2000.

Numerator (Column C)

- Patients who were screened for tobacco use at least once within 24 months before the end of the measurement period **and**
- Who received tobacco cessation intervention if identified as a tobacco user.

*Note: Include in the numerator patients with a negative screening **and** those with a positive screening who had cessation intervention if a tobacco user.*

Exclusions/Exceptions

- Denominator
  - o Documentation of medical reason(s) for not screening for tobacco use or for not providing tobacco cessation intervention (e.g., limited life expectancy, other medical reason).
- Numerator
  - o Not applicable.

Clinical Guidance

- If patients use any type of tobacco (i.e., smokes or uses smokeless tobacco), tobacco cessation intervention (counseling and/or pharmacotherapy) is expected.
- If a patient has multiple tobacco use screenings during the 24-month period, use the most recent screening which has a documented status of tobacco user or non-user.
- If tobacco use status of a patient is unknown, the patient does not meet the screening component required to be counted in the numerator and has not met the measurement standard. "Unknown" includes patients who were not screened or patients with indefinite answers.
- If the patient does not meet the screening component of the numerator but has an allowable medical exception, remove the patient from the denominator.
- The medical reason exception applies to the screening data element of the measure or to any of the tobacco cessation intervention data elements.
- If a patient has a diagnosis of limited life expectancy, that patient has a valid denominator exception for not being screened for tobacco use or for not receiving tobacco use cessation intervention (counseling and/or

pharmacotherapy) if identified as a tobacco user.

- Electronic nicotine delivery systems (ENDS), including electronic cigarettes for tobacco cessation, are not currently classified as tobacco. They are not to be evaluated for this measure.

UDS Reporting Considerations

- Include in the numerator records that demonstrate that the patient had been asked about their use of all forms of tobacco within 24 months before the end of the measurement period.

- Cessation counseling intervention for a tobacco user must occur at or following the most recent screening and before the end of the measurement year.

- Include patients who receive tobacco cessation intervention by any provider, including:

  o Received tobacco use cessation counseling services, *or*

  o Received an order for (a prescription or a recommendation to purchase an over-the-counter [OTC] product) a tobacco use cessation medication, *or*

  o Are on (using) a tobacco use cessation agent.

- Do not count as meeting the measurement standard written self-help materials.

- Identify preventive visits using "Preventive Care Services" CPT codes listed in the eCQM.

- The UDS denominator differs from the eCQM in that the eCQM

requires the patient population and numerator to be reported separately; for UDS purposes, the patients must be evaluated as one group.

Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Line 17a), CMS347v3

Measure Description

Percentage of the following patients at high risk of cardiovascular events aged 21 years and older who were prescribed or were on statin therapy during the measurement period:

- Patients 21 years of age or older previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); or

- Patients 21 years of age or older who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level greater than or equal to 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; or

- Patients 40 through 75 years of age with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL.

Calculate as follows:

Denominator (Universe) (Columns A and B)

- Patients 21 years of age and older who have an active diagnosis of ASCVD or ever had a fasting or direct laboratory result of LDL-C greater than or equal to 190 mg/dL

or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; or patients 40 through 75 years of age with Type 1 or Type 2 diabetes and with an LDL-C result 70-189 mg/dL recorded as the highest fasting or direct laboratory test result in the measurement year or the 2 years prior; with a *medical* visit during the measurement period.

Note*: Include patients who were born on or before December 31, 1997.*

Numerator (Column C)

- Patients who are actively using or who received an order (prescription) for statin therapy at any point during the measurement period.

Exclusions/Exceptions

- Denominator

  o Patients who have a diagnosis of pregnancy.

  o Patients who are breastfeeding.

  o Patients who have a diagnosis of rhabdomyolysis.

  o Patients with adverse effect, allergy, or intolerance to statin medication.

  o Patients who are receiving palliative care.

  o Patients with active liver disease or hepatic disease or insufficiency.

  o Patients with end-stage renal disease (ESRD).

o For patients 40 through 75 years of age with diabetes who have the most recent fasting or direct LDL-C laboratory test result less than 70 mg/dL and are not taking statin therapy.

- Numerator

  o Not applicable.

Specification Guidance

- Current statin therapy use (including statin medication samples provided to patients) must be documented in the patient's current medication list or ordered during the measurement period.

- Do not count other cholesterol lowering medications as meeting the measurement standard—only statin therapy meets the measurement standard.

- Ensure patients are not counted in the denominator more than once. Once a patient meets one set of denominator criteria (check from first listed in Measure Description to last), he/she is included and further risk checks are not needed.

- Intensity of statin therapy or lifestyle modification coaching is not being assessed for this measure—only prescription of any statin therapy.

UDS Reporting Considerations

- Not applicable.

Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet (Line 18), CMS164v7

Measure Description

Percentage of patients aged 18 years of age and older who were diagnosed with acute myocardial infarction (AMI), or who had a coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCIs) in the 12 months prior to the measurement period, **or** who had an *active* diagnosis of IVD during the measurement period, and who had documentation of use of aspirin or another antiplatelet during the measurement period.

Calculate as follows:

Denominator (Universe) (Columns A and B)

- Patients 18 years of age and older with a *medical* visit during the measurement period who had an AMI, CABG, or PCI during the 12 months prior to the measurement year or who had a diagnosis of IVD overlapping the measurement period.

Note: Include patients who were born on or before December 31, 2000.

Numerator (Column C)

- Patients who had an active medication of aspirin or another antiplatelet during the measurement period.

Exclusions/Exceptions

- Denominator
  - o Patients who had documentation of use of anticoagulant medications overlapping the measurement period.
  - o Patients who were in hospice care during the measurement period.
- Numerator
  - o Not applicable.

Specification Guidance

- Not applicable.

UDS Reporting Considerations

- Include in the numerator patients who received a prescription for, were given, or were using aspirin or another antiplatelet drug.

Colorectal Cancer Screening (Line 19), CMS130v8

Measure Description

Percentage of adults 50–75 years of age who had appropriate screening for colorectal cancer.

Calculate as follows:

Denominator (Universe) (Columns A and B)

- Patients 50 through 75 years of age with a *medical* visit during the measurement period.

Note: Include patients born on or after January 1, 1944, and on or before December 31, 1968.

Numerator (Column C)

- Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any *one* of the following criteria:

  o Fecal occult blood test (FOBT) during the measurement period.

  o Fecal immunochemical test (FIT)-deoxyribonucleic acid (DNA) during the measurement period or the 2 years prior to the measurement period.

  o Flexible sigmoidoscopy during the measurement period or the 4 years prior to the measurement period.

  o Computerized tomography (CT) colonography during the measurement period or the 4 years prior to the measurement period.

  o Colonoscopy during the measurement period or the 9 years prior to the measurement period.

Exclusions/Exceptions

- Denominator

  o Patients with a diagnosis or past history of colorectal cancer or total colectomy.

  o Patients who were in hospice care during the measurement period.

  o Patients 66 and older who are living long term in an institution for more than 90 days during the measurement period.

  o Patients 66 and older with advanced illness and frailty because it is unlikely that

patients will benefit from the services being measured.

- Numerator

  o Not applicable.

Specification Guidance

- Do not count digital rectal exam (DRE), FOBT tests performed in an office setting or performed on a sample collected via DRE.

UDS Reporting Considerations

- There are two FOBT test options: Guaiac fecal occult blood test (gFOBT) and the immunochemical-based fecal occult blood test (iFOBT).

- Tests (FOBT and FIT-DNA) performed elsewhere must be confirmed by documentation in the chart: either a copy of the test results or correspondence between the clinic staff and the performing lab/clinician showing the results.

- FOBTs can be used to document meeting the measurement standard. This test, if performed, is required each measurement year. For example, a patient who had an FOBT in November 2019 would still need one in 2020.

- Collect stool specimens for FOBT and FIT-DNA, as recommended by the manufacturer.

- FOBT and FIT-DNA test kits can be mailed to patients but receipt, processing, and documentation of the test sample is required.

HIV Linkage to Care (Line 20), no eCQM

Measure Description

Percentage of patients newly diagnosed with HIV who were seen for follow-up treatment within 30 days of diagnosis.[9]

Calculate as follows:

Denominator (Universe) (Columns A and B)

- Patients first diagnosed with HIV by the health center between October 1 of the prior year through September 30 of the current measurement year and who had at least one *medical* visit during the measurement period or prior year.

Note: Include patients who were diagnosed with HIV for the first time ever[10] by the health center between October 1, 2019, and September 30, 2020,[11] and had at least one medical visit during 2020 or 2019.

Numerator (Column C)

- Newly diagnosed HIV patients that received treatment within 30 days of diagnosis. Include patients who were newly diagnosed by your health center providers, **and**:
  - o Had a medical visit with your health center provider who initiates treatment for HIV, **or**

  - o Had a visit with a referral resource who initiates treatment for HIV.

Exclusions/Exceptions

- Denominator
  - o Not applicable.
- Numerator
  - o Not applicable.

Specification Guidance

- Not applicable.

UDS Reporting Considerations

- *Treatment must be initiated* within 30 days of the HIV diagnosis (not just a referral made, education provided, or retest at a referral site).

- Include patients in the numerator only if they received treatment for HIV care within 30 days of the diagnosis. If the treatment is by referral to another clinician/organization (such as a Ryan White provider), the medical treatment at the referral source must begin and the referral loop must be closed during the 30-day period. Closing the referral loop means the referring provider received documented confirmation that the visit was completed from the provider to whom the patient was referred.

- Identification of patients for this measure crosses years and may include prior-year patients.

- Reactive initial HIV tests and patients who self-identify as being HIV positive without documentation must be followed

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[9] Note that this measure does not conform to the calendar year reporting requirement.
[10] "Patients first diagnosed with HIV" is defined as patients without a previous HIV diagnosis who received a reactive initial HIV test confirmed by a positive supplemental antibody immunoassay HIV test.
[11] Because the measure allows up to 90 days to complete the follow-up, look back 90 days to find the entire universe of patients who should have had a follow-up during the measurement year.

by a supplemental test to confirm diagnosis.

- Do not include patients who:
  - o Were diagnosed elsewhere, even if they can provide documentation of the positive test result.
  - o Had a positive reactive initial screening test but not a positive supplemental test.
  - o Were positive on an initial screening test provided by you but were then sent to another provider for definitive testing and treatment.

Note: There are no ICD-10-CM or CPT codes to identify newly diagnosed HIV patients. It is strongly encouraged that you modify your HIT/EHR to record this information or keep track of the patients who are identified in a separate system.

Preventive Care and Screening: Screening for Depression and Follow-Up Plan (Line 21), CMS2v9

Measure Description

Percentage of patients aged 12 years and older screened for depression on the date of the visit using an age-appropriate standardized depression screening tool *and* if positive, a follow-up plan is documented on the date of the positive screen.

This is calculated as follows:

Denominator (Universe) (Columns A and B)

- Patients aged 12 years and older with at least one *medical* visit during the measurement period.

Note: Include patients who were born on or before December 31, 2006.

Numerator (Column C)

- Patients who:
  - o Were screened for depression on the date of the visit using an age-appropriate standardized tool *and*,
  - o If screened positive for depression, a follow-up plan is documented on the date of the positive screen.

Note: Include in the numerator, patients with a negative screening and those with a positive screening who had a follow-up plan documented.

Exclusions/Exceptions

- Denominator
  - o Patients with an active diagnosis for depression or a diagnosis of bipolar disorder.
  - o Patients:
    - Who refuse to participate.
    - Who are in urgent or emergent situations[12] where time is of the essence and to delay treatment would jeopardize the patient's health status.

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[12] Do not exclude patients seen for routine care in urgent care centers or emergency rooms you operate.

- ▪ Whose cognitive capacity, functional capacity or motivation to improve may impact the accuracy of results of standardized assessment tools.

- Numerator
  - o Not applicable.

Specification Guidance

- The depression screening must be reviewed and addressed in the office of the provider on the date of the visit; the screening must occur on the same date or up to 14 days prior to the date of the visit. Positive pre-screening results indicating a patient is at high risk for self-harm should receive more urgent intervention as determined by the provider.

- Standardized depression screening tools are normalized and validated for the age-appropriate patient population in which they are used and must be documented in the medical record.

- Use the most recent screening results.

- Examples of depression screening tools include, but are not limited to:

- Adolescent Screening Tools (12-17 years)
  - o Patient Health Questionnaire for Adolescents (PHQ-A)
  - o Beck Depression Inventory-Primary Care Version (BDI-PC)
  - o Mood Feeling Questionnaire (MFQ)

- o Center for Epidemiologic Studies Depression Scale (CES-D)
- o Patient Health Questionnaire (PHQ-9)
- o Pediatric Symptom Checklist (PSC-17)
- o Primary Care Evaluation of Mental Disorders (PRIME MD)-PHQ-2

- Adult Screening Tools (18 years and older)
  - o PHQ-9
  - o Beck Depression Inventory (BDI or BDI-II)
  - o CES-D
  - o Depression Scale (DEPS)
  - o Duke Anxiety-Depression Scale (DADS)
  - o Geriatric Depression Scale (GDS)
  - o Cornell Scale for Depression in Dementia (CSDD)
  - o PRIME MD-PHQ-2
  - o Hamilton Rating Scale for Depression (HAM-D)
  - o Quick Inventory of Depressive Symptomatology Self-Report (QID-SR)

- The follow-up plan must be related to a positive depression screening.

- Follow-up for a positive depression screening must include one or more of the following:
  - o Additional evaluation or assessment for depression.
  - o Suicide risk assessment.

o Referral to a practitioner who is qualified to diagnose and treat depression.

o Pharmacological interventions.

o Other interventions or follow-up for the diagnosis or treatment of depression.

UDS Reporting Considerations

- Do not count patients who are re-screened as meeting the measurement standard as a follow-up plan to a positive screen.

- Do not count a PHQ-9 screening that follows a positive PHQ-2 screening during the measurement period as meeting the measurement standard for a follow-up plan to a positive depression screening.

Dental Sealants for Children between 6-9 Years (Line 22), CMS277v0

Measure Description

Percentage of children, age 6–9 years, at moderate to high risk for caries who received a sealant on a first permanent molar during the measurement period.

Calculate as follows:

Denominator (Universe) (Columns A and B)

- Children 6 through 9 years of age with an oral assessment or comprehensive or periodic oral evaluation *dental* visit and are at moderate to high risk for caries in the measurement period.

Note: Include children who were born on or after January 1, 2010, and on or before December 31, 2012.

Numerator (Column C)

- Children who received a sealant on a permanent first molar tooth during the measurement period.

Exclusions/Exceptions

- Denominator

o Children for whom all first permanent molars are non-sealable (i.e., molars are either decayed, filled, currently sealed, or un-erupted/missing).

- Numerator

o Not applicable.

Specification Guidance

- The intent is to measure whether a child received a sealant on at least one of the four permanent first molars.

- "Elevated risk" is a finding at the patient level, not a population-based factor such as low socioeconomic status.

- Look for tooth-level data for sealant placement. Capture sealant application within buccal pits on a first permanent molar in the numerator.

UDS Reporting Considerations

- Include dental visits with the health center or with another dental provider who saw patients through a paid referral.

- Use ADA codes to document caries risk level determined through an assessment.

Note: Although draft eCQM reflects age 5 through 9 years of age, use age 6 through 9 as measure steward intended.

Additional information is available to clarify reporting. View **FAQs for Table 6B**.

Breast Cancer Screening (Line 11a), CMS125v8

Measure Description

Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period

This is calculated as follows:

Denominator (Universe) (Columns A and B)

- Women 51-74 years of age with a medical visit during the measurement period

Note: Include women who were born on or after January 1, 1946, and on or before December 31, 1969.

Numerator (Column C)

- Women with one or more mammograms during the 27 months prior to the end of the measurement period

Exclusions/Exceptions

- Denominator
  - o Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy.

- o Patients who were in hospice care during the measurement period.

- o Patients 66 and older who are living long term in an institution for more than 90 days during the measurement period.

- o Patients 66 and older with advanced illness and frailty because it is unlikely that patients will benefit from the services being measured.

- Numerator
  - o Not Applicable

Specification Guidance

This measure evaluates primary screening. Do not count biopsies, breast ultrasounds, or MRIs because they are not appropriate methods for primary breast cancer screening.

HIV Screening (Line 20a), CMS349v2

Measure Description

Percentage of patients aged 15-65 at the start of the measurement period who were between 15-65 years old when tested for HIV

This is calculated as follows:

Denominator (Universe) (Columns A and B)

- Patients 15 to 65 years of age at the start of the measurement period AND who had at least one outpatient medical visit during the measurement period

Numerator (Column C)

- Patients with documentation of an HIV test performed on or after their 15th birthday and before their 66th birthday

Note*: Include patients who were born on or after January 1, 1955, and on or before December 31, 2004.*

Exclusions/Exceptions

- Denominator
  - o Patients diagnosed with HIV prior to the start of the measurement period
- Numerator
  - o Not Applicable

Specification Guidance

- Provider must have documentation of the administration of the laboratory test present in the patient's medical record.

- In cases where the HIV test was performed elsewhere, providers cannot rely on patient attestation or self-report to meet the measure requirements. Providers must request documentation of those test results.

- If such documentation is not available, the patient should be considered still eligible for HIV screening.

- If such documentation is available, but cannot be provided in a standardized, structured format (to be readily incorporated as structured data within the EHR), providers should enter the information into their EHR as a laboratory test in a manner consistent with the EHR in use. If the specific HIV Laboratory Test LOINC code of the test is not known, the entry should use the more generic code LOINC panel code [75622-1].

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Depression Remission at Twelve Months (Line 21a), CMS159v8

Measure Description

The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event.

This is calculated as follows:

Denominator (Universe) (Columns A and B)

- Adolescent patients 12 to 17 years of age and adult patients 18 years of age and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 or PHQ-9M score greater than nine during the index event. Patients may be screened using PHQ-9 and PHQ-9M up to 7 days prior to the office visit (including the day of the office visit).

Numerator (Column C)

- Adolescent patients 12 to 17 years of age and adult patients 18 years of age and older who achieved remission at twelve months as demonstrated by a twelve month (+/- 60 days) PHQ-9 or PHQ-9M score of less than five

Exclusions/Exceptions

- Denominator
  - Patients who died
  - Patients who received hospice or palliative care services
  - Patients who were permanent nursing home residents
  - Patients with a diagnosis of bipolar disorder
  - Patients with a diagnosis of personality disorder
  - Patients with a diagnosis of schizophrenia or psychotic disorder
  - Patients with a diagnosis of pervasive developmental disorder
- Numerator
  - Not Applicable

Specification Guidance

- (TBD)

Table 6B: Quality of Care Measures

Reporting Period: January 1, 2020, through December 31, 2020

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

Section A – Age Categories for Prenatal Care Patients:
Demographic Characteristics of Prenatal Care Patients

Line	Age	Number of Patients (a)
1	Less than 15 years	[b
2	Ages 15-19	[bla
3	Ages 20-24	[blank
4	Ages 25-44	ank fo
5	Ages 45 and over	for de
6	Total Patients (Sum of Lines 1-5)	demo

Section B - Early Entry into Prenatal Care

Line	Early Entry into Prenatal Care	Women Having First Visit with Health Center (a)	Women Having First Visit with Another Provider (b)
7	First Trimester	[bla ration]	
8	Second Trimester	[blank tion]	
9	Third Trimester	[blank for d n]	

Section C - Childhood Immunization Status

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

Section D - Cervical and Breast Cancer Screening

Line	Cervical Cancer Screening	Total Female Patients Aged 23 through 64 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Tested (c)
11	MEASURE: Percentage of women 23-64 years of age who were screened for cervical cancer			

Line	Breast Cancer Screening	Total Female Patients Aged 51 through 74 (a)	Number Charts Sampled or EHR Total (b)	Number of Female Patients with one or more mammograms (c)

Line	Cervical Cancer Screening	Total Female Patients Aged 23 through 64 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Tested (c)
11a	MEASURE: Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period			

Section E - Weight Assessment and Counseling for Nutrition and Physical Activity of Children and Adolescents

Line	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Total Patients Aged 3 through 17 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Counseling and BMI Documented (c)
12	MEASURE: Percentage of patients 3–17 years of age with a BMI percentile *and* counseling on nutrition *and* physical activity documented		[blank for demonstration]	

Section F – Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Line	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate (c)
13	MEASURE: Percentage of patients 18 years of age and older with (1) BMI documented and (2) follow-up plan documented if BMI is outside normal parameters	[blank demonstra	[blank f demonstr	

Section G – Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Line	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Assessed for Tobacco Use *and* Provided Intervention if a Tobacco User (c)
14a	MEASURE: Percentage of patients aged 18 years of age and older who (1) were screened for tobacco use one or more times within 24 months, *and* (2) if identified to be a tobacco user received cessation counseling intervention			

Section H - Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Line	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Total Patients Aged 21 and Older at High Risk of Cardiovascular Events (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Prescribed or On Statin Therapy (c)
17a	MEASURE: Percentage of patients 21 years of age and older at high risk of cardiovascular events who were prescribed or were on statin therapy			

Section I - Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet

Line	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Total Patients Aged 18 and Older with IVD Diagnosis or AMI, CABG, or PCI Procedure (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Documentation of Aspirin or Other Antiplatelet Therapy (c)
18	MEASURE: Percentage of patients 18 years of age and older with a diagnosis of IVD or AMI, CABG, or PCI procedure with aspirin or another antiplatelet			

Section J - Colorectal Cancer Screening

Line	Colorectal Cancer Screening	Total Patients Aged 50 through 75 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Appropriate Screening for Colorectal Cancer(c)
19	MEASURE: Percentage of patients 50 through 75 years of age who had appropriate screening for colorectal cancer			

Section KL - HIV Measures

Line	HIV Linkage to Care	Total Patients First Diagnosed with HIV (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Seen Within 30 Days of First Diagnosis of HIV (c)
20	MEASURE: Percentage of patients whose first ever HIV diagnosis was made by health center staff between October 1 of the prior year and September 30 of the measurement year and who were seen for follow-up treatment within 30 days of that first-ever diagnosis			

Line	HIV Screening	Total Patients Aged 15 through 65 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Tested for HIV (c)
20a	MEASURE: Percentage of patients 15-65 years of age who have been tested for HIV within that age range			

Section L – Depression Measures

Line	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Total Patients Aged 12 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Screened for Depression and Follow-Up Plan Documented as Appropriate (c)
21	MEASURE: Percentage of patients 12 years of age and older who were (1) screened for depression with a standardized tool *and,* if screening was positive, (2) had a follow-up plan documented			

Line	Depression Remission at Twelve Months	Total Patients Aged 18 and Older with Major Depression or Dysthymia (a)	Number Charts Sampled or EHR total (b)	Number of Patients who Reached Remission (c)
21a	MEASURE: Percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/-60 days) after an index event			

Section M – Dental Sealants for Children between 6–9 Years

Line	Dental Sealants for Children between 6–9 Years	Total Patients Aged 6 through 9 at Moderate to High Risk for Caries (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Sealants to First Molars (c)
22	MEASURE: Percentage of children 6 through 9 years of age at moderate to high risk of caries who received a sealant on a first permanent molar			

Instructions for Table 7: Health Outcomes and Disparities

This table reports data on health status measures by race and Hispanic or Latino ethnicity. The health outcome and disparity measures reported are "intermediate outcome measures," which means that they document measurable outcomes of clinical intervention as a surrogate for good long-term health outcomes. Use and analysis of CQMs by health centers in their Plan, Do, Study, Act (PDSA) cycles is one tool that can lead to improved health care for patients.

Increasing the proportion of health center patients who have a good intermediate health outcome generally leads to improved health status of the patient population in the future. Specifically:

- **Low Birth Weight**: There will be fewer children who suffer the multiple negative sequelae of low birth weight, such as delayed or diminished intellectual and/or physical development, if fewer babies have low birth weight.

- **Controlling High Blood Pressure**: There will be less cardiovascular damage, fewer heart attacks, and less organ damage later in life if there is less uncontrolled hypertension.

- **Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)**: There will be fewer long-term complications, such as amputations, blindness, and end-organ damage, if there are fewer cases of poorly controlled diabetes.

Race and Ethnicity Reporting

Table 7 reports health outcome data by race and Hispanic or Latino ethnicity to provide information on health centers' efforts to help to reduce health disparities. Race and Hispanic or Latino ethnicity is self-reported by patients and should be collected as part of a standard registration process. Care must be taken by health centers that have separate reporting systems for patient registration and clinical data to ensure race and ethnicity data across the systems are aligned. Do not report more Hispanic or Latino patients with hypertension or more patients with hypertension of any given race on Table 7 than are reported for that race or for the Hispanic or Latino ethnicity on Table 3B.

Because the initial patient population for each measure is defined in terms of race and ethnicity, comparisons to the numbers on Tables 3B and 7 will be made when evaluating your submission. The numbers in Column A of Table 7 will not be equal to those that might be calculated on Table 3B because all patients seen for all reportable services are counted on Table 3B by race and ethnicity, but the clinical measures reported on Table 7 relate to medical patients of that race and ethnicity with specific conditions.

See the crosswalk of comparable fields in Appendix B.

Health centers that report on a sample of patients—and even those who report on their entire universe of patients—are cautioned against using their data to evaluate disparities in their own systems given small sample sizes. On a national level, however, reported data permits HRSA to evaluate the impact of health center services on disparate outcomes for target populations.

HIV-Positive Pregnant Women, Top Line (Line 0)

Report the total number of HIV-positive pregnant women served by the health center during the reporting year on Line "0," regardless of whether the health center provides prenatal care or HIV treatment for these women.

Deliveries Performed by Health Center Provider (Line 2)

Report the total number of deliveries performed by health center clinicians on Line 2.

- On this line ONLY, include deliveries, regardless of outcome, of women who were either part of or not part of the health center's prenatal care program during the calendar year. Include such circumstances as:

  o the delivery of another doctor's patients when the health center provider participates in a call group and is on call at the time of delivery;

  o emergency deliveries when the health center provider is on call for the emergency room;

  o deliveries of "undoctored" patients performed by a health center provider as a requirement for privileging at a hospital; and

  o deliveries by any clinician who is considered to be the health center's employee during the delivery, regardless of the method of compensation.

- Do not include deliveries for which a clinic provider separately bills, receives, and retains payment for the delivery.

Section A: Deliveries and Birth Weight Measure by Race and Hispanic/Latino Ethnicity, Columns 1a–1d

Report on _all_ prenatal care patients who are either provided direct care or referred for care. No sampling is permitted on this measure. Report all health center patients who delivered during the reporting period and all babies born to them in Columns 1a–1d. Include any woman who is a patient of the health center and is referred to another provider for some or all of her prenatal care.

Report women (Column 1a) and babies (Columns 1b, 1c, and 1d) separately by their race and ethnicity. Obtain race and ethnicity of mothers from the information on their patient registration forms. Obtain race and ethnicity of children from their registration forms, their birth certificates, or from their parent.

Prenatal Care Patients and Referred Prenatal Care Patients Who Delivered During the Year (Column 1a)

Report all health center prenatal care patients who delivered during the reporting period including those who health center staff cared for and delivered and those who had some or all care provided by a referral provider.

- Include all women who had deliveries, regardless of the outcome.

- Do not include deliveries when you have no documentation that the delivery occurred (women lost to inadequate follow-up).

- Do not include women who, based on their due date should have delivered, but you do not have explicit documentation of the delivery.

- Do not include miscarriages as deliveries.

- This column collects data on "patients who delivered." Report only one woman as having delivered, even if the delivery results in multiple births (e.g., twins or triplets), or is a stillbirth.

Note: The percentage of prenatal care patients who delivered can be calculated by dividing Table 7, Line i, Column 1a by Table 6B, Line 6, Column A.

Birth Weight of Infants Born to Prenatal Care Patients Who Delivered During the Year (Columns 1b–1d)

Low Birth Weight (Columns 1b and 1c), no eCQM

Measure Description

Percentage of babies of health center prenatal care patients born whose birth weight was below normal (less than 2,500 grams).

Note: The reporting of this measure captures all birth weight categories, not only those birth weights that meet the performance measurement.

Calculate as follows:

Denominator (Universe)
(Columns 1b + 1c + 1d)

- Babies born during the measurement period to prenatal care patients.

Numerator (Columns 1b + 1c)

- Babies born with a birth weight below normal (under 2,500 grams).

Exclusions/Exceptions

- Denominator
  o Stillbirths or miscarriages.
- Numerator
  o Not applicable.

Specification Guidance

- Not applicable.

UDS Reporting Considerations

- Report the total number of LIVE births during the reporting period for women who received prenatal care from the health center or a referral provider during the reporting period, according to the appropriate birth weight group (in grams):

  o **Very Low Birth Weight (Column 1b):** Weight at birth was less than 1,500 grams.

  o **Low Birth Weight (Column 1c):** Weight at birth was 1,500 grams through 2,499 grams.

  o **Normal Birth Weight (Column 1d):** Weight at birth was equal to or greater than 2,500 grams.

  Note: Be careful not to confuse pounds and ounces for grams when reporting these numbers.

- If the delivery is of multiple babies (i.e., twins or triplets), report the birth weight of each child separately.

  Note: Report data regardless of whether the health center did the delivery, referred the delivery to another provider, or the woman transferred to another provider on her own. Follow-up on all patients is required.

- In rare instances, there may be no birth outcomes recorded although there may be evidence (i.e., records indicate delivery occurred) that the mother delivered. Count the mother as having delivered with no birth outcomes.

- The number of deliveries reported in Column 1a will normally be different than the total number of infants reported in Columns 1b–1d because of multiple births and still births.

Note: This is a "negative" measure: The higher the number of infants born below normal birth weight, the worse the performance on the measure.

Although data are provided for each racial and ethnicity category, the performance measure looks only at the totals.[13]

Sections B and C: Other Health Outcome and Disparity Measures

In these sections, report the findings of reviews of services provided to targeted populations.

- Sections B and C specifically assess the health center's current medical patients (i.e., patients who had a medical visit at least once during the reporting period).

- Do not include patients whose *only* visits were for dental, mental health, or something other than medical care.

- Using the specified measure criteria, include patients seen for medical care even if the only care provided was in an urgent care setting or if patients were seen only once for acute care.

- For measures which require the completion of tests or procedures to meet the measurement standard, test results or

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[13] However, during the review of the UDS report, reviewers may question unusually high or low proportion of low birth weight babies for individual race or ethnicity categories.

procedures must be evidenced by documented results. Patient-self report is not accepted.

Note: In this section, the term "measurement period" is the same as the term "reporting period" and is intended to capture calendar year 2020 data.

Controlling High Blood Pressure (Columns 2a-2c), CMS165v8

Measure Description

Percentage of patients 18–85 years of age who had a diagnosis of hypertension during the measurement period and whose most recent blood pressure (BP) was adequately controlled (less than 140/90 mmHg) during the measurement period.

Calculate as follows:

Denominator (Universe)
(Columns 2a and 2b)

- Patients 18 through 85 years of age who had a *medical* visit and diagnosis of essential hypertension during the measurement period.

Note: Include patients who were born on or after January 1, 1934, and on or before December 31, 2000.

Numerator (Column 2c)

- Patients whose most recent blood pressure is adequately controlled (systolic blood pressure less than 140 mmHg and diastolic blood pressure less than 90 mmHg) during the measurement period.

Exclusions/Exceptions

- Denominator
  - o Patients with evidence of end-stage renal disease (ESRD), dialysis, or renal transplant before or during the measurement period.
  - o Patients with a diagnosis of pregnancy during the measurement period.
  - o Patients who were in hospice care during the measurement period.
  - o Patients 66 and older who are living long term in an institution for more than 90 days during the measurement period.
  - o Patients 66 and older with advanced illness and frailty because it is unlikely that patients will benefit from the services being measured.
- Numerator
  - o Not applicable.

Specification Guidance

- Only blood pressure readings performed by a clinician or a remote monitoring device are acceptable for numerator compliance with this measure.
- Do not include BP readings:
  - o Taken during an acute inpatient stay or and ED visit.
  - o Taken on the same day as a diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day

before the day of the test or procedure (with the exception of fasting blood test).

o   Reported by or taken by the member

- If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled." Count them in Columns 2a and 2b, but not in Column 2c.

- If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading.

UDS Reporting Considerations

- Do not include patients in the denominator with an initial diagnosis of hypertension after June 30 of the measurement period.

- Include patients who have an active diagnosis of hypertension even if their medical visits during the year were unrelated to the diagnosis.

- Include blood pressure readings taken at any visit type at the health center as long as the result is from the most recent visit.

Note: Health centers that have Office of the National Coordinator for Health IT (ONC)-certified I2I-Track, personal computer dimensional measurement inspection software (PC-DMIS), a patient electronic care system (PECS), population health management systems, or other supporting systems may use them to report the universe only if it can be limited to the

measurement period and only if it includes all required data elements (i.e., it includes data for the required time frame for all patients with hypertension from all service sites).

Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9 percent) (Columns 3a–3f), CMS122v8

Measure Description

Percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c (HbA1c) greater than 9.0 percent during the measurement period.

Calculate as follows:

Denominator (Universe) (Columns 3a and 3b)

Patients 18 through 75 years of age with diabetes with a *medical* visit during the measurement period.

Note: Include patients who were born on or after January 1, 1944, and on or before December 31, 2000.

Numerator (Column 3f)

- Patients whose most recent HbA1c level performed during the measurement year is greater than 9.0 percent and patients who had no test conducted during the measurement period.

Exclusions/Exceptions

- Denominator

o   Patients who were in hospice care during the measurement period.

o   Patients 66 and older who are living long term in an

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institution for more than 90 days during the measurement period.

- o Patients 66 and older with advanced illness and frailty because it is unlikely that patients will benefit from the services being measured.

- Numerator

- o Not applicable.

Specification Guidance

- Include patients in the numerator whose most recent HbA1c level is greater than 9 percent, the most recent HbA1c result is missing, or when no HbA1c tests were performed or documented during the measurement period.

- Only include patients with an active diagnosis of Type 1 or Type 2 diabetes in the denominator of this measure.

- Do not include patients with a diagnosis of secondary diabetes due to another condition (such as gestational diabetes) in the denominator.

UDS Reporting Considerations

- Include patients with a diabetes diagnosis made anytime during the year. Do not limit diagnosis to those made through June 30 as is done to identify patients with hypertension.

- Include patients who have an active diagnosis of diabetes even if their medical visits during the year were unrelated to the diagnosis.

- Even if the treatment of the patient's diabetes has been referred to a non-health center provider, the health center is expected to have the current lab test results in its records.

Note: This is a "negative" measure: The lower the number of adult patients with diabetes with poor diabetes control, the better the performance on the measure.

Although data are provided for each race and ethnicity category, the performance measure looks only at the totals.

Additional information is available to clarify reporting. View **FAQs for Table 7**.

Table 7: Health Outcomes and Disparities

Reporting Period: January 1, 2020, through December 31, 2020

Section A: Deliveries and Birth Weight

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

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: <1500 grams (1b)	Live Births: 1500–2499 grams (1c)	Live Births: ≥2500 grams (1d)
	Hispanic/Latino				
1a	Asian				
1b1	Native Hawaiian				
1b2	Other Pacific Islander				
1c	Black/African American				
1d	American Indian/Alaska Native				
1e	White				
1f	More than One Race				
1g	Unreported/Refused to Report Race				
	Subtotal Hispanic/Latino				
	Non-Hispanic/Latino				
2a	Asian				
2b1	Native Hawaiian				
2b2	Other Pacific Islander				
2c	Black/African American				
2d	American Indian/Alaska Native				
2e	White				
2f	More than One Race				
2g	Unreported/Refused to Report Race				
	Subtotal Non-Hispanic/Latino				
	Unreported/Refused to Report Race & Ethnicity				
h	Unreported/Refused to Report Race and Ethnicity				
i	**Total**				

Section B: Controlling High Blood Pressure

Line	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Number Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)
	Hispanic/Latino			
1a	Asian			
1b1	Native Hawaiian			
1b2	Other Pacific Islander			
1c	Black/African American			
1d	American Indian/Alaska Native			
1e	White			
1f	More than One Race			
1g	Unreported/Refused to Report Race			
	Subtotal Hispanic/Latino			
	Non-Hispanic/Latino			
2a	Asian			
2b1	Native Hawaiian			
2b2	Other Pacific Islander			
2c	Black/African American			
2d	American Indian/Alaska Native			
2e	White			
2f	More than One Race			
2g	Unreported/Refused to Report Race			
	Subtotal Non-Hispanic/Latino			
	Unreported/Refused to Report Race and Ethnicity			
h	Unreported/Refused to Report Race and Ethnicity			
i	**Total**			

Section C: Diabetes: Hemoglobin A1c Poor Control

Line	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Number Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)
	Hispanic/Latino			
1a	Asian			
1b1	Native Hawaiian			
1b2	Other Pacific Islander			
1c	Black/African American			
1d	American Indian/Alaska Native			
1e	White			
1f	More than One Race			
1g	Unreported/Refused to Report Race			
	Subtotal Hispanic/Latino			
	Non-Hispanic/Latino			
2a	Asian			
2b1	Native Hawaiian			
2b2	Other Pacific Islander			
2c	Black/African American			
2d	American Indian/Alaska Native			
2e	White			
2f	More than One Race			
2g	Unreported/Refused to Report Race			
	Subtotal Non-Hispanic/Latino			
	Unreported/Refused to Report Race and Ethnicity			
h	Unreported/Refused to Report Race and Ethnicity			
i	**Total**			

Instructions for Table 8A: Financial Costs

Table 8A reports the total cost of all activities that are within the scope of the project and covered by the program budget supported, in whole or in part, by (1) the Health Center Program grant covered by the UDS, *or* (2) the look-alike designation, *or* (3) the scope of the BHW primary care clinics. The same costs may be included in both a BHW clinic *and* a BPHC awardee or look-alike if they are included in the scope of both grants. The same costs *may not* be reported under both a BPHC grant and a look-alike designation.

Report all costs on Table 8A on an *accrual* basis. These are the costs attributable to the reporting period, including depreciation, regardless of when (or in the case of donations on Line 18, if) actual cash payments were made. (Note: Only report depreciation for capital expenditures, including BPHC capital grants). Do not report bad debts or the repayment of the principal of a loan, but do report interest on any such loans as an expense.

Accrued Costs, Allocated Costs, and Costs after Allocation (Column Definitions)

Column A - Accrued Costs

In this column, report the accrued direct costs associated with each of the service delivery cost centers listed. See Line Definitions for costs to include in each category. In addition, report the total facility cost and the total cost of non-clinical support services (also referred to as administrative costs) separately on Lines 14 and 15.

Column B - Allocation of Facility Costs and Non-Clinical Support Service Costs

In this column, report the allocation of facility and non-clinical support services costs (from Lines 14 and 15, Column A) to each of the direct cost centers. Use the following guidance to distribute these costs:

- Distribute the total of facility and non-clinical support services costs (reported in Column A, Lines 14 and 15) in Column B. The total for Column B will equal the amount reported on Line 16, Column A.

- Lines 1 and 3 both refer to aspects of the medical practice. It is acceptable to report the allocation of all medical facility and non-clinical support services on Line 1 if a more appropriate allocation between Lines 1 and 3 is not available.

- Allocate facility and non-clinical support services attributable to pharmacy to the non-supply line (Line 8a). Allocation for pharmaceutical supplies (Line 8b) is greyed out in the EHBs. Any allocation of overhead (which is usually minimal) that you choose to make for pharmaceuticals must be reported on Line 8a. This is true even if you did not report any direct pharmacy costs on Line 8a, Column A.

A more detailed description of what is included in the facility and non-clinical support category is provided below. The allocation of facility and non-clinical support services costs should

be done as follows, unless you have a more accurate method:

1. Allocate *facility costs* based on the proportion of usable square footage utilized for each of the cost centers, including medical, medical lab and X-ray, dental, mental health, substance use disorder, pharmacy, other professional, vision, enabling, other program-related services, quality improvement, and non-clinical support services. Square footage is generally limited to the portion of the health center's facility space used in the operation of the organization, not including common spaces such as hallways, restrooms, and utility closets.

- Assign hallways and similar shared space within a dedicated area to that area. For example, the hallways inside the medical suite that connects the exam rooms and the doctor's offices and the medical supply closets are considered medical space, not "common space."

- If space is owned by the health center and leased or rented to other parties but outside the scope of project, do not report the cost of the square footage associated with space on Line 14 or anywhere else.

- Allocate leased or rented space to Other Program-Related Services (Line 12) if it has been included inside the scope of project, and include the rent received on Table 9E under Other Revenue (Line 10).

- An alternative allocation method that effectively distributes facility costs that is approved or used by your auditors may be used, but save

backup paperwork for review and explain the methods in the table comment. Alternative methods often include the allocation of the cost of each building separately—especially when the per square foot costs of multiple buildings vary dramatically —and recognize substantial remodeling or renovation costs that affect only a portion of the program. For example, attribute the depreciation of a major remodeling of the medical exam rooms to medical costs only, rather than allocating them to all cost centers.

- Allocate a share of facility costs to non-clinical support services.

2. Allocate the Non-Clinical Support Services Costs to all other cost centers based on a straight-line allocation method.

- Allocate non-clinical support services costs after its share of facility costs have been allocated to this cost center.

- Allocate non-clinical support services costs based on the proportion of net costs (total costs excluding non-clinical support services and facility cost) that is attributable to (assigned to) each service category. For example, if medical staff account for 50 percent of net cost (excluding facility and non-clinical support services costs), then allocate 50 percent of the non-clinical support services cost to medical staff on Line 1.

- An alternative method that provides more accurate allocations may be used, but save backup paperwork for review and explain the methods used in the table comment. For example, it would be appropriate to

allocate the cost of billing and collection activities exclusively to those cost centers that generate bills.

- Reduce or eliminate the share of non-clinical support services allocated to pharmaceuticals when a very substantial cost is for pharmacy supplies, which requires only minimal administrative costs.

Column C – Total Cost After Allocation of Facility and Non-Clinical Support Services

This column reports the cost of each of the cost centers listed on Lines 1–13 after the allocation of facility and non-clinical support services. This cost is the sum of the direct cost, reported in Column A, plus the allocation of facility and non-clinical support services, reported in Column B. This calculation is done automatically in the EHBs.

In addition, report on Line 18 in Column C, the value of any donated facilities, services, and supplies. Report these non-cash donations as a positive number, and do not include them in any of the lines above.

This is the only place that the value of non-cash donations to the health center is reported. Do not report non-cash donations on Table 9E.

Line 19, Column C is the total cost, including the value of donations.

Note: All UDS calculations for cost centers, such as medical costs per medical visit, are based on "total cost" (Column C). Total costs are calculated based on the costs reported on Line 17 and exclude the value of donated services, supplies, or facilities.

BPHC Major Service Categories (Line Definitions)

Medical Care Services (Lines 1–4)

Include in this category costs for medical care personnel, services provided under agreement, laboratory and X-ray, and other direct costs wholly attributable to medical care (e.g., staff recruitment, equipment depreciation, medical supplies, professional dues and subscriptions, continuing medical education [CME] and travel associated with CME).

Do not include costs associated with pharmacy, including the in-clinic use of stock pharmaceuticals, dedicated QI staff, or other non-medical service categories.

Do not count psychiatry or ophthalmology costs in the medical cost center. Report them on mental health (Line 6) and vision (Line 9a), respectively.

Report non-clinical support services and facility costs associated with the medical practice first on Lines 14 and 15, Column A, and then allocate them to medical in Column B, Lines 1–3.

Medical Staff Costs (Line 1)

Report all medical staff costs.

- Include salaries and fringe benefits for medical care personnel supported directly or under contract, including nurses, medical assistants,

etc., but do not include lab and x-ray staff and associated expenses.

- Dedicated QI, including HIT/EHR informatics staff costs, are reported on Line 12a, not here.

- Include the accrued cost (if any) of medical interns and residents who were paid or paid for either directly or through a contract with their teaching institution.

- Include the cost for vouchered or contracted medical services here.

- In addition, include the cost of any medical visit paid for directly by the center, such as at-risk specialty care from an HMO contract or other specialty care.

- The costs of intake, medical records, and billing and collections are considered non-clinical support costs. Report on Line 15, not here.

- Report amounts on this line if the health center opts to permit one or more providers to retain Meaningful Use EHR incentive payments or transfers some or all of these payments to providers. Report the Meaningful Use EHR incentive payments received from Medicare or Medicaid as income on Table 9E on Line 3a.

Medical Lab and X-Ray Costs (Line 2)

Report all costs for medical lab and X-ray (including sonography, mammography, and any advanced forms of tomography).

- Include salaries and fringe benefits for lab and X-ray personnel supported directly or under contract, and all other direct costs, including but not limited to supplies, equipment depreciation, related travel, contracted or vouchered lab, and X-ray services.

Note: Report dental lab and X-ray costs as Dental, Line 5. If there are costs for retinography (most commonly for diabetic patients), report them in Vision Services, Line 9a.

Other Direct Medical Costs (Line 3)

Report all other direct costs for medical care, including but not limited to supplies, equipment depreciation, related travel, CME registration and travel, laundering of uniforms, recruitment, membership in professional societies, books, and journal subscriptions.

The cost of the medical aspects of an HIT/EHR system is reported on Line 3, including but not limited to the depreciation on software and hardware, training costs, and licensing fees. If the HIT/EHR covers other service categories (e.g., mental health, dental), allocate costs to the services it covers.

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 use disorder, pharmacy, vision, and services rendered by other professional personnel (e.g., chiropractors, naturopaths, occupational and physical therapists, speech and hearing therapists, podiatrists). Unlike medical, all costs are included on a single line.

Dental (Line 5)

Report all costs for the provision of dental services, including but not limited to staff, fringe benefits, contracted dental services, dental service and office supplies, equipment depreciation, related travel, dental HIT/EHR, dental lab services, and dental X-ray.

Report non-clinical support services and facility costs associated with the dental practice first on Lines 14 and 15, Column A, and then allocate to dental in Column B.

Mental Health (Line 6)

Report all direct costs for the provision of mental health services, *other than substance use disorder services*, including but not limited to staff, fringe benefits, supplies, equipment depreciation, mental health HIT/EHR, and related travel.

If a behavioral health program provides both substance use disorder and mental health 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, but they must be consistent with Table 5 allocations.

Report non-clinical support services and facility costs associated with the mental health practice first on Lines 14 and 15, Column A, and then allocate to mental health in Column B. (See also FAQs for Table 5).

Substance Use Disorders (Line 7)

Report all direct costs for the provision of substance use disorder 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 use disorder services, the cost should be allocated between the two programs, as should associated staff on Table 5. Allocations may be based on staffing or visits (from Table 5) or any other appropriate methodology, but they must be consistent with the reporting on Table 5.

Report non-clinical support services and facility costs associated with the substance use disorder program first on Lines 14 and 15, Column A, and then allocate to substance use disorder in Column B. (In addition, see FAQ discussion for Table 5).

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. Exclude the cost of pharmaceuticals. The cost of all pharmacists, including clinical pharmacists, is reported on this line.

Report all non-clinical support services and facility costs for both Lines 8a and 8b first on Lines 14 and 15, Column A, and then allocate to pharmacy *on Line 8a*, Column B.

Note: Report the cost of personnel engaged in assisting patients to become eligible for and/or receive free pharmaceuticals from manufacturers (often called PAPs) on Line 11e – Eligibility Assistance, not here.

If 340(b) drugs are purchased by or on behalf of a clinic and dispensed by a contract pharmacy, report the full dispensing fee and any other service fees (such as "share of profit," pharmacy benefit manager costs, inventory fees, ordering fees, or a charge of pharmacy computer services) on this line, regardless of whether the health center pays the full amount, pays a net after subtraction of income at the contract pharmacy, or simply receives a reduced net payment from the pharmacy.

Pharmaceuticals (Line 8b)

Report all costs for the purchase of pharmaceuticals, including the cost of vaccines and other stock drugs that may be used (or directly dispensed) by the health center.

- Include all pharmaceuticals, such as penicillin, Depo-Provera, and buprenorphine.

- Do not include other supplies here. (Report on Line 8a, Pharmacy).

- Do not include the value of donated pharmaceuticals. (Report these on Line 18, Column C).

- The cell for the allocation of facility and non-clinical support services costs associated with the purchase of pharmaceuticals is greyed out. To the extent that there are such costs (they would generally be limited to costs for purchasing and paying for the drugs), combine them with the

allocation for pharmacy costs and report them on Line 8a, Column B.

- If 340(b) drugs are purchased by or on behalf of a clinic and dispensed by a contract pharmacy, report the full cost of these drugs on this line, regardless of whether the health center pays the full amount, pays a net after subtraction of income at the contract pharmacy, or simply receives a reduced net payment from the pharmacy.

Other Professional (Line 9)

Report all direct costs for the provision of other professional and ancillary health care services, including but not limited to podiatry, chiropractic, acupuncture, naturopathy, speech and hearing pathology, or occupational and physical therapy. (A more complete list appears at Appendix A). Include provider and support staff, fringe benefits, supplies, equipment depreciation, related travel, and contracted services in direct costs.

Report non-clinical support services and facility costs first on Lines 14 and 15, Column A, and then allocate to "Other Professional" in Column B.

Note: There is a cell to specify the detail of other professional costs reported on this line.

Vision (Line 9a)

Report all direct costs for the provision of vision services including optometry, ophthalmology, and vision support staff. Include staff, fringe benefits, supplies (including frames and lenses), equipment depreciation, related travel, and contracted services in direct costs.

Include costs for retinography (for example, for diabetic patients) and any contract reading costs on Line 9a.

Report non-clinical support services and facility costs first on Lines 14 and 15, Column A, and then allocate to vision in Column B.

Total Other Clinical (Line 10)

The sum of Lines 5 + 6 + 7 + 8a + 8b + 9a.

Enabling, Other Program-Related Services, and Quality Improvement (Lines 11a–13)

Report enabling staff and related costs for case management, outreach, transportation, translation and interpretation, education, community health workers, eligibility assistance (including PAP eligibility), environmental risk reduction, and other services that support and assist in the delivery of primary care and facilitate patient access to care on Lines 11a through 11h. In addition, include the cost of staff and related costs for other program-related services, such as WIC, day care, ADHC, job training, delinquency prevention, and other activities not included in other BPHC categories, on Line 12. Finally, include costs associated with HIT/EHR informatics and QI on Line 12a.

Enabling (Line 11)

Enabling services include a wide range of services that support and assist primary care and facilitate patient access to care. Line 11 is calculated automatically as the total of the detail lines. Report all direct costs for the provision of enabling services, including but not limited to staff, fringe benefits, supplies, equipment depreciation, related travel, and contracted services.

Report non-clinical support services and facility costs first on Lines 14 and 15, Column A, and then allocate to enabling in Column B, Line 11.

Use Lines 11a–11h to detail the cost of seven specific types of enabling services and an "other" category for all other forms of enabling services.

- Case management (11a)
- Transportation (11b)
- Outreach (11c)
- Patient and community education (11d)
- Eligibility assistance (including pharmacy assistance program eligibility and health insurance coverage options) (11e)
- Translation/interpretation services (11f)
- Other (11g): Specify the other forms of enabling services included on this line if used.
- Community health workers (11h)

Note: *Descriptions of the services and staff that belong in each of these categories is included in the Table 5 instructions.*

Be sure costs are allocated in each of these enabling categories consistent with the staff and, for Lines 11a and 11d, visits reported on Table 5. If they are not (perhaps because the expenses are for non-personnel items or because of donated services, staff, or supplies), provide an explanation.

Other Program-Related (Line 12)

Report all direct costs for the provision of services not included in any other category on Line 12. These are most frequently other programs that support the health of the center's patients and mission but are not traditionally considered health care programs. This includes services such as WIC, child care centers, ADHC centers, fitness centers, Head Start and Early Head Start, and employment training programs. Report all direct costs for staff, fringe benefits, supplies, equipment depreciation, related travel, and contracted services. (Report staff for these programs on Line 29a of Table 5).

Report non-clinical support services and facility costs first on Lines 14 and 15, Column A, and then allocated in Column B to other program-related costs.

Include the estimated cost of something where part is program-related and part is not. Examples might include renting out space in the health center or providing retail pharmacy services to non-patient members of the community. Describe the program costs in the "specify" field provided.

Note: *Report the cost of space leased to others as Other Program-Related on Line 12, not Facility on Line 14. There is no need to associate overhead to this cost. Report the rental income for leased space on Table 9E on Line 10.*

Quality Improvement (Line 12a)

Report all direct costs for the QI program, including all personnel who are dedicated in whole or in part to QI. Although these staff tend to work in service delivery departments (e.g., medical, dental, mental health), they are accounted for separately here.

QI is part of every aspect of the health center. Do not attempt to allocate portions of time that QI staff spend attending meetings, participating in peer review, designing or interpreting QI findings, etc. to other service categories.

Include in the direct costs staff dedicated to the QI program and/or HIT/EHR system development and analysis, their fringe benefits, supplies, equipment depreciation, related travel, and contracted services.

Report non-clinical support services and facility costs first on Lines 14 and 15, Column A, and then allocate to QI in Column B.

Total Enabling, Other Program-Related, and Quality Improvement Services (Line 13)

The sum of Lines 11 + 12 +12a.

Facility and Non-Clinical Support Services Costs (Lines 14–16)

Include all traditional facility and non-clinical support services costs that are

later allocated to other cost centers. Specifically:

Facility Costs (Line 14)

Report facility costs, including all staff dedicated to facility services, their salaries, fringe benefits, and related travel, as well as rent and/or depreciation, facility mortgage interest (but not principal) payments, utilities, security, grounds keeping, facility maintenance and repairs, janitorial services, and all other related costs.

Do not report space leased to others on this line. Instead, report it as Other Program-Related costs on Line 12.

Report the depreciation of facilities, major renovations or capital equipment (e.g., building air conditioners), not the gross cost.

Non-Clinical Support Services Costs (Line 15)

Report non-clinical support services costs (sometimes referred to as administrative costs), including the cost of all non-clinical support services staff; billing and collections staff; medical records and intake staff; and the costs associated with them, including but not limited to salaries, fringe benefits, supplies, equipment depreciation, and travel.

Include senior administrative staff (CEO, CFO, COO, HR director, etc.) and their staff and supportive services in this category.

In addition, include other corporate costs (e.g., purchase of facility and liability insurance not including malpractice insurance, audits, legal fees, interest payments on non-facility

loans, communication costs including phone and internet, and board of directors' costs).

Include the cost of all patient support services (e.g., medical records and intake). Do not report as medical.

Include costs attributable to the board of directors, including travel, expenses, meetings, directors and officers insurance, registration and attendance at state or national meetings, etc.

Note: Do not include the "cost" of bad debts here or report them on this table in any way. (Report bad debt as an adjustment to patient self-pay charges on Table 9D on Line 13).

Note: Some grant programs limit the proportion of grant funds that may be used for non-clinical support services. **Do not consider those limits on "administrative" costs for those programs when completing Lines 14 and 15.** The "non-clinical support services" and facility categories for this report include all such personnel working at the health center, whether or not that cost was identified as "administrative" in any other grant application.

Total Facility and Non-Clinical Support Services (Line 16)

The sum of Lines 14 + 15.

Total Accrued Cost (Line 17)[14]

The sum of Lines 4 + 10 + 13 + 16.

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[14] This is the amount used in any BPHC calculation that is based on total cost.

Value of Donated Facilities, Services, and Supplies (Line 18)

Include the total imputed value of all in-kind and donated services, facilities, and supplies (including donated vaccines and other pharmaceuticals) 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 health center 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. Report on Line 18 the estimated reasonable acquisition cost of donated personnel, supplies, services, space rental, and depreciation for the use of donated equipment.

Do not include the value of these services in Column A on the lines above.

Calculate the estimated reasonable acquisition cost 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. For example, report donated pharmaceuticals (including vaccines) at the price that would be paid under the Federal Section 340(b) drug pricing program, not the manufacturer's suggested retail price. Evaluate donated clinical staff at the cost of hiring comparable staff, net of fringe benefits. *Do not* use the usual and customary charge for the services they provide.

Only recognize donated value when the intent of the donating parties is explicit and when the services, supplies, etc.

are both prudent and necessary to the health center's operation.

If the health center is not paying NHSC for assignees, include the full market value of NHSC federal assignee(s), including "ready responders." Capitalize NHSC-furnished equipment, including a dental operatory, at the amount reported on the NHSC Equipment Inventory Document, and report the appropriate depreciation expense for the reporting period.

Describe the donated items in detail using the "specify" field provided.

Total with Donations (Line 19)

The sum of Lines 17 and 18, Column C.

Relationship between Table 5 and Table 8A

The staffing on Table 5 is routinely compared to the costs on Table 8A since staff makes up over 70 percent of the cost of most health centers. See the crosswalk of comparable fields in Appendix B.

Additional information is available to clarify reporting. View **FAQs for Table 8A**.

Table 8A: Financial Costs
Reporting Period: January 1, 2020, through December 31, 2020

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
	Financial Costs of Medical Care			
1	Medical Staff			
2	Lab and X-ray			
3	Medical/Other Direct			
4	**Total Medical Care Services** (Sum of Lines 1 through 3)			
	Financial Costs of Other Clinical Services			
5	Dental			
6	Mental Health			
7	Substance Use Disorder			
8a	Pharmacy not including pharmaceuticals			
8b	Pharmaceuticals			
9	Other Professional (Specify: _____)			
9a	Vision			
10	**Total Other Clinical Services** (Sum of Lines 5 through 9a)			
	Financial Costs of Enabling and Other Services			
11a	Case Management			
11b	Transportation			
11c	Outreach			
11d	Patient and Community Education			
11e	Eligibility Assistance			
11f	Interpretation Services			
11g	Other Enabling Services (Specify: _____)			
11h	Community Health Workers			
11	**Total Enabling Services Cost** (Sum of Lines 11a through 11h)			
12	Other Related Services (Specify: _____)			
12a	Quality Improvement			
13	**Total Enabling and Other Services** (Sum of Lines 11, 12, and 12a)			

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
	Facility and Non-Clinical Support Services and Totals			
14	Facility			
15	Non-Clinical Support Services			
16	**Total Facility and Non-Clinical Support Services** (Sum of Lines 14 and 15)			
17	**Total Accrued Costs** (Sum of Lines 4 + 10 + 13 + 16)			
18	Value of Donated Facilities, Services, and Supplies (specify: _____)			
19	**Total with Donations** (Sum of Lines 17 and 18)			

Instructions for Table 9D: Patient-Related Revenue

This table collects information on charges, collections, supplemental payments, contractual allowances, self-pay sliding fee discounts, and self-pay bad debt write-off. The statute requires that *all* health centers have a fee schedule, based on locally prevailing rates and actual health center costs, and that they discount these fees (see discussion regarding [sliding fee discounts](#) below), based on a patient's income and family size. Health centers are also required to make reasonable efforts to collect payment from patients and/or their third-party payers. *Note that, unlike Table 8A, Table 9D is reported on a **cash basis**.*

Rows: Payer Categories and Form of Payment

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

Form of Payment

Non-Managed Care – Fee-for-Service

Report charges which are billed to a third-party payer (or directly to a patient) that list each of the services provided using CPT codes (for medical) and the charge associated with each of these services. Other services (dental, mental health, pharmacy, etc.) have similar fee schedules. Third-party payers pay some or all of the bill, generally based on agreed-upon maximums or discounts.

Managed Care – Capitated

Report charges billed to a managed care payer which lists each of the services provided and the associated fee; the HMO or managed care organization pays the health center a monthly capitation fee *regardless of whether any services were rendered during the month*.

If the billed services are on a list of covered services in the agreement between the health center and the HMO, no further payment is provided by the HMO (although a federally qualified health center [FQHC] wrap-around payment may be paid for Medicaid, Medicare, or CHIP services to adjust total payment to FQHC prospective payment system (PPS) rates).

If the service is "carved out" (i.e., not included in the listed services), reflect the charge for these services as a managed care fee-for-service.

Report the capitation (monthly payment) as a collection, not as an additional charge.

Managed Care – Fee-for-Service

Report charges for services provided to patients who are assigned to the health center and must receive their primary care from the health center—hence the managed care inclusion—but for whom no monthly fee is paid. Instead, the HMO pays some or the entire bill, generally based on agreed-upon maximums or discounts for services.

A supplemental wrap-around payment may also be paid, especially in Medicaid programs. In addition to basic services to fee-for-service managed care patients, reflect carved-out charges and collections for capitated patients on these lines.

Payer Categories

Medicaid (Lines 1–3)

Report all services billed to and paid for by Medicaid (Title XIX), regardless of whether payment comes directly or through a fiscal intermediary or an HMO. For example, in states with a capitated Medicaid program, where the health center has a contract with a private plan like Blue Cross, the payer would be Medicaid, even though the actual payment may have come from Blue Cross.

Note: Include EPSDT, which has various names in different states and is a part of Title XIX. The EPSDT program includes some children who are eligible for the screening services only and are not included in the rest of the Medicaid program. Always report their charges on Line 1.

- CHIP (or CHIP-RA), which has different names in different states, is sometimes paid through Medicaid. If this is the case, include it here.

- Note that some states are experimenting with the Medicaid expansion program by providing funds for eligible individuals to purchase their own insurance. *Classify these payers as Medicaid, not as Private.*

- Include here the portion of the charges for dually eligible patients that are reclassified to Medicaid after being initially submitted to Medicare.

- In a small number of cases, Medicaid patients are enrolled in a "share of cost" program where they pay some portion of the fee as a co-payment or a deductible. In this case,

reclassify the patient's share of the cost to Self-Pay.

- Recognize charges and collections for patients enrolled in ADHC or Program of All-inclusive Care for the Elderly (PACE) programs under the appropriate payer. Treat as discussed in Appendix B.

Medicare (Lines 4–6)

Report 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, including Medicare Advantage, where the health center has a contract with a private plan like Blue Cross, consider the payer to be Medicare, even though the actual payment may come from Blue Cross.

- If a patient is covered by both Medicare and Medicaid, or by Medicare and a private payer, reclassify the portion of the charge not paid by Medicare to these other payment sources.

- Reclassify co-payments due from patients to Self-Pay after the initial Medicare payment is received and allowances are taken.

- Recognize charges and collections for patients enrolled in Adult Day Health Care or PACE programs under the appropriate payer. Treat as discussed in Appendix B.

Other Public (Lines 7–9)

Report all services billed to and paid for by state or local government programs other than indigent care programs.

- The most common of these would be CHIP *when paid for through commercial carriers*. (See above if CHIP is paid through Medicaid.)

- Include family planning programs such as Title X programs, BCCCPs (with various state names), and other dedicated state or local programs. Although these programs are considered Other Public payers, patients are generally classified as Uninsured on Table 4.

- Include state-run insurance plans, such as the Massachusetts' Common Health Plan.

- ***Do not include state or local indigent care programs***. Report patients whose only payment source is a state or local indigent care program as "uninsured" on Table 4 and their charges, and any associated self-pay collections, etc. on the "self-pay" line, Line 13, as described below.

- Do not report third-party coverage purchased through state or federal exchanges (which may be subsidized) here. Report as Private unless determined to be enrolled through subsidies from a Medicaid Expansion program, which are to be reported as Medicaid.

Private (Lines 10–12)

Report all services billed to and paid for by commercial insurance companies or by other third-party payers as Private. Do not include any services that fall into one of the other categories.

- As noted above, classify elsewhere services covered by Medicaid, Medicare, and CHIP programs that use commercial programs as intermediaries.

- Include insurance purchased for public employees or retirees such as Tricare, Trigon, and the Federal Employees Insurance Program, as well as workers' compensation.

- Report charges and collections associated with insurance purchased through state exchanges here unless you can identify them as being enrolled through purchased subsidies from a Medicaid expansion program.

- 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 a provision of medical care at a per-session or other negotiated rate.

- Include charges and collections associated with supplemental insurance (typically amounts not paid/disallowed by Medicare but covered by other insurance) as Private.

Self-Pay (Line 13)

Report all charges and collections where the patient is responsible as "self-pay," including charges for indigent care programs as described below.

Note: *Include the reclassified co-payments, deductibles, and charges for uncovered services for otherwise insured*

individuals that become the patient's personal responsibility.

State or Local Indigent Care Programs:

Report on state or local indigent care programs that subsidize services rendered to the uninsured as follows:

- Report all charges for these services and collections from patients on the "self-pay" line (Line 13, Columns A and B);

- *Report all amounts not collected or due from the patients as sliding fee discounts or bad debt write-off, as appropriate*, on Line 13, Columns E and F; and

- Report collections from the associated state and local indigent care programs on Table 9E on Line 6a and specify the name of the program paying for the services.

Columns: Charges, Payments, and Adjustments Related to Services Delivered (Reported on a Cash Basis)

Column A – Full Charges this Period

Report in Column A the total charges for each payer source. This will initially reflect the total full charges (per the health center's fee schedule) for services rendered to patients in that payer category during the calendar year. Record charges for services that are billed to **and** covered in whole or in part by a payer, or the patient, even if some or all of them are subsequently written off as contractual allowances, sliding fee discounts, or bad debts. Always report full gross charges.

Do not record "contractual allowances" as a charge. Instead, report the difference between gross charges and contracted payments from third-parties as described below in Allowances.

Do not include charges that are generally not billable to or covered by traditional third-party payers. 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 payer (e.g., Medicaid) accepts billing and pays for these services.

Include charges for eyeglasses, pharmaceuticals, durable medical equipment, and other similar supply items. Do not include charges for pharmaceuticals, including vaccines, *donated* to the health center or directly to a patient through the health center since the clinic may not legally charge for these. Include charges for dispensing or injecting these pharmaceuticals if they appear on bills and are collected from first and third-parties.

Report pharmaceuticals dispensed through a (340(b)) contract pharmacy at the pharmacy's UCR gross charge even though they are sold at a discount to clinic patients.

Note*: Under no circumstances should the actual amount paid by Medicaid or Medicare (such as FQHC, G code, or T code rates) or the amount paid by any other payer be used as the actual charges. Charges must come from the health center's schedule of fees, typically based on CPT codes, or retail charge (for pharmacy).*

Reclassifying Charges

Some patients have more than one source of payment for their services. In these instances, a charge goes to one carrier, who may deny some or all of the charge. Move the unpaid portion of charges to the secondary payer and to a tertiary payer if one exists and, eventually, to the patient as a self-pay charge. Only report the amount owed by payer after reclassifying charges to the appropriate payer.

Reduce amounts for which another third-party or a private individual can be billed (e.g., amounts due from patients or "Medigap" payers for co-payments) from the initial charges to the primary payer and record or reclassify them as charges due from the secondary source of payment.

Charges rejected by a payer that need reclassification (including deductibles and co-insurance) should be reversed as negative charges if your management information system does not reclassify them automatically.

Reclassifying these charges by utilizing an adjustment (allowance) and rebilling to another category is an incorrect procedure since it will result in an overstatement of total gross charges by including the charges twice, as well as the adjustments and payments.

Column B – Amount Collected This Period

Report in Column B the gross receipts for the year on a cash basis, regardless of the period in which the paid services were rendered. Include FQHC reconciliations, managed care pool distributions, pay-for-performance

(P4P) payments, quality bonuses (excluding HRSA's Quality Improvement Awards), court settlements, and other payments. Report these additional payments in Column B and in Columns c1, c2, c3, and/or c4.

When a contract pharmacy is dispensing 340(b) drugs on behalf of the health center, report the *gross* payments to the pharmacies by patients and third parties in Column B.

Note: *Record charges and collections for deductibles and co-payments that are charged to, paid by, and/or due from patients as "self-pay" on Line 13.*

Columns C1–C4 – Retroactive Settlements, Receipts, or Paybacks

Report in Columns c1–c4 retroactive settlements, receipts, and paybacks, *in addition to including them in Column B.* Payments by third parties from a current or prior period are included in Column B, reduced from Column D, and *also* broken out and reported in Columns c1–c4. Most common are Medicaid, Medicare, and CHIP FQHC PPS reconciliations and wrap-around payments. In addition, include managed care pool distributions, P4P payments, quality bonuses (excluding HRSA's Quality Improvement Awards), and paybacks to FQHC payers or HMOs.

Column C1 – Collection of Reconciliation/Wrap-Around, Current Year

Enter FQHC cash receipts from reconciliations (lump sum retroactive adjustments based on the filing of a cost report) and wrap-around payments (additional amounts for each visit to bring payment up to FQHC level) from

Medicare, Medicaid, or Other Public payers that are for services *provided during the current reporting period. Include the current-year component, if any, of multi-year settlements here*. In states that pay the FQHC rate upon billing, no wrap-around payments will generally be reported.

Column C2 – Collection of Reconciliation/Wrap-Around, Previous Years

Enter FQHC cash receipts from reconciliations (lump sum retroactive adjustments based on the filing of a cost report) and wrap-around payments (additional amounts for each visit to bring payment up to FQHC level) from Medicare, Medicaid, or Other Public payers that are for *services provided during previous reporting periods. Include the prior-year component of multi-year settlements here*. In states that pay the FQHC rate upon billing, no wrap-around payments will generally be reported.

Note: Apportion settlement data reported in Columns c1 and c2 between the fee-for-service lines and the managed care lines when both payment reimbursement methods are used. You may use the percent distribution of visits, charges, or net charges as the basis for the allocation.

Column C3 – Collection of Other Payments Including Pay for Performance, Quality Bonuses, Risk Pools, and Incentives

Enter other cash payments including managed care risk pool redistribution, incentives including P4P incentives, and quality bonuses from any payer.

CMS primary care demonstration funds may include payment for a person

being enrolled in the grant. Include these payments here, regardless of whether there is a visit involved.

Include settlements that may result from a court decision that requires a payer to make a settlement, including a multi-year settlement. These payments may apply to either a managed care or non-managed care payer.

Note: Do not include eligible provider payments from CMS for implementing EHRs (commonly referred to as Meaningful Use payments). Record these payments separately on Line 3a of Table 9E.

Column C4 – Penalty/Payback

Enter payments made by the health center to payers because of overpayments collected earlier.

In addition, enter "penalty" payments made to managed care plans for overutilization of the inpatient or specialty pool funds. (This is now a rare occurrence.)

Do *not* include as paybacks anticipated bonuses that were not earned because P4P goals were not met, regardless of whether they were budgeted.

Note: If a center arranges to have its "repayment" deducted from its monthly payment checks, report the amount deducted in Column c4 as if it had been paid to the third-party in cash during the year and add the same amount to the amount received in Column B. In addition, add the repayment to Column D as an allowance. Such paybacks may stretch across multiple reporting periods. Report only the amount paid back in the current reporting period.

Column D – Allowances

Report in Column D allowances granted as part of an agreement with a third-party payer. Virtually all insurance companies have a maximum amount they pay for a given service and the center agrees to write off the difference between what they charge and that contracted amount – these are considered "allowances."

In some states, Medicaid pays the contracted amount and then later pays a wrap-around and/or reconciliation. Reduce the initial allowance by the amount of retroactive settlements and receipts (reported in Columns c1, c2, and c3), including current and prior year FQHC reconciliations, managed care pool distributions, quality or P4P awards, and other payments. This may result in reporting a negative number as the allowance in Column D.

Add to allowances any overpayments made by payer which the health center pays back or for health center payments for penalties (reported in Column c4).

If, due to a contract or agreement, Medicaid, Medicare, other third parties, or other public payers reimburse less than the health center's full charge and the health center cannot bill the patient for the remainder, enter (and write off) the remainder or reduction on the appropriate payer line in Column D at the time the explanation of benefits (EOB) or advice of allowance specifies.

Under FQHC programs, it is possible that the cash payment will be greater than the charge when the health center is paid based on cost. In this case, record the adjustment in Column D as a negative amount. (Report financial adjustments received under FQHC programs in Columns c1 and c2, as well as in Column B.)

Note: Do not report amounts for which another third-party or a private individual can be billed (e.g., amounts due from patients or "Medigap" payers for co-payments) as allowances. Reduce these amounts from the initial charges to the primary payer and record or reclassify them as charges due from the secondary source of payment. Classify these amounts as adjustments only when all sources of payment have failed and further collection is not anticipated.

Because capitated plans typically pay on a per-member, per-month basis, and make this payment in the current month of enrollment, these plans typically do not carry significant receivables. For capitated plans (Lines 2a, 5a, 8a, and 11a only) the allowance column (Column D) is 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) *which span the beginning or end of the calendar year*.

In addition, note that self-pay (Line 13, Column D) is greyed out because

allowances given to self-pay patients based on their income and family size are recorded as sliding fee discounts. Valid self-pay receivables that are not paid should eventually be recorded as self-pay bad debt.

Column E – Sliding Fee Discounts

Report reductions to patient charges based on the patient's ability to pay. Processes detailed in the health center's sliding fee discount policies and procedures determine these discounts. Include discounts to required co-payments and deductibles, as applicable.

Do not report discounts to patients who are provided with other write-offs, most commonly a discount for prompt payment or prepayment, anywhere in the UDS Report. These discounts are not recorded on the UDS.

Do not report automatic discounting of charges for specific categories of patients (e.g., students, persons experiencing homelessness, or agricultural workers). Only report amounts discounted based on information collected about income and family size.

Note: Only patients may be granted a sliding fee discount based on their ability to pay. Column E is greyed out on all other lines. When a sliding fee discount is used to write off part of a charge originally made to a third-party, such as Medicare or a private insurance company's co-payment or deductible, first reclassify the charge to self-pay.

To reclassify, first reduce the third-party charge by the amount due from the patient and then increase the self-pay charges by this same amount. No other type of

discounts should be wrapped into or included in the sliding fee discount.

Column F – Bad Debt Write-Off

Report amounts billed to and defaulted on by any patient. **In the UDS, record *only* self-pay bad debts.** Bad debt write-off (Line 13, Column F) may occur due to the health center's inability to locate persons, a patient's refusal to pay, a patient with an income greater than 200 percent of the poverty guideline who is unable to pay, or a patient's inability to pay even after the sliding fee discount is granted. Health centers are encouraged to write off bad debts but may not consider the write-off or forgiveness to be a sliding fee discount.

If the current clinic record, at the time of service, shows that the patient would be eligible for a sliding fee discount, report the write-off as a sliding fee discount (Column E). However, if the patient would otherwise be ineligible, do not report the write-off as a sliding fee discount. This situation occurs most frequently when a source of funds permits a discount to persons whose income exceeds 200 percent of poverty (for example, the Title X Family planning program mandates discounts up to 250 percent of the FPG and the Ryan White program mandates discounts for patients with incomes up to 300 percent of FPG). By law, the discount may not be granted using health center grant-related resources or reported as a sliding fee discount on the UDS, but this does not preclude the health center from writing off or waiving the charges under some other policy.

To maintain responsible financial records, write-off bad debts on a routine basis. In some systems, this is accomplished by posting an allowance for bad debts rather than writing off individual patient accounts. Record amounts removed from the center's self-pay receivables through either *(but not both)* mechanism here.

Report the amount of the sliding fee discount calculated based on the patient's income and family size on Line 13, Column E. If the health center has not recorded the patient's income and family size and eligibility level, do not write off the amount as a sliding fee discount. If there are no sliding fee discounts, charges must either be collected or written off as a bad debt.

Under no circumstances are bad debts to be reclassified as sliding fee 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 fee 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, still report the amount written off as bad debt, not a sliding fee discount. At the time of the visit, it was a valid debt collectable from the patient.

Only record bad debts *from patients* on this table. An insurance company may default on legitimate debts as they go bankrupt, but do not calculate or report these data.

Other Write-Offs

Some health centers use additional write-offs. In some cases, a private, local, or state grant permits writing off charges to a certain class of individuals. In other cases, a cash discount is provided for pre-payment or payment at time of service. Some providers claim the right to grant "courtesy discounts" to patients. Do not record these discounts on the UDS. In any such case, report the full undiscounted charge in Column A and the amount collected in Column B. Do not report the amount of the other write-off.

Total Patient-Related Income (Line 14)

Enter the sum of Lines 3, 6, 9, 12, and 13. The EHBs will calculate this line automatically.

Additional information is available to clarify reporting. View **FAQs for Table 9D**.

Table 9D: Patient Related Revenue
Reporting Period: January 1, 2020, through December 31, 2020

Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Retroactivettlements, SeReceip ts, and Paybacks (c)		Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty / Payback (c4)	Allowances (d)	Sliding Fee Discounts (e)	Bad Debt Write Off (f)
				Collection of Reconciliation/ Wrap-Around Current Year (c1)	Collection of Reconciliation/ Wrap-Around Previous Years (c2)					
1	Medicaid Non-Managed Care									
2a	Medicaid Managed Care (capitated)									
2b	Medicaid Managed Care (fee-for-service)									
3	**Total Medicaid** (Sum of Lines 1 + 2a + 2b)									
4	Medicare Non-Managed Care									
5a	Medicare Managed Care (capitated)									
5b	Medicare Managed Care (fee-for-service)									
6	**Total Medicare** (Sum of Lines 4 + 5a + 5b)									
7	Other Public, including Non-Medicaid CHIP, Non-Managed Care									
8a	Other Public, including Non-Medicaid CHIP, Managed Care (capitated)									
8b	Other Public, including Non-Medicaid CHIP, Managed Care (fee-for-service)									

Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Collection of Reconciliation/ Wrap-Around Current Year (c1)	Collection of Reconciliation/ Wrap-Around Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty/ Payback (c4)	Allowances (d)	Sliding Fee Discounts (e)	Bad Debt Write Off (f)
9	**Total Other Public** (Sum of Lines 7 + 8a + 8b)									
10	Private Non-Managed Care									
11a	Private Managed Care (capitated)									
11b	Private Managed Care (fee-for-service)									
12	**Total Private** (Sum of Lines 10 + 11a + 11b)									
13	**Self-pay**									
14	**TOTAL** (Sum of Lines 3 + 6 + 9 + 12 + 13)									
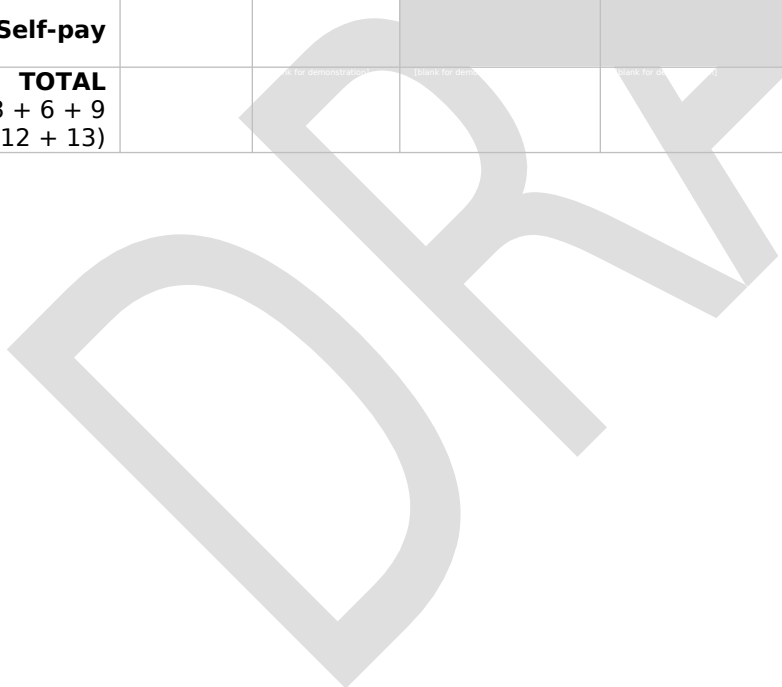
Instructions for Table 9E: Other Revenue

This table collects and reports information on non-patient income received during the reporting period that supported activities described in the scope of project(s) covered by the Health Center Program grant, the look-alike program, or the HRSA BHW primary care program. (Look-alike health centers and BHW primary care clinics will file this table but will have no income from the BPHC Health Center Grant program on Line 1.) Report income received on a "cash basis," and include all funds received during the calendar year that supported the federally approved project even if the revenue was accrued (earned) during the previous year or was received in advance and considered "unearned revenue" in the center's books on December 31.

Use the "**last party rule**" to report other revenues. The "last party rule," for UDS reporting purposes, means that grant, contract, and other funds should always be reported based on the entity from which the health center received them, regardless of their original origin. For example, funds awarded to the health center by the state for maternal and child health services usually include a mixture of federal funds, such as Title V, and state funds. Nonetheless, report these funds as state grants. Similarly, WIC funds provided by the U.S. Department of Agriculture generally pass through the state, and are reported on Line 6 as State funds, not on Line 3 as Federal funds. A rare exception to the rule is the Medicare and Medicaid EHR Incentive Grants received for eligible providers (Line 3a). In rare cases, these payments may go directly to the clinic's providers. It is presumed that these funds will be turned over to the clinic. Report these funds on Line 3a even though the payment may come from the provider and not directly from CMS. (See below for further details on Meaningful Use funds.)

BPHC Grants

Lines 1a through 1e

Report *drawdowns* made during the reporting period for the Health Center Program (section 330) grant. Amounts should be consistent with the PMS-272 federal cash transaction report.

- Report MHC grant drawdowns on Line 1a.
- Report CHC grant drawdowns on Line 1b.
- Report HCH drawdowns on Line 1c.
- Report PHPC drawdowns on Line 1e.

Note: *Supplemental funding and quality improvement awards from HRSA are provided as part of the 330 grant. Report these grant funds on the appropriate 330 grant Lines 1a–1e, as specified in the health center Notice of Award.*

Total Health Center Program (Line 1g)

The EHBs automatically calculates the total of Lines 1a through 1e.

Capital Development Grants (Line 1k)

Report the amount of Capital Development Grant dollars drawn down. This includes funds from the

Health Center Program facility program as well as funds from the HRSA-administered school-based health center capital grant program.

Report Capital Assistance for Hurricane Response and Recovery Efforts (CARE) and other funds awarded by HRSA to assist in the reconstruction and repair of facilities destroyed or damaged by natural disasters here.

Total BPHC Grants (Line 1)

This line reports the total of Lines 1g (Total Health Center Program) and 1k (Capital Development Grants). Be sure that all BPHC Health Center Program (section 330) grant funds drawn down during the year are included on Line 1. This calculation is done automatically in the EHBs.

Reflect direct funding, including NAP or expansion funds, only on the BPHC Grant lines.

Do not include BPHC funds passed through another BPHC health center, and do not reduce the amounts by money that the health center passed through to other centers including "sub-awardees" or "sub-recipients." Report the amount passed through as a cost on Table 8A, either in cost center categories or, if it is a lump sum on Line 12, Other Related Services.

Other Federal Grants

Ryan White Part C – HIV Early Intervention Grants (Line 2)

Report the amount of Ryan White Part C funds the health center has drawn down during the reporting period.

Guidance for reporting other Ryan White funds is as follows:

- Report Ryan White Part A, Impacted Area grants, from county or city governments on Line 7 (if they are first sent to a third-party, report the funds on Line 8. Report on Line 3 when the reporting entity is a county or city government and the funds were received directly from the Ryan White Part A federal program).

- Report Part B grants from the state on Line 6, unless they are first sent to a county or city government (in which case, report on Line 7) or to a third-party (in which case, report the funds on Line 8).

- Report Part D funds from the HIV/AIDS Bureau on Line 3.

- Report Special Projects of Regional and National Significance (SPRANS) grants which are generally direct federal grants, on Line 3.

Other Federal Grants (Line 3)

Report the amount and source of any other federal grant revenue received during the reporting period that falls within the scope of the project(s). These grants include only those funds received directly by the health center from the U.S. Treasury.

Do not include federal funds first received by a state or local government or other agency and then passed on to the health center, such as WIC or Part A or Part B Ryan White funds. Include these on Lines 6 through 8.

Describe ("Specify") the program(s) (include names and amounts) so the UDS Reviewer can confirm that the

classification of the program as a federal grant is appropriate. The most common "other federal" grants reported are from the Office of Minority Health (OMH), Indian Health Service (IHS), Housing and Urban Development (HUD), and Substance Abuse and Mental Health Services Administration (SAMHSA).

Dually funded IHS/HRSA-funded health centers report IHS funds (not including PL 93-638 Compact funds) on this line. Report PL 93-638 Compact funds on Line 6a, Indigent Care.

Medicare and Medicaid EHR Incentive Grants for Eligible Providers (Line 3a)

Report funds from the Medicare and Medicaid EHR Incentive Program grants (also known as "Meaningful Use awards") funded through the American Recovery and Reinvestment Act of 2009 (ARRA). They provide incentives to Eligible Providers (as defined by CMS) for the adoption, implementation, upgrading, and meaningful use of certified EHRs.

In rare cases, these payments go directly to the clinic's providers, but they are most commonly paid to the providers' designee (generally, the health center). It is presumed that, if the payment goes to the employees, these funds will be turned over to the health center. Report them on this line even though the payment may come from the provider and not directly from CMS. This is an exception to the "last party" rule. In the event the provider retains some or all of these grants as part of their compensation, record the total amount on this line and the amount retained by the provider on Table 8A, Line 1, as staff compensation.

Total Other Federal Grants (Line 5)

The EHBs automatically calculate the total of Line 2 + Line 3 + Line 3a.

Non-Federal Grants or Contracts

"Grants and Contracts" are defined as all *amounts received* (not only grants) on a line item or similar basis which are not tied to the delivery of services.

State Government Grants and Contracts (Line 6)

Report the amount of funds received from state government grants or contracts.

Include grants of flat sums to support the operation or a component of the health center with no specific tie to a level of service. Most include line item budgets which support specific staff positions or other costs.

Do not include funds from state indigent care programs or from Medicaid or CHIP here. When a state grant or contract program other than an indigent care program pays a health center based on the amount of health care services provided or on a negotiated fee for service or fee per visit, report the charges, collections, and allowances on Table 9D as "Other Public," not on Table 9E. This is most commonly seen in family planning and cancer detection programs.

Describe ("Specify") the program(s) (include names and amounts) so the UDS Reviewer can confirm that the classification of the program as a state grant is appropriate.

State/Local Indigent Care Programs (Line 6a)

Report the amount of funds received from state/local indigent care programs that subsidize services rendered to patients who are uninsured (examples include Massachusetts Free Care Pool, New Jersey Uncompensated Care Program, New York Public Goods Pool Funding, New Mexico Tobacco Tax program, and the Colorado Indigent Care Program). Include amounts allocated to the health center by tribes from their IHS PL 93-638 Compact funds.

Report payments from private contracts between a health center and a tribe as Private on Table 9D.

Describe ("Specify") the program (include the name and amount) so the UDS Reviewer can confirm that the classification of the program as a state/local indigent care program is appropriate. Do not use this line for any program not listed above without specific instructions provided at a state or regional UDS training program, from the UDS Support Center, or in communication with the UDS Reviewer.

Cross-table Reporting Guidance for Indigent Programs

Report payments received from state or local indigent care programs subsidizing services rendered to patients who are uninsured on Line 6a of this table whether the actual payment to the health center is made on a per-visit basis or as a lump sum for services rendered.

Report patients covered by these programs as uninsured on Table 4 unless they have some other form of insurance.

Report all associated charges, sliding fee discounts, and bad debt write-offs on the self-pay line (Line 13) on Table 9D. Monies collected from the patients covered by indigent programs should be reported on Table 9D in Column B.

Care should be taken to ensure that none of the funds reported on Line 6a of Table 9E are also reported as income in Column B of Table 9D.

Local Government Grants and Contracts (Line 7)

Report the amount received from local governments during the reporting period that covers costs included in the scope of the health center's project(s). Include grants of flat sums to support the operation of the health center with no specific tie to discrete services.

Do *not* include funds from local indigent care programs here.

When a local grant or contract pays a health center based on the amount of health care services provided or on a negotiated fee for service or fee per visit, report the charges, collections,

and allowances on Table 9D as "Other Public" services, not on Table 9E.

Describe ("Specify") the programs (include names and amounts) so the UDS Reviewer can confirm that the classification of the program as a local grant is appropriate.

Foundation/Private Grants and Contracts (Line 8)

Report the amount received from foundations or private organizations during the reporting period that covers costs included within the scope of the project(s). Include funds transferred from a primary care association, another health center, or another community service provider on this line regardless of their origin.

Describe ("Specify") the programs (include names and amounts) so the UDS Reviewer can confirm that the classification of the program as a foundation/private grant or contract is appropriate.

Total Non-Federal Grants and Contracts (Line 9)

The EHBs calculate the total of Lines 6, 6a, 7, and 8 automatically.

Other Revenue (Line 10)

Report Other Revenue receipts included in the federally approved scope of project that are unrelated to charge-based services or to grants and contracts described above. Include fund-raising, interest income, rent from tenants, medical records fees, individual monetary donations, vending machines, pharmacy sales to the public (i.e., non-health center patients), etc.

Describe ("Specify") these sources (include names and amounts) of "other revenue."

Do not enter the value of in-kind or other donations made to the health center. Report these only on Line 18 of Table 8A.

In addition, do not report the proceeds of any loan received, either for operations or in the form of a mortgage.

Do not report the receipt or recognition of in-kind "community benefit" from a third-party here or anywhere else on the UDS unless it is received as a cash donation.

Under no circumstances should payments or net payments from a pharmacy contracted to dispense 340(b) pharmaceuticals appear on this line (or anywhere on Table 9E). Report all patient pharmacy income (gross income) on Table 9D and record all expenses on Table 8A. (In addition, see Appendix B for cross-table pharmacy reporting.)

Total Other Revenue (Line 11)

The EHBs automatically calculate the total of Lines 1, 5, 9, and 10.

Additional information is available to clarify reporting. View **FAQs for Table 9E**.

Table 9E: Other Revenues

Reporting Period: January 1, 2020, through December 31, 2020

Line	Source	Amount (a)
	BPHC Grants (Enter Amount Drawn Down – Consistent with PMS 272)	
1a	Migrant Health Center	
1b	Community Health Center	
1c	Health Care for the Homeless	
1e	Public Housing Primary Care	
1g	**Total Health Center** (Sum Lines 1a through 1e)	
1k	Capital Development Grants, including School-Based Health Center Capital Grants	
1	**Total BPHC Grants** (Sum of Lines 1g + 1k)	[b
	Other Federal Grants	
2	Ryan White Part C HIV Early Intervention	nk]
3	Other Federal Grants (specify: _____)	
3a	Medicare and Medicaid EHR Incentive Payments for Eligible Providers	
5	**Total Other Federal Grants** (Sum of Lines 2–3a)	
	Non-Federal Grants or Contracts	
6	State Government Grants and Contracts (specify: _____)	
6a	State/Local Indigent Care Programs (specify: _____)	
7	Local Government Grants and Contracts (specify: _____)	
8	Foundation/Private Grants and Contracts (specify: _____)	
9	**Total Non-Federal Grants and Contracts** (Sum of Lines 6 + 6A + 7 + 8)	
10	Other Revenue (non-patient related revenue not reported elsewhere) (specify:_____)	
11	**Total Revenue** (Sum of Lines 1 + 5 + 9 + 10)	

Appendix A: Listing of Personnel

All line numbers in the following table refer to Table 5. Not all services delivered by a "provider" count as visits. Do not count interactions with "non-providers" as visits. Use the Provider definitions to classify personnel as a "provider" or "non-provider."

Personnel by Major Service Category	Provider	Non-Provider
Physicians		
Family practitioners (Line 1)	X	
General practitioners (Line 2)	X	
Internists (Line 3)	X	
Obstetricians/Gynecologists (Line 4)	X	
Pediatricians (Line 5)	X	
Licensed medical residents—line determined by specialty	X	
Other Specialist Physicians (Line 7)		
Allergists	X	
Cardiologists	X	
Dermatologists	X	
Orthopedists	X	
Surgeons	X	
Urologists	X	
Other specialists and sub-specialists	X	
Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives		
Nurse practitioners (Line 9a)	X	
Physician 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 nurses (RNs)	X	
Licensed practical nurses/Licensed vocational nurses		X
Nurse emergency medical services (EMS)/Nurse emergency medical technicians (EMT)	X	
Other Medical Personnel (Line 12)		
Nurse aides/assistants (certified and uncertified)		X
Clinic aides/medical assistants (certified and uncertified medical technologists)		X
Unlicensed interns and residents		X
EMS/EMT staff (not credentialed as a nurse)		X
Laboratory Personnel (Line 13)		
Pathologists		X
Medical technologists		X
Laboratory technicians		X
Laboratory assistants		X
Phlebotomists		X

Personnel by Major Service Category	Provider	Non-Provider
X-Ray Personnel (Line 14)		
Radiologists		X
X-Ray technologists		X
X-Ray technicians		X
Radiology assistants		X
Ultrasound technicians		X
Dentists (Line 16)		
General practitioners	X	
Oral surgeons	X	
Periodontists	X	
Endodontists	X	
Other Dental		
Dental hygienists (Line 17)	X	
Dental therapists (Line 17a)	X	
Dental assistants, advanced practice dental assistants (Line 18)		X
Dental technicians (Line 18)		X
Dental aides (Line 18)		X
Dental students (including hygienist students) (Line 18)		X
Mental Health (Line 20) **and Substance Use** (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	
Psychiatric nurse practitioners (Line 20b)	X	
Nurses—psychiatric and mental health (Line 20b)	X	
Unlicensed mental health providers, including trainees (interns or residents) and "certified" staff (Line 20c)	X	
Alcohol and drug abuse counselors (Line 21)	X	
RN counselors (Line 20b or 21)	X	
All Other Professional Personnel (Line 22)		
Audiologists	X	
Acupuncturists	X	
Chiropractors	X	
Community health aides and practitioners	X	
Herbalists	X	
Massage therapists	X	
Naturopaths	X	
Registered dietitians, including nutritionists/dietitians	X	
Occupational therapists	X	
Podiatrists	X	
Physical therapists	X	
Respiratory therapists	X	
Speech therapists/pathologists	X	
Traditional healers	X	
Vision Services Personnel		
Ophthalmologists (Line 22a)	X	
Optometrists (Line 22b)	X	
Ophthalmologist/optometric assistants (Line 22c)		X
Ophthalmologist/optometric aides (Line 22c)		X
Ophthalmologist/optometric technicians (Line 22c)		X

Personnel by Major Service Category	Provider	Non-Provider
Pharmacy Personnel (Line 23)		
Pharmacists, clinical pharmacists		X
Pharmacy technicians		X
Pharmacist assistants		X
Pharmacy clerks		X
Enabling Services		
Case Managers (Line 24)		
Case managers	X	
Care/referral coordinators	X	
Patient advocates	X	
Social workers	X	
Public health nurses	X	
Home health nurses	X	
Visiting nurses	X	
Registered nurses	X	
Licensed practical nurses/licensed vocational 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 /licensed vocational nurses	X	
Outreach Workers (Line 26)		
Outreach workers		X
Patient Transportation Workers (Line 27)		
Patient transportation coordinators		X
Drivers, including mobile van drivers		X
Eligibility Assistance Workers (Line 27a)		
Benefits assistance workers		X
Pharmacy assistance program eligibility workers		X
Eligibility workers		X
Patient navigators		X
Patient advocates		X
Registration clerks		X
Certified assisters		X
Interpretation (Line 27b)		
Interpreters		X
Translators		X
Community health workers		X
Community health advisors or representatives		X
Lay health advocates		X
Promotoras		X
Other Enabling Services Personnel (Line 28)		
Other enabling services personnel		X

Personnel by Major Service Category	Provider	Non-Provider
Other Program-Related Services Staff (Line 29a)		
WIC workers		X
Head start workers		X
Housing assistance workers		X
Childcare workers		X
Food bank/meal delivery workers		X
Employment/educational counselors		X
Exercise trainers/fitness center staff		X
Adult day health care, frail elderly support staff		X
Quality Improvement Staff (QI) (Line 29b)		
QI nurses		X
QI technicians		X
QI data specialists		X
Statisticians, analysts		X
Quality assurance/quality improvement and HIT/EHR design and operation staff		X
Management and Support Staff (Line 30a)		
Project directors		X
Chief executive officer/executive directors		X
Chief financial officers/fiscal officers		X
Chief information officers		X
Chief medical officers		X
Secretaries/administrative assistants		X
Administrators		X
Directors of planning and evaluation		X
Clerk typists		X
Personnel directors		X
Receptionists		X
Directors of marketing		X
Marketing representatives		X
Enrollment/service representatives		X
Fiscal and Billing Staff (Line 30b)		
Finance directors		X
Accountants		X
Bookkeepers		X
Billing clerks		X
Cashiers		X
Data entry clerks		X
IT Staff (Line 30c)		
Directors of data processing		X
Programmers		X
IT help desk technicians		X
Data entry clerks		X
Facility (Line 31)		
Janitors/custodians		X
Security guards		X
Groundskeepers		X
Equipment maintenance personnel		X
Housekeeping personnel		X

Personnel by Major Service Category	Provider	Non-Provider
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 supervisors	<blank>	X
Patient records technicians	<blank>	X
Patient records clerks	<blank>	X
Patient records transcriptionists	<blank>	X
Registration clerks	<blank>	X
Appointments clerks	<blank>	X

Appendix B1: Frequently Asked Questions (FAQs)

The following section, which is organized by table, provides guidance on common questions about UDS data reporting. We encourage health center staff completing the UDS Report to review this section after reading the corresponding table chapter to best understand the reporting requirements.

FAQs for ZIP Code by Medical Insurance

1. Are there any changes to this table?
No.

2. Do we need to collect information and report on the ZIP code of all our patients?
Yes. Although health centers report residence by ZIP code for all patients, some centers may draw patients from many ZIP codes outside of their normal service area. To ease the burden of reporting, consolidate ZIP codes with 10 or fewer patients in the "Other" category.

3. Do we need to collect information and report on the primary medical insurance of all our patients?
Yes. Although the ZIP code of a patient may be "unknown," medical insurance information must be obtained for every person counted as a patient.

4. If a patient did not receive medical care, do we still need their medical insurance information? What about dental patients?

Yes. This information is about patients' primary insurance resources, not billing. Obtain medical insurance information for *all* patients, even dental-only patients. The primary medical insurance is typically the first insurance billed.

5. Does the number of patients reported by ZIP code need to equal the total number of unduplicated patients reported on Tables 3A, 3B, and 4?
Yes. Several tables and sections must match:

- The total number of patients reported by ZIP code (including "unknown" and "other") on the ZIP Code Table must equal the number of total unduplicated patients reported on Table 3A and sections of Tables 3B and 4.

- The insurance totals reported on the ZIP code table must equal insurance reported on Table 4. Specifically,

  o the total for Column B (Uninsured) must equal Table 4, Line 7, Columns A + B;

  o the total for Column C (Medicaid, CHIP, Other Public) must equal the sum of Table 4, Line 8, Columns A + B and Line 10, Columns A + B;

  o the total for Column D (Medicare) must equal Table 4, Line 9, Columns A + B; and

o   the total for Column E (Private) must equal Table 4, Line 11, Columns A + B.

6. We had a site that closed and is no longer in-scope. Do we report sites or services that are removed from scope in the UDS Report?
Yes. If services or sites are removed from your scope of service, report on all activities (visits, staff, income, etc.) up until the date they were removed.

FAQs for Tables 3A and 3B

1. Have the data elements for Tables 3A or 3B changed?
No.

2. Our health center collects more robust race and ethnicity data than required by the UDS. Why is the data limited?
The UDS classifications are 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 a minimum of five 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, the OMB states that respondents should be offered the option of selecting more than one race. Line 6 permits reporting of

those people who have chosen to report two or more races.

3. Do we have to report the race and Hispanic or Latino ethnicity of all of our patients?
Yes. The UDS requires the classification of race and Hispanic/Latino ethnicity information to assess health disparities across sub-populations. OMB has stipulated the format for the classification of this information, and the UDS follows these standards. Health centers whose data systems do not support such reporting must enhance their systems to permit the required level of reporting, rather than using the "unreported/refused to report" categories.

4. How are patients of Hispanic or Latino ethnicity reported?
Race and ethnicity data appear in a matrix on Table 3B. Patients who in other systems might be reported as Hispanic or Latino independent of race are reported in Column A of the UDS as Hispanic or Latino and reported on Lines 1 through 7 based on their race. If Hispanic/Latino is the only identification recorded in the center's patient files, report these patients in Column A on Line 7 as having an "unreported" racial identification, and update your data system to permit the collection of both race and ethnicity.

5. Can we have a choice on our registration form of "more than one race"?
No. To count patients as being of "more than one race," they must have the option of checking two or more boxes under race and have

indeed checked more than one. This methodology is the same used in the census and mandated by OMB.

6. How are individuals who receive different types of services or use more than one of our health center's service delivery sites reported? For example, how do we report a person who receives both medical and dental services or a woman who receives primary care from one clinic site but gets prenatal care at another?
Tables ZIP Code, 3A, 3B, and 4 each provide an unduplicated patient count. Count each person who has at least one visit reported on Table 5 only once on ZIP Code, Table 3A, 3B, and 4, regardless of the type or number of services they receive or where they receive them. We define visits in detail in the Instructions for Visits, Patients, and Providers section. Note the following:

- Do not count people who receive WIC services and no other services at the health center as patients on Table 3A or 3B (or anywhere on the UDS).

- Do not count people who only receive imaging or lab services or whose only service was an immunization or screening test as patients on Table 3A or 3B (or anywhere on the UDS).

- Do not count people who only receive health status checks and health screenings as patients on Table 3A or 3B (or anywhere on the UDS).

7. Our HIT/EHR changed during the year. Can we just add the information from the two systems together to report this table?
No. Because the same patient might be counted in each system, it would result in a potential over-count this year, followed by a huge apparent reduction in patients the following year. It is the health center's responsibility to ensure there is no duplication of data. Because this may be a time-consuming process, it should be initiated as soon as the year ends to ensure enough time prior to the initial submission date.

8. Should the numbers on Tables 3A and 3B tie to UDS data reported on other tables?
Yes.

The sum of Table 3A, Line 39, Columns A and B (total patients by age and by sex assigned at birth) must equal:

- Total Patients by ZIP Code;

- Table 3B, Line 8, Column D (total patients by Hispanic or Latino ethnicity and race);

- Table 3B, Line 19 (total patients by sexual orientation);

- Table 3B, Line 26 (total patients by gender identity);

- Table 4, Line 6 (total patients by income); and

- Table 4, Line 12, Columns A and B (total patients by insurance status).

The sum of Table 3A, Lines 1–18, Columns A and B (total patients age 0–17 years) must equal:

- Table 4, Line 12, Column A (total patients age 0–17 years).

The sum of Table 3A, Lines 19–38, Columns A and B (total patients age 18 and older) must equal:

- Table 4, Line 12, Column B (total patients age 18 and older).

9. I have a separate data system for my mental health patients. How do I include their data on these tables?

Health centers must not duplicate their data. Count patients only once, regardless of the number of different types of services they receive. This may require the downloading and merging of data from each system to eliminate duplicates or to check them manually. This can be a time-consuming and potentially expensive process and should start as soon as the year ends to ensure sufficient time for completion prior to the submission due date.

10. What do we do if we did not collect sexual orientation and/or gender identity elements?

All health centers are required to include these data elements in the registration or intake forms or during the visit. If you did not implement the gathering of sexual orientation and/or gender identity data, report patients on Table 3B as "Don't know" on Line 17 (sexual orientation) and as "Other" on Line 24 (gender identity). Do not use sex at birth reported on Table 3A to complete gender on Table 3B.

11. Does the UDS require health care providers to ask minors for sexual orientation and gender identity data?

The collection of sexual orientation and gender identity data is not required for minors. The information should be included in the system if a patient chooses to self-report their sexual orientation and gender identity and included in the corresponding lines.

12. Will parents be able to access their child's response to a UDS sexual orientation and gender identity inquiry?

There are specific provisions about protecting confidentiality of minors for patient visits related to sexual health. Generally, these are "minor consent" laws which permit treatment to be provided to and data collected from minors without their parent's knowledge or approval. Certain other idiosyncratic rules, such as in Massachusetts, may permit clinicians to designate a minor as a "mature minor" and not

have to disclose certain information to a parent. Your state Primary Care Association may have this detail.

13. How are the categories for sexual orientation and gender identity defined?
The UDS classifications are based on the guidance provided in the [2015 Edition Health Information Technology (HIT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications](#).

FAQs for Table 4

1. Are there any changes to this table?
Yes. Permanent supportive housing is now reported separately from other housing arrangements.

2. If we do not receive direct funding under the HCH, MHC, or PHPC programs, do we need to report the total number of special population patients served?
Yes. Even health centers that do not receive targeted grant funding for special populations are required to complete:

- Line 16 (the total number of patients seen during the reporting period who were agricultural workers or their family members),

- Line 23 (total number of patients known to have experienced homelessness at the time of any service during the year),

- Line 24 (patients of a school-based health center),

- Line 25 (veterans), and

- Line 26 (total number of patients served at a health center located in or immediately accessible to a public housing site).

You will not complete the details on Lines 17–22 if you did not receive HCH funding—only enter the total.

You will not complete the details on Lines 14 and 15 if you did not receive MHC funding—only enter the total.

3. Should the number of patients by income and insurance source equal the total number of unduplicated patients reported on Tables 3A and 3B and the ZIP Code Table?
Yes.

4. Who do we report as Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site on Line 26?
Report the total number of patients (not only those who reside in public housing) who are served at any health center site that *you consider* (based on your definitions) to be located in or immediately accessible to public housing, regardless of whether or not the health center receives funding under section 330(i) PHPC.

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 reports patients' medical coverage. All health centers must collect medical coverage information from all patients even if they have not been provided medical services.

*Note: If a patient has Medicaid, Private, or Other Public dental insurance, you **may** assume they have the same kind of medical insurance. If they do not have dental insurance, you may not assume they are uninsured for medical care.*

6. Patients who are experiencing homelessness or who are agricultural workers generally do not have income verification. Can we report them as having income below poverty?
No. You can report them as having unknown income, but not as being below poverty unless you verify this at least annually. However, subject to your health center's financial policies and procedures, you may document their income in your system based on their verbal attestation of their income.

7. We serve students at a school-based health center. They often do not know what insurance they have, if any, and they have no information on their family's income. Can we report them as below poverty and uninsured?

No. You may not report them as below poverty and uninsured. Obtain insurance information from the parents of students served at school-based health centers, unless they are exclusively receiving minor consent services. Minor consent services are defined by state law and are generally limited to a very specific range of services, such as those related to contraception, sexually transmitted diseases, and mental health. Not all states provide for them. For all other services, children will require parental consent, and the consent form should include income and insurance information.

Note: Subject to the health center's policies and procedures, it is acceptable to ask for this information and to assure parents that you will not bill the insurance without their knowledge. If you do not obtain parental consent, report the child as having unknown income. The patient's health insurance is required, even if it is not billed.

8. Our state is using Medicaid expansion provisions to assist patients with buying private insurance. Should we count them as Medicaid or Private?
If patients are Medicaid expansion patients, report them as Medicaid, Line 8a. (This may require looking for specific plan numbers or other identifying characteristics in patients' insurance enrollment.) If you are unable to identify Medicaid expansion patients, report them as Private, Line 11.

9. What timing determines a patient's homeless status and shelter arrangement?

For all health centers (regardless of HCH funding status), include the total number of patients who experienced homelessness at any point of service during the year on Line 23.

For awardees that receive HCH funding, continue to count patients seen who are no longer experiencing homelessness due to becoming residents of permanent housing for 12 months after their last visit as homeless.

For awardees who receive HCH funding, report all patients reported on Line 23 by their shelter arrangement on Lines 17–22.

Asking health centers to report patients experiencing homelessness by their sheltering arrangements as of their first visit during the reporting year is intended to help health centers determine to which shelter arrangement they should report a patient if shelter status changes during the year.

10.   Do the totals need to equal other sections or tables?
The following totals must be equal across tables and sections:

- ZIP Code Table, Column B must equal Table 4, Line 7, Columns A and B.

- ZIP Code Table, Column C must equal Table 4, Line 8 and 10, Columns A and B.

- ZIP Code Table, Column D must equal Table 4, Line 9, Columns A and B.

- ZIP Code Table, Column E must equal Table 4, Line 11, Columns A and B.

- The sum of Table 3A, Line 39, Column A and B (total patients by age and gender) must equal Table 3B, Line 8, Column D (total patients by race and Hispanic/Latino ethnicity); Table 3B, Line 19 (total patients by sexual orientation); Table 3B, Line 26 (total patients by gender identity); Table 4, Line 6 (total patients by income); and Table 4, Line 12, Columns A and B (total patients by medical insurance status).

- The sum of Table 3A, Lines 1–18, Columns A and B (total patients age 0-17 years) must equal Table 4, Line 12, Column A (total patients age 0–17 years).

- The sum of Table 3A, Lines 19–38, Columns A and B (total patients age 18 and older) must equal Table 4, Line 12, Column B (total patients age 18 and older).

- The sum of Table 3A, Line 39, Columns A and B (total patients by age and gender) must equal Table 4, Line 12 Columns A and B (total patients by insurance status).

The same is true for Grant Reports.

11.   Do we determine a patient's income relative to the federal poverty guidelines based on the location of the health center or the residence of the patient?

Use the federal poverty guidelines based on the location of the health center. All states (except Alaska and Hawaii) and the U.S. territories use the standard poverty guidelines. For patients being served in Alaska or Hawaii, use the federal poverty guidelines established for those locations.

12.   Is it possible to have more members in one month (average) than total patients in an insurance category?

It is possible, although it would be unusual (although not impossible) for the number of member months for any one payer (e.g., Medicaid) to exceed 12 times the number of patients reported on the corresponding insurance line. As a rule, there is a relationship between the member months reported on Lines 13a and 13b and the insured persons reported on Lines 7 through 11.

FAQs for Table 5

1. Are there changes to this table?

Yes. A new column has been added to permit the reporting of telemedicine/virtual visits. Additionally, a new addendum to this table reports mental health treatment provided by medical providers and substance use disorder treatment provided by medical and mental health providers.

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

If you have group treatment sessions for substance use disorder, mental health, or behavioral health, record the visit in each participant's chart. If interaction with an individual in a group is not recorded in a participant's chart, that participant is not counted as a patient and the interaction is not counted as a visit. Each patient charted in a group session must be billed and the service must be paid consistent with health center policy by either the patient, insurance, or another contract maintained by the health center. If some patients/visits are billed and others are not billed, only count those that are billed.

Do not count group medical visits or group health education visits. Although in some instances they may be billable, the UDS specifically does not count these as visits.

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

Count staff who are hired as full-time clinicians as 1.0 FTE regardless of the number of direct patient care hours they provide. Count providers hired as full-time who have released time to compensate for on-call hours, hours spent on clinical committees, or who receive leave for continuing education or other activities as 1.0 FTE.

Do not adjust the time spent by a physician (for example) while not in contact with the patient, such as

charting, reviewing labs, filling prescriptions, returning phone calls, or arranging for referrals. These tasks are considered part of his/her time as a physician. The exception to this rule is when a medical director or chief medical officer is engaged in non-clinical activities at the corporate level, in which case time is allocated to the non-clinical category. This does not, however, include non-clinical activities in the medical area, such as chairing or attending meetings, supervising staff, writing clinical protocols, designing formularies, setting hours, or approving specialty referrals.

Note: Count loan-repayment recipients as full-time. Note that the FQHC Medicare intermediary has different definitions for full-time providers which are not to be used in reporting on the UDS.

4. Our physicians work 35-hour weeks. Do we report as 87.5 percent (35 divided by 40) FTEs?
No. Count them as 1.0 FTE. BPHC does not require 40-hour workweeks. Use whatever workweek time is considered full-time.

5. Should the total number of patients reported on Table 3A be equal to the sum of the several types of service patients on Table 5?
Not unless the only services you provide are medical services. On Table 5, report patients for each type of service received. For example, count a patient who receives both medical and dental services once as a medical patient on Line 15 and once as a dental patient on Line 19. Because there

are seven different types of services identified on Table 5, a patient who is counted only once on Table 3A may be counted in up to seven different places on Table 5.

6. If I report costs for case management services on Table 8A, do I have to report case managers on Table 5?
Usually there should be a logical consistency between Table 5 and Table 8A. If a health center reports the costs for case management services, one would expect to see case managers reported on Table 5, unless the service was contracted with no staff time specifically identified. Similarly, if there are staff members on Table 5, we would expect costs on Table 8A unless staff are volunteers. Some services do not involve staff. Spending funds on bus tokens, for example, would involve transportation costs on Table 8a, but no staff on Table 5.

7. How are contracted providers and their activities reported on Table 5?
If the contracted provider is paid based on time worked (for example, one day per week), report the FTE on Table 5, Column A, as well as the visits and patients receiving services from this provider. (See Appendix B for a more complete discussion of calculating the FTE of these providers.) If the contracted provider is paid on a fee-for-service basis, do not report FTE on Table 5, Column A, but report the visits and patients. Note that this is likely to trigger an edit in the EHBs data entry system that you must explain, but it is not an error.

8. Where should we report behavioral health?

In some systems, behavioral health is another name for mental health, and the staff and visits are reported on Lines 20a through 20c. However, some health centers have merged the roles of mental health provider and substance use disorder provider into a single role, which they call a behavioral health provider. In this instance, the health center has two choices. The first is to assert that substance use disorder problems are mental health problems and classify its behavioral health staff as mental health staff on Lines 20a, 20a1, 20a2, 20b, or 20c. Another method is to carefully record the time and activities of these dual function providers. In this case, identify each visit as either a mental health visit or a substance use disorder visit so the patients and visits can be correctly classified. In addition, keep track of providers' time so that FTEs on Table 5 (and associated costs on Table 8A) can be accurately allocated and recorded to the appropriate line.

9. If a psychiatric nurse practitioner provides mental health and substance use disorder (behavioral health) services to the same patient during a visit, how should we count this?

Because substance use disorder is also seen as a mental health diagnosis, count the visit under mental health for the main part of table 5. Do not count the visits as one of each type. In the addendum, separately report the substance use disorder service provided by the

clinician during the visits. Classify the provider and costs (on Table 8A) as mental health.

10. Do I count the time of volunteer clinicians, interns, or residents?

Yes. Volunteers, (some) interns, and residents are licensed practitioners and their time is counted like any other practitioner. Note, however, that some may work shorter days because they are in educational sessions, may have more vacation time or other time off than other practitioners, or, in the case of volunteers, do not have vacations or holidays. This would make them less than full-time. See the more complete discussion of counting volunteers, interns, and residents in Appendix B.

11.   We contract with many licensed physicians to over-read our tests: an ophthalmologist reads the retinal photos that our medical assistant takes, a radiologist over-reads the X-rays that our X-ray tech takes, the outside laboratory's pathologist provides the test results from their machines, and a consulting cardiologist confirms findings of our electrocardiograms (EKGs). Should we report them as staff, and do we count what they do as visits?

Tests are not counted as visits anywhere in the UDS. Do not count the time (FTE) of any person who is working on a contract basis when the payment is not for their time worked but, rather, for the activity that they perform. Do not count these activities, *which are important to the provision of comprehensive care to patients,* separately. Count the costs on Table 8A, but note that, under some circumstances, the EHBs may identify an exception (costs with no staff) that you will need to explain.

12.   Where do we report community health workers that we employ?

Report staff with responsibility as a community health worker on Line 27c. If, however, you are using this term to describe someone who is performing the tasks normally associated with a medical assistant, an outreach worker, or another job title, count them in the corresponding category.

13.   Where do we report medical providers whose only activity at a visit is providing MAT?

Report this activity on the line of the credentialed staff providing this treatment (i.e., the physicians are counted in medical [Lines 1–8], even if they only provide substance use disorder services at the visit). Do not count them on the substance use disorder line of the main part of Table 5. Additionally, report the activity in the substance use disorder section of the addendum (i.e., the physicians are counted on Line 21a of the addendum).

14.   Are virtual/telemedicine visits only permitted after a face-to-face visit at the health center?

No, although most telemedicine visits will occur from a referral from a face-to-face visit. If the first or only visit is a reportable virtual visit, health centers must register the patients and collect and report all relevant demographic, service, clinical, and financial data on the UDS tables.

FAQs for Table 5A

1. Are there changes to this table?
Yes. This table has been removed.

FAQs for Table 6A

1. Are there changes to this table?
Yes. Some diagnosis and service codes have been updated.

2. If a case manager or health educator serves a patient who, for example, has diabetes, we often report that diagnostic code for the visit. Should we report this on Table 6A?

No. Report only visits with medical, dental, mental health, substance use disorder, and vision providers who are diagnosing according to their own field on Table 6A.

3. The instructions call for diagnoses and services at visits. If we provide the service but it is not counted as a visit (such as an immunization given at a health fair), should it be reported on this table?

Do not count services given at health fairs, regardless of who provides the service or the level of documentation that is done. *But, do count the visit if a service is provided because of a prescription or plan from an earlier counted visit.* For example, count it if a provider asks a woman to come back in four months for a mammogram. However, do not count it if the service is a self-referral where no clinical visit is necessary or provided (such as an HIV test at a health fair or a senior citizen coming in for a flu shot).

4. Some diagnostic and/or procedure codes in our system are different from the codes listed. What do we 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 table provides examples of problems and solutions:

Line	Problem	Potential Solution
1	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 a state BCCCP 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. Do not count EPSDT follow-up visits in this category.

5. The instructions specifically say that the source of information for Table 6A is "billing systems or HITs." There are some services for which we do not bill and/or for which there are no visits in our system. What do we do?

Do not count referrals for which you do not pay (e.g., sending women to the county health department for a mammogram). Although health centers are only required to report data derived from billing systems or HITs, the reported data may understate services in the circumstances described below. In today's EHRs, virtually all diagnoses and/or services should be captured in one of the templates available. To

more accurately reflect the level of service, use other codes in the system to enable the tracking.

Line	Problem	Potential Solution
21	HIV test samples are collected by us but processed and paid for by the state and do not show on the visit form or in the billing system.	Preferred: Use the correct code, but report a zero charge.
Multiple	Tests (such as HIV tests, Pap tests, etc.) are ordered and samples collected by us. We send samples to a reference lab for processing, but the lab bills Medicaid or Medicare directly.	Preferred: Use the correct code, but report a zero charge.
22	Mammograms are paid for but are conducted by a contractor and do not show in the billing system for individual patients.	Preferred: Use the correct code, but report a zero charge. Alternative: Use the bills from the independent contractor to identify the mammograms conducted and the patients who received them and report these numbers.
23	Pap tests are processed and paid by the state and do not show on the visit form or in the billing system.	Preferred: Use the correct code, but report a zero charge.

Line	Problem	Potential Solution
24	Flu shots and other vaccinations are not counted because the vaccines are obtained at no cost to the center.	Preferred: Use the correct code, but report a zero charge.
25	Contraceptive management is funded under Title X or a state family planning program and does not have a Z30- diagnosis or ICD V25- attached to it.	Preferred: Add a "dummy code" you can map to the Z30- or V25- code. Alternative: Code with both the Z30- (or V25-) and the state-mandated code, but suppress printing of the Z30- or V25- code. Take care not to count the same visit twice.

6. Are we required to report all diagnoses and services rendered during a visit?

Yes and no. No, because there are many diagnoses that may be used but not reported on Table 6A. Yes, because documentation and reporting of all diagnoses (not just primary diagnosis) and services rendered during all UDS-countable visits are required. It is important that you appropriately document the breadth of comprehensive services delivered during each visit, including behavioral health services provided during a medical visit (e.g., SBIRT and/or treatment and counseling for mental health and substance use disorders).

7. What happens if the CPT or ICD-10-CM codes change again?

The codes are reviewed annually by the UDS Support Center staff. If you think a CPT, ICD, or ADA code for a measure is not reflected in the list, contact the UDS Support Center at udshelp330@bphcdata.net. Staff will review the code(s) with BPHC and incorporate approved changes to codes in the manual for future reporting.

FAQs for Table 6B

1. Are there any changes to the table this year?

Yes. The specifications for the clinical measures reported have been revised to align with the CMS eCQMs. The quality of care measures are aligned with the most current eCQMs for Eligible Professionals for the 2020 reporting period. (Other updates are available, but they should not to be used for the 2020 reporting.)

Additionally, the coronary artery disease (CAD) measure has been replaced by the e-specified Statin Therapy for the Prevention and Treatment of Cardiovascular Disease measure.

2. A child came in only once during the year for an injury and never returned for well-child care. Do we have to consider her chart to not have met the measurement standard since we only treated the child for the injury?

Yes. After a patient enters a health center's system of medical care, the center is expected to be responsible

for providing all needed preventive health care and/or document that s/he has received it. Report the patient in the universe (denominator) but not the numerator, since the record did not meet the measurement standard.

3. What if a woman we treat for hypertension and diabetes goes to an OB/GYN in the community for her women's health care? Do we still have to consider her in our universe for the Pap test measure? What if we do not offer Pap tests?

After the patient has been seen in your clinic, you are responsible for ensuring that she has the appropriate cervical cancer screening. This can be done by providing the Pap test or documenting the results of a test that someone else performed. Health centers are encouraged to coordinate care and document Pap test results by contacting providers. Consider the woman as part of your universe if she received *any* medical visit(s) in the measurement year. If there is no evidence of a timely cervical cancer screening included in her chart, consider this as not having met the measurement standard.

4. If we sent a woman to the health department for her Pap test but the results are not posted, can we call the health department, get the results, post them, and then count the record as having met the measurement standard?

Yes. The health center may obtain a copy of the patient's test result to include in her record for future care.

5. If we inform parents of the importance of immunizations but they refuse to have their child immunized, may we count the record as having met the measurement standard if the refusal is documented?

No. A child is fully immunized only if there is documentation that the child received the vaccine or there is contraindication for the vaccine, evidence of the antigen, or history of illness.

6. Are parents required to bring to the health center documentation of childhood immunizations received outside the health center?

Parents are encouraged to provide documentation of immunizations that their children received elsewhere, but other mechanisms of obtaining this information are also acceptable as long as all immunizations are appropriately reviewed and documented in your system. Document childhood immunizations by contacting providers of immunizations directly to obtain documentation by fax, by requesting health center patients mail a copy of their immunization history, through receipt of payment for the vaccine from the pharmacy, by finding the child in a state or county immunization registry, or through other appropriate means.

7. Some of the immunization details are different from those used by the Centers for Disease

Control and Prevention (CDC) in the Clinic Assessment Software Application (CASA) or Comprehensive-CASA reviews of our clinic. May we use these CDC standards to report on the UDS?

No. HRSA is now using the CMS eCQM standards to evaluate provision of vaccines to children. Using a different set of standards will distort the data. A center *may* use a different set of standards for its own internal QI/quality assurance program, but these may not be substituted for the UDS reporting definitions.

8. We want to use data from the clinical measures to compare our sites and our providers to one another. As a result, we would like to sample using a larger universe. Is this permitted?

No. A sample size of 70 charts must be used. This facilitates the development of state, national, and other roll-up reports. Additionally, any change in the sample size would bias the sample and provide distortions in the data set. Most health center systems can provide these results without modifying the reporting requirements.

9. Is the Pap test review for women starting at age 21 or at age 23?

For this measure, look only at women who were age 23 through age 64 at some point in the measurement year. Because the measure asks about Pap tests *administered* in 2020, 2019, or in 2018, it is possible that a 23-year-old woman would have been 21 in 2016. If she received a Pap test in that year, she would be considered to have met the measurement standard. Although you look only at women who are 23 through 64, their qualifying test may have been done when they were 21 through 64.

10.   Does "counseling for nutrition and ... physical activity" have specific content that must be provided? Does it need to be provided if the child is within the normal range?

No. The counseling has no specific required content, although it does have specific CPT coding requirements. It is tailored by the clinician given the patient's BMI percentile and other clinical and social data.

Yes. The counseling must be provided to all children and adolescents. Counseling is aimed at promoting routine physical activity and healthy eating for *all* children and adolescents. Note that, for younger children, counseling will be provided to the parent or caregiver.

11.   For adult patients, our protocol calls for weight to be measured at every visit but for height to be measured "at least

once every 2 years." Is this acceptable?

BMI is calculated from current height and weight. Both height and weight must be measured within twelve months of the most recent visit and may be obtained from separate visits.

12.   The measure says that there must be intervention for tobacco users. What specific interventions must be used?

The system defines a broad range of counseling and pharmacotherapy for this measure, which is at the discretion of the clinicians.

13.   How should we collect data for measures that require a look-back period?

Many of the UDS CQMs (e.g., cervical cancer screening, colorectal cancer screening, childhood immunizations, and others) require a look-back period. It is important that this information is noted in patient records. It is recommended that you obtain records for new patients from their former providers to document their prior treatment, including data for look-back periods. Medical records obtained from other providers may be recorded in the health center's HIT/EHR consistent with internal medical records policies, at which point they could be used in the performance review. Additionally, if you change EHRs, ensure that the prior data is transferred over to the new system.

14.   Can we use National Quality Forum (NQF) or Healthcare Effectiveness Data and Information Set (HEDIS)

directly to report on the clinical measures?

No. For UDS reporting, you must report on the clinical measures defined by UDS and outlined in this manual, most of which align with CMS's Meaningful Use eCQMs.

15.   Which patients are we required to report in the universe for the dental sealants measure?

Health centers providing dental services directly on site or through paid referral under contract must report on all dental patients age 6 through 9 who are at elevated risk for caries in the universe count. Note that caries risk assessment must be based on patient-level factors and documented with appropriate ADA codes. This may not be based on population-based factors, such as low socioeconomic status.

16.   Do DNA colorectal cancer screening tests meet the measurement standard for the colorectal cancer screening measure?

Yes. FIT-DNA colorectal cancer screening tests (such as Cologuard) meet the standard for colorectal cancer screening measure when performed during the measurement period or the two years prior to the measurement period.

17.   What should we do if we do not have adequate documentation about the tooth on which a sealant was placed?

In these situations, pull 70 patient charts using a random sample and have the reviewer evaluate the

chart records to find evidence for the sealant being applied to a permanent first molar. If the tooth descriptor (or tooth number) is undocumented and there is insufficient documentation to determine whether at least one of the sealant(s) was placed on a permanent first molar, the record will not be included in the numerator and may lower the overall measure score (percentage).

18. If a patient who is newly diagnosed with HIV dies before they receive treatment, do we count them in the HIV measure?
Yes. Include the patient in the denominator (universe) assuming they met the diagnosis criteria. If they died before receiving the first visit for initiation of treatment, do not count them in the numerator.

19. Do quit lines meet the measurement standard for tobacco cessation?
Yes. Tobacco cessation services provided by quit lines do meet the standard for tobacco screening and cessation intervention measure if the intervention is documented in the medical records.

20. Can brand-name prescriptions meet the measurement standard for measures which include a pharmaceutical component?
Yes. Since only scientific or generic names are stored in the RxNorm value sets, the health center and vendor need to map the generic and brand names when a new equivalent or brand name is discovered missing from RxNorm.

21. We would like to recommend changes to specific eCQM requirements being collected in the UDS. Can HRSA make the changes based on our feedback?
Although HRSA is interested in learning about eCQM changes you would recommend, you should contact the measure steward through the ONC Issue Tracking System to submit recommendations to existing eCQM logic.

FAQs for Table 7

1. Are there any changes to the table this year?
Yes. The specifications for the clinical measures reported have been revised to align with CMS' eCQMs. The quality of care measures are aligned with the most current eCQMs for Eligible Professionals for the 2020 reporting period. Although there are other updates available, they are not to be used for the 2020 reporting.

2. When would we use Row h —"Unreported/Refused to Report" race and ethnicity?
Use Row h only in those instances where patients do not provide their race *and* do not state whether they are Hispanic or Latino. Report patients who provide a race but do not answer affirmatively to a question about Hispanic or Latino ethnicity as Non-Hispanic or Latino on the appropriate race line (Lines 2a–2g). Report patients who indicate they are Hispanic or Latino but do not provide a race on Line 1g.

3. Data are requested by race and Hispanic or Latino ethnicity. How are these to be coded?

Code race and Hispanic or Latino ethnicity on this table in the same manner coded on Table 3B. Refer to instructions for Table 3B for further information. Care should be taken to ensure the same information is recorded in both the medical chart and the registration form to avoid errors.

4. Are patients with diabetes required to bring to the health center documentation of HbA1c tests received from outside the health center?

The health center is required to have HbA1c test results in patient charts. If the health center does not perform the test, contact the provider who performed the tests. The documentation can be brought in by the patient, but can also be obtained by fax, by requesting that the patient mail a copy of test results, or through other appropriate means.

5. We want to use the data from the clinical measures to compare our sites and our providers to one another. As a result, we would like to use a larger universe. Is this permitted?

No. A sample size of 70 charts must be used. This facilitates the development of state, national, and other roll-up reports. Additionally, any change in the sample size would bias the sample and provide distortions in the data set. Most health center systems can provide

these results without modifying the reporting requirements.

6. In Section A, Deliveries and Birth Outcomes, should the race and ethnicity of the baby be the same as the mother?

Not necessarily. Report the race and ethnicity of the mother (Column 1a) separately from the child (Column 1b, 1c, or 1d). The baby's race and ethnicity may be different from the mother.

7. How do we report miscarriages and pregnancy terminations?

You don't. Report all pregnant women in your (direct or by referral) prenatal care program on Table 6B, but report only those women who deliver on Table 7. Consider a stillbirth to be a delivery for purposes of reporting in Column 1a, but do not report the baby in Columns 1b, 1c, or 1d.

8. How do we determine "active diagnosis" that is required for some measures?

Patient health records frequently contain a "problem list," a list of "active diagnoses," or lists by other names. Any diagnosis on the list for part or all of the measurement year is considered active.

FAQs for Table 8A

1. Are there any changes to this table?

No.

2. How do we account for donated services?

If a provider comes to your health center and renders a service to your

patients, report 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 2-hour period, report as the amount what you would pay an optometrist for 2 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, *do not report the activity, the charge, or the value of the time or service on the UDS*. For example, if you refer a patient to a cardiologist who provides free consultation, do not count the visit or the monetary value of the provider's service.

3. How do we account for donated drugs?
If drugs are donated directly to the health center, which then dispenses them to a patient, calculate and report on Line 18 the value of the drug *at what a reasonable payer would pay for them*. This is NOT the retail cost of the drug; it is the 340(b) price of the drug—an amount that 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 health center, this is not a donation to the center. However, since we are interested in knowing the total value of supplies provided to the health center *directly or indirectly*, we encourage you to include the value on Line 18.

4. We get most of our vaccines through Vaccines for Children (VFC) or other state and county programs. Are these considered donated drugs and accounted for here?
Yes. Report the value of donated drugs that are used in the clinic, such as vaccines, on Line 18 in Table 8A—again, at the reasonable cost.

5. My doctors were paid the EHR incentive payments directly by CMS. If we let them keep some or all of these dollars, are they reported anywhere on Table 8A?
Yes. Establish reporting mechanisms whereby your providers inform you of payments received and account for these funds. If providers are permitted to retain some or all of these funds, report the amount on Line 1. In addition, report the Meaningful Use EHR payments received from Medicare or Medicaid on Table 9E on Line 3a.

6. What method of overhead (facility and non-clinical support services) allocation should we use for this table?
It is preferable that you first allocate facility cost to all cost centers, including administration based on square footage, and then apply administrative cost based on the percent distribution of direct costs.

7. Do we need to allocate overhead for contracted services?
Contracted services do not warrant a full overhead charge given that they do not involve the management of

personnel. However, the procurement and supervision of those arrangements do consume overhead that should be reported. Contracted services are often charged at a rate that covers the accounting and contract management.

8. Why do our financial statements not tie to the UDS financials?

The UDS financials (Tables 8A, 9D, and 9E) will not tie to your financial statements for the following possible reasons:

(1) If the fiscal year is not January 1–December 31,

(2) Out-of-scope activities will be in your financial statements but must not be included in the UDS,

(3) Tables 9D and 9E are on a cash basis, not accrual, and

(4) Contributed services are not reported as income or as expenditure as they would be in an audit.

FAQs for Table 9D

1. Are there any changes to this table?
No.

2. How should charges and collections for patients enrolled in an indigent care program be handled?

Report such charges on the self-pay Line 13 in Column A. Do not report payments received from state or local indigent care programs subsidizing services rendered to

patients who are uninsured on this table. Report these payments, whether made on a per-visit basis or as a lump sum for services rendered, on Line 6a of Table 9E. See Table 9E **Cross-Table Reporting Guidance for Indigent Programs** for specific instructions.

Do not classify anything as an indigent care program without first reviewing this in a UDS Training Program, with your UDS Reviewer, or with the UDS Support Center.

3. Are the data on this table cash- or accrual-based?

Table 9D is a "cash" table. Entries represent gross charges and adjustments for the reporting calendar year and actual cash receipts for the year.

4. Should the lines of the table "balance?"

No. Normally, charges (Column A) minus collections (Column B) minus adjustments (Columns D, E, and F) will not equal zero. 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 remain 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 defined in the UDS to be the difference between charges and collections, provided there are no early or late capitation payments that cross the calendar year.

5. If we have not received any reconciliation payments for the reporting period, what do we report in Column c1 (current year reconciliations)?

Since you only report current *reconciliations* in Column c1, do not report any reconciliation (although you may have received wrap-around payments which are reported here).

6. We often use our sliding fee discount program to write-off the co-payment portion of the Medicare charge for our certified low-income patients. The sliding fee discount column (Column E) is blanked out for Medicare. How do we record this write-off?

Remove the amount of the co-payment from the charge column of the Medicare line (Lines 4–6, as appropriate) and then add it to the self-pay line (Line 13). It can then be written off as a sliding fee discount on Line 13. Use the same process for any other co-payment or deductible write-off.

7. 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 it is done automatically by your PMS/HIT/EHR or manually, reflect this reclassification of charges that end up being the responsibility of a party other than the initial party. As a rule, your system will make this adjustment in some way, but you may need to work with your vendor to get a report on the amounts transferred.

8. How do we report the charges and collections for pharmaceuticals dispensed at our contract pharmacies?

We discuss contract pharmacy reporting at length in Appendix B. In general, report the full charge in Column A by payer. Then, report the amount received from the patient (on Line 13) or insurance company (on Line 10) in Column B. Report the amount that is written off for an insurance company in Column D. Report the amount written off for a patient as a sliding fee discount in Column E. Similar rules apply if drugs are "carved in" for Medicaid and Medicare.

9. How should we report the charges associated with "G-codes"?

G-codes specify a reimbursement rate associated with a package of services that your health center has described to Medicare. (Similar amounts may be paid to you by other third-party payers as well.) For UDS, report in:

- Column A: The sum of actual fee schedule/CPT-related charges for visits

- Column B: What your health center received for payment

- Column D: The discounted amount disallowed between charges and the amount received

Remember to reduce the charges by the Medicare co-payment (20 percent of the allowable charge). The payment from Medicare will be similarly adjusted. See discussion of reclassifying co-payments.

Note: If both the actual charge and the G-code charge are routinely used in your system, you must remove the G-code charges by running a report to get the total for G-code charges for the year and then subtracting this number from the total charges (actual plus G-code). Report the difference in Column A. Reduce Column D by the G-code amount if it was adjusted using a similar process.

FAQs for Table 9E

1. Are there any changes to this table?

Yes. The Capital Improvement Program (Line 1j) is no longer active, and funds are no longer available.

2. 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 covered by any of the four BPHC grant programs, the look-alike program, or the BHW primary care clinics program. Report only cash receipts received during the calendar year. In the case of a grant, this amount equals the cash amount received during the year, not the award amount (unless the full award was paid/drawn down during the year).

3. How should we report indigent care funds?

Report payments received from state or local indigent care programs subsidizing services rendered to patients who are uninsured (including patients covered by a tribe's 638 funds) on Line 6a of Table 9E, whether the actual payment to the health center is made on a per-visit basis or as a lump sum for services rendered.

Report patients covered by these programs as uninsured on Table 4.

Report all charges, self-pay patient collections, sliding fee discounts, and bad debt write-offs on the self-pay line (Line 13) on Table 9D.

Report monies collected from the patients covered by indigent programs on Table 9D. However, do not report funds reported on Line 6a of Table 9E on Table 9D.

Appendix B: Special Multi-Table Situations

Several conditions require special consideration in the UDS because they affect multiple tables that must then be reconciled. This appendix presents some particular situations, along with instructions on how to deal with them, including:

- Contracted care (specialty, dental, mental health, etc.) that is paid for by the reporting health center

- Services provided by a volunteer provider

- Interns and residents

- WIC

- In-house pharmacy or dispensary services for health center patients

- In-house pharmacy for community (i.e., for non-patients)

- Contract pharmacies

- Donated drugs

- Clinical dispensing of drugs

- ADHC/PACE

- Medi-Medi crossovers

- 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

- CHIP

- Carved-out services

- Migrant voucher programs and other voucher programs

- Incarcerated patients

- New start or new access point

- Relationship between staff on Table 5 and costs on Table 8A

- Relationship between race and ethnicity on Table 3B and Table 7

Contracted Care (specialty, dental, mental health, etc.)

Contracted care is services paid for by the health center.

Tables Affected	Treatment
5	Count providers (Column A) if the contract is for a portion of an FTE (e.g., one day a week OB/GYN = 0.20 FTE). Do *not* count if the contract is for a service (e.g., $X per visit or $55 per resource-based relative value unit [RBRVU]). *Always* count visits (Column B or B2), regardless of method of provider payment or location of service (health center's site or contract provider's office).
6A	Health center receives encounter form or equivalent from contract provider and reports diagnoses and/or services provided as applicable.
6B, 7	If contract clinician provides any services that are subject to quality measures, collect and report all data from contractor (e.g., birth weight of a child from contract obstetrician, last HbA1c from an endocrinologist, sealants placed from a dentist).
8A	Column A, Accrued Cost: Report cost of provider/service on applicable line. If the provider receives a "co-payment" or a "nominal fee" from the patient, report the sum of that and what the center pays. Column B, Facility and Non-Clinical Support Services: Health center will generally use a lower facility and non-clinical support services allocation rate for off-site services. Include all facility and non-clinical support costs in the direct charge Column A if the provider is off-site.
9D	Charge (Column A) is the health center's UCR charge if on-site; use the contractor's UCR charge if off-site. Collection (Column B) is the amount received by *either* the health center *or* contractor from first or third parties. Allowance (Column D) is the amount disallowed by a third-party for the charge (if on Lines 1–12). Sliding Fee Discount (Column E) is the amount written off for eligible patients per the center's fiscal policies (Line 13), if applicable. Calculate as UCR charge, minus amount collected from patients, minus amount owed by patients as their share of payment. Do not include payment by the health center here.

Services Provided by a Volunteer Provider

Volunteers are not paid by the health center for services, which they provide on-site. This includes volunteer staff (including AmeriCorps/HealthCorps, but not NHSC) who provide services on or off site on behalf of the health center. FTE can be included in the UDS report when there is a basis for determining their hours.

Tables Affected	Treatment
5	Column A, Provider FTE: Report FTE for services provided on-site at the health center's clinic. FTE must be calculated. Use hours volunteered as the numerator. Because volunteers do not receive paid leave benefits, the denominator is the number of hours that a comparable employee spends performing their job. Reduce a full-time schedule of 2,080 hours (for example) by vacation, sick leave, holidays, and continuing education normally provided to employees. As a rule, use hours worked divided by a number somewhere around 1,800. Do not count providers who provide services at their own offices. Column B, Clinic Visits and Column B2, Virtual Visits: Count visits only for services provided at a site in the health center's scope of service and under its control.
6A	Count diagnoses and/or services provided on site, as applicable.
8A	Column C, Line 18: Report the value of the time donated by volunteers on this line *only*.
9D	The charges for their services are treated the same as for staff if the provider is on-site. Do not include charges for volunteer providers who are off-site.

Interns and Residents

Health centers often use people who are in training, referred to variously as interns or residents, depending on their field and their licensing. Medical residents are generally licensed practitioners. Some mental health interns, as well as other providers, may be licensed practitioners who are training for a higher level of certification or licensing.

Tables Affected	Treatment
5	Column A: Count licensed interns and residents in the credentialing category they are *pursuing*. For example, count a family practice resident on Line 1 as a Family Physician. Depending on the arrangement, FTEs may be calculated like any other employee (if they are being paid by the health center) or like a volunteer (if they are *not* being paid). See volunteer providers, immediately above. Columns B and B2: Record visits between a medical resident and a patient as visits to that resident or intern. Do not credit the visits to the supervisor of the resident or intern under any circumstance. Count visits of a licensed mental health provider on Lines 20a, 20a1, 20a2, or 20b. Count unlicensed mental health providers on Line 20c.
8A	*If the intern or resident is paid by the health center or* their cost is being paid through a contract that <u>pays</u> a third-party for the interns or residents, report the cost in Column A on the appropriate line (Line 1 for medical, Line 5 for dental, etc.). If the health center is not paying an intern, resident *or* third-party, report the *value of the donated time* on Line 18. Be sure to describe the nature of the donation on the table.

Women, Infants, and Children (WIC)

Tables Affected	Treatment
3A, 3B, 4	Do not count clients whose only contact with the health center is for WIC services and who receive no other services listed on Table 5 from providers outside of WIC. Do not count as patients anyone whose only health center contact is for WIC nutritional, health education, or enabling services.
5	Count staff (Column A) on Line 29a. Do not report visits and patients (Columns B, B2, and C).
8A	Column A, Net (Accrued) cost: Include the total cost of the program on Line 12 in Column A. Column B, Facility and Non-Clinical Support Services: Since much of the non-clinical support services cost of the program will be included in the direct costs, it is presumed that overhead will be at a significantly lower rate.
9D	Do not report anything associated with the WIC program.
9E	Income for WIC programs, though originally federal, generally comes to health centers from the state, though some receive it from a lower-level intermediary. If the health center *is* receiving WIC funds from a state government, the grant/contract funds received go on Line 6. Report funds from an intermediary on Line 8.

In-House Pharmacy or Dispensary Services for Health Center Patients

Include only that part of the pharmacy that is paid by the health center and dispensed by in-house staff (see below for other situations).

Tables Affected	Treatment
5	Column A, Staff: Report pharmacy staff on Line 23. If they have only an incidental responsibility to provide assistance in enrolling patients in PAPs, include them on Line 23. Include clinical pharmacists on Line 23 even if they spend time outside of the pharmacy. Report staff members other than pharmacists who spend time with PAP programs on Line 27a, Eligibility Assistance. Columns B and B2, Visits: The UDS does not count interactions with pharmacy staff as visits, whether it is for filling prescriptions or associated education or other patient/provider support. This is true for clinical pharmacists with expanded clinical privileges, as well.
8A	Line 8a, Column A, Other Pharmacy Direct (Accrued) Costs: Report all other operating costs of the pharmacy on Line 8a. Include salaries, benefits, pharmacy computers, supplies, etc. Line 8b, Column A, Pharmaceutical Direct (Accrued) Costs: Place the actual cost of drugs the pharmacy bought on Line 8b. Include the cost of vaccines, contraceptives, injectable antibiotics, and other drugs dispensed in the clinic and not in a pharmacy on Line 8b. The value of donated drugs is *not* reported here. That amount *is* reported on Line 18 in Column C. Line 11e, Column A, Eligibility Assistance Direct (Accrued) Costs: Report (on Line 11e) the cost of staff (full-time, part-time, or allocated time) helping patients to become eligible for PAPs and all related supplies, equipment depreciation, etc. Column B, Facility and Non-Clinical Support Services: Report all facility and non-clinical support services costs associated with pharmacy and pharmaceuticals (Lines 8a and 8b) on Line 8a. Although there may be some facility and non-clinical support services costs 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: Report the value of donated drugs, including vaccines, (generally calculated at 340(b) rates) on this line *only.*
9D	Column A: Charge is the health center's full retail charge for dispensed drugs. Column B: Collection is the amount received from patients or other third parties/insurance companies. Column D: Allowance is the amount a third-party disallows for the charge (if on Lines 1–12). Column E: Sliding fee discount is the amount written off for eligible patients per health center policies (Line 13). Calculate as retail charge, minus amount collected from patients if any, minus amount owed by patients if any, as their share of payment.

Tables Affected	Treatment
9E	Do *not* report the value of donated drugs on this table; report on Table 8A, Line 18 (see below). The charges for drugs dispensed to patients go on Table 9D, not on this table.

In-House Pharmacy for Community (i.e., for non-patients)

Many health centers that own licensed pharmacies also provide services to members of the community at large who are not health center patients. Careful records must be maintained at these pharmacies to ensure that non-patients do not receive drugs purchased under section 340(b) provisions. 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, do not report its activities on the UDS. If it is in scope, treat the public portion as an "other activity," as follows:

Tables Affected	Treatment
5	Column A, Staff: Report allocated public portion of staff on Line 29a: Other Programs and Services.
8A	Report all related staff and pharmacy costs, including cost of pharmaceuticals, on Line 12: Other Related Services.
9E	Report all income from public pharmacy on Line 10: Other, and specify from "Public access pharmacy."

Contract Pharmacy Dispensing to Clinic Patients, Generally Using 340(b) Purchased Drugs

Tables Affected	Treatment
5	Do not report staff, visits, or patients for pharmacy dispensing.
8A	Report the amount the pharmacy charges for managing dispensing of drugs on Line 8a. Report the full amount paid for pharmaceuticals, either directly by the clinic or indirectly by the pharmacy, on Line 8b. If the pharmacy buys prepackaged drugs, *and there is no reasonable way to separate the pharmaceutical costs from the dispensing/administrative costs*, report all costs on Line 8b. Associated non-clinical support services (overhead) costs will go on Line 8a in Column B, even though Line 8a Column A is blank. Report payments to pharmacy benefit managers on Line 8a. Share of profits: Some pharmacies engage in fee splitting and keep a share of profit. Report this as a payment to the pharmacy on Line 8a.

Tables Affected	Treatment
9D	Charge (Column A) is the health center/contract pharmacy's full retail charge for the drugs dispensed. If retail is unknown, ask the pharmacy for retail prices for the drugs dispensed. Collection (Column B) is the amount received from patients or insurance companies. Health centers must collect this information from the contract pharmacy. (Note: Most health centers do not have this sort of arrangement for Medicaid patients, unless explicitly stated.) Allowance (Column D) is the amount disallowed by a third-party for the charge (if on Lines 1–12). Sliding Fee Discount (Column E) is the amount written off for eligible patients per health center policies (Line 13). Calculate as retail charge (or pharmacy charge), minus amount collected from patients (by pharmacy or health center), minus amount owed by patients as their share of payment.
9E	Do not report pharmacy income on Table 9E, and *do not use Table 9E to report net income from the pharmacy*. Report actual gross income on Table 9D.

Donated Drugs, Including Vaccines

Tables Affected	Treatment
8A	If the drugs are donated to the health center and then dispensed to patients, report their value (generally calculated at 340(b) rates) on Line 18, Column C. If the drugs are donated directly to the patient, the health center is not required to report the value of the drugs; however, it is preferred that the value be included for a better understanding of the program.
9D	If the health center charges patients a dispensing fee, report this amount (only) and its collection and/or write-off.
9E	Do not report any amount, even though generally accepted accounting principles (GAAP) might suggest another treatment for the value.

Clinical Dispensing of Drugs

Clinic areas of health centers dispense many pharmaceuticals, including vaccines, allergy shots, contraceptives, and drugs used in MAT of opiate use. This may be a service associated with the visit or, in the case of vaccinations, a community service. These services do not count as a visit, but charging patients for them is appropriate unless the clinic received the drugs for free.

Tables Affected	Treatment
3A, 3B, 4	Do not count these people as patients if this is the only service they received during the year.
5	Do not count these services as visits.
6A	Do not count these on Table 6A; they are not visits.
8A	Report drug costs on Line 8b Pharmaceuticals (*not* on Line 3, Other Medical Costs). In the case of vaccines obtained at no cost through Vaccines for Children or other state or local programs, report the value on Line 18: Donated Services and Supplies.

Tables Affected	Treatment
9D	Report full charges, collections, allowances, and discounts, as appropriate. Note that it is *not appropriate* to charge for a pharmaceutical that has been donated. However, an administration and/or dispensing fee *is* appropriate. Note that Medicare has separate flu vaccine rules.
9E	Do not report any amount, even though GAAP might suggest another treatment for the value.

ADHC and PACE

Medicare, Medicaid, and certain other third-party payers often recognize ADHC programs. They involve caring for an infirm, frail, or elderly patient during the day to permit family members to work and to avoid the institutionalization, and preserve the health, of the patient. They are quite expensive and may involve extraordinary per member per month (PMPM) capitation payments but are cost effective compared to institutionalization. Patients who have both Medicare and Medicaid coverage are treated as Medi-Medi, as described below. PACE is even more expansive and may include ADHC services, as well as services to maintain independence for the elderly.

Tables Affected	Treatment
3A, 3B, 4	Count the people seen during the year in ADHC and PACE programs as patients if the interaction is a reportable visit.
5	When a provider does a formal, separately billable, examination of a patient at the ADHC/PACE facility, treat it as any other medical visit. Do not count the nursing, observation, monitoring, and dispensing of medication services that are bundled together to form an ADHC service as a visit for the purposes of reporting. Staff are included on Line 29a, Other Programs and Services.
6A, 6B, 7	Report the clinical activity provided to patients at ADHC and PACE facilities, as appropriate, on the clinical tables.
8A	If the health center provides and bills medical services separately from the ADHC charge, the associated costs are on Lines 1–3. Report all other costs on Line 12. Similarly, include PACE costs over and above medical and pharmacy costs on Line 12.
9D	Report ADHC charges and collections on this table, generally as Medicaid and/or Medicare. Because of FQHC procedures, it is possible that there will also be significant positive or negative allowances. In addition, see Medi-Medi below.

Medi-Medi/Dually Eligible

Some individuals are eligible for and enrolled in both Medicare and Medicaid (commonly referred to as Medi-Medi or Dually Eligible). In this case, Medicare is primary and billed first. After Medicare pays its (usually FQHC-associated Z code or geographic rate adjusted) fee, the remainder is billed to Medicaid, which pays an amount based on policy that varies from state to state.

Tables Affected	Treatment
4	Report patients on Line 9, Medicare. Do not report as Medicaid. In addition, report these patients on Line 9a, Dually Eligible (Medicare and Medicaid); this line is a subset of the total reported on Line 9, Medicare.
9D	While initially the entire charge shows as a Medicare charge, after Medicare makes its payment the remaining allowable amount is reclassified to Medicaid. Report the payment received from Medicaid on Line 1 in Column B. Report the difference between the charge and the collection as a positive or negative allowance, depending on the amount.

Certain Grant-supported Clinical Care Programs: BCCCP, Title X, etc.

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 grant period (usually the state fiscal 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.

These are fee-for service or fee-per-visit programs only.

Tables Affected	Treatment
4	These programs are *not* insurance. They pay for a service, but health centers must classify patients according to their primary health insurance carrier. Most of these programs do not serve insured patients, so report most of the patients on Line 7 as uninsured.
9D	While the patient is uninsured, there *is* an "other public" payer for the service. Report the clinic's usual and customary charge for the service (*not* the negotiated fee paid by the public entity) on Line 7 in Column A and the payment in Column B. Because the payment will almost always be different from the charge, report the difference as an allowance in Column D.
9E	Do not report the grant or contract covering the fee-for-service or fee-per-visit amount *on Table 9E*. Fully account for this on Table 9D.

State or Local Safety Net Programs

These pay for a wide range of clinical services for uninsured patients, generally those under an income limit. 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. Most of these programs set payment caps and often make payments in a different fiscal year.

Tables Affected	Treatment
4	While patients may need to meet eligibility criteria, these programs are not public insurance. Count patients receiving care through these programs on Line 7 as uninsured, unless they have insurance.
9D	The health center's usual charges for each service are charged directly to patients (reported on Line 13, Column A). If patients pay any co-payment, report it in Column B. If they are responsible for a co-payment but do not pay it, it remains a receivable until it is collected or is written off as bad-debt in Column F. Report the rest of the charge (or all the charge if there is no required co-payment) as a sliding fee discount in Column E.
9E	Report the total amount received during the calendar year from the state or local indigent care program on Line 6a.

Workers' Compensation

Workers' compensation is a form of liability insurance for employers and not health insurance for employees.

Tables Affected	Treatment
4	If workers' compensation covers a patient's bills, the patient usually has related insurance. Report that on Table 4 (even if the health center is not billing the insurance). Patients with work-related insurance go on Line 11 (Private). Those without *any* health insurance go on Line 7 (Uninsured).
9D	Report charges, collections, and allowances for workers' compensation-covered services on Line 10 (Private Non-Managed Care).

Tricare, Trigon, Public Employees Insurance, Etc.

Many government employees have insurance.

Tables Affected	Treatment
4	Report them on Line 11 (Private), *not on Line 10a.*
9D	Report charges, collections, and allowances on Lines 10–12 (Private), *not on Lines 7–9.*

Contract Sites

Some health centers have included in their scope of service a site (such as a school, workplace, or jail) where they provide services to patients at a contracted flat rate per session or other similar rate *that is not based on the volume of work performed.* The agreement generally stipulates whether and under what circumstances the clinic may bill third-parties.

Tables Affected	Treatment
4	Lines 1–6, Income: Obtain information on income from patients. In prisons, assume that all are below poverty (Line 1). In schools, income should be that of the parent(s) or "unknown." In the case of minor consent services, patients should be reported as 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 form of medical insurance the patient has, regardless of the clinic's ability to bill that source. (Medicaid often covers children in school-based clinics even though they have another provider. Report these children as Medicaid patients.) The clinic's contracting agency is not an insurer. (Schools and jails are not "other public insurance.") *Except for confidential minor consent services, it is not acceptable to report a student as uninsured.*
5	Count all visits as appropriate. Do not reduce or reclassify FTEs for travel time.
8A	Costs will generally be considered 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 clinic charges a visit to a third-party such as Medicaid*, report the clinic's usual and customary charges on Line 10, Column A (Private). Report the amount paid by the contractor in Column B. Report the difference (positive or negative) in Column D (Allowances).
9E	Do not report contract revenue on Table 9E.

CHIP

The Children's Health Insurance Program (CHIP) provides health coverage to eligible children, through both Medicaid and separate CHIP programs. CHIP is administered by states, according to federal requirements. The program is funded jointly by states and the federal government.

Tables Affected	Treatment
4	Medicaid: If Medicaid handles CHIP and the enrolled patients are identifiable, report them on Line 8b. *If it is not possible to differentiate CHIP administered through Medicaid from Medicaid,* report the enrolled patients on Line 8a with all other Medicaid patients. Non-Medicaid: Report CHIP-enrolled patients in states that do not use Medicaid as "Other Public CHIP" on Line 10b. Do not report the enrollees on Line 11 (Private) even if a commercial insurance plan administers the program.

Tables Affected	Treatment
9D	Medicaid: Report on Lines 1–3, as appropriate. Non-Medicaid: Report on Lines 7–9 (Other Public), as appropriate. Do not report on Lines 10–12 (Private), even if a commercial insurance company administers the plan.

Carve-Outs

Relevant to capitated managed care only: The health center has a capitated contract with an HMO that stipulates that one set of CPT codes will be covered by the capitation, regardless of service frequency, and another set of codes (or all other codes) the HMO will pay on a fee-for-service basis (the carve-outs) when appropriate. Most common carve-outs involve mental health, lab, radiology, and pharmacy, but may include specific specialty care or diagnoses (e.g., perinatal care or HIV).

Tables Affected	Treatment
4	Patient Member Months: Member months are reported on Line 13a in the appropriate column, regardless of whether the patient made use of services in any or all of those months. *Make no entry on Line 13b (fee-for-service managed care member months) for the carved-out services, regardless of payments received*.
9D	Lines 2a/b, 5a/b, 8a/b, 11a/b: Report capitation payments on the "a" lines and carve-out payments on the "b" lines. Report wrap-around payments on both lines using the health center's allocation process.

Incarcerated Patients

Some health centers contract with jails or 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.

Tables Affected	Treatment
4	Assume prisoner income is below poverty (Line 1). Unless the institution has arranged for inmate Medicaid enrollment, assume that inmates are uninsured. Classify patients according to their primary health insurance carrier regardless of whether the services will be billed to the insurer. These patients are usually uninsured.
9D	The jail or prison pays for the patient's services. Report the clinic's usual and customary charge for the service on Line 10 (Private) in Column A and the payment in Column B. Because the payment will almost always be different from the charge, report the difference as an allowance in Column D.
9E	Do not report the grant or contract on Table 9E. Report revenue fully on Table 9D.

HIT/EHR Staff and Costs

HIT, including EHR systems (some of which have integrated PMS), record clinical activities and help clinicians manage and integrate patient services. As such, they are part of a QI program, though some aspects count in other service categories.

Tables Affected	Treatment
5	Include staff that document services in the HIT/EHR, or perform help desk, data entry, training, and technical assistance functions as part of the appropriate *service category* for which they perform these functions, not as IT staff or QI staff. Report staff members dedicating some or all of their time to design, operation, and oversight of QI systems; data specialists; statisticians; and HIT/EHR or medical form designers as QI staff on Line 29b. Report staff managing the hardware and software of a practice management billing and collection system as non-clinical support staff, under IT, Line 30c.
8A	Report costs for staff that document services in the HIT/EHR, or perform help desk, data entry, training, and technical assistance functions as part of the appropriate *service category* for which they perform these functions for, not as IT staff or QI staff. Report costs associated with licenses, depreciation of the hardware and software, software support services, and annual fees for other aspects of the HIT/EHR on Line 3 (Other Medical). If the HIT/EHR covers dental and/or mental health, then you may logically allocate some of costs to these lines, as well. Report costs for staff noted above as being included in QI on Line 12a. Report costs for staff managing the hardware and software of a practice management billing and collection system as non-clinical support, Line 15.

Issuance of Vouchers for Payment of Services

Voucher programs have traditionally delivered primary and specialty care services to agricultural workers in geographically dispersed areas. Some homeless and other health center programs also use vouchers to outsource care they cannot provide in house. This involves contracting with providers outside of the health center. Vouchers authorize a third-party provider to deliver the services, and the voucher goes to the health center for payment. Payment is generally at less than the provider's full fee but is consistent with other payers, such as Medicaid.

Tables Affected	Treatment
3A, 3B, 4	Count patients even if the only service that they receive is a paid vouchered service, if these services would make the patient eligible for inclusion if the center provided them. A vouchered taxi ride or prescription would *not* make the patient "countable" because health centers do not count transportation and pharmacy services on Table 5, but a vouchered eye exam does count.
5	Column A: There is no way to account for the time of the voucher providers. As a result, report zero FTEs for these services. If there is a provider who works at the center, count the FTE of that provider. For example, count the one-day-a-week family practitioner as 0.20 FTEs on Line 1. Columns B and B2: Count all visits covered by voucher. DO NOT count visits where the referral is to a provider who is not paid in full for the service (e.g., a "voucher" to a doctor who donates five visits per week or one that pays a portion of the provider's fee and the rest is the patient's responsibility does NOT generate a visit on Table 5).
6A, 6B, 7	Diagnoses and Services: The Voucher Program should receive a bill from the provider, similar to a HCFA-1500 that lists the services and diagnoses. Health centers should track these and report them on Tables 6A, 6B, and 7.
8A	Cost of Vouchered Services: Report the costs on the appropriate service line. Report medical vouchers on Line 1, not Line 3. Report *only* those costs paid directly by the health center. Discounts: Virtually all clinical providers receive less than their full fee. Some health centers report the amount of these discounts as "donated services." *While this is not required,* health centers may report the difference between the voucher provider's full fee and the contracted voucher payment as a donated service on Line 18, Column C.

Tables Affected	Treatment
9D	Column A, Charges: Report the full charge that providers show on their Health Care Financing Administration (HCFA)-1500, on Line 13 (Self-pay). Do not use the voucher amount as the full charge. Column B, Collections: If the patient paid the voucher program or the voucher provider a nominal or other fee, report this in Column B. Column E, Sliding Fee Discounts: Report the difference between the full charge and the amount that the patient was *supposed to pay* in Column E. Do not report the full amount in Column E if the patient should have paid the health center or voucher provider but did not. Column F, Bad Debt: Report any amount (such as a nominal fee) that the patient was supposed to pay to the health center but did not. Report bad debts according to the health center's financial policies. Do not report amounts that were due but not paid to the referral provider.

New Start or New Access Point (NAP)

Health center sites may be added in-scope at any point during the reporting period. NAP grants or designations may be added prior to October 1 during the reporting period. Health centers must submit data for the full calendar year, so health center sites or NAPs operational prior to the start of the Notice of Award must submit data on all tables with activity covering January 1 to December 31.

Tables Affected	Treatment
ZIP, 3A, 3B, 4	It is understood that a health center may have never collected some of the data required to be reported in the UDS prior to the start of Notice of Award, such as veteran status, gender identity, member months in managed care, etc. Provide the best data available, but for the first year *only*, you may have some unusual numbers. Work with your UDS Reviewer to explain apparent data inconsistencies.
6B, 7	When it comes to the clinical measures, you may need to use a sampling process instead of relying on your PMS or HIT/EHR. See Appendix C for details. If the added site or the health center will transition HIT/EHR during the year, gather the information for the year across the two systems and analyze them in a separate database to remove any duplication in the data.

Relationship between Staff on Table 5 and Costs on Table 8A

Staff classifications should be consistent with cost classifications. The chart below illustrates the relationship between the two tables. The staffing on Table 5 is routinely compared to the costs on Table 8A during the review and analysis process. If there is a reason why such a comparison would look unusual (e.g., volunteers on Table 5 result in no cost on Table 8A or contractor costs on Table 8A with no corresponding FTEs on Table 5), include an explanation on Table 8A.

FTEs Reported on Table 5, Line:	Have Costs Reported on Table 8A, Line:
1–12: Medical providers and clinical support staff	1: Medical staff
13–14: Lab and X-ray	2: Lab and X-ray
16–18: Dental (e.g., dentists, dental hygienists, dental therapists)	5: Dental
20a–20c: Mental Health	6: Mental Health
21: Substance Use Disorder	7: Substance Use Disorder
22: Other Professional (e.g., nutritionists, podiatrists)	9: Other Professional
22a–22c: Vision (ophthalmologists, optometrists, optometric assistants, other vision care)	9a: Vision
23: Pharmacy	8a: Pharmacy
24–28: Enabling (e.g., case management, outreach, eligibility)—relationship of the detail follows. Note that the cost categories on Table 8A are not in the same sequential order as they appear on Table 5.	11a–11g: Enabling
24: Case Managers	11a: Case Management
25: Patient/Community Education Specialists	11d: Patient and Community Education
26: Outreach Workers	11c: Outreach
27: Transportation Staff	11b: Transportation
27a: Eligibility Assistance Workers	11e: Eligibility Assistance
27b: Interpretation Staff	11f: Interpretation Services
27c: Community Health Workers	11h: Community Health Workers
28: Other Enabling Services	11g: Other Enabling Services
29a: Other programs and services (non-health related services including WIC, job training, housing, childcare, etc.)	12: Other Related Services
29b: Quality Improvement staff	12a: Quality Improvement
30a–30c and 32: Non-clinical support services including patient support (e.g., corporate, intake, medical records, billing, fiscal and IT staff)	15: Non-Clinical Support Services
31: Facility (e.g., janitorial staff)	14: Facility

Relationship between Race and Ethnicity on Tables 3B and 7

The patient population for each clinical measure on Table 7 is defined in terms of race and ethnicity, and comparisons are made to the race and ethnicity numbers reported on Table 3B. The following table illustrates the crosswalk between the comparable fields across the two tables.

Race	Ethnicity	Table 3B Reference	Table 7 Reference
Asian	Hispanic	Line 1, Column A	Line 1a
	Non-Hispanic	Line 1, Column B	Line 2a
Native Hawaiian	Hispanic	Line 2a, Column A	Line 1b1
	Non-Hispanic	Line 2a, Column B	Line 2b1
Other Pacific Islander	Hispanic	Line 2b, Column A	Line 1b2
	Non-Hispanic	Line 2b, Column B	Line 2b2
Black/African American	Hispanic	Line 3, Column A	Line 1c
	Non-Hispanic	Line 3, Column B	Line 2c
American Indian/Alaska Native	Hispanic	Line 4, Column A	Line 1d
	Non-Hispanic	Line 4, Column B	Line 2d
White	Hispanic	Line 5, Column A	Line 1e
	Non-Hispanic	Line 5, Column B	Line 2e
More than Once Race	Hispanic	Line 6, Column A	Line 1f
	Non-Hispanic	Line 6, Column B	Line 2f
Unreported/Refused to Report Race	Hispanic	Line 7, Column A	Line 1g
	Non-Hispanic	Line 7, Column B	Line 2g
Unreported/Refused to Report Race	Unreported/Refused to Report Ethnicity	Line 7, Column C	Line h

Appendix C: Sampling Methodology for Manual Chart Reviews

Introduction

For each measure discussed on Tables 6B and 7 (except the perinatal measures), health centers have the option of reporting on their entire patient population as a universe or selecting a scientifically drawn random sample. While this is an option, HRSA strongly encourages health centers to report using their full EHR or HIT system. Similarly, while a reduced universe containing a minimum of 80 percent of all medical (or dental for the sealants measure) patients from all service delivery sites and grant-funded programs in the defined universe is permitted, full EHR or HIT system reporting is preferred.

Note: *Health centers using a sample for any medical clinical quality measure will be ineligible for HRSA quality improvement awards.*

Note: *Data source must cover the review period (e.g., 5 years for Pap tests, 2 years for immunizations) and include information to assess meeting the standard with the clinical measure, as well as to evaluate exclusions.*

If you can meet all conditions, reporting on the universe—even a reduced universe—generally provides access to pre-programmed tools, which can facilitate reporting. You may only use a reduced universe if the factors that required its use are unrelated to the measure variables (see instructions for Tables 6B and 7). This is not a sample, and the methods discussed here are not relevant to these situations.

If the health center cannot report on at least 80 percent of the universe (or chooses not to use its HIT/EHR), a random sample must be used to report.

Note: *The health center can report on the full universe for some measures, a reduced universe for others, and a sample for still others.*

Random Sample

A random sample is a part of the universe where each member of the universe has the exact same chance of inclusion as every other member.

A true random sample generates outcomes similar to those of the universe of patients because the sample is representative.

Step-by-step Process for Reporting Clinical Measures Using a Random Sample

Perform the following steps for each sample. Create a new random sample for each measure.

Step 1: Identify the patient population to be sampled (the universe).

Define the universe for the measure. The universe must include:

- All active (measurement year) medical patients,
- All sites in the scope of project,
- All funding streams, and
- Any and all contracted medical services.

Identify the number of patients who fit, or who initially appear to fit, the criteria for that measure. (Because you will review each record in the sample, you can remove any that was mistakenly included.) Create a list and number each member of the patient population in the universe. The list may be in any sequence because randomization will remove any order bias.

Step 2: Prepare the correct sample size.

BPHC mandates a sample size of 70.

Step 3: Select the random sample.

Using one of two recommended sampling methodologies (see below), identify the sample of 70 charts.

Step 4: Review the sample of records to determine for each record whether it has met the standard for the clinical measure.

For each measure, review available data sources to identify any automated sources to simplify data collection. Because health centers augment the automated data fields (if any) for these sources with text and scanned documents, they do not need to be available for all patients. Examples of data sources include:

- EHRs
- Disease-specific (PC-DMIS, PECs, i2i-track, etc.) databases
- State immunization registries for vaccine histories
- Logs
- PMS

For each patient in the sample, determine whether sufficient information is available in these alternative resources to meet the standard. If you cannot meet the standard using the alternative source, review text and scanned information to retrieve required information. For example, consider a woman's chart that shows she is an active medical patient but does not show the CPT or ICD-10-CM code for a Pap test. Review scanned documents to see if there is a copy of a Pap test done by another agency in the record.

Step 5: Replace patients you exclude from the sample.

Best practices would dictate that the methodology used to select the sample (or the universe) should be able to test for each required criterion. Some criteria (such as the age of the patient) are easily implemented. Others, such as whether a woman has ever had a hysterectomy, may not be available. When you cannot use criteria to include patients in the universe, you may use them to exclude patients from a sample. If you determine that a record does not meet the standard criteria, remove the case (record). If the review is of a sample of records, then select another record to replace the original.

Replace an excluded record with a substitute. Use the replacement methodology described for the sample selected. Any criteria that was missed in selecting a record (e.g., not noting that the woman had a hysterectomy) may be used to exclude a record.

Methodology for Obtaining a Random Sample

You may use either of the two approved methods for generating a random sample and a sample of replacements for excluded patients:

- Work with a list of random numbers generated for your total patient population.

- Select a random starting point and use a calculated interval to find each next member of the sample.

Use either method to create a "replacement list" to replace records that were excluded during the review process.

Option #1: Random Number List

The preferred method for selecting a random sample is to use a random number list. You can create an individualized list of random numbers at the Randomizer website. The website requires no password or subscription to access. To obtain a list of random numbers, complete the questions documented below.

Identifying an Initial List

1. Request one list of 70 numbers.

2. Complete the "Number Range" by entering 1 as the first number and the total number of patients in the universe for the particular measure under consideration as "n." For example, if there are 628 children who turn 2 years old in the reporting year in the universe, enter 628 as n.

3. Click on the button, "Randomize Now!" The site will produce a list of randomly generated numbers. These numbers correspond with the numbered list of patients in the universe prepared in Step 1 above. It is helpful to ask the site to sort the selected random numbers from lowest to highest.

Identifying a Replacement

To create a sample of records to substitute for excluded records, follow the instructions for creating a list of random numbers for a replacement sample. Rather than selecting 70 numbers for the set, select a smaller sample of 5 to 10 charts. In this instance, do not sort the list because doing so will bias the replacement sample toward the lower numbers on the list.

If, upon review, you must exclude a record from the original random sample of 70, replace it with one from the replacement sample. Because of the need to replace ineligible charts, you may have to exclude more than 70 records to meet the standard for a particular measure, but the final sample will include 70 records that meet all the selection criteria.

Alternatively, for example, you can draw a sample of 80 patients and use the first 70. If you must replace one, use the 71st, then the 72nd, and so on. In this instance, do not request a sorted list because it will have a bias toward lower numbers.

Input	Initial Sample	Replacements
Set of numbers	1	1
Number per set	70	At least 5 or more if needed
Number range = 1-n	Last number in sequence	Last sequence number in list
Unique numbers	Yes	Yes

Input	Initial Sample	Replacements
Sort numbers	Yes, least to greatest	No

Option #2: Interval

Identifying an Initial List

Sample interval (SI) size equals population size (number in universe) divided by sample size (70).

The second method uses the same numbered list of records in the universe created in Step 1 above. To generate the sample:

1. Calculate the SI by dividing the number of records in the universe by 70.

2. Randomly pick a record from the first SI. For example, if the SI is 10, the first SI includes charts number 1 through number 10. Randomly select one record from this interval to use as your first record.

3. Then, select every nth record where n is the SI until you reach the desired sample size. In our example, if the first patient selected is number 8, and the SI is 10, then the remaining patients to be selected are numbers 18, 28, 38, etc.

   First sequence # plus SI equals second #

4. Continue through list until you have identified all 70.

Example		Sample interval (SI) = 3
Record #	Account #	
1	951456	**First record = #2** *Selected at random between 1 and 3*
2	234951	
3	492374	

Example		Sample interval (SI) = 3
4	157614	
5	736812	**Next record = #5** (2+3)
6	453764	
7	416145	
8	801784	**Next record = #8** (5+3)
9	481454	
10	487151	
11	158124	**Next record = #11** (8+3)
12	625182	
13	789415	
14	781763	**Next record = #14** (11+3)
15	745405	<blank>

Identifying a Replacement

If a selected record needs to be excluded from the sample, return to the original list and substitute the next record on the list after the excluded record. If the replacement record must be excluded, select the record after that on the list until an eligible record is selected. Resume selection using the next chart you had pre-selected for the sample. If you run out of records on the list, continue your count back at the beginning of the universe. In this manner, more than 70 records may be evaluated for meeting the standard for a particular measure, but include 70 records that meet all the selection criteria in the final sample.

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

Instructions

The HIT Capabilities Form includes a series of questions on HIT capabilities, including EHR interoperability and eligibility for Meaningful Use. The HIT Form must be completed and submitted as part of the UDS submission. The form includes questions about the health center's implementation of an EHR, certification of systems, and how widely adopted the system is throughout the health center and its providers.

Questions

The following questions appear in the EHBs. Complete them before you file the UDS Report. Instructions for the HIT questions are on-screen in EHBs as you complete the form. Respond to each question based on your health center *status as of December 31*.

1. Does your center currently have an Electronic Health Record (EHR) system installed and in use?

   a. Yes, installed at all sites and used by all providers

   b. Yes, but only installed at some sites or used by some providers

   c. No

If the health center installed it, indicate if it was in use by December 31, by:

   a. **Installed at all sites and used by all providers**: For the purposes of this response, "providers" mean all medical providers, including physicians, nurse practitioners, physician assistants, and certified nurse midwives. Although some or all of the dental, mental health, or other providers may also be using the system, as may medical support staff, this is not required to choose response a. For the purposes of this response, "all sites" means all permanent sites where medical providers serve health center medical patients and does not include administrative-only locations, hospitals or nursing homes, mobile vans, or sites used on a seasonal or temporary basis. You may check this option even if a few, newly hired, untrained employees are the only ones not using the system.

   b. **Installed at some sites or used by some providers:** Select option b if one or more permanent sites did not have the EHR installed, or in use (even if this is planned), or if one or more medical providers (as defined above) do not yet use the system. When determining if all providers have access to the system, the health center should also consider part-time and locum providers who serve clinic patients. Do not select this option if the only medical providers who did not have access were those who were newly hired and still being trained on the system.

   c. Select "no" if no EHR was in use on December 31 even if you had the system installed and training had started.

This question seeks to determine whether the health center installed an EHR by December 31 and, if so, which product is in use, how broad is access to the system, and what features are available and in use. Do not include PMS or other billing systems even though they can often produce much of the UDS data. If the health center purchased an EHR, but has not yet placed it into use, answer "no."

If a system is in use (i.e., if a or b has been selected above), indicate it has been certified by the Office of the National Coordinator - Authorized Testing and Certification Bodies.

1a. Is your system certified by the Office of the National Coordinator for Health IT (ONC) Health IT Certification Program?

   a. Yes

   b. No

Health centers are to indicate in the blanks the vendor, product name, version number, and ONC-certified health IT product list number. (More information is available at https://chpl.healthit.gov/#/search). If you have more than one EHR (if, for example, you acquired another practice with its own EHR), report the EHR that will be the successor system.

   1a1. Vendor

   1a2. Product Name

   1a3. Version Number

   1a4. ONC-certified Health IT Product List Number

1b. Did you switch to your current EHR from a previous system this year?

   a. Yes

   b. No

If "yes, but only at some sites or for some providers" is selected above, a box expands for health centers to identify how many sites have the EHR in use and how many (medical) providers are using it. Please enter the number of sites (as defined above) where the EHR is in use and the number of providers who use the system (at any site). Include part-time and locum medical providers who serve clinic patients. Count a provider who has separate login identities at more than one site as just one provider.

1c. Do you use more than one EHR or data system across your organization?

   If yes, what is the reason?

   a. Second EHR/data system is used during transition to primary EHR

   b. Second EHR/data system is specific to one service type (e.g. dental, behavioral health)

   c. Second EHR/data system is used at specific sites with no plan to transition

   d. Other (please specify) _____

1d. Is your EHR up to date with the latest software and system patches?

1e. When do you plan to update?

2. Question removed.

3. Question removed.

4. Which of the following key providers/health care settings does your center electronically exchange clinical information with? (Select all that apply)

    a. Hospitals/Emergency rooms

    b. Specialty clinicians

    c. Other primary care providers

    d. Labs or imaging

    e. Health information exchange (HIE)

    f. None of the above

    g. Other (please describe_____)

5. Does your center engage patients through health IT in any of the following ways? (Select all that apply)

    a. Patient portals

    b. Kiosks

    c. Secure messaging

    d. Other (please describe _____)

    e. No, we do not engage patients using HIT

6. Question removed.

7. How do you collect data for UDS clinical reporting (Tables 6B and 7)?

    a. We use the EHR to extract automated reports

    b. We use the EHR but only to access individual patient charts

    c. We use the EHR in combination with another data analytic system

    d. We do not use the EHR

8. Question removed.

9. Question removed.

10. How does your health center utilize HIT and EHR data beyond direct patient care? (Select all that apply)

    a. Quality improvement

    b. Population health management

    c. Program evaluation

    d. Research

    e. Other (please describe _____)

    f. We do not utilize HIT or EHR data beyond direct patient care

11. Does your health center collect data on individual patients' social risk factors, outside of the data reportable in the UDS?

    a. Yes

    b. No, but in planning stages to collect this information

    c. No, not planning to collect this information

12. Which standardized assessment(s) to collect information on social determinants of health or social risk factors, if any, do you use? (Select all that apply)

    a. Accountable Health Communities Screening Tools

    b. Upstream Risks Screening Tool and Guide

    c. iHELP

    d. Recommend Social and Behavioral Domains for EHRs

    e. Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)

    f. Well Child Care, Evaluation, Community Resources, Advocacy Referral, Education (WE CARE)

    g. WellRx

h. Health Leads Screening Toolkit

i. Other (please describe _____)

j. We do not use a standardized screener

c. Not sure

12a. Please provide the total number of patients that screened positive for the following:

a. Food insecurity _____

b. Housing insecurity _____

c. Financial strain _____

d. Lack of transportation/access to public transportation _____

12b. If you do not use a standardized assessment to collect this information, please comment why. (Select all that apply)

a. Have not considered/unfamiliar with assessments

b. Lack of funding for addressing these unmet social needs of patients

c. Lack of training for staff to discuss these issues with patients

d. Inability to include in patient intake and clinical workflow

e. Not needed

f. Other (please specify _____)

13. Does your center integrate a statewide Prescription Drug Monitoring Program (PDMP) database into the health information systems such as Health Information Exchanges, electronic health record (EHR) systems, and/or pharmacy dispensing software (PDS) to streamline provider access to controlled substance prescriptions?

a. Yes

b. No

Appendix E: Other Data Elements

Instructions

Health centers are becoming increasingly diverse and comprehensive in the care and services provided. These questions capture the changing landscape of healthcare centers to include expanded services and delivery systems.

Questions

Report on these data elements as part of your UDS submission. Topics include medication-assisted treatment (MAT), telehealth, and outreach and enrollment assistance. Respond to each question based on your health center status *as of December 31*.

1. Medication-Assisted Treatment (MAT) for Opioid Use Disorder

    a. How many physicians, certified nurse practitioners, and physician assistants,[15] on-site or with whom the health center has contracts, have obtained a Drug Addiction Treatment Act of 2000 (DATA) waiver to treat opioid use disorder with medications specifically approved by the U.S. Food and Drug Administration (FDA) for that indication?

    b. How many patients received medication-assisted treatment for opioid use disorder from a physician, certified nurse practitioner, or physician assistant, with a DATA waiver working on behalf of the health center?

2. Did your organization use telemedicine to provide remote clinical care services?

    (The term "telehealth" includes "telemedicine" services but encompasses a broader scope of remote healthcare services. Telemedicine is specific to remote clinical services whereas telehealth may include remote non-clinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services.)

    a. Yes

    2a1. Who did you use telemedicine to communicate with? (Select all that apply)

    a. Patients at remote locations from your organization (e.g., home telehealth, satellite locations)

    b. Specialists outside your organization (e.g., specialists at referral centers)

    2a2. What telehealth technologies did you use? (Select all that apply)

    a. Real-time telehealth (e.g., live videoconferencing)

    b. Store-and-forward telehealth (e.g., secure email with photos or videos of patient examinations)

    c. Remote patient monitoring

    d. Mobile Health (mHealth)

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[15] With the enactment of the Comprehensive Addiction and Recovery Act of 2016, Public Law 114-198, opioid treatment prescribing privileges have been extended beyond physicians to include certain qualifying nurse practitioners (NPs) and physician assistants (PAs).

2a3. What primary telemedicine services were used at your organization? (Select all that apply)

    a. Primary care

    b. Oral health

    c. Behavioral health: Mental health

    d. Behavioral health: Substance use disorder

    e. Dermatology

    f. Chronic conditions

    g. Disaster management

    h. Consumer health education

    i. Provider-to-provider consultation

    j. Radiology

    k. Nutrition and dietary counseling

    l. Other (Please specify: _____)

b. No. If you did not have telemedicine services, please comment why (Select all that apply).

    a. Have not considered/unfamiliar with telehealth service options

    b. Policy barriers (Select all that apply)

      i. Lack of or limited reimbursement

      ii. Credentialing, licensing, or privileging

      iii. Privacy and security

      iv. Other (Please specify: _____)

c. Inadequate broadband/ telecommunication service (Select all that apply)

    i. Cost of service

    ii. Lack of infrastructure

    iii. Other (Please specify: _____)

d. Lack of funding for telehealth equipment

e. Lack of training for telehealth services

f. Not needed

g. Other (Please specify: _____)

3. Provide the number of all assists provided during the past year by all trained assisters (e.g., certified application counselor or equivalent) working on behalf of the health center (employees, contractors, or volunteers), regardless of the funding source that is supporting the assisters' activities. Outreach and enrollment assists are defined as customizable education sessions about affordable health insurance coverage options (one-on-one or small group) and any other assistance provided by a health center assister to facilitate enrollment.

Enter number of assists

_____

Note: *Assists do not count as visits on the UDS tables.*

Appendix F: Workforce

Instructions

It is important to understand the current state of health center workforce training and different staffing models to better support recruitment and retention of health center professionals. This section includes a series of questions on health center workforce.

Questions

Report on these data elements as part of your UDS submission. Topics include health professional education/training and satisfaction surveys. Respond to each question based on your health center status *as of December 31*.

1. Does your health center provide health professional education/training? Health professional education/training does not include continuing education units.

    a. Yes

    b. No

1a. If yes, which category best describes your health center's role in the health professional education/training process?

    a. Sponsor[16]

    b. Training site partner[17]

    c. Other (please describe _____)

2. Please indicate the range of health professional education/training offered at your health center and how many individuals you have trained in each category within the last year.

	a. Pre-Graduate/Certificate	b. Post-Graduate Training
Medical		
1. Physicians	[blank]	
a. Family Physicians		
b. General Practitioners		
c. Internists		
d. Obstetrician/Gynecologists		
e. Pediatricians		
f. Other Specialty Physicians		
2. Nurse Practitioners		
3. Physician Assistants		

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[16] A sponsor hosts a comprehensive health profession education and/or training program, the implementation of which may require partnerships with other entities that deliver focused, time-limited education and/or training (e.g., a teaching health center with a family medicine residency program).

[17] A training site partner delivers focused, time-limited education and/or training to learners in support of a comprehensive curriculum hosted by another health profession education provider (e.g., month-long primary care dentistry experience for dental students).

	a. Pre-Graduate/Certificate	b. Post-Graduate Training
4. Certified Nurse Midwives		
5. Registered Nurses		
6. Licensed Practical Nurses/ Vocational Nurses		
7. Medical Assistants		
Dental		
8. Dentists		
9. Dental Hygienists		
10. Dental Therapists		
Mental Health and Substance Use Disorder		
11. Psychiatrists		
12. Clinical Psychologists		
13. Clinical Social Workers		
14. Professional Counselors		
15. Marriage and Family Therapists		
16. Psychiatric Nurse Specialists		
17. Mental Health Nurse Practitioners		
18. Mental Health Physician Assistants		
19. Substance Use Disorder Personnel		
Vision		
20. Ophthalmologists		
21. Optometrists		
Other Professionals		
22. Chiropractors		
23. Dieticians/Nutritionists		
24. Pharmacists		
25. Other (please specify _____)		

3. Provide the number of health center staff serving as preceptors at your health center ____

4. Provide the number of health center staff (non-preceptors) supporting health center training programs ____

5. How often does your health center implement satisfaction surveys for providers?

   a. Monthly

   b. Quarterly

   c. Annually

    d. We do not currently conduct provider satisfaction surveys

    e. Other (please describe _____)

6. How often does your health center implement satisfaction surveys for general staff?

    a. Monthly

    b. Quarterly

    c. Annually

    d. We do not currently conduct staff satisfaction surveys

    e. Other (please describe _____)

Appendix G: Health Center Resources

Several resources are available to assist health centers with UDS Reporting or EHBs system questions:

Description	Contact	E-mail	Phone
UDS reporting questions	UDS Support Center	udshelp330@bphcdata.net	866-837-4357 (866-UDS-HELP)
EHBs account and user access questions	HRSA Call Center	HRSA Call Center	877-464-4772 Option 3
EHBs electronic reporting issues	HRSA Call Center	HRSA Call Center	877-464-4772 Option 1

Other data and resource links, including this manual, a complete set of the UDS tables (note that the table view within EHBs may look different but contains the same fields), notifications of changes to reporting criteria, training opportunities, and other materials can be found on the BPHC website, the UDS Training Website, or the UDS Modernization Initiative page.

Strategic partnerships, including health center-controlled networks, national cooperative agreements, primary care associations, and primary care offices can be found on the BPHC Quality Improvement website.

Resources are available to assist health centers serving special populations with meeting performance requirements and training needs:

Organization	Website	Contact and E-mail	Phone
National Association of Community Health Centers (NACHC)	http://www.nachc.org	Cindy Thomas cthomas@nachc.com	301-347-0400

PHPC Program

Organization	Website	Contact and E-mail	Phone
National Nurse-Led Care Consortium (NNCC)	http://nurseledcare.org/	Kristine Gonnella kgonnella@nncc.us	215-503-7556
National Center for Health in Public Housing (NCHPH)	http://www.nchph.org	Jose Leon info@nchph.org	703-812-8822

MHC Program

Organization	Website	Contact and E-mail	Phone
Migrant Clinicians Network (MCN)	http://www.migrantclinician.org	Theressa Lyons tlyons@migrantclinician.org	512-579-4511
National Center for Farmworker Health (NCFH)	http://www.ncfh.org	Sylvia Partida partida@ncfh.org	512-312-5457

HCH Program

Organization	Website	Contact and E-mail	Phone
National Health Care for the Homeless Council (NHCHC)	http://www.nhchc.org	Dr. Alaina Boyer aboyer@nhchc.org	615-226-2292
Corporation for Supportive Housing (CSH)	http://www.csh.org	Colleen Velez colleen.velez@csh.org	609-802-5765

Other Vulnerable Populations

Organization	Website	Contact and E-mail	Phone
Association of Asian Pacific Community Health Organizations (AAPCHO)	http://www.aapcho.org	Joe Lee joelee@aapcho.org	510-909-9299
National LGBT Health Education Center	http://www.lgbthealtheducation.org	Alex Keuroghlian lgbthealtheducation@fenwayhealth.org	617-927-6354
National Center for Medical-Legal Partnership	http://www.medical-legalpartnership.org	Ellen Lawton ellawton@gwu.edu	617-549-1733
Health Information and Technology, Evaluation, and Quality (HITEQ) Center	http://hiteqcenter.org/	Alyssa Carlisle hiteqinfo@jsi.com	844-305-7440

Oral Health

Organization	Website	Contact and E-mail	Phone
National Network for Oral Health Access	http://www.nnoha.org	Phillip Thompson executivedirector@nnoha.org	303-957-0635 x6

UDS Production Timeline and Report Availability

Health centers can access their current year and prior year UDS reports, as well as several standard reports, through the EHBs web link.

- UDS Preliminary Reporting Environment: October–December 2020
- UDS data collection and reporting: January 1–February 15, 2021
- Deadline for submitting a complete UDS Report: February 15, 2021
- UDS reporting freeze: March 31, 2021
- Standard UDS Reports are available in EHBs, as shown below.
  - o Release of UDS Rollup Reports, Awardee and Look-Alike Profiles, and Awardee Comparison Data Views will be available on the BPHC webpages in August 2021.
  - o Service area data will be available on the UDS Mapper website in August 2021.

UDS Report Level	Timing	Description	Awardee	Look-Alike
Finalized Health Center Tables and XML Data File	June	Provides health center with data for each of the eleven UDS tables, the HIT, Other Data Elements, and Workforce forms	HC	HC
Health Center Trend Report	July/August	Compares the health center's performance for key performance measures (in three categories: Access, Quality of Care/Health Outcomes, and Financial Cost/Viability) with national and state averages over a 3-year period	HC, S, N	HC, N
UDS Summary Report	July/August	Summarizes and analyzes the health center's current UDS data using measures across various tables of the UDS report	HC, S, N	HC, N
UDS Rollup Report	July/August	Compiles annual data reported by health centers; provides summary data for patient demographics, socioeconomic characteristics, staffing, patient diagnoses and services rendered, quality of care, health outcomes and disparities, financial costs, and revenues	S, N	N
Performance Comparison Report	September	Summarizes and analyzes the health center's latest UDS data giving details at awardee, state, national, urban, and rural levels with trend comparisons and percentiles	Includes all levels	Includes all levels

Abbreviations indicate geographies and detail level for which each report is available.

HC=Health Center, S=State, N=National

UDS CQMs and National Programs Crosswalk

The following table crosswalks the UDS CQMs and other national programs using these measures. Specification details are available at the eCQI Resource Center. Use the Office of National Coordinator Issue Tracking System to report issues or ask questions about eCQM specifications.

ID	Measure Title	Measure Steward	CMS eCQM	NQF #	CMS Medicaid Core Set	Healthy People 2020	MIPS / QPP
Table 6B, Line 7	**Early Entry to Prenatal Care**	n/a	n/a	n/a	n/a	MICH-10.1	No
Table 6B, Line 10	**Childhood Immunization Status**	National Committee for Quality Assurance	CMS117v8	n/a	Child Core	n/a	Yes
Table 6B, Line 11	**Cervical Cancer Screening**	National Committee for Quality Assurance	CMS124v8	n/a	Adult Core	C-15	Yes
Table 6B, Line 11a	**Breast Cancer Screening**	National Committee for Quality Assurance	CMS125v8	n/a			
Table 6B, Line 12	**Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents**	National Committee for Quality Assurance	CMS155v8	n/a	Child Core	n/a	Yes
Table 6B, Line 13	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up Plan**	Centers for Medicare and Medicaid Services	CMS69v8	421e	n/a	n/a	Yes
Table 6B, Line 14a	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**	Physician Consortium for Performance Improvement	CMS138v8	28e	Adult Core	n/a	Yes

ID	Measure Title	Measure Steward	CMS eCQM	NQF #	CMS Medicaid Core Set	Healthy People 2020	MIPS / QPP
Table 6B, Line 17a	**Statin Therapy for the Prevention and Treatment of Cardiovascular Disease**	Centers for Medicare and Medicaid Services	[CMS347v3](#)	n/a	n/a	n/a	Yes
Table 6B, Line 18	**Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet**	National Committee for Quality Assurance	[CMS164v7](#)	68	n/a	n/a	Yes
Table 6B, Line 19	**Colorectal Cancer Screening**	National Committee for Quality Assurance	[CMS130v8](#)	n/a	n/a	C-16	Yes
Table 6B, Line 20	**HIV Linkage to Care**	n/a	n/a	n/a	n/a	n/a	No
Table 6B, Line 20a	**HIV Screening**	Center for Disease Control and Prevention	[CMS349v2](#)	n/a			
Table 6B, Line 21	**Preventive Care and Screening: Screening for Depression and Follow-Up Plan**	Centers for Medicare and Medicaid Services	[CMS2v9](#)	418e	Adult Core	n/a	Yes
Table 6B, Line 21a	**Depression Remission at Twelve Months**	Minnesota Community Measurement	[CMS159v8](#)	710e			
Table 6B, Line 22	**Dental Sealants for Children between 6-9 Years**	Dental Quality Alliance - American Dental Association	CMS277 (draft)	2508 (claims-based measure)	Child Core	OH-12.2	No
Table 7, Section A	**Low Birth Weight**	Centers for Disease Control and Prevention	n/a	1382	n/a	MICH-8.1	No
Table 7, Section B	**Controlling High Blood Pressure**	National Committee for Quality Assurance	[CMS165v8](#)	n/a	Adult Core	HDS-12	Yes

ID	Measure Title	Measure Steward	CMS eCQM	NQF #	CMS Medicaid Core Set	Healthy People 2020	MIPS / QPP
Table 7, Section C	**Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)**	National Committee for Quality Assurance	CMS122v8	n/a	Adult Core	D-5.1	Yes

Notes: n/a = Not applicable, NQF = National Quality Forum, MIPS = Merit-based Incentive Payment System, QPP = Quality Payment Program

Appendix H: Glossary

Accrual basis: Reported when the expense occurs, not when the cash is received.

Aged and disabled former migratory agricultural workers: As defined in section 330 (g)(1)(B), individuals who have previously been migratory agricultural workers but who no longer work in agriculture because of age or disability.

Allowance: A discount granted to a third-party payer as part of an agreement between the health center and the payer.

Bad debt: Amounts billed to and defaulted by a patient responsible for payment.

Capitation: An agreed-upon amount that a managed care payer pays to the provider (health center) for providing all of the services in an agreed-upon list. The payer/HMO pays the health center a set amount monthly, regardless of whether any services were rendered during the month.

Cash basis: Reported when the cash is received or expended, not when an obligation occurs.

CHIP or CHIP-RA or S-CHIP: The Children's Health Insurance Program Reauthorization Act (CHIP-RA) provides primary health care coverage for children and, on a state-by-state basis, others, especially pregnant women, mothers, or parents of these children. CHIP coverage can be provided through the state's Medicaid program and/or through contracts with private insurance plans.

Contract staff: People who work under contract at the health center, as opposed to being on salary. They may or may not work regular assigned hours and may or may not receive benefits. They do not have withholding taxes deducted from their paychecks, and they have their income reported to the Internal Revenue Service (IRS) on a 1099 form.

Dually eligible: Patient enrolled in both Medicare and Medicaid, with Medicare being the primary insurance.

Electronic health record (EHR): A digital record of a patient's status and interactions with a health center, including real-time, patient-centered information available quickly and securely to authorized users.

Exclusions or exceptions: As used in clinical measure reporting, patients not to be considered or included in the denominator (exclusions) or removed if identified (exceptions).

Federal poverty guidelines: An annual statement of the amount of income below which an individual or family of different sizes are considered to be in poverty.

Fee-for-service: Charges which are billed to a third-party payer (or directly to a patient) that list each of the services provided using CPT codes and the charge associated with each of these services.

Fee schedule: A listing of fixed fees for goods or services.

First trimester (prenatal care): Women who were estimated to be pregnant up through the end of the 13th week after their last menstrual period.

Full-time equivalent (FTE): One person who works full-time for the year. Fractions of an FTE are used to identify part-time or part-year individuals, and multiples of an FTE are used to identify multiple individuals.

Full-time staff: People generally employed 40 hours per week, but subject to organizational definitions. Full-time staff generally receive benefits, have withholding taxes deducted from their paychecks, and have their income reported to the IRS on a W2 form. Staff may or may not have a contract. Staff are full-time when they are so defined in their contract and/or when their benefits reflect this status.

Gender identity: A person's internal sense of their gender as a male, female, a combination of male and female, or another gender; this may or may not align with one's sex assigned at birth.

Gross charges: The full, undiscounted cost of a product or a service.

Hispanic or Latino: Persons of specific Spanish or Latino heritage, lineage, descent, or country of birth.

Homeless: A person who lacks housing (without regard to whether the individual is a member of a family), including individuals whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and individuals who reside in transitional housing. May include children and youth at risk of homelessness, homeless veterans, and veterans at risk of homelessness.

Income: Earnings over a given period of time used to support an individual/household unit based on a set of criteria of inclusions and exclusions. Income is distinguished from assets, as assets are a fixed economic resource while income comprises earnings.

Indigent care programs: State or local programs that pay in whole or in part for services rendered to people who are uninsured. Indigent care programs include 638 compact programs for tribal groups.

Last party rule: Reporting of grant and contract funds based on the entity from which the health center received them, regardless of their original origin.

Locum tenens: People who work at the health center on an as-needed basis during a part-time absence of another provider and when the center is unable to hire a full- or part-time staff person until the position is filled. Locums are uniquely identifiable because they work for an agency, and the center pays the agency rather than the individual. They do not receive benefits from the health center (although they may from the agency they work for) and generally are not covered by the health center's professional liability insurance.

Managed care: A system where a premium is paid to an organization that contracts with a health center to provide a range of services to patients assigned to the health center.

Medicaid: Federal and state-run programs operating under the guidelines of Titles XIX and XXI (as appropriate) of the Social Security Act.

Medicaid expansion: A program that makes Medicaid available to more patients and that requires states to opt-in to participate.

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

Member month: One person enrolled in a managed care plan for one month.

Migratory agricultural workers: For the purposes of health centers receiving a Health Center Program award or designation under section 330(g) of the Public Health Service Act, individuals whose principal employment is in agriculture, who have been so employed within 24 months, and who establish for the purposes of such employment a temporary abode. This includes dependent family members of the individuals described above and individuals who are no longer employed in migratory or seasonal agriculture because of age or disability who are within such catchment area.

National Health Service Corps (NHSC) assignees: Members of the NHSC assigned by the Corps to a health center. This includes members of the NHSC Loan Repayment Program. These individuals are employees of the U.S. government.

Numerator: As used in clinical measure reporting, records (a subset of the denominator) that meet the measurement standard for the specified measure.

Off-site contract providers: Providers who are contracted for the services who work at a location that is not an in-scope site as defined in a health center application.

On-call providers: Providers who fill in briefly when someone is absent but may stay for an extended period if the center is unable to hire a full- or part-time staff person for a position. Unlike locums, health centers pay on-call providers directly. They may or may not receive all the benefits or a salary and may or may not have payroll and income taxes withheld.

Part-time staff: People employed by the health center for fewer than 40 hours per week. They receive benefits consistent with their FTE, have withholding taxes deducted from their paychecks, and have their income reported to the IRS on a W2 form. Staff may or may not have a contract.

Part-year staff: Persons employed or contracted for full or part time for a specific period that may be once or recurring.

Patient: A person who has at least one reportable visit in one or more categories of services: medical, dental, mental health, substance use disorder, vision, other professional, and enabling.

Penalty/paybacks: Payments made by health centers to payers because of overpayments collected earlier or for over-utilization of the inpatient or specialty pool funds in managed care plans.

Performance measure: A quantifiable indicator used to evaluate how well the health center is achieving standards.

Prenatal care (first visit): The date a patient has a visit with a physician, NP, PA, or CNM who conducts a prenatal exam to initiate pregnancy-related health care.

Public housing: Public housing agency-developed, owned, or assisted low-income housing, including mixed finance projects, but excludes housing units with no public housing agency support other than Section 8 housing vouchers.

Race: A physical or social categorization of a person, presumably based on inheritance.

Reclassify: Transfer of amounts due from one payer to another payer, including the patient.

Reconciliations: Lump-sum retroactive adjustments based on the filing of a cost report.

Residents/trainees: Individuals in training for a license or certification who provide services at the health center under the supervision of a more senior person. Many of these trainees (especially medical and dental residents) already have licenses.

Sex: The anatomical and physiological biology of a person assigned at birth.

School-based health center: A health center located on or near school grounds (including pre-school, kindergarten, and primary through secondary schools) that provides comprehensive preventive and primary health services.

Seasonal agricultural workers: For the purposes of health centers receiving a Health Center Program award or designation under section 330(g) of the Public Health Service Act, individuals whose principal employment is in agriculture on a seasonal basis and who do not meet the definition of a migratory agricultural worker.

Second trimester (prenatal care): Women who were pregnant and estimated to be between the start of the 14th week and the end of the 27th week after their last menstrual period.

Sexual orientation: How a person describes their emotional and sexual attraction to others as straight, lesbian or gay, bisexual, or another sexual orientation.

Sliding fee discount: A discount applied to the fee schedule which adjusts fees based on the patients' ability to pay based on their income.

Straight-line allocation: Allocating non-clinical support services costs based on the proportion of net costs (total costs excluding non-clinical support services and facility cost) that is attributable to (assigned to) each service category.

Third trimester (prenatal care): Women who were estimated to be pregnant for 28 weeks or more weeks after their last menstrual period.

Universe (denominator): As used in clinical measure reporting, patients who fit the detailed criteria described for inclusion in the specific measure to be evaluated.

Veteran: Persons discharged from the uniformed services of the United States.

Visit: A documented contact between a patient and a licensed or credentialed provider who exercises his/her independent, professional judgment in the provision of services to the patient. (Virtual visits are allowable for each of the service categories).

Volunteers: People who work at the health center but not paid for their work.

Wrap-around payments: An amount equal to the difference between the usual payment and an agreed-upon flat fee, known as an FQHC or PPS rate.