Bureau of Primary Health Care (BPHC)

LOGO

UNIFORM DATA SYSTEM (UDS)
Calendar Year 2007

UDS Reporting Instructions for Section 330 Grantees

BUREAU OF PRIMARY HEALTH CARE

BPHC UNIFORM DATA SYSTEM MANUAL

For use to submit Calendar Year 2007 UDS Data

U.S. Department of Health and Human Services
Health Resources and Services Administration
Bureau of Primary Health Care
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2007 UNIFORM DATA SYSTEM MANUAL

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NOTE: TABLE 1, TABLE 9A AND TABLE 9B, WHICH WERE INCLUDED IN THE ORIGINAL UDS, HAVE BEEN DELETED.

INTRODUCTION

This 12th edition of the Bureau of Primary Health Care's User's Manual: Uniform Data System (UDS) updates all instructions and modifications issued since the first UDS reporting year (1996). **This Manual supersedes all previous manuals, including instructions provided on the BPHC Web site prior to October 2007.**

The Manual includes a brief introduction to the Uniform Data System, instructions for submitting the UDS, definitions of terms as they are used in the UDS and detailed instructions for completing each table. Where relevant, the table-specific instructions also include a set of "Questions and Answers", addressing issues that are frequently raised when completing the tables. Three appendices are included which: (A:) list personnel by category and indicate whether or not they produce countable "encounters" for the purpose of the UDS; (B:) define types of service as used in the UDS, and (C:) describe how to report data which must be conceptualized the same way on multiple tables. It is suggested that the detail in Appendix C be checked if any of the issues listed on the first page are relevant to the submitting grantee.

The UDS is an integrated reporting system used by all grantees of the following primary care programs administered by the Bureau of Primary Health Care (BPHC), Health Resources and Services Administration:

- **Community Health Center**, as defined in Section 330(e) of the Health Centers Consolidation Act as amended;
- **Migrant Health Center**, as defined in Section 330(g) of the Act;
- **Health Care for the Homeless**, as defined in Section 330(h) of the Act;
- **Public Housing Primary Care**, as defined in Section 330(i) of the Act.

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

The UDS includes two components:

- The **Universal Report** is completed by all grantees. This report provides data on services, staffing, and financing **across all programs**. The Universal Report is the source of unduplicated data on BPHC programs.
- The **Grant Reports** are completed by a sub-set of grantees **who receive multiple BPHC grants**. These reports repeat all or part of the elements of five of the Universal Report tables. They provide comparable data for that portion of their program that falls within the scope of a project **funded under a particular grant.** Separate Grant Reports are required for the Migrant Health Center, Homeless Health Care, and Public Housing Primary Care grantees *unless* a grantee is funded under one and only one of these programs. No Grant Report is submitted for the portion of multi-funded grantee's activities supported by the Community Health Center grant.

The UDS is composed of 13 tables intended to yield consistent operational and financial data that can be compared with other national and State data and trended over time. These tables are:

- Center/Grantee Profile Cover Sheet: Includes contact information for key positions and

organization information including service delivery site locations and zip codes of patients served.

- Table 2: Reports on 76 types of services offered by the grantee and the delivery method(s) used, if any, to provide these services.
- Table 3A: Provides a profile of patients by age and gender.
- Table 3B: Provides a profile of patients by race, ethnicity, and language.
- Table 4: Provides a profile of patients by poverty level and third party insurance source. Reports the number of special population patients receiving services.
- Table 5: Reports staffing full-time equivalents by position, encounters by provider type, and patients by service type.
- Table 6: Reports patients and encounters for selected diagnoses and services.
- Table 7: Provides a profile of patients receiving prenatal services, birth outcomes reported by race and by ethnicity, and other perinatal care information.
- Table 8A: Details direct and indirect expenses by cost center.
- Table 8B: Details direct expenses for enabling services.
- Table 9C: Reports revenues, expenses and other information for managed care programs.
- Table 9D: Reports full charges, collections and allowances by payor.
- Table 9E: Reports non patient-service income.

The UDS report is always a calendar year report. Agencies whose funding begins, either in whole or in part, after the beginning of the year, or whose funding is terminated, again either in whole or in part, before the end of the year, are nonetheless required to report on the entire year to the best of their ability.

Persons served by BPHC-supported clinics are referred to as “patients.” Inconsistent language, referring to such persons as “patients”, “clients”, or “users” has led to some confusion in the past. *There is no intent to change the individuals who are being counted or reported on in the UDS process. All persons previously referred to and counted under any of these terms will continue to be counted in the UDS.*

GENERAL INSTRUCTIONS

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

WHO SUBMITS REPORTS AND REPORTING PERIODS

Reports are submitted directly by each BPHC grantee who is the direct recipient of one or more BPHC grants. *Reporting UDS data is a requirement of continuing grant funding, and failure to report can have an impact on a grantee's continued funding.* All grantees are expected to report for the entire calendar year, even if they were funded, in whole or in part, for less than the full year. The one exception to this rule is for grantees who are funded for the first time after October 1 of the year and who have had no other BPHC funds during the year. The following information. reported on all UDS Tables. is completed automatically by the UDS software:

- **DATE OF EXPORT** – The date the export file was created – it is presumed that it will be transmitted on this same date.
- **REPORTING PERIOD** – The time period covered by the report. All reports cover an entire calendar year. The reporting period is January 1 through December 31 of each reporting year.
- **UDS NUMBER** – The identifying number assigned to the grantee by the BPHC.

Due Dates and Revisions to Reports

Initial submissions of all UDS reports are due by **February 15** of each calendar year. Submission is electronic, by upload, email or disk, as instructed in the reporting software.

If revisions to your 2007 UDS tables are needed after your data have been exported from the software, you must contact the toll free **UDS Help Line** at **866-UDS-HELP (866-837-4357).** If you have already been contacted by a UDS data editor, coordinate all data changes with that individual. In general, changes up to February 15th are done through the Help Line. After February 15th, changes are generally submitted through your editor.

UDS reports may be revised for a period of up to 27 months from their original due date. That means that revisions for the UDS report for Calendar Years 2005 (which was due February 15, 2006) may be submitted through May 15, 2008. Revisions for the CY 2006 report may be submitted through May 15, 2009. For revision of Prior Year UDS Reports, you will need to contact the toll free **UDS Help Line** at **866-UDS-HELP (866-837-4357)** for instructions.

HOW AND WHERE TO SUBMIT DATA

- **Grantees will receive custom software in late December or early January which will be used to enter UDS data. The software includes a system for submitting completed UDS reports electronically.**
- If a grantee does not receive the software or has difficulty in submitting the data electronically, the grantee will need to contact the UDS Help Line: **866-UDS-HELP**.
- Data are submitted in one of three ways. (Extensive instructions are included in the software package):
    1) Electronically: by attaching the file to an e-mail and sending it to submit330uds@bphcdata.net.
    2) Through the built-in File Transfer Protocol (FTP) in the UDS software (detailed instructions are provided in the software.)

3) In rare instances, and after instructions from the UDS Support Line, data can be mailed to: **BPHC UDS Data, P.O. Box 333, Concord, NH 03302-0333**

DEFINITIONS

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

ENCOUNTERS

Encounter definitions are needed both to determine who is counted as a patient (Tables 3A, 3B, 4 & 6) and to report total encounters by type of provider staff (Table 5). **Encounters are documented, face-to-face contacts between a patient and a provider who exercises independent professional judgment in the provision of services to the patient. To be included as an encounter, services rendered must be documented in the patient's record.** Appendix A provides a list of health center personnel and the *usual* status of each as a provider or non-provider for purposes of UDS reporting. Encounters which are provided by contractors, **and paid for by the grantee,** such as Migrant Voucher encounters or out-patient or in-patient specialty care associated with an at-risk managed care contract, are considered to be encounters and are counted on the UDS to the extent that they meet all other criteria. (Note that many interactions between patients and CHC staff and contractors are *not* considered to be encounters. These are discussed further below.)

The five criteria specified above are very general. More specifically, these definitions and the criteria for defining and reporting encounters are discussed below:

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

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

3. When a provider renders services to several patients simultaneously, the provider can be credited with an encounter for each person only if the provision of services is noted in **each** person's health record. Such visits are generally limited to behavioral health services. Examples of such non-medical "group encounters" include: family therapy or counseling sessions and group mental health counseling during which several people receive services and the services are noted in each person's health record. In such situations, **each** patient is normally billed for the service. Medical visits must be provided on an individual basis. Patient education or health education classes (e.g., diabetes control or smoking cessation)

are not credited as encounters.

4. An encounter may take place in the health center or at any other site or location at which project-supported activities are carried out. Examples of other sites and locations include mobile vans, hospitals, patients' homes, schools, nursing homes, homeless shelters, and extended care facilities. Encounters also include contacts with patients who are hospitalized, where health center medical staff member(s) follow the patient during the hospital stay as physician of record or where they provide consultation to the physician of record. A provider may not generate more than one inpatient encounter per patient per day.

5. Such services as drawing blood, collecting urine specimens, performing laboratory tests, taking X-rays, giving immunizations, and filling/dispensing prescriptions (including injected prescriptions) do not constitute encounters, regardless of the level or quantity of supportive services.

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

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

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

8. The encounter criteria **are not** met in the following circumstances:
   - When a provider participates in a community meeting or group session that is **not** designed to provide clinical services. Examples of such activities include information sessions for prospective patients, health presentations to community groups (high school classes, PTA, etc.), and information presentations about available health services at the center.
   - When the only health service provided is part of a large-scale effort, such as a mass immunization program, screening program, or community-wide service program (e.g., a health fair).
   - When a provider is primarily conducting outreach and/or group education sessions, not providing direct services.
   - When the **only** services provided are lab tests, x-rays, immunizations, TB tests and/or prescription refills.
   - Services performed under the auspices of a WIC program or a WIC contract.

Further definitions of encounters for different provider types follow:

PHYSICIAN ENCOUNTER – An encounter between a physician and a patient.

NURSE PRACTITIONER ENCOUNTER – An encounter between a Nurse Practitioner and a patient in which the practitioner acts as an independent provider.

PHYSICIAN ASSISTANT ENCOUNTER – An encounter between a Physician Assistant and a patient in which the practitioner acts as an independent provider.

CERTIFIED NURSE MIDWIFE ENCOUNTER – An encounter between a Certified Nurse Midwife and a patient in which the practitioner acts as an independent provider.

NURSE ENCOUNTER (Medical) – An encounter between an R.N., L.V.N. or L.P.N. and a patient in which the nurse acts as an independent provider of medical services exercising independent judgment, such as in a triage encounter. Services which meet this criteria may be provided under standing orders of a physician, under specific instructions from a previous visit, or under the general supervision of a physician or Nurse Practitioner/Physicians Assistant/Certified Nurse Midwife (NP/PA/CNM) who has no direct contact with the patient during the visit, but must still meet the requirement of exercising independent professional judgment. (Note that some states prohibit an LVN or an LPN to exercise independent judgment, in which case no encounters would be counted for them. Note also that, under no circumstances are services provided by Medical Assistants or other personnel without nursing licenses counted as nursing visits.)

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

MENTAL HEALTH ENCOUNTER – An encounter between a licensed mental health provider (psychiatrist, psychologist, LCSW, and certain other Masters Prepared mental health providers licensed by specific states,) or an unlicensed mental health provider credentialed by the center, and a patient, during which mental health services (i.e., services of a psychiatric, psychological, psychosocial, or crisis intervention nature) are provided.

SUBSTANCE ABUSE ENCOUNTER – An encounter between a substance abuse provider (e.g., credentialed substance abuse counselor, rehabilitation therapist, psychologist) and a patient during which alcohol or drug abuse services (i.e., assessment and diagnosis, treatment, aftercare) are provided.

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

CASE MANAGEMENT ENCOUNTER – An encounter between a case management provider and a patient during which services are provided that assist patients in the management of their health and social needs, including patient needs assessments, the establishment of service plans, and the maintenance of referral, tracking, and follow-up systems. These must be face to face with the patient. Interactions on behalf of a patient with third parties are not counted as case management encounters.

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

PROVIDER

A provider is the individual who assumes primary responsibility for assessing the patient and documenting services in the patient's record. Providers include only individuals who exercise independent judgment as to the services rendered to the patient during an encounter. Only one provider who exercises independent judgment is credited with the encounter, even when two or more providers are present and participate. If two or more providers of the same type divide up the services for a patient (e.g., a family practitioner and a pediatrician both seeing a child) only one may be credited with an encounter. Where health center staff are following a patient in the hospital, the primary responsible center staff person in attendance during the encounter is the provider (and is credited with an encounter), even if other staff from the health center and/or hospital are present. (Appendix A provides a listing of personnel, indicating whether or not they are considered a provider who can generate encounters for purposes of UDS reporting.)

If contract providers who are part of the scope of the approved grant-funded program and who are paid by the center with grant funds or program income, serve center patients and document their services in the center's records, they are considered providers. (A discharge summary or similar document in the medical record will meet this criteria.) Also, contract providers paid for specific visits or services with grant funds or program income, who report patient encounters to the direct recipient of a BPHC grant (e.g., under a migrant voucher program or contractors with homeless grantees) are considered providers and their activities are to be reported by the direct recipient of the BPHC grant. Since there is no time basis in their report, no FTE is reported for such individuals.

PATIENT

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

The **Universal Report** includes as patients all individuals who have at least one encounter during the year within the scope of activities supported by **any** BPHC grant covered by the UDS. In any given category (e.g. medical, dental, enabling, etc.) in the Universal Report, each patient is counted once and only once, even if s/he received more than one type of service or receives services supported by more than one BPHC grant. For each **Grant Report**, patients include individuals who have at least one encounter during the year within the scope of project activities supported by the specific BPHC grant. A patient counted in any cell on a Grant Report is also included in the same cell on the Universal Report.

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

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

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

FULL-TIME EQUIVALENT EMPLOYEE

A full-time equivalent (FTE) of 1.0 means that the person worked full-time for one year. Each agency defines the number of hours for "full-time" work. For example, if a physician is hired full-time and works 36 hours per week, she is a 1,0 FTE. The full-time equivalent is based on employment contracts for clinicians and exempt employees; FTE is calculated based on paid hours for non-exempt employees. FTEs are adjusted for part-time work or for part-year employment. In an organization that has a 40 hour work week (2080 hours/year), a person who works 20 hours per week (i.e., 50% time) is reported as "0.5 FTE." In some organizations different positions have different time expectations. Positions with different time expectations, especially clinicians, should be calculated on whatever they have as a base for that position. Thus, if physicians work 36 hours per week, this would be considered1.0 FTE, and an 18 hour per week physician would be considered as 0.5 FTE, regardless of whether other employees work 40 hours weeks. FTE is also based on the number of months the employee works. An employee who works full time for four months out of the year would be reported as "0.33 FTE" (4 months/12 months).

Staff may provide services on behalf of the grantee on a regularly scheduled basis under many different arrangements including, but not limited to: salaried full-time, salaried part-time, hourly wages, National Health Service Corps assignment, under contract, or donated time. Individuals who are paid by the grantee on a fee-for-service basis only and do not have specific assigned hours, are not counted in the calculation of FTEs since there is no basis for determining their hours.

Residents are considered providers and their time is counted. To calculate the FTE for a resident, use the number of hours they in spend clinic activities (i.e., with patients, discussing patient care with their proctor, or participating in clinic committees) as the numerator of the equation. Use the number of hours a full time physician normally works as the denominator in the equation. For example, if a full time physician works 36 hours a week, and gets one week for CME, two weeks for sick leave, four weeks for vacation, and 12 paid holidays, the denominator would be 1533.6 hours [(52-1-2-4-2.4)*36]. If a resident spends 950 hours in clinic activities during the year they would be counted as 0.62 FTE (950/1533.6).

INSTRUCTIONS BY TABLE

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

OVERVIEW OF UDS REPORT

The UDS includes two components:

- The **Universal Report** is completed by all grantees. This report provides data on services, staffing, and financing **across all programs**. The Universal Report is the source of unduplicated data on BPHC programs.
- The **Grant Reports** are completed by a sub-set of grantees **who receive multiple BPHC grants**. These reports repeat all or part of the elements of five of the Universal Report tables. They provide comparable data for that portion of their program that falls within the scope of a project **funded under a particular grant.** Separate Grant Reports are required for the Migrant Health Center, Homeless Health Care, and Public Housing Primary Care grantees *unless* a grantee funded under one specific program receives no other BPHC funding. No Grant Report is submitted for the portion of multiply funded grantee's activities supported by the Community Health Center grant.

The **Universal Report** provides a comprehensive picture of all activities within the scope of BPHC-supported projects. In this report grantees should report on the total unduplicated number of patients and activities **within the scope of projects supported by any and all BPHC primary care programs covered by the UDS**.

For **Grant Reports,** grantees provide data on the patients and activities within that part of their program which is **funded under a particular grant**. Because a patient can receive services through more than one type of BPHC grant, and not all grants are reported separately, totals from the Grant Reports cannot be aggregated to generate totals in the Universal Report. It is, however, logically impossible for the number in any cell of a grant report to be greater than the comparable cell in the universal report.

Grantees that receive only one BPHC grant are required to complete only the Universal Report. Agencies with multiple BPHC grants complete a Universal Report for the combined projects and a separate grant report for each Migrant, Homeless, and/or Public Housing program grant. Examples include the following:

- A CHC grantee (Section 330e) that has a Health Care for the Homeless grant (Section 330h) completes a Universal Report and a Homeless Grant Report--but does not complete a Grant Report for the CHC grant.
- A CHC grantee (Section 330e) that also has Migrant Health (Section 330g) and Homeless (Section 330h) grants, completes a Universal Report, a Grant Report for the Homeless grant, and a grant report for the Migrant grant.
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NOTE: The reporting software will automatically identify the reports which must be filed and prompt the grantee if one is left out.

If the reporting grantee provides services through a contract with another organization that is the direct recipient of a BPHC grant, both entities report the patients, utilization, costs and revenues associated with those patients, though only the grantee will have a Grant Report to complete.

The table below indicates which tables are included in the Universal Report and Grant Reports. Also listed are tables that have been deleted from the UDS since the system was initiated in 1996. No further reference to any of the deleted tables is made in this Manual.

TABLE		UNIVERSAL REPORT	GRANT REPORTS
CENTER/GRANTEE PROFILE			
Cover Sheet	Grantee and Service Delivery Site Information	X	
Table 1:	NO LONGER REPORTED		
Table 2:	Services Offered	X	
PATIENT PROFILE			
Table 3(A):	Patients by Age and Gender	X	X
Table 3(B)	Patients by Race and Ethnicity, Patients best served in a language other than English	X	X
Table 4:	Socioeconomic Characteristics	X	X
STAFFING AND UTILIZATION			
Table 5:	Staffing and Utilization	X	<partial>
Table 6:	Selected Diagnoses and Services	X	X
Table 7:	Perinatal Profile	X	
FINANCIAL			
Table 8(A-B):	Costs	X	
Table 9(A-B):	NO LONGER REPORTED		
Table 9(C-E)	Managed Care and Revenue	X	

INSTRUCTIONS FOR CENTER/GRANTEE PROFILE COVER SHEET

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

GRANTEE LEGAL NAME; ADDRESS OF GRANTEE ADMINISTRATIVE OFFICES:

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

CEO/EXECUTIVE DIRECTOR OR PROJECT DIRECTOR:

- Provide the name of the CEO, Executive Director, or Project Director of the grantee organization. Public health departments, other public entities, or other very large organizations (e.g., universities or hospitals) should list the individual responsible for directing the BPHC-funded project.
- Provide the phone number and e-mail address of the CEO, Executive or Project Director. BPHC and/or its contractor will use this e-mail address to contact you during the UDS editing process and will send the feedback report to this address.

CMO/CLINICAL DIRECTOR:

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

CHAIRPERSON OF THE GOVERNING BOARD, HEALTH OFFICER, OR OTHER ACCOUNTABLE INDIVIDUAL (E.G. CHAIR OF THE BOARD OF SUPERVISORS, PRESIDENT OF THE BOARD OF TRUSTEES, ETC.):

- Provide the name of the Chair of the grantee organization's Governing Board. State and local health departments receiving grants that do not include requirements for a Governing Board (e.g., Health Care for the Homeless grantees) should provide the name of the State Health Officer or Local Health Officer or other accountable individual, as appropriate.

GRANTEE CONTACT PERSON:

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

SCHOOL HEALTH COORDINATOR:

- Provide the name of the grantee staff person with primary responsibility for <u>any</u> school

based health center activities managed by the grantee. If a name is listed here, the UDS will expect a number on Table 4, Line 23: Total school based health center patients.

HOMELESS PROGRAM COORDINATOR:

- Provide the name of the grantee staff person with primary responsibility for any homeless program managed by the grantee, regardless of whether or not BPHC funding supports the activities. If a name is listed here, the UDS will expect a number on Table 4, Line 22: Total Homeless patients.

PUBLIC HOUSING PROGRAM COORDINATOR:

- Provide the name of the grantee staff person with primary responsibility for any public housing program managed by the grantee, regardless of whether or not BPHC funding supports the activities.

MEDICAID PROVIDER BILLING NUMBER:

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

MEDICAID PHARMACY NUMBER:

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

NUMBER OF SERVICE DELIVERY SITES:

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

NUMBER OF NHSC ASSIGNEES*:*

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

GRANTEE PARTICIPATION IN AN INTEGRATED SERVICES NETWORK:

- Check one box (only) for participation in a horizontal network, a vertical network, or both. Grantees that do not participate in a network will check 'No ISN Participation'. An integrated services network is defined as a group of safety net providers collaborating through the redesign of practices to integrate services, optimize patient outcomes, and/or negotiate managed care contracts on behalf of the participating collaborators. Vertical integration is the collaboration of different types of providers, such as health centers, specialists, and hospitals. Horizontal integration is the collaboration occurring across the

same type of provider, i.e. integration with other health centers and/or primary care providers.

- Report if the network received Integrated Services Development Initiative (ISDI) funds from BPHC during the current year by checking the ISDI box. Check this box whether or not the grantee is the direct recipient of the funds and regardless of whether the grant may have expired during the year.

FEDERAL TORT CLAIMS ACT (FTCA):

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

DRUG PRICING PARTICIPATION:

- Check the box indicating whether or not you participated in the 340(b) drug pricing program during the reporting period, regardless of whether or not you are reporting that you participated in an "alternative drug pricing program."
- Check the box if you participate in an alternate drug pricing program, regardless of whether or not you are reporting that you participated in a "340(b) drug pricing program." (Alternative drug pricing programs are programs, often sponsored by health care consortiums, designed to lower the cost of pharmaceuticals to members by facilitating group purchasing activities.)

SERVICE DELIVERY SITES*:*

- A service delivery site is defined as any place where a health center provides clinical services to a defined geographic service area or population on a regular (e.g., daily, weekly, or monthly) scheduled basis. There is no minimum number of hours per week that services must be available. The site must, however, be operated as part of the health center's current approved scope of project. In order to be considered a site:
  - Encounters must be generated at the site through documented face-to-face contact between patients and providers;
  - Encounters are provided by health care professionals who exercise independent judgment in the provision of services to the patient; and
  - Services at the site must be provided on behalf of the health center which retains control and authority over the provision of services (e.g., as applicable, billing and medical records).
- **Service delivery sites may include**, but are not limited to, health care facilities, schools, migrant camps, homeless shelters, and mobile vans where health services are provided. Site examples include:
  - Any full-time or part-time clinic location – address of site should be listed;
  - Primary care services at a homeless shelter for 4 hours every Thursday – address of site should be listed;
  - Migrant clinic location open only during 6 months of the year – address of site should be listed.
  - If a health center provides encounters at a number of similar locations (day care centers, soup kitchens, homeless shelters, migrant camps, etc.) the individual locations need not be listed, however a single "site" for "multiple (shelters, migrant camps, etc.) locations" should then be included *for each type of location*.
  - If a mobile van provides primary care services at multiple locations on a defined schedule, the locations where the van provides services do not need to be listed as sites; however the category of "mobile van" should be listed
- **Service delivery *sites* do not include other activities/locations** where the only services delivered do not generate encounters (e.g. filling prescriptions, taking x-rays,

giving immunizations, performing street outreach or providing health education, etc.). Examples of sites that should ***not*** be listed as service delivery sites include:

- Locations for off-site activities required by the health center and documented as part of the employment agreement or contract between the health center and the provider (e.g., health center physicians providing coverage at the hospital emergency room or participating in hospital call for unassigned patients and nursing homes where providers follow their patients).
- Locations where the site is administrative only, including but not limited to voucher distribution sites.
- WIC-only sites

BPHC recognizes that some delivery "activities/locations" described above have been approved as part of the scope of project and have therefore appeared on previously submitted Exhibit B Service Site Forms. Although not considered sites as defined above, these "activities/locations" will continue to be documented in continuation applications and to be considered part of the approved scope of project. Any new additions or deletions must be requested through the Change in Scope process, consistent with guidance provided in PIN 2002-07.

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

1. Indicate by checking the appropriate box whether the site operates year-round or less than year-round.
2. Indicate by checking the appropriate box whether the service delivery location operates full-time or part-time. Full-time is defined as operational 35 or more hours per week. Part-time is operational less than 35 hours per week. If the site is part-time indicate how many hours per week it is operational. A site that is open full time on a less than year-round basis is reported as full time, even though its may have been open for far less than 1820 hours during the year.
3. Indicate by checking the appropriate box whether the site is Urban or Rural. This is based upon the patients seen at the clinic, not the actual physical location of the site. (Note – each grantee has an overall "urban / rural" designation which is not affected by this selection. Some agencies may operate both rural and urban sites.)
4. Indicate the location or type(s) of facility, using codes in the drop-down menu. Each service delivery location may be described by up to two site-types. These codes (#1-15) provide information on the type of facility in which the site is located, NOT the specific services offered at the site. Examples of coding are shown below:
    - A community-based primary care service delivery location not located in a health department or substance abuse treatment clinic/facility should be coded as "1" – Community Based Primary Care Clinic.
    - A primary care service delivery location located in a health department should be coded "5" – Health Department Clinic.
    - A primary care service delivery location located in a substance abuse clinic should be coded "6" – Substance Abuse Treatment Clinic/Facility.
    - A community-based homeless grantee service delivery location located in a mental health clinic operated by a local health department should be coded "5" – Health Department Clinic and "8" – Mental Health Clinic.
5. If you have separate Medicaid billing numbers for each of your clinic or pharmacy sites, record those on the grid for each site as appropriate. If your agency uses a single billing number, leave these blank.

PATIENT BY ZIP CODE:

Grantees must report the number of patients by zip code for all patients. This information will enable BPHC to better identify areas served by health centers as well as minimize problems arising as a result of service area overlap.

- It is the BPHC's goal to identify residence by zip code for all patients served, but it is understood that residence information may not be available for all patients. This is particularly true for centers that serve transient groups. Special instructions cover two of these groups:
    - Homeless Patients: While many homeless patients live in shelters, transitional housing, and other locations for which a zip code can be obtained, others – especially those living on the street -- do not know or will not share an exact location. Where a zip code location cannot be obtained or the location offered is questionable, grantees should use the zip code of the location where the patient is being served as a proxy. Similarly, if the patient has no other zip code and receives services on a mobile van, the zip code of the site in which services are being offered should be cited where this information is available.
    - Migrant Patients: Many Migrant Farm Workers may have a permanent residence in a community far from the location of their work and the site where they are receiving services. For the purpose of the UDS report, grantees are to use the zip code of the patient's temporary housing location near the service delivery location.

  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".

  Although grantees are expected to report residence by zip code for all patients, it is recognized that large centers, as well as those located in tourist or hunting/fishing locations may draw a small number of patients from a large number of zip codes. To ease the burden of reporting, zip codes with less than ten patients may be aggregated and reported in an "Other" category. At a minimum, health centers should report 80 percent of patients with known zip codes by individual zip code.

QUESTIONS AND ANSWERS FOR CENTER/GRANTEE PROFILE COVER SHEET

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

2. **Do we need to collect information on and report on the zip code of all of our patients?**
   Yes. Instead of asking that individual sites be identified by area served, grantees are to report on the zip codes of their patients. Although grantees are expected to report residence by zip-code for all patients, it is recognized that large centers may draw a small number of patients from a large number of zip-codes. To ease the burden of reporting, zip codes with less than 10 patients may be aggregated and reported in an "Other" category. At a minimum, health centers should report 80% of patients with known zip codes by individual zip code.

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

CENTER/GRANTEE PROFILE

COVER SHEET

GRANTEE LEGAL NAME		
Address of Grantee Administrative Offices	Street	
	City	
	State	
	9-Digit zip code (required)	-
CEO/Executive Director or Project Director	Name	
	Phone	Extension
	E-Mail	
Clinical Director	Name	
	Phone	Extension
	E-Mail	
Chairperson, Governing Board, Health Officer, or other Accountable Individual (e.g. Chair of Board of Supervisors, President of the Board of Trustees, etc.)	Name	
Grantee Contact Person (Person completing report):	Name	
	Street	
	City	
	State	Zip -
	Phone	Extension
	Fax	
	E-mail	
School Health Coordinator	Name	
Homeless Program Coordinator	Name	
Public Housing Program Coordinator	Name	
Medicaid Provider Billing Number: (Organization Wide Only)		
Medicaid Pharmacy Number: (Organization Wide Only)		

CENTER/GRANTEE PROFILE
COVER SHEET

Number of service delivery sites supported by BPHC Grant(s)	
Number of NHSC Assignees as of 12/31	
Grantee Participation in an Integrated Services Network	CHECK ONE BOX: ☐ Horizontal Network ☐ Vertical Network ☐ Both (Horizontal & Vertical Integration) ☐ No ISN Participation
	If participation in a network was indicated above, did the network receive ISDI funding from BPHC at any time in the past? ☐ Yes ☐ No
Federal Tort Claims Act (FTCA) Deemed?	☐ Yes ☐ No
340(b) Drug Pricing Participation?	☐ Yes ☐ No
Alternative drug discounting program?	☐ Yes ☐ No

CENTER/GRANTEE PROFILE

COVER SHEET

NOTE: Use Location Codes listed below to describe the type of facility in which the service delivery site is located. More than one location code may apply for a given service delivery site. Use Medicaid numbers for service delivery sites only if applicable. For location code 11, School Based Health Center, include name of school in service delivery site name.

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

Location Codes to identify the type of facility or location:

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

CENTER/GRANTEE PROFILE

COVER SHEET

PATIENTS BY ZIP CODE

Zip Code	Patients
Other Zip Codes	
Unknown Residence	
TOTAL	

INSTRUCTIONS FOR TABLE 2 – SERVICES OFFERED AND DELIVERY METHOD

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

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

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

    - **PROVIDED BY GRANTEE** – Includes services rendered by salaried employees, contracted providers, National Health Service Corps Staff, volunteers and others such as out-stationed eligibility workers who render services in the grantee's name.

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

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

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

QUESTIONS AND ANSWERS FOR TABLE 2

1. **Are there any changes to this table?**
   There are no changes to this table since the CY 2004 reporting year.

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

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

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

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

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

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

INSTRUCTIONS FOR TABLES 3A AND 3B –PATIENTS BY AGE, GENDER, RACE/ETHNICITY AND LINGUISTIC PREFERENCE

Tables 3A and 3B provide demographic data on patients of the program and are included in **both** the Universal Report and the Grant Reports.

For the **Universal Report**, include as patients all individuals receiving at least one face-to-face encounter for services as described below which is within the scope of any of the programs covered by UDS. Regardless of the number or types of services received, each patient is to be counted only once on Table 3A, once in the race section of Table 3B, once in the ethnicity section of Table 3B and a maximum of once in the language section of Table 3B.

The **Grant Reports** include only individuals who received at least one face-to-face encounter within the scope of the program in question. As discussed in the Universal Report paragraph above, patients are to be reported only once in each section of each report filed, however if the same patient is served in more than one program, they will be reported on the grant report for each program that served them.

An encounter is a face-to-face contact between a patient and a provider who exercises independent professional judgment in the provision of services to the individual, and the services rendered must be documented to be counted as an encounter. See the "General Instructions: Definitions" section above, for complete definitions of patients and encounters.

TABLE 3A: PATIENTS BY AGE AND GENDER

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

TABLE 3B: PATIENTS BY RACE, LATINO IDENTITY AND LINGUISTIC PREFERENCE

Effective with this version of the UDS, all patients are categorized by *both* race *and* by Latino/Hispanic identity. Each patient will be reported once in the top section of the table on Latino/Hispanic identity and once in the middle section on race. Centers which have not used a system like this should review instructions on how to report their patient population.

RACE:

- Report the number of patients in each racial category. The total on Table 3B line 11 must equal the total on Table 3A, line 39 Columns A + B.
- All patients must be classified in one of the racial categories (including "Unreported / Refused to report"). This includes individuals who *also* consider themselves to be "Latino" or "Hispanic". If your data system has not separately classified Latino/Hispanic patients by race, they will be reported on line 10 as "unreported"
- Asian patients are further divided on the Race table into three separate ethnic categories:
    - 5a. Native Hawaiian – individuals who trace their ancestry to the native population of the Hawaiian islands.
    - 5b. Pacific Islanders -- patients who trace their ancestry to the islands considered to be part of Melanesia, Micronesia and Polynesia. (Do not include patients from Indonesia, the Philippines, Japan, or any other islands in the Pacific.)
    - 5c. Asian – all other Asian patients.

    - Line 5. “Asian / Hawaiian / Pacific Islander”, must equal lines 5a + 5b + 5c
- “American Indian” (line 7) should be considered to include patients who consider themselves to be members of Indian tribes from all of North, South, and Central America, not just those from the United States.
- Note the addition of Line 9 “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 which lists the races and tells the patient to “check all that apply”.
- Note that the line for “Hispanic or Latino”, has been deleted from the Race section of the table. Take extra care not to mistakenly report Latino populations on line 9.

LATINO IDENTITY (ETHNICITY):

- Report the number of patients in each category. The total on Table 3B line 4 must equal the total on Table 3A, line 39 Columns A + B.
- This table really *only* collects information on whether or not patients considers themselves to be of Latino or Hispanic identity.
    - Report on line 1 individuals from the continents of South America and North America and from the Caribbean islands who consider themselves to be “Latinos.”
    - Report all other patients on line 2 – “all other”.

The mix of race and ethnicity categories can be confusing to reporting entities. Some common examples may serve to clarify their use:

- A center which has categories of “Asian, Black, White, and Latino” would report those patients who selected “Latino” on line 10 (“unreported”) in the “Race” portion of the table and line 1 of the Latino / Hispanic Identity portion of the table.
- In the same situation, a patient who selected “White” would be reported on line 8 (White) in the “Race” portion of the table and line 2 (All other) of the Latino/Hispanic Identity portion of the table.
- A patient who reports themselves to be “Black Latino” would be counted on line 6 (Black) in the “Race” portion of the table and line 1 of the Latino Identity portion of the table.
- A patient who reported themselves to be “French Creole” would be reported on line 10 (Unreported) in the “Race” portion of the table and line 2 (All other) of the Latino Identity portion of the table.

LINGUISTIC PREFERENCE:

- Report on line 12 the number of patients who are best served in a language other than English or with sign language.
- Include those patients who were served by a bilingual provider and those who may have brought their own interpreter.

NOTE: Data reported on line 12, Linguistic preference, **only** may be estimated if the health center does not maintain actual data in its PMS. Wherever possible, the estimate should be based on a sample.

QUESTIONS AND ANSWERS FOR TABLES 3A AND 3B

1. **Are there any changes to Tables 3A or 3B?**
   Yes. In 2007 an additional race category, "More than one race", and information about Latino / Hispanic identity were added. With the addition of this information, 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 Office of Management and Budget (OMB). These standards govern the categories used to collect and present federal data on race and ethnicity. The OMB requires five minimum categories (White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander) for race. In addition to the five race groups, the OMB also states that respondents should be offered the option of selecting more than one race. The addition of Line 9 permits reporting of those people who have chosen to report two or more races.

2. **How do you report Latino Patients now?**
   In 2007, we have divided table 3B into two sections. Patients who, in the past, were reported as Latino / Hispanic will be reported on line 1 *and* will be reported on lines 5a through 10 as appropriate. If "Latino" is the only identity recorded in the center's files, these patients will be reported on line 10 as having an "Unreported" racial identification.

3. **How do we report individuals who receive different types of services or use more than one of the grantee's service delivery sites? For example, a person who receives both medical and dental services or a woman who receives primary care from one clinic, but gets prenatal care at another.**
   UDS Tables 3A and 3B provide unduplicated counts of patients. Grantees are required to report each patient once and only once on Table 3A and once in each section of Table 3B, regardless of the type or number of services they receive or where they receive them. Each person who has received at least one encounter reported on Table 5 is to be counted once and only once on Table 3A and in lines 1-7 of Table 3B. Encounters are defined in detail in the General Instructions. Note the following:
   - Persons who only receive WIC services and no other services at the agency are not to be counted as patients or reported on Table 3A.
   - Persons who only receive lab services or whose only service was an immunization or screening test as part of a community wide health promotion/disease prevention effort are not to be counted as patients or reported on Table 3A.

4. **Do we need to collect information on and report on the race *and* ethnicity of all of our patients?**
   Yes. According to the Office of Management and Budget (OMB) this information must be collected for all patients. Race/ethnicity is best self-reported by patients and patients may refuse to provide the information. Patients for whom there is no racial information are reported on Line 10 of Table 3B. Patients for whom there is no Latino identity information are reported on line 2.

NOTE: The sum of Table 3A, Line 39, Column A + B must equal Table 3B, Lines 4 and 11; Table 4, Line 6; and Table 4 Line 12, Column A + B. The sum of Table 3A, Lines 1-20, Column A + B must equal Table 4, Line 12, Column A.

TABLE 3A – PATIENTS BY AGE AND GENDER

	AGE GROUPS	MALE PATIENTS (a)	FEMALE PATIENTS (b)
NUMBER OF PATIENTS			
1	Under age 1		
2	Age 1		
3	Age 2		
4	Age 3		
5	Age 4		
6	Age 5		
7	Age 6		
8	Age 7		
9	Age 8		
10	Age 9		
11	Age 10		
12	Age 11		
13	Age 12		
14	Age 13		
15	Age 14		
16	Age 15		
17	Age 16		
18	Age 17		
19	Age 18		
20	Age 19		
21	Age 20		
22	Age 21		
23	Age 22		
24	Age 23		
25	Age 24		
26	Ages 25 – 29		
27	Ages 30 – 34		
28	Ages 35 – 39		
29	Ages 40 – 44		
30	Ages 45 – 49		
31	Ages 50 – 54		
32	Ages 55 – 59		
33	Ages 60 – 64		
34	Ages 65 – 69		
35	Ages 70 – 74		
36	Ages 75 – 79		
37	Ages 80 – 84		
38	Age 85 and over		
39	**TOTAL PATIENTS** (SUM LINES 1-38)		

TABLE 3B – PATIENTS BY ETHNICITY/RACE/LANGUAGE

USERS BY HISPANIC / LATINO IDENTITY		NUMBER (a)
NUMBER OF PATIENTS		
1.	Hispanic or Latino	
2.	All others (including Unreported)	
3.	<not used>	
4.	**TOTAL PATIENTS** (SUM LINES 1-2 MUST = LINE 11)	

Note: Line 4 must = Table 3a, Line 39 Column a + b)

USERS BY RACE		NUMBER (a)
NUMBER OF PATIENTS		
5a.	Asian	
5b.	Native Hawaiian	
5c.	Other Pacific Islander	
5.	**TOTAL ASIAN/HAWAIIAN/PACIFIC ISLANDER** (SUM LINES 5A + 5B + 5C)	
6.	Black/African American (including Blacks or African Americans of Latino or Hispanic Descent)	
7.	American Indian/Alaska Native (including American Indians or Alaska Natives of Latino/Hispanic Descent)	
8.	White (including Whites of Latino/Hispanic Descent)	
9.	More than one race	
10.	Unreported / Refused to report	
11.	**TOTAL PATIENTS** (SUM LINES 5 - 10 MUST = LINE 4)	

Note: Line 4 must = Table 3a, Line 39 Column a + b)

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

INSTRUCTIONS FOR TABLE 4 – SOCIOECONOMIC CHARACTERISTICS

Table 4 provides descriptive data on the socioeconomic status of health center patients. The table is included in **both** the Universal Report and the Grant Reports.

For the **Universal Report**, include as patients all individuals receiving at least one face-to-face encounter for services within the scope of any of the programs covered by UDS. The **Grant Reports** include only individuals who received at least one face-to-face encounter that was within the scope of the program in question. **Patients are to be reported only once per section in each report filed.**

NOTE: The sum of Table 3A, Line39, Column A + B (total patients by age and gender) must equal Table 4, Line 6 (patients by income) and Line 12, Column A + B (patients by insurance status.) The sum of Table 3A, Lines 1-20, Columns A + B must equal Table 4, Line 12, Column A. Similarly, total patients reported on the Grant Reports on Tables 3A, 3B and 4 must be equal.

INCOME AS PERCENT OF POVERTY LEVEL, LINES 1 - 6

Grantees are expected to collect income data on all patients, but are not required to collect this information more frequently than once during the year. If income information is updated during the year, report the most current information available. *Patients for whom the information was not collected within the last year **must** be reported on line 5 as unknown.* Do not allocate patients with unknown income. Knowing that a patient is homeless or a migrant or on Medicaid is not adequate to classify that patient as having an income below the poverty level.

Income is defined in ranges relative to the Federal poverty guidelines (e.g., < 100 percentage of the federal poverty level). In determining a patient's income relative to the poverty level, grantees should use official poverty line guidelines defined and revised annually. The official Poverty Guidelines are published in the Federal Register in February or March of each year. (Available at http://aspe.hhs.gov/poverty/07poverty.shtml)

Every patient reported on Table 3A must be reported once (and only once) on lines 1 through 5. The sum of Table 3A, Line39, Column A + B (total patients by age and gender) must equal Table 4, Line 6 (patients by income). The same is true for Grant Reports.

PRINCIPAL THIRD PARTY INSURANCE SOURCE, LINES 7 - 12

This portion of the table provides data on patients by principal source of insurance for primary medical care services. (Other forms of insurance, such as dental or vision coverage, are not reported.) Patients are divided into 2 age groups (Column A) 0 - 19 and (Column B) age 20+. Primary patient medical insurance is divided into six types as follows:

- S-CHIP (Line 8b or 10b) – The State Child Health Insurance Program (also known as S-CHIP) provides primary health care coverage for children and, on a state by state basis, others – especially parents of these children. CHIP coverage can be provided through the state's Medicaid program and/or through contracts with private insurance plans. In some states that make use of Medicaid, it is difficult to distinguish between regular Medicaid and CHIP-Medicaid. In other states the distinction is readily apparent (e.g., they may have different cards). Where it is not obvious, CHIP may often still be identifiable from a "plan" code or some other embedded code in the membership number. This may also vary from county to county within a state. Obtain information from the state and/or county on their

coding practice. If there is no way to distinguish between them, classify all covered patients as "regular" Medicaid. In those states where CHIP is contracted through a private third party payor, participants are to be classified as "other public-CHIP" (Line 10b) not as private.

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

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

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

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

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

An additional categories is reported on Table 4 for patients who are uninsured (line 7).

Every patient reported on Table 3A must be reported once (and only once) on lines 7 through 11. The sum of Table 3A, Line39, Column A + B (total patients by age and gender) must equal Table 4, Line 12 (patients by insurance status.) The same is true for Grant Reports.

SPECIFIC INSTRUCTIONS FOR REPORTING PATIENTS BY SOURCE OF INSURANCE

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

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

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

> **MEDICAID =** Line 8b includes Medicaid-CHIP enrollees only; Line 8a includes all other enrollees; and Line 8 is the sum of 8a + 8b.
>
> **OTHER PUBLIC =** Line 10b includes CHIP enrollees who are covered by a plan other than Medicaid; Line 10a includes all other persons with other public insurance (Grantees are asked to describe the programs so the UDS editor can make sure that the classification of the program as other public is appropriate.); and Line 10 is the sum of 10a + 10b.

SELECTED PATIENT CHARACTERISTICS - LINES 13 - 23

Selected patient characteristics ask for a count of persons who are enrolled in or otherwise eligible for participation in one or more of the Bureau's "special population" programs (including migrant and seasonal agricultural workers, and persons who are homeless) and patients who are served in school-based health centers (regardless of whether or not these were once categorically funded by BPHC.)

MIGRANT OR SEASONAL AGRICULTURAL WORKERS AND THEIR DEPENDENTS, LINES 13 - 15

All grantees are required to report on Line 15 the combined total number of patients seen during the reporting period who were either migrant or seasonal agricultural workers or their dependents. Section 330(g) grantees (only!) are asked to provide separate totals for migrant and for seasonal agricultural workers on Lines 13 and 14. For Section 330(g) grantees, Lines 13 + 14 = 15

DEFINITIONS OF MIGRANT AND SEASONAL AGRICULTURAL WORKERS

> **MIGRANT AGRICULTURAL WORKERS –** Defined by Section 330(g) of the Public Health Service Act, a migrant agricultural worker is an individual *whose principal employment is in agriculture* on a seasonal basis (as opposed to year-round employment) and who <u>establishes a temporary home for the purposes of such employment</u>. Migrant agricultural workers are usually hired laborers who are paid piecework, hourly or daily wages. The definition includes those individuals who have had such work as their principle source of income within the past 24 months as well as their dependent family members who have also used the center. The dependent 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 equally eligible to be classified as migrant as are those who migrate *to* a community to work there.
>
> **SEASONAL AGRICULTURAL WORKERS** – Seasonal agricultural workers are individuals *whose principal employment is in agriculture* on a seasonal basis (as opposed to year-round employment) and who <u>do not establish a temporary home for purposes of employment</u>. Seasonal agricultural workers are usually hired laborers who are paid piecework, hourly, or daily wages. The definition includes those individuals who have been so employed within the past 24 months and their dependent family members who have also used the center.
>
> For both categories of workers, agriculture is defined as farming of the land in all its branches, including cultivation, tillage, growing, harvesting, preparation, and *on-site* processing for market or storage. Persons employed in <u>*aqua*</u>culture, lumbering, poultry processing, cattle ranching, tourism and all other non-farm-related seasonal work are **not** included.

HOMELESS PATIENTS, LINES 16 - 22

All grantees are to report the total number of patients, known to have been homeless at the time of any service provided during the reporting period, on Line 22. Only section 330(h) Homeless Program grantees will provide separate totals for homeless program patients by type of shelter arrangement.

- The shelter arrangement reported is their arrangement as of the first visit during the reporting period.
- "Street" includes living outdoors, in a car, in an encampment, in makeshift housing/shelter or in other places generally not deemed safe or fit for human occupancy.
- Persons who spent the prior night incarcerated or in a hospital should be reported based on where they intend to spend the night after their encounter. If they do not know, code as "street".
- Section 330(h) Homeless Program grantees should report previously homeless patients now housed *but still eligible for the program* on Line 20, "other".

DEFINITION OF A HOMELESS PATIENT

HOMELESS PATIENTS – Are defined as patients who lack 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.

SCHOOL BASED HEALTH CENTER PATIENTS, LINE 23

All grantees that identified a school based health center as a service delivery site on the UDS Cover Sheet are to report the total number of patients who received primary health care services at the school service delivery sites(s) listed.

A school based health center is a health center located on or near school grounds, including pre-school, kindergarten, and primary through secondary schools, that provides on-site comprehensive preventive and primary health services.

QUESTIONS AND ANSWERS FOR TABLE 4

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

2. **If information on a patient's income is not known, can we use insurance or eligibility for entitlement services as a proxy?**
   No. Patients for whom the information was not collected within the last year ***must*** be reported on line 5 as unknown. *Do not* allocate patients with unknown income. Knowing that a patient is homeless or a migrant or on Medicaid is not adequate to classify that patient as having an income below the poverty level.

3. **If we do not receive a Health Care for the Homeless, or Migrant grant, do we need to report the total number of special population patients served?**
   Yes. All grantees, regardless of whether they receive targeted grant funding for special populations, are required to complete Lines 15 (total number of patients known to have been homeless at the time of service), 22 (the total number of patients seen during the reporting period who were either migrant or seasonal agricultural workers or their dependents), and Line 23 (the total number of patients who received primary health care services at the school service delivery location(s) listed.) Grantees who did not receive special population funding are not required to complete Lines 13-14 and 16-21.

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

5. **There no longer is a grant report for School Based Clinics. Do we still need to complete a line for patients served in such sites?**
   Yes, Line 23 is to be completed by any grantee which operates a school based clinic, regardless of whether or not they ever received earmarked funds from BPHC for such a clinic.

TABLE 4 – SOCIOECONOMIC CHARACTERISTICS

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

PRINCIPAL THIRD PARTY INSURANCE SOURCE		0-19 (a)	20 AND OLDER (b)
7.	**NONE/ UNINSURED**		
8a.	Regular Medicaid (Title XIX)		
8b.	S-CHIP Medicaid		
8.	**TOTAL MEDICAID** (LINE 8A + 8B)		
9.	**MEDICARE** (TITLE XVIII)		
10a.	Other Public Insurance Non S-CHIP (specify:_____)		
10b.	Other Public Insurance S-CHIP		
10.	**TOTAL PUBLIC INSURANCE** (LINE 10A+LINE 10B)		
11.	**PRIVATE INSURANCE**		
12.	**TOTAL (SUM LINES 7 + 8 + 9 +10 +11)**		

CHARACTERISTIC		NUMBER OF PATIENTS (a)
13.	Migrant (330g grantees only)	
14.	Seasonal (330g grantees only)	
15.	**TOTAL MIGRANT/SEASONAL AGRICULTURAL WORKER OR DEPENDENT (ALL GRANTEES REPORT THIS LINE)**	
16.	Homeless Shelter (330h grantees only)	
17.	Transitional (330h grantees only)	
18.	Doubling Up (330h grantees only)	
19.	Street (330h grantees only)	
20.	Other (330h grantees only)	
21.	Unknown (330h grantees only)	
22.	**TOTAL HOMELESS (ALL GRANTEES REPORT THIS LINE)**	
23.	**TOTAL SCHOOL BASED HEALTH CENTER PATIENTS (ALL GRANTEES REPORT THIS LINE)**	

INSTRUCTIONS FOR TABLE 5 – STAFFING AND UTILIZATION

For the **Universal Report**, all staff, all encounters and all patients are reported in Columns A, B and C. For the **Grant Reports, *only Columns B and C are to be completed***. (Column A will appear "grayed out" in the computer version and printouts of the Grant Report tables.) Every eligible encounter must be counted on the Universal Report including all those reported in the Grant Reports. Grant Reports provide data on patients supported by funds which are within the scope of one of the non-CHC grants and the encounters which they had during the year. This includes all encounters supported with either grant or non-grant funds.

This table provides a profile of grantee staff, the number of encounters they render and the number of patients served. Unlike Tables 3 and 4, where an unduplicated count of patients is reported, Column C of Table 5 is designed to report the number of unduplicated patients within each of six major service categories: medical, dental, mental health, substance abuse, other professional services, and enabling. Thus, the same patient may be counted in column C on line 15 (unduplicated medical patients) and line 19 (unduplicated dental patients) if they received both medical and dental services during the year. The staffing information in Table 5 is designed to be compatible with approaches used to describe staff for financial/cost reporting, while ensuring adequate detail on staff categories for program planning and evaluation purposes. (NOTE: Staffing data are not reported on the Grant Report tables.)

INSTRUCTIONS FOR COMPLETING TABLE 5 - COLUMN A - FTES

This table includes FTE staffing information on all individuals who work in programs and activities that are within the scope of the project for all of the programs covered by UDS. (The FTE column is completed only on the Universal Report. Staff are not separated according to the different BPHC funding streams.) **All staff are to be reported in terms of annual Full-Time Equivalents (FTEs)**. A person who works 20 hours per week where 40 hours per week is considered full time (i.e., someone who works 50 percent time) is reported as "0.5 FTE." Positions or agencies with less than a 40 hour base, especially clinicians, should be calculated on whatever they have as a base for that position. Similarly, an employee who works 4 months out of the year would be reported as "0.33 FTE" (4 months/12 months). (See page 9 of this Manual for detailed instructions on calculating FTEs).

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

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

An individual who is hired as a full-time clinician must be counted as 1.0 FTE regardless of the number of "direct patient care" or "face-to-face hours" they provide. Providers who have released

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

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

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

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

- **MENTAL HEALTH SERVICES (Lines 20a, b, c and 20)**
  - **Psychiatrists**
  - **Other licensed clinicians**, including psychiatric nurses, psychiatric social workers, clinical psychologists, clinical social workers, and family therapists
  - **Other mental health staff, including** individuals providing counseling, treatment or support services related to mental health professionals.

- **SUBSTANCE ABUSE SERVICES (Line 21)** - Psychiatric nurses, psychiatric social workers, mental health nurses, clinical psychologists, clinical social workers, and family therapists and other individuals providing counseling and/or treatment services related to substance abuse.

- **ALL OTHER PROFESSIONAL HEALTH SERVICES (Line 22)** - Occupational and physical therapists, nutritionists, podiatrists, optometrists, naturopaths, chiropractors, acupuncturists and other staff professionals providing health services. Note: WIC nutritionists and other professionals working in WIC programs are reported on Line 29a, Other Programs and Services Staff. (A more complete list is included in Appendix A.)

- **PHARMACY SERVICES (Line 23)** Pharmacists (including clinical pharmacists), pharmacist assistants and others supporting pharmaceutical services. Note that effective 2005, the time (and cost) of individuals spending all or part of their time in assisting patients to apply for free drugs from pharmaceutical companies are to be classified as "other enabling workers", on line 28.

- **ENABLING SERVICES (Lines 24 - 29)**
  - **Case Managers** - staff who provide services to aid patients in the management of their health and social needs, including assessment of patient medical and/or social services needs, and maintenance of referral, tracking and follow-up systems. Case managers may provide eligibility assistance, if performed in the context of other case management functions. Staff may include nurses, social workers and other professional staff as well as paraprofessionals and locally trained staff.
  - **Patient and Community Education Specialists** - health educators, community education specialists, family planning workers, HIV specialists, and others who provide information about health conditions and guidance about appropriate use of health services that is not otherwise classified under outreach. Note that virtually all medical staff provide health education at some point. Only count those individuals whose time is being dedicated exclusively to health education for the period being counted.
  - **Outreach Workers** - individuals conducting case finding, education or other services to identify potential clients and/or facilitate access/referral of clients to available services.
  - **Eligibility Assistance Workers** - all staff providing assistance in securing access to available health, social service, pharmacy and other assistance programs, including Medicaid, WIC, SSI, food stamps, TANF, and related assistance programs. [NOTE: THIS IS A NEW LINE! PREVIOUSLY MOST CENTERS REPORTED THESE INDIVIDUALS EITHER UNDER CASE MANAGEMENT OR UNDER "OTHER" ENABLING. CREATING THIS NEW LINE SHOULD CLARIFY WHERE THE STAFF SHOULD BE REPORTED.]
  - **Personnel Performing Other Enabling Service Activities** - all other staff performing services listed in Appendix B as enabling services, such as child care, referral for housing assistance, interpretation and translation.

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

  Some grantees, especially "umbrella agencies," operate programs which, while within their scope of service, are not directly a part of their medical or social health services. These include WIC programs, job training programs, head start or early head start programs, shelters, housing programs, etc. The staff for these programs are reported under Other Programs and Related Services. The cost of these programs are reported on Table 8A on line 12.

- **ADMINISTRATION AND FACILITY (Lines 30 - 33)**

- **Administration** - executive director, the corporate administrative portion of the medical director, physicians or nurses with corporate (not clinical) administrative responsibilities, secretaries, fiscal and billing personnel, and all other staff including support staff with administrative responsibilities.
- **Facility** - staff with facility support and maintenance responsibilities, including custodians, housekeeping staff, security staff, and other maintenance staff.
- **Patient Services Support Staff** - intake staff and medical/patient records.

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

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

INSTRUCTIONS FOR COMPLETING TABLE 5 COLUMN B (ENCOUNTERS) AND COLUMN C (PATIENTS)

ENCOUNTERS (Column B) – An encounter is a documented, face-to-face contact between a patient and a provider who exercises independent professional judgment in the provision of services to the individual. (See General Instructions for further details on the definition of encounters). Grantees are to report encounters during the reporting period rendered by staff identified in column a, regardless of whether the staff are salaried or contracted based on time worked. ***No*** encounters are reported for personnel who are not "providers who exercise independent professional judgment" within the meaning of the definition above. In addition, the BPHC had chosen not to require reporting grantees to report on encounters for certain other classes of staff, even if they *do* exercise professional judgment. In Column B, the cells applicable to these staff (e.g., laboratory, transportation, outreach, pharmacy etc.) are blocked out.

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

1) the service was provided to a patient of the Grantee by a provider that is not part of the grantee's staff (neither salaried nor contracted on the basis of time worked),
2) the service was paid for in full by the grantee, and
3) the service otherwise meets the above definition of an encounter.

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

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

For example, a person receiving only medical services is reported once (as a medical patient on Line 15) regardless of the number of encounters made. A person receiving medical, dental and enabling services is reported once as a medical patient (Line 15), once as a dental patient (Line 19)

and once as an enabling patient (Line 29), but is counted *only* once on each appropriate line in column C, regardless of the number of visits reported in column B. An individual patient may be counted once (and **only** once) in each of the following categories:

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

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

QUESTIONS AND ANSWERS FOR TABLE 5

1. **Are there changes to this table?**
   Yes. Lines 10a and 27a were added and line 25 was renamed.
   - **1)** Line 10a "Total Midlevel Practitioners" sums the FTE for Nurse Practitioners (Line 9a), Physicians Assistants (Line 9b) and Certified Nurse Midwives (Line10), This row calculates automatically and requires no input by the grantee.
   - **2)** Line 27a "Eligibility Assistance Workers" reports FTEs for all staff providing assistance in securing access to available health, social service, pharmacy and other assistance programs, including Medicaid, WIC, SSI, food stamps, TANF, and related assistance programs. These FTEs were previously included on Line 28 Other Enabling.
   - **3)** Line 25 "Patient and Community Education Specialists" reports FTEs for both categories of health education staff. The FTEs corresponding with staff costs reported on Table 8B Lines 7 and 9 should be reported on Table 5 Line 25. Note that, while there is room to show encounters, only one-on-one patient education services are eligible to be counted.

2. **How do I count participants in a group session?**
   If you have group treatment sessions (e.g., for substance abuse or mental health) you must record the encounter in each participant's chart and charge each participant before you can count an encounter for each participant. If an encounter is not recorded in a participant's chart, that participant may not be counted as a patient. *No group medical encounters are counted on the UDS.* Though in some instances they may be billable, the UDS specifically does not count as encounters activities in such sessions.

3. **How do I report the FTEs for a clinician who regularly sees patients 75 percent of the time and covers after-hours call the remaining 25 percent of his/her time?**
   An individual who is hired as a full-time clinician must be counted as 1.0 FTE regardless of the number of "direct patient care" or "face-to-face hours" they provide. Providers who have released time to compensate for on-call hours or hours spent on clinical committees, or who receive leave for continuing education or other reasons are still considered full-time if this is how they were hired. The time spent by providers doing administrative work such as charting, reviewing labs, filling prescriptions, returning phone calls, arranging for referrals, etc. is not to be adjusted for. The one exception to this rule is when a Medical Director is engaged in *corporate* administrative activities, in which case time can be allocated to administration. This does not, however, include *clinical* administrative activities including chairing or attending meetings, supervising staff, and writing clinical protocols. Note that Uniform Government Services (UGS), the FQHC Medicare intermediary, has different definitions for full time providers. These UGS definitions are ***not*** to be used in reporting on the UDS,

4. **Is it appropriate for the total number of patients reported on Table 3A to be equal to the sum of the several types of patients on Table 5?**
   Almost never. On Table 5, the grantee reports **patients for each type of service, with the patient counted once for each type of service received.** Thus a person who receives both medical and dental services would be counted once as a medical patient on Line 15 and once as a dental patient on Line 19. Because there are six different types of patients identified on Table 5, a patient who is counted only once on Table 3A may be counted up to six different places on Table 5.

   Grantees which provide only medical services *will* report the same number of total patients on Table 3A as they do medical patients on Table 5 (Line 15). But where an agency has more than

one type of patient (e.g., medical and dental or medical and enabling) the sum of the numbers in column c of Table 5 will *never* be the same as those on Table 3A.

5. **If I report case management services on Table 2 or costs for them on Tables 8A and 8B, do I have to report case managers on Table 5?**
   Yes. There should be a logical consistency between Table 5 and Tables 2 and 8A and 8B. If a grantee reports that case management services are provided by the grantee (i.e., Table 2, Column A is marked), one would expect to see case managers reported on Table 5. For example, if nurses also have case management duties, their time (FTEs) should be split.

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

7. **If a clinician provides mental health and substance abuse (behavioral health) services to the same patient during an encounter, how should this be counted?**
   Because "substance abuse" is also seen as a mental health diagnosis, it is permissible to count the encounter as mental health. Under no circumstances would it be counted as "one of each." The provider will also need to be classified as mental health for this encounter as must be the cost of the provider on Table 8A.

TABLE 5 – STAFFING AND UTILIZATION

Personnel by Major Service Category		FTEs (a)	Clinic Encounters (b)	Patients (c)
1	Family Practitioners			
2	General Practitioners			
3	Internists			
4	Obstetrician/Gynecologists			
5	Pediatricians			
6	Psychiatrists now reported on line 20a			
7	Other Specialty Physicians			
8	**Total Physicians (Lines 1 - 7)**			
9a	Nurse Practitioners			
9b	Physician Assistants			
10	Certified Nurse Midwives			
10a	Total Midlevel Practitioners (Lines 9a-10)			
11	Nurses			
12	Other Medical personnel			
13	Laboratory personnel			
14	X-ray personnel			
15	**Total Medical Care (Lines 8 – 14)**			
16	Dentists			
17	Dental Hygienists			
18	Dental Assistants, Aides, Techs			
19	**Total Dental Services (Lines 16 - 18)**			
20a	Psychiatrists			
20b	Other Licensed Mental Health Providers			
20c	Other Mental Health Staff			
20	**Mental Health Services (Lines 20a-c)**			
21	**Substance Abuse Services**			
22	**Other Professional Services**			
23	**Pharmacy Personnel**			
24	Case Managers			
25	Patient and Community Education Specialists			
26	Outreach Workers			
27	Transportation Staff			
27a	Eligibility Assistance Workers			
28	Other Enabling Services			
29	**Total Enabling Services (Lines 24-28)**			
29a	**Other Programs and Services (specify:_____)**			
30	Administrative Staff			
31	Facility Staff			
32	Patient Services Support Staff			
33	**Total Admin & Facility (Lines 30 - 32)**			
34	**Total (Lines 15+19+20+21+22+23+29+29a+33)**			

INSTRUCTIONS FOR TABLE 6 – SELECTED DIAGNOSES AND SERVICES RENDERED

This table reports data on selected diagnoses and services rendered. It is designed to provide information on diagnoses and services of greatest interest to BPHC using data maintained for billing purposes. As a *subset* of diagnoses and services, Table 6 is not expected to reflect the full range of diagnoses and services rendered by a grantee. The selected conditions seen and services provided represent those that are prevalent among BPHC patients or a sub-group of patients *or* are generally regarded as sentinel indicators of access to primary care. Diagnoses reported on this table are those made by a medical, dental or behavioral health provider *only*. Thus, if a case manager sees a diabetic patient, the encounter is *not* to be reported on Table 6.

The table is included in **both** the Universal Report and Grant Reports.

- The **Universal Report** reports on encounters in the indicated diagnostic or service categories and a count of all individuals who had at least one encounter in the indicated diagnostic or service category within the scope of any and all BPHC - supported projects included in the UDS.
- The **Grant Report** reports only those encounters provided and those individuals served within the scope of the program being reported on.

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

SELECTED TESTS/SCREENINGS/PREVENTIVE SERVICES – Lines 21 through 26 present the name and applicable ICD-9CM diagnostic and visit codes and/or CPT procedure codes for selected tests, screenings, and preventive services which are particularly important to the populations served. On several lines both CPT codes and IC9 codes are provided. Grantees should use *either* the CPT codes *or* the ICD9 codes for any given line, *not both!*

SELECTED DENTAL SERVICES – Lines 27 through 34 present the name and applicable ADA procedure codes for selected dental services. Wherever appropriate, services have been grouped into code ranges. Some codes are included on more than one line. In these cases the service would be counted on *each* line.

INSTRUCTIONS FOR REPORTING *ENCOUNTERS* - COLUMN (A).

LINES 1 – 20: Diagnostic Data.

ENCOUNTERS BY SELECTED DIAGNOSES (Lines 1-20). Report the total number of encounters during the reporting period where the indicated diagnosis is listed on the encounter/billing records as the **primary** diagnosis **only**. If an encounter has a primary diagnosis which is one of the many diagnoses not listed on Table 6, it is not reported. Note that, while most encounters are not reported on this table, those which *are* counted, are reported for only the primary diagnosis on lines 1 through 20. All visits are entered into clinic practice management / billing systems, with one diagnosis listed as primary and successive diagnoses listed as secondary, tertiary, etc. Any single encounter may be counted a maximum of one time on lines 1 – 20 regardless of the number of diagnoses listed for the visit, though it may also be counted on lines 21 - 26.

LINES 21 – 34: Service Data.

ENCOUNTERS BY SELECTED TESTS/SCREENINGS/PREVENTIVE AND DENTAL SERVICES (Lines 21-34). Report the total number of encounters at which one or more of the listed diagnostic tests, screenings, and/or preventive services were provided. Note that codes for these services may either be diagnostic (ICD-9) codes or procedure (ADA or CPT-4) codes. During one encounter more than one test, screening or preventive service may be provided, in which case, each would be counted.

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

INSTRUCTIONS FOR REPORTING ***PATIENTS*** - COLUMN (B)

LINES 1 – 20: Diagnostic Data.

PATIENTS BY DIAGNOSIS – For Column B report each individual who had one or more encounter during the year where the primary diagnosis was the indicated diagnosis (e.g., a patient with one or more encounters for hypertension (Line 11, Column A) is counted once as a patient (Line 11, Column B) regardless of how many times they were seen.) A patient is counted once and only once regardless of the number of encounters made for that specific diagnosis. Any patient may have encounters with different primary diagnoses, for example, one for hypertension and one for diabetes, on different days. In this case, the patient would be reported once for each primary diagnosis used during the year.

LINES 21 – 26: Services Data.

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

LINES 27 – 34: Dental Services Data.

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

QUESTIONS AND ANSWERS FOR TABLE 6

1. **Are there any changes to the table this year?**
   Yes. Selected ICD-9, ADA and CPT codes have been updated. See changes on Lines 1, 6, 9, 22, 24, 28, 29 and 31.

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

3. **The instructions call for diagnoses or services at encounters. If we provide the service, but it is not counted as an encounter (such as immunizations given at a health fair) should it be reported on this table?**
   If the service is provided *as a result of a prescription or plan from an earlier visit* **it *is* counted.** For example, if a provider asked a woman to come back in four months for a Pap test, it would be counted. But if the service is a self-referral where no clinical visit is necessary or provided (such as a senior citizen coming in for a flu shot,) **it *is not* counted.**

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

LINE #	PROBLEM	POTENTIAL SOLUTION
1 and 2	HIV diagnoses are kept confidential and alternative diagnostic codes are used.	Include the alternative codes used at your center on these lines as well.
26	Well child visits are charged to the state EPSDT program using a special code (often starting with W, X, Y or Z).	Add these special codes to the other codes listed and count all such visits as well. Do not count EPSDT follow-up visits in this category.

5. **The instructions specifically say that the source of information for Table 6 is "billing systems." There are some services for which I do not bill my patients, so there are no encounters in my system. What do I do?**
   While grantees are <u>only required</u> to report data derived from billing systems, the reported data will understate services in the circumstances described. In order to more accurately reflect your level of service, grantees are encouraged to use other sources of information (e.g., referral or tracking logs), although there is no requirement to do so. The following provides examples of these sources.

LINE #	PROBLEM	POTENTIAL SOLUTION
21	We collect the sample, but our HIV Tests are processed and paid for by the State and do not show on the encounter form or in the billing system.	Use other data sources such as logs of HIV tests conducted or reports to Ryan White programs and use this number of tests.
22	Mammograms are paid for, but are conducted by a contractor and do not show in the billing system for individual patients.	Use the bills from the independent contractor to identify the total number of mammograms conducted during the course of the year and report this number.
23	We collect the sample, but out Pap tests are processed and paid for by the State and do not show on the encounter form or in the billing system.	Use other data sources such as logs of Pap tests conducted and use this number of tests.
24	Flu shots and children's vaccines are not counted because they are obtained at no cost by the center and we do not bill the patient for the shot.	Use the Medicare cost report data on influenza vaccination reimbursements as an estimate for the number of actual encounters where flu shots were administered. Begin to code these with a zero charge.
25	Contraceptive management is funded under Title X or a state family planning program and does not have a V-25 diagnosis attached to it.	Use records developed for the Title X or state family planning program to count the number of family planning visits. Take care not to count the same visit twice.

TABLE 6 –
SELECTED DIAGNOSES AND SERVICES RENDERED

DIAGNOSTIC CATEGORY		APPLICABLE ICD-9-CM CODE	NUMBER OF ENCOUNTERS BY PRIMARY DIAGNOSIS (A)	NUMBER OF PATIENTS WITH **PRIMARY** DIAGNOSIS (B)
SELECTED INFECTIOUS AND PARASITIC DISEASES				
1.	Symptomatic HIV	042.xx, 079.53		
2.	Asymptomatic HIV	V08		
3.	Tuberculosis	010.xx – 018.xx		
4.	Syphilis and other sexually transmitted diseases	090.xx – 099.xx		
SELECTED DISEASES OF THE RESPIRATORY SYSTEM				
5.	Asthma	493.xx		
6.	Chronic bronchitis and emphysema	490.xx – 492.xx 496.xx		
SELECTED OTHER MEDICAL CONDITIONS				
7.	Abnormal breast findings, female	174.xx; 198.81; 233.0x; 793.8x		
8.	Abnormal cervical findings	180.xx; 198.82; 233.1x; 795.0x		
9.	Diabetes mellitus	250.xx; 775.1x		
10.	Heart disease (selected)	391.xx – 392.0x 410.xx – 429.xx		
11.	Hypertension	401.xx – 405.xx;		
12.	Contact dermatitis and other eczema	692.xx		
13.	Dehydration	276.5x		
14.	Exposure to heat or cold	991.xx – 992.xx		

TABLE 6 –
SELECTED DIAGNOSES AND SERVICES RENDERED

DIAGNOSTIC CATEGORY		APPLICABLE ICD-9-CM CODE	NUMBER OF ENCOUNTERS BY PRIMARY DIAGNOSIS (A)	NUMBER OF PATIENTS WITH **PRIMARY** DIAGNOSIS (B)
SELECTED CHILDHOOD CONDITIONS				
15.	Otitis media and eustachian tube disorders	381.xx – 382.xx		
16.	Selected perinatal medical conditions	770.xx; 771.xx; 773.xx; 774.xx – 779.xx (excluding 779.3x)		
17.	Lack of expected normal physiological development (such as delayed milestone; failure to gain weight; failure to thrive)--does not include sexual or mental development; Nutritional deficiencies	260.xx – 269.xx; 779.3x; 783.3x – 783.4x;		
SELECTED MENTAL HEALTH AND SUBSTANCE ABUSE CONDITIONS				
18.	Alcohol related disorders	291.xx, 303.xx; 305.0x 357.5x		
19.	Other substance related disorders (excluding tobacco use disorders)	292.1x – 292.8x 304.xx, 305.2x – 305.9x 357.6x, 648.3x		
20a.	Depression and other mood disorders	296.xx, 300.4 301.13, 311.xx		
20b.	Anxiety disorders including PTSD	300.0x, 300.21, 300.22, 300.23, 300.29, 300.3, 308.3, 309.81		
20c.	Attention deficit and disruptive behavior disorders	312.8x, 312.9x, 313.81, 314.xx		
20d.	Other mental disorders, excluding drug or alcohol dependence (includes mental retardation)	290.xx 293.xx – 302.xx (excluding 296.xx, 300.0x, 300.21, 300.22, 300.23, 300.29, 300.3, 300.4, 301.13); 306.xx - 319.xx (excluding 308.3, 309.81, 311.xx, 312.8x, 312.9x,313.81,314.xx)		

TABLE 6 –
SELECTED DIAGNOSES AND SERVICES RENDERED

SERVICE CATEGORY		APPLICABLE ICD-9-CM OR CPT-4 CODE(S)	NUMBER OF ENCOUNTERS (A)	NUMBER OF PATIENTS (B)
SELECTED DIAGNOSTIC TESTS/SCREENING/PREVENTIVE SERVICES				
21.	HIV test	**CPT-4:** 86689; 86701-86703; 87390-87391		
22.	Mammogram	**CPT-4:** 77055 - 77057 OR **ICD-9:** V76.11; V76.12		
23.	Pap test	**CPT-4:** 88141-88155; 88164-88167 OR **ICD-9:** V72.3; V72.31; V76.2		
24.	Selected Immunizations: Hepatitis A, Hemophilus Influenza B (HiB), Influenza virus, Pneumococcal, Diptheria, Tetanus, Pertussis (DTaP) (DTP) (DT), Mumps, Measles, Rubella, Poliovirus, Varicella, Hepatits B Child)	**CPT-4:** 90633-90634, 90645 – 90648; 90657 – 90660; 90669; 90700 – 90702; 90704 – 90716; 90718; 90720-90721, 90723; 90743 – 90744; 90748		
25.	Contraceptive management	**ICD-9:** V25.xx		
26.	Health supervision of infant or child (ages 0 through 11)	**CPT-4:** 99391-99393; 99381-99383; 99431-99433 **OR** **ICD-9:** V20.xx; V29.xx		
SELECTED DENTAL SERVICES				
27.	I. Emergency Services	**ADA:** D9110		
28.	II. Oral Exams	**ADA:** D0120, D0140, DO145,D0150, D0160, D0170, D0180		
29.	Prophylaxis – adult or child	**ADA:** D1110, D1120,		
30.	Sealants	**ADA:** D1351		
31.	Fluoride treatment – adult or child	**ADA:** D1203, D1204		
32.	III. Restorative Services	**ADA:** D21xx, D23xx, D27xx		
33.	IV. Oral Surgery (extractions and other surgical procedures)	**ADA:** D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7260, D7261, D7270, D7272, D7280		
34.	V. Rehabilitative services (Endo, Perio, Prostho, Ortho)	**ADA:** D3xxx, D4xxx, D5xxx, D6xxx, D8xxx		

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

I International Classification of Diseases, 9th Revision, 6th Edition, Clinical Modification, Volumes 1 and 2, 2004. Reston, VA: St. Anthony Publishing. Codes for HIV Infection reflect revisions published in MMWR Volume 43, No. RR-12, September 30, 1994.

II Physicians' Current Procedural Terminology, 4th edition, CPT 2006. American Medical Association.

III Current Dental Terminology, CDT 5, 2006. American Dental Association.

INSTRUCTIONS FOR TABLE 7 – PERINATAL PROFILE

This table provides detail on pregnant and postpartum women patients and their newborn infants, as well as services rendered by grantees that provide prenatal care. Table 7 is included in the Universal Report only.

DATA REPORTED BY ALL GRANTEES

TOTAL PATIENTS KNOWN TO BE PREGNANT – NO LONGER REPORTED

TOTAL PATIENTS KNOWN TO BE HIV-POSITIVE AND PREGNANT (Line 2) – Report the total number of patients known to have been both pregnant and infected with HIV at some time during the reporting period, regardless of whether the woman received services from the grantee directly related to the pregnancy or to HIV infection.

NOTE: All grantees, whether or not they provide or assume primary responsibility for a client's perinatal care services, complete Line 2. Requesting this information does not mean that the grantee must provide pregnancy or HIV testing if those services are not in the scope of their services.

DATA REPORTED ONLY BY GRANTEES WHO PROVIDE PRENATAL CARE

All grantees that provide or assume primary responsibility *for some or all of a patient's prenatal care* , regardless of whether the grantee does the delivery, complete the remaining sections of Table 7. **All data reported apply only to patients who received prenatal care services during the reporting period.**

DEMOGRAPHIC CHARACTERISTICS OF PRENATAL CARE PATIENTS

AGE OF PRENATAL CARE PATIENTS (Lines 3-8) – Report the total number of patients who received prenatal care services, *at any time during the reporting period*, by age group. Be sure to include women who began prenatal care during the previous reporting period and continued into this reporting period as well as women who began 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.

RACE OF PRENATAL CARE PATIENTS (Lines 9-15) – Report the number of prenatal care patients during the reporting period in each racial category. The total women reported on line 15 must equal the total by age reported on line 8 above. All patients must be classified in one of the racial categories (including "Unreported / Refused to report"). This includes individuals who *also* consider themselves to be "Latino" or "Hispanic". If your data system has not separately classified these individuals by race, then report them all on line 10 as "unreported" Asian, Native Hawaiian and Other Pacific Islander patients should be reported separately on Lines 9a, 9b and 9c; the total number of Asian, Native Hawaiian and Other Pacific Islander patients will be reported on Line 9. (See more details on reporting by race on Table 3B.) The total women reported on line 15 must equal the total by age reported on line 8 above and the total by Latino / Hispanic Identity reported on line 30 below.

LATINO IDENTITY OF PRENATAL CARE PATIENTS (Lines 28 - 30) – Report the number of prenatal care patients during the reporting period in each category. The total women

reported on line 30 must equal the total by age reported on line 8 and the total by Race reported on line 15 above. This section collects information *only* on whether or a patient considers herself to be of Latino or Hispanic identity.

- Report on line 28 women from the continents of South America and North America and from the Caribbean islands who consider themselves to be "Latinos" or "Hispanic."
- *If you collect detailed ethnic identity data* that differentiates between various countries in South and Central America and the Caribbean, lump all of these together and report them on line 28.
- *If you collect detailed ethnic identity data* that reports on any other national or ethnic groups (for example Bosnian, Somalian, Croatian, French), report these patients on line 29.
- *If you do not collect detailed ethnic identity data* report all other patients on line 29 as "Unreported" ethnicities.

TRIMESTER OF ENTRY INTO PRENATAL CARE

TRIMESTER OF FIRST VISIT (Lines 16-18) –All patients who received prenatal care during the reporting period, are reported on lines 16 – 18. The reporting trimester (line) is determined by the trimester of their pregnancy that they were in when they began prenatal care either at one of the grantee's service delivery locations or with another provider. A woman who begins her prenatal care with the grantee is reported in Column A. A woman who begins her prenatal care at another provider and then comes to the center, is counted once and only once in Column B, and is not counted in Column A. Prenatal care is considered to have begun at the time the patient has her first visit with the obstetrical care giver, not when she registers for care at the center or has lab tests done. A woman is counted only once regardless of the number of trimesters during which she receives care.

- **FIRST TRIMESTER** – Includes women who received prenatal care during the reporting period and whose first visit occurred when she was estimated to be anytime less than 13 weeks after conception. If the woman began prenatal care during the first trimester at the grantee's service delivery location, she is reported on Line 16 Column A; if she received prenatal care from another provider before coming to the grantee's service delivery location, she is reported on Line 16 Column B.
- **SECOND TRIMESTER –** Includes women who received prenatal care during the reporting period and whose first visit occurred when she was estimated to be between the 13th and through the 26th week after conception. If the woman began prenatal care during the second trimester at the grantee's service delivery location, she is reported on Line 17 Column A; if she received prenatal care from another provider before coming to the grantee's service delivery location, she is reported in Column B under the trimester of entry (second (Line 17)).
- **THIRD TRIMESTER** – Includes women who received prenatal care during the reporting period and whose first visit occurred when she was estimated to be 27 weeks or more after conception. If the woman began prenatal care during the third trimester at the grantee's service delivery location, she is reported on Line 18 Column A; if she received prenatal care from another provider before coming to the grantee's service delivery location, she is reported in Column B under the trimester of entry (third (Line 18)).

Be careful to report women who were first seen by another provider correctly. If, for example, a woman begins prenatal care with a provider other than the health center

during her first trimester, and then transfers to the health center in her third trimester, she must be counted as a FIRST trimester entry in column B, not a third trimester entry.

NOTE: Line 8 (total prenatal care patients by age) and the sum of Lines 16-18 Column A + Column B (total prenatal care patients by trimester) must be the same.

DELIVERY, POSTPARTUM AND WELL CHILD CARE

This section reports on deliveries, infant birthweight, and infant and postpartum visits. All data except line 19a, center deliveries, are to be reported by both racial subcategories and Latino / Hispanic Identify to enable BPHC to account for impact on racial and ethinc disparities.

PRENATAL CARE PATIENTS WHO DELIVERED DURING THE YEAR (Line 19) – Report the total number of women who both received prenatal care from the grantee during the reporting period and who were known to have delivered during the year, even if the delivery was done by another provider. Include all deliveries, regardless of the outcome, but do not include deliveries where you have no documentation that the delivery occurred (for example, for women who may have moved out of the area and/or who were lost to follow-up.)

> NOTE: Line 19, Column H (total deliveries by race) and column K (total deliveries by Latino / Hispanic Identity) should be the same, but they should ***not*** be identical Line 8 (total prenatal care patients by age).

DELIVERIES BY CENTER CLINICIANS (Line 19a) – Report the total number of deliveries performed by center clinicians during the reporting period in Column H. (This line is not reported by the race / ethnicity of the women delivered.) On this line ONLY, **grantee is to** include deliveries of women who were *not* part of the grantee's prenatal care program during the calendar year. This would include such circumstances as the delivery of another doctor's patients when the clinic provider participates in a call group and is on call at the time of delivery and emergency deliveries when the clinic provider is on-call for the emergency room; and deliveries of "un-doctored" patients who are assigned to the provider as a requirement for privileging at a hospital. Include as "health center clinicians" any clinician who is paid by the provider, regardless of the method of compensation.

BIRTHWEIGHT OF INFANTS BORN TO PRENATAL CARE PATIENTS DURING THE YEAR (Lines 20-22) – Report the total number of live births during the reporting period for women who received prenatal care from the grantee or referral provider during the reporting period, according to the appropriate birthweight group. **NOTE:** Grantees must report deliveries and the birthweight of children delivered for **all** women who were in their prenatal care program and who delivered during the reporting period, *regardless of whether the grantee did the delivery themselves or referred the delivery to another provider.* The number of deliveries reported on line 19 will normally not be the same as the total number of infants reported on lines 20 – 22 because of multiple births.

PRENATAL CARE PATIENTS WHO RETURNED FOR POSTPARTUM CARE DURING THE YEAR (Line 23) – Report the total number of women who:

- received prenatal care from the grantee during the reporting period**,**
- delivered during the reporting period,
- and returned to the grantee within 8 weeks of delivery for postpartum care during the reporting period.

INFANTS WHO RECEIVED A NEWBORN VISIT (Line 24). Report the total number of infants who:

- were born during the reporting period
- to women who received prenatal care from the grantee during the reporting period,
- who also received a newborn care visit from the grantee during the reporting period,
- and who did so during the first 4 weeks after birth.

WIC ENROLLEES

This section of Table 7 tracks enrollment of prenatal care patients in the Special Supplemental Food Program for Women, Infants and Children (WIC). Report the total number of patients in the following three categories:

- **PRENATAL CARE PATIENTS –** Line 25 reports only women who are enrolled in the prenatal care program, not a grantee's total WIC program. It asks how many of the women reported on Line 8 (total prenatal care patients by age) were also enrolled in WIC, either at your center or elsewhere. The number is never more than the number reported on Line 8.
- **INFANTS –** Line 26 reports only children born in a grantee's prenatal care program, not a grantee's total WIC program. It asks how many of the children reported on Lines 20-22 (infants by birthweight) were also enrolled in WIC, either at your center or elsewhere.
- **POSTPARTUM CARE PATIENTS** – Line 27 reports only women in the prenatal care program who delivered during the year, not a grantee's total WIC program. It asks how many of the women reported on Line 19 Column H as having delivered this year were also enrolled in WIC, either at your center or elsewhere.

NOTE: Grantees are expected to provide case management for their perinatal care patients and to track whether or not they received WIC services. Report on all successful referrals regardless of whether or not the grantee actually operates the WIC program to which the woman was referred. NOTE ALSO that a woman may be reported in more than one category (i.e. a woman may be reported as having been both a prenatal and a postpartum WIC program enrollee).

QUESTIONS AND ANSWERS FOR TABLE 7

1. **Are there any changes to this table?**
   Yes. This year we have altered the race and ethnicity section to include two separate parts – one on race and one on ethnicity or Latino identity. Each woman delivering and child born is to be entered once according to their race and once according to their Latino identity. Each section has an "Unreported" column to be used if data are missing. IN ADDITION, there is now a "more than one race" column to use where your system collects multiple races. See instructions for section 3B for further information.

2. **If a prenatal patient in one year (e.g., 2006) gives birth in the next year (i.e., 2007) without having prenatal care in that year (i.e., 2007), is the delivery reported for that year (i.e., 2007)?**
   The delivery is NOT reported in 2007, nor was it to be reported in 2006. The table only includes data on women who received prenatal care during the year.

3. **Are deliveries of women who are not in the grantee's prenatal care program excluded from Table 7?**
   Except for line 19a, the answer is "Yes". For example, women who are delivered by a center provider as a result of being in a call group or staffing the emergency room, are not counted on this form on the lines that report on patients, deliveries, or postpartum visits. They are counted only as a delivery on line 19a.

4. **Are birth outcomes of prenatal care patients delivered by a non-grantee provider to be reported?**
   Yes. Comprehensive prenatal care includes case management and thus case tracking is a responsibility of all grantees.

TABLE 7 – PERINATAL PROFILE

SECTION 1: ALL GRANTEES		
CHARACTERISTICS		**NUMBER OF PATIENTS** (a)
1.	Total Patients Known to be Pregnant	THIS LINE NO LONGER REPORTED
2.	Total Patients Known to be HIV+ Pregnant Women	
*** CONTINUE ONLY IF YOU PROVIDE PRENATAL SERVICES!! ***		
SECTION II: GRANTEES WHO PROVIDE PRENATAL CARE		
A. DEMOGRAPHIC CHARACTERISTICS OF PRENATAL CARE PATIENTS		
AGE		NUMBER OF PATIENTS (A)
3.	Less than 15 years	
4.	Ages 15-19	
5.	Ages 20-24	
6.	Ages 25-44	
7.	Ages 45 and Over	
8.	Total Patients (Sum lines 3 – 7)	
RACE		NUMBER OF PATIENTS (A)
9a.	Asian	
9b.	Native Hawaiian	
9c.	Other Pacific Islander	
9.	**TOTAL: ASIAN / HAWAIIAN / PACIFIC ISLANDER** (Sum Lines 9a through 9c)	
10.	Black/African – American	
11.	American Indian/Alaska Native	
12.	White	
13.	More than one race	
14	Unreported / Refused to Report	
15.	**Total Patients** (Sum Lines 9 through14)	
LATINO / HISPANIC IDENTITY		NUMBER OF PATIENTS (A)
28.	Latino / Hispanic	
29.	All Other including Unreported / Refused to report	
30.	**Total Patients** (Sum Lines 28 + 29)	

TABLE 7 – PERINATAL PROFILE

B. TRIMESTER OF ENTRY INTO PRENATAL CARE

	Trimester of First Known Visit for Women Receiving Prenatal Care During Reporting Year	Women Having First Visit with Grantee (a)	Women Having First Visit with Another Provider (b)
16.	First Trimester		
17.	Second Trimester		
18.	Third Trimester		

C. Delivery, Postpartum and Infant Utilization During The Calendar Year by race

		Asian (a)	Native Hawaiian (b1)	Pacific Islander (b2)	Black or African American (c)	American Indian or Alaska Native (d)	White (e)	More Than One Race (f)	Unreported / Refused to report (g)	Total (h)
19	Prenatal Care patients who delivered during the year									
19a	Deliveries performed by grantee provider									
20	Births less than 1,500 grams (very low)									
21	Births 1,500 to 2,499 grams (low)									
22	Births 2,500 grams or more (normal)									
23	Prenatal care patients who received post-partum care within 8 weeks of delivery									
24	Infant who received newborn visit within 4 weeks of birth									

D. Delivery, Postpartum and Infant Utilization During The Calendar Year by Latino identity.

		Latino / Hispanic (i)	All Others including Unreported (j)	Total (k)
19	Prenatal Care patients who delivered during the year			
20	Births less than 1,500 grams (very low)			
21	Births 1,500 to 2,499 grams (low)			
22	Births 2,500 grams or more (normal)			
23	Prenatal care patients who received post-partum care within 8 weeks of delivery			
24	Infant who received newborn visit within 4 weeks of birth			

D. ENROLLMENT OF PRENATAL CARE PATIENTS AND THEIR INFANTS IN WIC
(Only Patients Who Receive Prenatal Services From The Grantee)

		Number of Patients (a)
25.	Prenatal Care Patients	
26.	Infants	
27.	Postpartum Care Patients	

INSTRUCTIONS FOR TABLE 8A – FINANCIAL COSTS

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

DIRECT AND LOADED COSTS (COLUMN DEFINITIONS)

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

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

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

> **FACILITY COSTS** should be allocated based on the amount of square footage utilized for Medical, Dental, Mental Health, Substance Abuse, Pharmacy, Other Professional, Enabling, Other Program Related Services and Administration. Square Footage refers to the portion of the grantee's facility space used in the operation of the organization, not including common spaces such as hallways, rest rooms, and utility closets. For reporting purposes, the square footage associated with space owned by the grantee and leased or rented to other parties should not be included if it is considered to be outside of the scope of the project. If it has been included inside the scope of project, it should be allocated to Other Related Services (Row 12) and the rent received should be included on Table 9E under Other Revenue (Line 10).
>
> **ADMINISTRATIVE COSTS** should be allocated *after* facility costs have been allocated, and should include the facility costs allocated to it. Administrative cost is allocated based on a straight line allocation method. The proportion of total cost (excluding administrative cost) that is attributable to each service category should be used to allocate administrative cost. For example, if medical staff account for 50 percent of total cost (excluding administration) then 50 percent of administrative cost is allocated to medical staff. If you have an alternative method that provides more accurate allocations, it may be used, but save your paperwork for review and explain the methods used in the table note.

Column C : This column shows the "fully loaded" cost of each of the cost centers listed on Lines 1 - 13. The loaded cost is the sum of the direct cost, reported in Column A, plus the allocation of overhead, reported in Column B. This calculation is now done automatically in the reporting software. Column C also shows the value of any donated facilities, services and supplies on Line 18. These non-cash donations should be reflected as a positive number, and are not included in any of the lines above. Note that this is the only place that the value of non-cash donations are

shown. Non-cash donations are never reported on Table 9E. Line 19, Column C is the total cost including the value of donations.

BPHC MAJOR SERVICE CATEGORIES (LINE DEFINITIONS)

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

STAFF COSTS (Line 1) – Include all staff costs, including salaries and fringe benefits for personnel supported directly or under contract, for medical care staff *except lab and x-ray staff*. The costs of intake, medical records and billing and collections are considered administrative and should be included on Line 15 and allocated in Column B. Include the cost for vouchered or contracted medical services on line 1.

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

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

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

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

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

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

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

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

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

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

OTHER PROFESSIONAL (Line 9) – Report all direct costs for the provision of other professional and ancillary health care services including but not limited to: optometry, podiatry, chiropractic, acupuncture, naturopathy, speech, occupational and physical therapy, etc. (A more complete list appears at Appendix A.) Included in direct costs are staff, fringe benefits, supplies, equipment depreciation, related travel, and contracted services. Corporate administrative and facility costs should be included on Line 15 Column A and allocated in Column B.

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

C. **ENABLING AND OTHER PROGRAM RELATED SERVICES** (Lines 11 - 13) – This category includes enabling staff and related costs for case management, outreach, transportation, translation and interpretation, education, eligibility assistance – including pharmacy assistance program eligibility, environmental risk reduction and other services that support and assist in the delivery of primary medical services and facilitate patient access to care. The cost of these services are also reported on Table 8B. For definitions of specific enabling services, see Appendix B.

It also includes the cost of staff and related costs for other program related services such as WIC, day care, job training, delinquency prevention and other activities not included in other BPHC categories.

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

OTHER PROGRAM RELATED (Line 12) – Report all direct costs for the provision of services not included in any other category here. This includes services such as WIC, childcare centers, and training programs. Report all direct costs for staff, fringe benefits, supplies, equipment depreciation, related travel and contracted services. (Staff for these programs are now reported on line 29a of Table 5.) Corporate administrative and facility costs should be included on Line 15 Column A and allocated in Column B. Grantees are asked to describe the program costs so the UDS editor can make sure that the classification of the program as an “other related program” is appropriate.

TOTAL ENABLING AND OTHER PROGRAM RELATED SERVICES (Line 13) – The sum of

lines 11 + 12.

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

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

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

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

TOTAL OVERHEAD (Line 16) – The sum of lines 14 + 15.

E. **TOTAL ACCRUED COST** (Line 17) – It is the sum of lines 4 + 10 +13 + 16

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

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

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

depreciation expense should be shown in this category for the reporting period.

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

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

CONVERSION FROM FISCAL TO CALENDAR YEAR

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

Step 1: Calculate the proportion of the calendar reporting period covered by the cost report and use that ratio to calculate the proportion of cost in each category attributable to the calendar year. Example: A grantee whose fiscal year ends March 31, 2007, allocates 25 percent of costs in each cost category to the 2007 calendar year.

Step 2: Using the trial balance for the end of December, determine the total cost for the remainder of the calendar year for each column. For example, a grantee whose fiscal year ends March 31, 2007 would use the nine-month trial balance for December 31. (**Note:** Grantees who do not accrue depreciation monthly should adjust depreciation to an annual total.)

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

QUESTIONS AND ANSWERS FOR TABLE 8A.

1. **Are there any changes to this table?**
   There are no changes to Table 8A for 2007.

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

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

4. **How are donated drugs accounted for?**
   If drugs are donated directly to the health center which then dispenses them to a patient, the value of the drugs is *calculated at what a reasonable payor would pay for them* and is reported on line 18. This is NOT the retail cost of the drug, it is the 340(b) price of the drug – an amount which is generally 40% - 60% 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 and need not be accounted for or reported. I

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

TABLE 8A – FINANCIAL COSTS

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

INSTRUCTIONS FOR TABLE 8B – ENABLING SERVICES

Table 8B should be completed by all types of BPHC grantees covered by the UDS. The table provides information on the costs of enabling services that are important components of BPHC-supported programs, but which are not broken out on Table 8A, where they are shown on Line 11 Column A. This table includes only direct costs of service, and not allocation of overhead expenses. Costs are to be reported on an accrual basis in the same manner as costs are reported on Table 8A.

MENTAL HEALTH/SUBSTANCE ABUSE SERVICES. (Lines 1 – 3 are no longer reported as of the 2002 reporting period.)

ENABLING SERVICES. Most of the enabling services included in this section are defined in Appendix A. To the extent possible, distribute direct staff and other direct costs associated with enabling services into the listed service categories. Enabling services staff includes those for whom FTE data were provided on Table 5. **For Lines 4 through 12**, include total direct costs for each of the listed service types. Include all staff costs including fringe benefits and other associated direct costs (e.g., equipment depreciation, supplies, related travel, professional liability insurance, etc.). Grantees should provide estimates where costs cannot be broken out by type of service. If a particular enabling service is not provided, leave the cost line blank for that service.

TOTAL ENABLING SERVICES COSTS (Line 13) – Sum Lines 4 through 12.

NOTE: This must match Table 8A, Line 11, Column A.

QUESTIONS AND ANSWERS FOR TABLE 8B

1. **Are there any changes to this table?**
   No. However, as of last year Eligibility Assistance services are to be reported on Line 11. In the past, the most common "other" enabling service noted was "eligibility services". This includes staff whose primary function is assisting patients to become eligible for Medicaid, S-Chip, Pharmacy Assistance Programs or other public/private benefit programs. Line 12 remains "other" and a "specify" button is to be used to explain the contents of the line.

2. **Can the cost of enabling services reported on Table 8B be higher than the cost for enabling services reported on Table 8A, line 11?**
   No. The total enabling services in 8B should equal the enabling costs reported on Table 8A, Line 11, Column A (prior to the allocation of facility and administrative costs) and should be less then Table 8A, Line 11 Column C.

3. **Is it permissible for donated costs to be included in Table 8B?**
   No.

4. **Is WIC included as an enabling service?**
   No. WIC is not included in the list of enabling services in Appendix B. NOTE: Services such as WIC, Headstart, and other non-medical services are reported on line 12 of Table 8A as Other Related Services).

TABLE 8B – ENABLING SERVICES

SERVICE		COST (a)
MENTAL HEALTH/SUBSTANCE ABUSE SERVICES		
1-3	(These lines are no longer required.)	
ENABLING SERVICES		
4.	Case Management	
5.	Transportation	
6.	Outreach	
7.	Patient Education	
8.	Translation/Interpretation	
9.	Community Education	
10.	Environmental Health Risk Reduction	
11.	Eligibility Assistance	
12.	Other Enabling Services (specify: _____)	
13.	**TOTAL ENABLING SERVICES COST (SUM LINES 4 - 12)**	

INSTRUCTIONS FOR TABLE 9C – MANAGED CARE REVENUE AND EXPENSES

The content of this table has not changed since the 2002 Reporting period.

Table 9C should be completed by all grantees participating in Medicare, Medicaid, commercial, or other managed care plans; it is included only in the Universal Report. Grantees should also report the number of enrollees (only!) in Primary Care Case Management (PCCM) programs. If the grantee has more than one managed care contract of a particular type with Medicare, Medicaid, commercial, or other insurers, the information for each category should be added together and reported as a total.

> NOTE: There is one exception to this rule. Managed care plans covering only dental care, mental health care or pharmacy should ***not*** be reported on this table.

This report includes revenue, expense, enrollment, and utilization information for capitated and fee-for-service managed care plans. It also includes information on the number of enrollees in PCCM programs, though number of enrollees is the only information collected on these programs.

CAPITATED (PRE-PAID) PLANS – Are defined as plans under which the grantee receives a fixed payment per enrollee (member) per month. Payment is generally made in advance, generally on a monthly basis, and covers all services included in the plan's contract with the center. Under capitated arrangements, the grantee may also contract to be at full or partial risk for services beyond traditional primary care services.

FEE-FOR-SERVICE PLANS (FFS) – Are defined as plans under which the grantee receives payment on a fee-for-service basis for enrollees, when the enrollees receive contractually specified services. As a rule, the provider receives a list of eligible enrollees just as it would for a capitated program and these enrollees must receive all their primary care and other stipulated services from their "Primary Care Provider" or PCP.

PRIMARY CARE CASE MANAGEMENT PROGRAMS - Are defined as arrangements whereby the grantee receives a case management fee, and is expected to serve as gatekeeper for the enrollee, providing referrals to more specialized services. While PCCM providers generally also provide the primary care services for the patient, this may not be required by the program. Table 9C only requests information on PCCM enrollees, reported on Line 11. Do not include any revenue or expenditures for PCCM enrollees on this Table. The nominal fee paid for these PCCM services is reported on Table 9D on Line 1.

SOURCE OF PAYMENT – Medicaid and Medicare payments should be reported according to the original source of payment. For example, if a center has a contract with a private HMO to provide services to enrolled Medicaid patients, this would be reported under Medicaid. Similarly, S-CHIP programs which are operated by private HMOs are classified under the "Other Public" payment source.

SCOPE OF PROJECT – This table requires the grantee to report on all activities included in their managed care contracts, within the "Scope of Project" in the grantee's application for BPHC funding. The contract the project has with the managed care plan determines the types of services reported on this table. Ordinarily, the Scope of Project includes all (or virtually all) services included in a grantee's managed care contract. A small number of grantee's have contracts that include services, which are not included in the grantee's application for BPHC funding (e.g., inpatient hospital services). These services are considered "outside the scope of

the project" and are not reported on this table.

SERVICES WITHIN THE SCOPE OF PROJECT – Services within the scope of BPHC supported projects are often restricted to primary care but in some Centers may include lab, x-ray, pharmacy and/or specialty services. They may be covered by capitation or by fee-for-service payments. The defining element is whether or not they are included in the funded BPHC project (and its budget) and reported on in the Financial Status Report (FSR). Services within the scope of project are included in all of these documents. **S**ervices outside of scope have not been reported since CY-2000.

REVENUE

CAPITATION REVENUE FOR SERVICES (Line 1a) **–** Enter the accrued revenue from capitation for services. This figure is equal to the capitation *earned* during the calendar year, regardless of when it was received, though capitation is almost always received in the same year that it is earned. This amount generally equals the collection reported in Table 9D Column B minus retroactive and wraparound payments, unless there were late or early capitation payments received. Report only the capitation earned from the HMO on this line. Other payments are reported below.

FEE-FOR-SERVICE REVENUE FOR SERVICES (Line 1b) **–** Enter the "net accrued revenue" from fee-for-service for services. This figure is equal to the income *earned* during the calendar year, regardless of when it was or will be received. It is equal to full charges less all actual or anticipated disallowances or allowances *except* that allowances for anticipated FQHC settlements on these charges are *not* included here.

Note that a contract may pay a capitation to cover the cost of the basic visit, and pay fee-for-services for other costs such as lab, x-ray and pharmacy. In this instance the grantee will report income on both line 1a and 1b.

TOTAL REVENUE FOR SERVICES (Line 1) – Enter the sum of Lines 1a and 1b.

COLLECTIONS FROM STATE MEDICAID OR FEDERAL MEDICARE RECONCILIATIONS OR WRAP AROUND PAYMENTS FOR THE CURRENT YEAR. (Line 3a) – Enter the (cash) amount received from Medicaid and Medicare reconciliation payments (payments based on the settlement of a cost report) and/or wrap around payments (amounts paid to bring reimbursement to cost or a negotiated fee-per-visit amount) for services rendered in the current (reporting) calendar year. **NOTE: In most circumstances, these cells should equal Table 9D Column c1 totals for managed care.**

COLLECTIONS FROM STATE MEDICAID OR FEDERAL MEDICARE RECONCILIATIONS AND WRAP AROUND PAYMENTS FOR A PRIOR BILLING PERIOD. (Line 3b) – Enter the (cash) amount received from Medicaid and Medicare reconciliation payments (payments based on the settlement of a cost report) and/or wrap around payments (amounts paid to bring reimbursement to cost or a negotiated fee-per-visit amount) for services which were rendered in prior years. **NOTE: In most circumstances, these cells should equal Table 9D Column C2 totals for managed care.**

NOTE: If reconciliations and/or wrap around payments are made for a grantee's fiscal year, and the fiscal year does not correspond to the calendar year, payments must be allocated between the current and prior calendar years. Grantees may use a

straight line allocation methodology; for example, a grantee receiving reconciliations and/or wrap around payments covering the fiscal year April 1, 2006 - March 31, 2007 would allocate 25 percent of the payment to the current year (i.e., 2007) and 75 percent to the prior year (i.e., 2006). Grantees with more sophisticated cost allocation systems may use their own systems but be sure to keep documentation.

COLLECTIONS FROM PATIENT CO-PAYMENTS AND FROM MANAGED CARE PLANS FOR OTHER RETROACTIVE PAYMENTS (Line 3c) – Enter the (cash) amount received from patient co-payments and from other retroactive payments such as risk pools, incentives, and withholds. The income may have been earned in this or any preceding year.
NOTE: In many instances these cells *will not* equal Table 9D Column C3 totals for managed care because co-payments are recognized on this line, but are not reported in Column C3 of Table 9D.

PENALTIES OR PAYBACKS TO MANAGED CARE PLANS (Line 3d) – Enter the (cash) amount paid during the reporting period as a result of penalties imposed by managed care plans, and FQHC paybacks. The penalties may have been "earned" in this or any preceding year.

TOTAL MANAGED CARE REVENUE (Line 4) – Enter the sum of Lines 1, 3a, 3b, 3c minus Line 3d.

EXPENSES

Expenses as used in this section means "accrued costs". To the extent it is maintained, grantees should include "Incurred but not reported costs" (IBNR) for the reporting period for which they are liable. All amounts are reported on a modified accrual basis.

CAPITATION EXPENSES FOR SERVICES (Line 5a) – Enter the cost of providing the capitated services reported, i.e., the visits reported on line 9a and other associated costs (e.g. lab, x-ray, pharmacy, etc.) covered by the capitation.

FEE-FOR-SERVICE EXPENSES FOR SERVICES (Line 5b) – Enter the cost of providing the fee-for-service services reported, i.e., the visits reported on line 9b and other associated costs (e.g. lab, x-ray, pharmacy, etc) covered by the fee-for-service payments. Note that a contract may pay a capitation for basic visits and pay fee-for-services for other costs such as lab, x-ray and pharmacy. In this instance the grantee will report associated costs for the "carved out services" separately on line 5b.

TOTAL EXPENSES FOR MANAGED CARE SERVICES (Line 5) – Enter the sum of Lines 5a and 5b.

NOTE: Not all centers formally maintain a cost-accounting system that reports these data in this format. If this is the case, one of the following methods for calculating these required numbers may be used retrospectively:

1. **AVERAGE COST PER ENCOUNTER**: Virtually all health centers have a process to develop a Medicaid and/or Medicare approved cost per encounter. *Presuming that the services offered under the managed care program are the same as those in the FQHC program* it is simple to take the total number of encounters reported on lines 9a and/or 9b and multiply this number times the average cost per encounter. The results would be placed on lines 5a and/or 5b.

2. **RATIO OF CHARGES**: *If the center has a cost based fee schedule* (and this is necessary to

use this method) a more accurate method of calculating costs is possible. This system would permit the center's cost analysis to be sensitive to different levels of services provided to prepaid patients as compared to others. (For example, because there is no incentive to multiple visits, a center may try to do more at a single visit than to call the patient back.)

In this methodology, the center looks at the total *charges* for services to managed care patients and compares it to the total charges for this same set of services for all patients in the system. This ratio (charges for managed care divided by charges for all patients) is then multiplied times the total cost of providing those services. The result is a more complex but, theoretically, more accurate statement of expenses. Note that this has to be done for each type of third party payor on Table 9C.

UTILIZATION DATA

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

MEMBER MONTHS FOR MANAGED CARE (CAPITATED) (Line 8a) – Enter the total capitated member months by source of payment. This is derived by adding the total enrollment reported by the plan for each month.

MEMBER MONTHS FOR MANAGED CARE (FEE-FOR-SERVICE) (Line 8b) – Enter the total fee-for-service member months by source of payment. A fee-for-service member month is defined as one patient being assigned to a service delivery location for one month during which time the patient may use only that center's services, but for whom the services are paid on a fee-for-service basis. NOTE: Do not include individuals who receive "carved-out" services under a fee-for-service arrangement if those individuals have already been counted for the same month as a capitated member month.

TOTAL MEMBER MONTHS FOR MANAGED CARE (Line 8) – Enter the sum of Lines 8a and 8b.

MANAGED CARE ENCOUNTERS (CAPITATED) (Line 9a) – Enter the total encounters for **capitated** enrollees by source of payment.

MANAGED CARE ENCOUNTERS (FEE-FOR-SERVICE) (Line 9b) – Enter the total encounters **for fee-for-service** enrollees by source of payment.

TOTAL MANAGED CARE ENCOUNTERS (Line 9) – Enter the sum of Lines 9a and 9b.

ENROLLEES IN MANAGED CARE PLANS (CAPITATED) (Line 10a) – Enter the number of capitated enrollees by source of payment as of (i.e., for the month of) December 31 of the reporting period.

ENROLLEES IN MANAGED CARE PLANS (FEE-FOR-SERVICE) (Line 10b) – Enter the number of fee-for-service enrollees by source of payment as of (i.e., individuals assigned to the grantee for the month of) December 31 of the reporting period.

TOTAL MANAGED CARE ENROLLEES (Line 10) – Enter the sum of Lines 10a and 10b.

ENROLLEES IN PRIMARY CARE CASE MANAGEMENT PROGRAMS (Line 11) – Enter the **number of enrollees in PCCM programs** as of December 31 of the reporting period.

NUMBER OF MANAGED CARE CONTRACTS (Line 12) – Enter the **number of managed care contracts** as of December 31 of the reporting period. If a contract with an HMO covers two different types of patients, e.g., Medicaid and Commercial, count it once in each column. If a single HMO has different "options" in its contract (e.g., a high benefit vs. a moderate benefit commercial plan) count it only once in the appropriate column.

QUESTIONS AND ANSWERS FOR TABLE 9C

3. **Are there any changes to this table?**
   There are no changes to Table 9C for 2007.

3. **What is the difference between a PCCM program and a FFS plan that also pays case management fees?**
   Under a FFS managed care plan, an entity (e.g., HMO, HIO, provider network, etc.) is capitated and at risk. This capitated entity is usually (but not always) someone other than the primary care provider (PCP), and contracts with the PCP. PCCM is almost always a contract between the primary care provider and the state, involves neither risk nor incentives, and generally has no penalties if utilization is excessive. PCCM rarely involves payment of capitation for primary care services.

3. **We have a capitated managed care contract, but some services are "carved-out" and paid on a fee-for-service basis. How do we report?**
   Report revenue and expenses for the carve-out services on the appropriate fee-for-service lines. Report managed care fee-for-service encounters on Line 9b, but do NOT report managed care member months for fee-for-service plans on Line 8b nor enrollees on 10b. Since these persons have already been reported under capitation, counting them under fee-for-service would result in double counting individuals in the plan.

3. **Do we report PCCM contracts on Line 9?**
   No.

TABLE 9C – MANAGED CARE REVENUE AND EXPENSES

	PAYOR CATEGORY	MEDICAID (a)	MEDICARE (b)	OTHER PUBLIC INCLUDING NON-MEDICAID CHIP (c)	PRIVATE (d)	TOTAL (e)
REVENUE						
1a.	Capitation revenue for Services					
1b.	Fee-for-Service revenue for Services					
1.	**TOTAL REVENUE FOR SERVICES (LINES 1A + 1B)**					
3a.	Collections from Medicaid or Medicare reconciliation/ wrap around (For current year)					
3b.	Collections from Medicaid or Medicare reconciliation/ wrap around (For prior years)					
3c.	Collections from patient co-payments and from managed care plans for other retroactive payments / risk pool/ incentive/ withhold					
3d.	Penalties or paybacks to managed care plans					
4.	**TOTAL MANAGED CARE REVENUE (SUM LINE 1 + 3A + 3B + 3C) - (LINE 3D)**					
EXPENSES						
5a.	Capitation expenses for Services					
5b.	Fee-for-Service expenses for Services					
5.	**TOTAL EXPENSES FOR SERVICES (LINES 5A + 5B)**					
7.	**TOTAL MANAGED CARE EXPENSES (LINES 5)**					
UTILIZATION DATA						
8a	Member months for managed care (capitated)					
8b	Member months for managed care (fee-for-service)					
8.	**TOTAL MEMBER MONTHS FOR MANAGED CARE (LINES 8A + 8B)**					
9a	Managed Care Encounters (capitated)					
9b	Managed Care Encounters (fee-for-service)					
9.	**TOTAL MANAGED CARE ENCOUNTERS (LINES 9A + 9B)**					
10a.	Enrollees in Managed Care Plans (capitated) (as of 12/31)					
10b.	Enrollees in Managed Care Plans (fee-for-service) (as of 12/31)					
10	**TOTAL MANAGED CARE ENROLLEES (LINES 10A + 10B) (AS OF 12/31)**					
11	Enrollees in Primary Care Case Management Programs (PCCM)					
12	Number of Managed Care Contracts					

INSTRUCTIONS FOR TABLE 9D – PATIENT-RELATED REVENUE (SCOPE OF PROJECT ONLY)

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

ROWS: PAYOR CATEGORIES AND FORM OF PAYMENT

Five payor categories are listed: Medicaid, Medicare, Other Public, Private, and Self Pay. Except for Self Pay, each category has three sub-groupings: non-managed care, capitated managed care, and fee-for-service managed care. Note that while similar data elements on Table 9C *exclude* dental-only or mental health-only managed care plans, information reported on table 9D *includes* these charges, collections and allowances on the managed care lines.

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

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

OTHER PUBLIC – LINES 7 - 9. Grantees should report as "**Other Public**" all services billed to and paid for by State or local governments through programs *other than indigent care programs.* The most common of these would be S-CHIP, the State based Children's Health Insurance Program, which has many different names in different states, *when it is paid for through commercial carriers.* (See above if it is paid through Medicaid.) Other Public also includes family planning programs, BCCCP (Breast and Cervical Cancer Control Programs with various state names,) contracts with correctional facilities, and other dedicated state or local programs as well as state insurance plans, such as Washington's Basic Health Plan or Massachusetts' Commonwealth Plan. **Other Public does not include state or local indigent care programs.** Patients whose only payment source is one of these other public programs are reported as "uninsured" on Table 4.

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

- Report all charges for these services and collections from patients as "self-pay" (line 13 of this table);
- Report all amounts not collected from the patients as sliding discounts or bad debt write-off, as appropriate, on line 13 of this table; and
- Report collections from the associated state and local indigent care programs on table 9E. State/local indigent care programs are now reported on a separate line (line 6a – "state/local indigent care programs") on that table.

PRIVATE – LINES 10 - 12. Grantees should report as "**Private**" all services billed to and paid for by commercial or private insurance companies. Specifically, *do not* include any services that fall into one of the other categories. As noted above, charges etc. for Medicaid, Medicare and S-CHIP programs which use commercial programs as intermediaries are classified elsewhere. Private insurance *includes* insurance purchased for public employees or retirees such as Tricare, Trigon, the Federal Employees Insurance Program, Workers Compensation, etc.

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

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

FULL CHARGES THIS PERIOD (Column A) – Record in Column a the total charges for each payor source. This should always reflect the full charge (per the fee schedule) for services rendered to patients in that payor category. Charges should only be recorded for services that are billed to **AND** covered in whole or in part by a payor, the patient, or written off to sliding fee discounts.

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

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

Charges for pharmaceuticals donated to the clinic or directly to a patient through the clinic should not be included since the clinic may not legally charge for these drugs. Charges for standard dispensed pharmaceuticals, however, are to be included.

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

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

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

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

COLLECTION OF RECONCILIATION/WRAP AROUND, CURRENT YEAR (Column C1) – Enter FQHC cash receipts from Medicare and Medicaid that cover services provided during the current reporting period.

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

COLLECTION OF OTHER RETROACTIVE PAYMENTS INCLUDING RISK POOL/INCENTIVE/WITHHOLD (Column C3) – Enter other cash payments including managed care risk pool redistribution, incentives, and withholds, from any payor. These payments are only applicable to managed care plans. (Note: While table 9C includes co-payments in a similar data element, this column does *not* include co-payments. They are recorded on line 13 as self pay collections.)

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

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

ALLOWANCES (Column D) – Allowances are granted as part of an agreement with a third-party payor. Medicare and Medicaid, for example, may have a maximum amount they pay, and the center agrees to write off the difference between what they charge and what they receive. *Allowances must be reduced by the net amount of retroactive settlements and receipts reported in the columns C1, C2, C3, C4, including current and prior year FQHC reconciliations, managed care pool distributions and other payments. This will often result in a negative number being reported as the allowance in Column D.*

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

Example: The State Title XIX Agency has paid $40 for an office visit that was billed at a full charge of $75. The $75 should be reported on Line 1 Column A as a full charge to Medicaid.

After payment was made, the $40 payment is recorded on Line 1 Column B. The $35 reduction is reported as an adjustment on Line 1 Column D.

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

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

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

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

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

NOTE: Only self-pay patients may be granted a sliding discount based on their ability to pay. All other cells are blanked out. For this reason, "Column E" is a "virtual column" on the electronic version of the UDS, appearing below line 14 on the screen. When a charge originally made to a third party such as Medicare or a private insurance company has a co-payment or deductible written off, THE CHARGE MUST FIRST BE RECLASSIFIED TO SELF-PAY. TO RECLASSIFY, first reduce the third-party charge by the amount due from the patient and increase the self-pay charges by this same amount.

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

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

Under no circumstances are bad debts to be reclassified as sliding discounts, even if the write off to bad debt is occasioned by a patient's inability to pay the remaining amount due. For example, a patient eligible for a sliding discount is supposed to pay 50 percent of full

charges for a visit. If the patient does not pay, even if he or she later qualifies for a 100 percent discount, the amount written off must still be reported as bad debt, not sliding discount. At the time of the visit, it was a valid collectable from the patient.

Only bad-debts from patients are recorded on this table. While some insurance companies do, in fact, default on legitimate debts as they go bankrupt, centers are not asked to report these data. For this reason, "column F" is a "virtual column" on the electronic version of the UDS, appearing below line 14 on the screen.

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

QUESTIONS AND ANSWERS FOR TABLE 9D

1. **Are there any changes to this table?**
   There are no changes to Table 9D for 2007.

2. **Are there any important issues to keep in mind for this table?**
   Payments received from state or local indigent care programs subsidizing services rendered to the uninsured are not reported on this table. All such payments, whether made on a per encounter basis or as a lump sum for services rendered, shall be recorded on Table 9E. See Table 9E for specific instructions. Grantees receiving payments from state/local indigent care programs that subsidize services rendered to the uninsured should:
   - Report all charges for these services and collections from patients as "self-pay" (Line 13);
   - Report all amounts not collected from the patient as sliding discounts or bad debt, as appropriate, on Line 13 of this table;
   - Report collections from the state/local indigent care programs on Table 9E. State/local indigent care programs are now to be reported as a separate category (Line 6a - state/local indigent care programs).

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

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

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

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

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 or not it is done automatically by your PMS the UDS report must reflect this reclassification of all charges that end up being the responsibility of a party other than the initial party.

TABLE 9D (PART I OF II) – PATIENT RELATED REVENUE (SCOPE OF PROJECT ONLY)

PAYOR CATEGORY		FULL CHARGES THIS PERIOD (a)	AMOUNT COLLECTED THIS PERIOD (b)	RETROACTIVE SETTLEMENTS, RECEIPTS, AND PAYBACKS (c)				ALLOWANCES (d)	SLIDING DISCOUNTS (e)	BAD DEBT WRITE OFF (f)
				COLLECTION OF RECONCILIATION /WRAP AROUND CURRENT YEAR (c1)	COLLECTION OF RECONCILIATION/WRAP AROUND PREVIOUS YEARS (c2)	COLLECTION OF OTHER RETROACTIVE PAYMENTS INCLUDING RISK POOL/ INCENTIVE/ WITHHOLD (c3)	PENALTY/ PAYBACK (c4)			
1.	Medicaid Non-Managed Care									
2a.	Medicaid Managed Care (capitated)									
2b.	Medicaid Managed Care (fee-for-service)									
3.	**TOTAL MEDICAID** (LINES 1+ 2A + 2B)									
4.	Medicare Non-Managed Care									
5a.	Medicare Managed Care (capitated)									
5b.	Medicare Managed Care (fee-for-service)									
6.	**TOTAL MEDICARE** (LINES 4 + 5A+ 5B)									
7.	Other Public including Non-Medicaid CHIP (Non Managed Care)									
8a.	Other Public including Non-Medicaid CHIP (Managed Care Capitated)									

TABLE 9D (PART II OF II) –
PATIENT RELATED REVENUE (SCOPE OF PROJECT ONLY)

PAYOR CATEGORY		Full Charges This Period (a)	AMOUNT COLLECTED THIS PERIOD (b)	RETROACTIVE SETTLEMENTS, RECEIPTS, AND PAYBACKS (c)				ALLOWANCES (d)	SLIDING DISCOUNTS (e)	BAD DEBT WRITE OFF (f)
				COLLECTION OF RECONCILIATION /WRAP AROUND CURRENT YEAR (c1)	COLLECTION OF RECONCILIATION/ WRAP AROUND PREVIOUS YEARS (c2)	COLLECTION OF OTHER RETROACTIVE PAYMENTS INCLUDING RISK POOL/ INCENTIVE/ WITHHOLD (c3)	PENALTY/ PAYBACK (c4)			
8b.	Other Public including Non-Medicaid CHIP (Managed Care fee-for-service)									
9.	**TOTAL OTHER PUBLIC** (LINES 7+ 8A +8B)									
10.	Private Non-Managed Care									
11a.	Private Managed Care (capitated)									
11b.	Private Managed Care (fee-for-service)									
12.	**TOTAL PRIVATE** (LINES 10 + 11A + 11B)									
13.	Self Pay									
14.	**TOTAL** (LINES 3 + 6 + 9 + 12 + 13)									

INSTRUCTIONS FOR TABLE 9E – OTHER REVENUE

Line 1f – School Based Health Centers – has been removed. Funds previously reported on this line are now reported on line 1b – Community Health Center. Line 4 has been removed. Funds previously reported on this line are now reported on line 3 – both lines were for the same purpose.

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

BPHC GRANTS

LINES 1A THROUGH LINE 1E – Enter draw-downs during the reporting period for all BPHC grants in the primary care cluster. These include the four primary care programs included in the UDS. Note that lines 1d and 1f no longer are reported. Amounts should be consistent with the PMS-272 report.

TOTAL HEALTH CENTER CLUSTER (Line 1g) – Enter the total of Lines 1a through 1e.

INTEGRATED SERVICES DEVELOPMENT INITIATIVE GRANTS (line 1h) – Enter the amount of the Integrated Services Development Initiative grant dollars drawn down.

SHARED INTEGRATED MANAGEMENT INFORMATION SYSTEMS GRANTS (line 1i) – Enter the amount of the Shared Integrated Management Information Systems grant dollars drawn down.

CAPITAL IMPROVEMENT PROGRAM GRANTS (line 1j) – Enter the amount of Capital Improvement Program grant dollars drawn down.

TOTAL BPHC GRANTS (Line 1) – Enter the total of Lines 1g (Total Health Center Cluster), 1h (Integrated Services Development Initiative Grants), 1i (Shared Integrated Management Information Systems Grants), and 1j (Capital Improvement Program Grants). Be sure that all BPHC Section 330 grant funds drawn down during the year are included on line 1. NOTE: The amounts shown on the BPHC Grant Lines should reflect **direct funding** only. They should not include BPHC funds passed through to you from another BPHC grantee nor should they be reduced by money that you passed through to other centers.

OTHER FEDERAL GRANTS

RYAN WHITE TITLE III HIV EARLY INTERVENTION (Line 2) – Enter the amount of the Ryan White Title III funds drawn down in the reporting period. (NOTE: Ryan White Title I, Impacted Area, grants come from County or City governments and are reported on Line 7 (unless they are first sent to a third party in which case the funds are reported on Line 8.) Title II grants come from the state and are reported on Line 6, unless they are first sent to a County or City government (in which case they are reported on Line 7) or to a

third party (in which case the funds are reported on Line 8.) SPRANS grants are generally direct Federal grants, and are reported on line 3.

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

TOTAL OTHER FEDERAL GRANTS (Line 5) – Enter the total of Line 2 + Line 3.

NON-FEDERAL GRANTS OR CONTRACTS

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

STATE/LOCAL INDIGENT CARE PROGRAMS (Line 6a) – Enter the amount of funds received from state/local indigent care programs that subsidize services rendered to the uninsured (examples include Massachusetts Free Care Pool, New Jersey Uncompensated Care Program, NY Public Goods Pool Funding, California Expanded Access to Primary Care Program, Tobacco Tax programs in Arizona and New Mexico, and the Colorado Indigent Care Program). Grantees are asked to describe the programs so the UDS editor can make sure that the classification of the program as a state/local indigent care program is appropriate.

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

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 grantee’s project(s). Grantees are asked to describe the programs so the UDS editor can make sure that the classification of the program as a local grant is appropriate.

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

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

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

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

NOTE: GRANT FUNDS SHOULD ALWAYS BE REPORTED BASED ON THE ENTITY THAT AWARDS THEM, REGARDLESS OF THEIR ORIGIN. FOR EXAMPLE, FUNDS AWARDED BY THE STATE FOR MATERNAL AND CHILD HEALTH SERVICES USUALLY INCLUDE A MIXTURE OF FEDERAL FUNDS SUCH AS TITLE V AND STATE FUNDS. THESE SHOULD BE REPORTED AS STATE GRANTS BECAUSE THEY ARE AWARDED BY THE STATE. WIC FUNDS ARE TOTALLY PROVIDED BY THE FEDERAL DEPARTMENT OF AGRICULTURE, BUT ARE ALWAYS PASSED THROUGH THE STATE AND ARE REPORTED ON LINE 6 AS STATE FUNDS.

QUESTIONS AND ANSWERS FOR TABLE 9E

1. **Are there any changes to this table?**
   No. However, in 2006 Line 1f – School Based Health Centers – was removed. Funds previously reported on this line are now reported on line 1b – Community Health Center. Similarly, Line 4 was removed. Funds previously reported on this line are now reported on line 3 – both lines were for the same purpose.

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. Only cash receipts received during the calendar year should be reported. In the case of a grant, this amount equals the cash amount received during the year not the full award amount unless the full award was paid during the year.

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

TABLE 9E – OTHER REVENUES

	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 CLUSTER** (SUM LINES 1A THROUGH 1E)	
1h.	Integrated Services Development Initiative	
1i.	Shared Integrated Management Information Systems	
1j.	Capital Improvement Program Grants	
1.	**TOTAL BPHC GRANTS** (SUM LINES 1G + 1H + 1I + 1J)	
OTHER FEDERAL GRANTS		
2.	Ryan White Title III HIV Early Intervention	
3/4.	Other Federal Grants (specify:_____)	
5.	**TOTAL OTHER FEDERAL GRANTS** (SUM LINES 2 - 4)	
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 LINES 6 + 6A+7+8)	
10.	Other Revenue (Non-patient related revenue not reported elsewhere) (specify:_____)	
11.	**TOTAL REVENUE** (LINES 1+5+9+10)	

APPENDIX A: LISTING OF PERSONNEL

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

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

PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NON-PROVIDER
• X-Ray Technician		X
DENTISTS (Line 16)		
• General Practitioners	X	
• Oral Surgeons	X	
• Periodontists	X	
• Endodontists	X	
OTHER DENTAL		
• Dental Hygienists (Line 17)	X	
• Dental Assistant (Line 18)		X
• Dental Technician (Line 18)		X
• Dental Aide (Line 18)		X
MENTAL HEALTH (Line 20) & **SUBSTANCE ABUSE** (Line 21)		
• Psychiatrists (Line 20a)	X	
• Psychologists (Line 20b or c)	X	
• Social Workers - Clinical And Psychiatric (Line 20b or c)	X	
• Nurses - Psychiatric And Mental Health (Line 20b)	X	
• Alcohol And Drug Abuse Counselors (Line 20c)	X	
• Nurse Counselor (Line 20b)	X	
ALL OTHER PROFESSIONAL PERSONNEL (Line 22)		
• Audiologists	X	
• Acupuncturists	X	
• Chiropractors	X	
• Herbalists	X	
• Massage Therapists		
• Naturopaths	X	
• Occupational Therapists	X	
• Optometrists	X	
• Podiatrists	X	
• Physical Therapists	X	
• Respiratory Therapists	X	
• Speech Therapists / Pathologists	X	
• Traditional Healers	X	
• Nutritionists/Dietitians	X	
PHARMACY PERSONNEL (Line 23)		
• Pharmacist, Clinical Pharmacist		X
• Pharmacist Assistant		X
• Pharmacy Clerk		X
ENABLING SERVICES		
CASE MANAGERS (Line 24)		

PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NON-PROVIDER
• Case Managers	X	
• Social Workers	X	
• Public Health Nurses	X	
• Home Health Nurses	X	
• Visiting Nurses	X	
• Registered Nurses	X	
• Licensed Practical Nurses	X	
HEALTH EDUCATORS (Line 25)		
• Family Planning Counselors	X	
• Health Educators	X	
• Social Workers	X	
• Public Health Nurses	X	
• Home Health Nurses	X	
• Visiting Nurses	X	
• Registered Nurses	X	
• Licensed Practical Nurses	X	
OUTREACH WORKERS (Line 26)		X
PATIENT TRANSPORTATION WORKERS (Line 27)		
• Patient Transportation Coordinator		X
• Driver		X
OTHER ENABLING SERVICES PERSONNEL (Line 28)		
• Child Care Workers		X
• Eligibility Assistance Workers		X
• Interpreters/Translators		X
OTHER RELATED SERVICES STAFF (Line 29a)		
• WIC Workers		X
• Head Start Workers		X
• Housing Assistance Workers		X
• Food Bank / Meal Delivery Workers		X
• Employment / Educational Counselors		X
ADMINISTRATION (Line 30)		
• Project Director		X
• Administrator		X
• Finance Director		X
• Accountant		X
• Bookkeeper		X
• Secretary		X

PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NON-PROVIDER
• Director of Planning And Evaluation		X
• Clerk Typist		X
• Billing Clerk		X
• Cashier		X
• Director of Data Processing		X
• Key Punch Operator		X
• Personnel Director		X
• Receptionist		X
• Director of Marketing		X
• Marketing Representative		X
• Enrollment/Service Representative		X
FACILITY (Line 31)		
• Janitor/Custodian		X
• Security Guard		X
• Groundskeeper		X
• Equipment Maintenance Personnel		X
• Housekeeping Personnel		X
PATIENT SERVICES SUPPORT STAFF (Line 32)		
• Medical And Dental Team Clerks		X
• Medical And Dental Team Secretaries		X
• Medical And Dental Appointment Clerks		X
• Medical And Dental Patient Records Clerks		X
• Patient Records Supervisor		X
• Patient Records Technician		X
• Patient Records Clerk		X
• Patient Records Transcriptionist		X
• Registration Clerk		X
• Appointments Clerk		X

APPENDIX B: SERVICE DEFINITIONS

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

SERVICE CATEGORY	DEFINITIONS
PRIMARY MEDICAL CARE SERVICES	
General Primary Medical Care (Line 1)	Provision of basic preventive and curative medical services.
Diagnostic Laboratory (Technical Component) (Line 2)	Technical component of laboratory procedures. Does not include services of a physician to order or to analyze/interpret results from these procedures.
X-Ray Procedures (Technical Component) (Line 3)	Technical component of diagnostic X-ray procedures. Does not include services of a physician to order or to analyze/interpret results from these procedures.
Diagnostic Tests/Screenings (Professional Component) (Line 4)	Professional services to order and analyze/interpret results from diagnostic tests and screenings. Includes services of a physician to order or to analyze/interpret results from these procedures.
Emergency Medical Services (Line 5)	Provision of emergency services on a regular basis to meet life, limb or function-threatening conditions. Nearly all centers will provide EMS via referral arrangements.
Urgent Medical Care (Line 6)	Provision of medical care of an urgent or immediate nature on a routine or regular basis.
24-Hour Coverage (Line 7)	The availability of services on a 24-hour basis.
Family Planning Services (Contraceptive Management) (Line 8)	Provision of contraceptive/birth control or infertility treatment. Counseling and education by providers are included here; when provided by other staff, include under enabling services.
HIV Testing and counseling (Line 9)	Testing and counseling for HIV. Counseling and education by providers included here; when provided by other staff, include under enabling services.
Testing Blood Lead Levels (Line 10)	Testing to ensure that levels of lead in blood are below critical levels. Tests are generally conducted for at risk children.
Immunizations (Line 11)	Provision of the following preventive vaccines: Diphtheria, Pertussis, Tetanus, Measles, Mumps, Rubella, Poliovirus, Influenza virus, Hepatitis B, Hemophilus influenza B.
Following Hospitalized Patients (Line 12)	Visits to health center patients during hospitalizations.
OBSTETRICAL AND GYNECOLOGICAL CARE	
Gynecological Care (Line 13)	Gynecological services provided by a nurse, nurse practitioner, nurse midwife or physician, including annual pelvic exams and Pap tests, follow-up of abnormal findings, and diagnosis and treatment of sexually transmitted diseases/infections. This category does not include family planning services.
Obstetrical Care (Lines 14 through 20)	Provision of listed services (i.e., prenatal care, antepartum fetal assessment, ultrasound, genetic counseling and testing, amniocentesis, labor and delivery professional care, postpartum care) related to pregnancy, delivery and postpartum care.
SPECIALTY MEDICAL CARE	
Directly observed TB therapy (Line 21)	Delivery of therapeutic TB medication under direct observation of center staff.
Respite Care (Line 22)	Recuperative or convalescent services used by homeless

SERVICE CATEGORY	DEFINITIONS
	people with medical problems who are too ill to recover on the streets or in a shelter. It includes the provision of shelter and medical care with linkages to other health care services such as mental health, oral health, substance abuse treatment and social services.
Other specialty care (Line 23)	Services provided by medical professionals trained in any of the following specialty areas: Allergy; Dermatology; Gastroenterology; General Surgery; Neurology; Optometry/Ophthalmology; Otolaryngology; Pediatric Specialties; Anesthesiology.
DENTAL CARE	
Dental Care (Lines 24 through 27)	Provision by a dentist or dental hygienist of the listed services: preventive, restorative, emergency, and rehabilitative.
MENTAL HEALTH/SUBSTANCE ABUSE SERVICES	
Mental Health Treatment/ Counseling (Lines 28 & 31) Developmental Screening (Line 29) 24-Hour Crisis Intervention/ Counseling (Line 30)	Mental health therapy, counseling, or other treatment provided by a mental health professional.
Substance Abuse Treatment/ Counseling (Lines 32 & 33)	Counseling and other medical and/or psychosocial treatment services provided to individuals with substance abuse (i.e., alcohol and/or other drug) problems. May include screening and diagnosis, detoxification, individual and group counseling, self-help support groups, alcohol and drug education, rehabilitation, remedial education and vocational training services, and aftercare.
Comprehensive Mental Health / Substance Abuse Screening. (Line 33a)	Comprehensive mental health / substance abuse screening is a tool used to identify individuals / clients / patients with emotional problems, mental illness, and /or addictive disorders who may desire or benefit from behavioral health and recovery services designed to promote mental health and wellness. The screening is conducted by or under the direction of the following licensed behavioral health providers: clinical or counseling psychologist, psychiatrist, clinical social worker, marriage/family therapist, psychiatric nurse specialist or professional counselor.
OTHER PROFESSIONAL SERVICES	
Hearing Screening (Line 34)	Diagnostic services to identify potential hearing problems.
Nutrition Services Other Than WIC (Line 35)	Advice and consultation appropriate to individual nutrition needs.
Occupational Or Vocational Therapy (Line 36)	Therapy designed to improve or maintain an individual's employment/career skills and involvement.
Physical Therapy (Line 37)	Assistance designed to improve or maintain an individual's physical capabilities.
Pharmacy (Line 38)	Dispensing of prescription drugs and other pharmaceutical products.
Pharmacy – Physician Dispensing (Line 39)	Operation of a dispensary at a clinic service delivery location where the clinicians are responsible for doing the actual

SERVICE CATEGORY	DEFINITIONS
	dispensing of the drugs.
Vision Screening (Line 40)	Diagnostic services to identify potential vision problems.
Podiatry (Line 41)	Services provided by a medical professional licensed to diagnose and treat conditions affecting the human foot, ankle, and their governing and related structures, including the local manifestations of systemic conditions.
Optometry (Line 42)	Services provided by a medical professional licensed or certified to diagnose, treat and manage diseases and disorders of the visual system, the eye and associated structures as well as diagnosis of related systemic conditions.
ENABLING SERVICES	
Case Management (Line 43)	Client-centered service that links clients with health care and psychosocial services to ensure timely, coordinated access to medically appropriate levels of health and support services and continuity of care. Key activities include: 1)assessment of the client's needs and personal support systems; 2) development of a comprehensive, individualized service plan; 3)coordination of services required to implement the plan; client monitoring to assess the efficacy of the plan; and 4) periodic re-evaluation and adaptation of the plan as necessary.
Child Care (Line 44)	Assistance in caring for a patient's young children during medical and other health care visits.
Discharge Planning (Line 45)	Services related to arranging an individual's discharge from the hospital (e.g., home health care).
Eligibility Assistance (Line 46)	Assistance in securing access to available health, social service, pharmacy and other assistance programs, including Medicaid, WIC, SSI, food stamps, TANF, and related assistance programs. Does not include eligibility assistance provided by grantee or government staff under arrangements for Out-stationed Eligibility Workers, as mandated by law; report the latter on line 51.
Environmental Health Risk Reduction (Line 47)	Includes the detection and alleviation of unhealthful conditions associated with water supplies, sewage treatment, solid waste disposal, rodent and parasitic infestation, field sanitation, housing, and other environmental factors related to health (e.g., lead paint abatement and pesticide management).
Health Education (Line 48)	Personal assistance provided to promote knowledge regarding health and healthy behaviors, including knowledge concerning sexually transmitted diseases, family planning, prevention of fetal alcohol syndrome, smoking cessation, reduction in misuse of alcohol and drugs, improvement in physical fitness, control of stress, nutrition, and other topics. Included are services provided to the client's family and/or friends by non-licensed mental health staff which may include psychosocial, caregiver support, bereavement counseling, drop-in counseling, and other support groups activities.
Interpretation/Translation Services (Line 49)	Services to assist individuals with language/communication barriers in obtaining and understanding needed services.
Nursing Home and Assisted-Living Placement (Line 50)	Assistance in locating and obtaining nursing home and assisted-living placements.
Outreach (Line 51)	Case finding, education or other services to identify potential clients and/or facilitate access/referral of clients to services.

SERVICE CATEGORY	DEFINITIONS
Transportation (Line 52)	Transportation, including tokens and vouchers, provided by the grantee for patients.
Out-Stationed Eligibility Workers (Line 53)	Provision of assistance to individuals to enable them to qualify for Medicaid, under provisions of Federal law requiring Out-Stationed Eligibility Workers.
Home Visiting (Line 54)	Provision of services in the client's home. Not inclusive of services such as medical, home nursing, case management etc. which have their own categories.
Parenting Education (Line 55)	Individual or group sessions designed to enhance the child-rearing skills of parents/caregivers.
Special Education Program (Line 56)	Educational programs designed for children with a disability.
Other (Line 57)	This line provides the opportunity to identify an enabling service you are providing that is otherwise not listed. Please specify the service provided.
PREVENTIVE SERVICES RELATED TO TARGET CLINICAL AREAS	
Pap test (Line 58)	Microscopic examination of cells collected from the cervix to detect cancer, changes in cervix, or non-cancerous conditions such as infection or inflammation.
Fecal Occult Blood Test (Line 59	Test to check for small amounts of hidden blood in stool.
Sigmoidoscopy (Line 60)	An examination of the rectum and lower part of the colon through a tube which contains a light source and a camera lens.
Colonoscopy (Line 61)	An examination of the rectum and entire colon using a colonoscope. Procedure can be used to remove polyps or other abnormal tissue.
Mammograms (Line 62)	An x-ray of the breast.
Smoking Cessation Program (Line 63)	A clinical and public-health intervention program for smoking cessation which may involve identification of smokers, diagnosis of nicotine dependence, and self-help products and counseling.
Glycosylated Hemoglobin Measurement For People With Diabetes (Line 64)	A test that assesses the average blood glucose level during several months.
Urinary Microalbumin Measurement For People With Diabetes (Line 65)	A laboratory procedure to detect very small quantities of protein in the urine indicating kidney damage.
Foot Exam For People With Diabetes (Line 66)	A foot examination using monofilaments to test for sensation from pressure that identifies those patients who have lost protective sensation in their feet.
Dilated Eye Exam For People With Diabetes (Line 67)	An examination in which the pupils are dilated in order to check for diabetic eye disease.
Blood Pressure Monitoring (Line 68)	Tracking blood pressure through regular measurement of blood pressure.
Weight Reduction Program (Line 69)	A program in which patients are taught to eat healthy foods, engage in exercise, and monitor caloric intake in order to lose weight and improve their health.
Blood Cholesterol Screening (Line 70)	A blood test that will detect the levels of cholesterol and triglycerides in the body in order to discover if there are abnormal or unhealthy levels of cholesterol in the blood.
Follow-up testing and related health care services for abnormal newborn bloodspot screening (Line 71)	Conducting additional newborn screening (using the bloodspot screening or other methods) to assess for common and/or serious health conditions of newborn infants.

SERVICE CATEGORY	DEFINITIONS
OTHER SERVICES	
WIC Services (Line 72)	Nutrition and health counseling services provided through the Special Supplemental Food Program for Women, Infants and Children
Head Start (Line 73)	Comprehensive developmental services for low-income, preschool children less than 5 years of age
Food Banks / Delivered Meals (Line 74)	Provision of food or meals, not the finances to purchase food or meals.
Employment/ Educational Counseling (Line 75)	Counseling services to assist an individual in defining career/employment/educational interests, and in identifying employment opportunities and/or education options
Assistance in Obtaining Housing (Line 76)	Assistance in locating and obtaining suitable shelter, either temporary or permanent. May include locating costs, moving costs, and/or rent subsidies.

APPENDIX C: SPECIAL MULTI-TABLE SITUATIONS

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

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

ISSUE	TABLES AFFECTED	TREATMENT
Contracted Care (Specialty, dental, mental health, etc.) *(Service must be paid for by grantee!)*	5	**Providers (Column A)** are counted if the contract is for a portion of an FTE (e.g., one day a week OB = 0.20 FTE). Providers are *not* counted if contract is for a service (e.g., $X per visit or $55 per RBRVU). **Encounters (Column B)** are *always* counted, regardless of method of provider payment or location of service (grantee's site or contract provider's office.)
	6	Grantee receives encounter form or equivalent from contract provider, counts primary diagnosis and/or services provided as applicable.
	8A	**Column A: Net Cost.** Cost of provider/service is reported on applicable line. **Column B: Overhead.** Grantee will generally use a lower "overhead rate" for off-site services.
	9D	**Charge (Column A)** is grantee's UCR charge if on-site; as contractor's UCR charge if off site. **Collection (Column B)** is the amount received by *either* grantee *or* contractor from first or third parties. **Allowance (column D)** is amount disallowed by a third party for the charge (if on lines 1 – 12) **Sliding Discount (column E)** is amount written off if the patient is uninsured (line 13). Calculated as UCR charge minus amount collected from patient, minus amount owed by patient as their share of payment.
Services provided by a volunteer provider *(Service are not paid for by grantee!)*	5	**Providers (Column A)** are counted if the service is provided on site at grantees clinic. Hours volunteered are used to calculate FTE as with any other part time provider. Providers *are not counted* if their services are provided at their own offices. **Encounters (Column B)** are counted only if the service is provided at the site in the contractors scope of service and under the grantee's control.
	6	Grantee counts primary diagnosis and/or services provided on site, as applicable.
	9D	If on-site, treated exactly the same as for staff. Do not include if off-site.
WIC	Cover Sheets	Do not list WIC-only sites on the cover pages.
	3A, 3B, 4	Clients whose only contact with the grantee is for WIC services and who do not receive another form of service counted on Table 5 from providers outside of the WIC program *are not counted as patients on any of these tables.* Do not count as patients because of health education or enabling services provided by WIC.

ISSUE	TABLES AFFECTED	TREATMENT
	5	**Staff (Column A)** are counted on line 29a. **Encounters and patients (Columns B and C)** are *never* reported unless otherwise justified.
	8A	**Column A: Net costs.** Total cost of program reported in column a. **Column B: Overhead.** Since much of the administrative cost of the program will be included in the direct costs, it is presumed that overhead will be at a significantly lower rate.
	9D	Nothing associated with the WIC program is to be reported on this table.
	9E	Income for WIC programs, though originally federal, comes to grantees from the State. Unless the grantee *is* a state government, the grant/contract funds received are reported on line 6.
In-house pharmacy or dispensary services for grantee's patients [see below for other situations]. *(including only that part of pharmacy that is paid for by the grantee and dispensed by in-house staff.)*	5	**Column A: Staff.** Pharmacy staff are normally reported on line 23. To the extent that the pharmacy staff have an incidental responsibility to provide assistance in enrolling patients in Pharmaceutical Assistance Programs, they are included on line 23. Staff (generally not including pharmacists) who spend a readily identifiable portion of their time with PAP programs should be counted on line 28, the "other enabling" line. **Column B: Encounters.** The UDS does not require the counting or reporting of encounters with pharmacy whether it is for filling prescriptions or associated education or other patient / provider support.
	8A	**Line 8b, Column A: Pharmaceutical Direct Costs.** The actual cost of drugs purchased by the pharmacy is placed on line 8b. (The value of donated drugs (generally calculated at 340(b) rates) is reported on line 18 in column c.) **Line 8a, column A: Other Pharmacy Direct Costs.** All other operating costs of the pharmacy are shown on line 8a. Include salaries, benefits, pharmacy computers, supplies, etc. **Line 11, column A: Enabling Direct Costs.** Show the staff and other costs of staff (full-time, part-time or allocated time) spent assisting patients to become eligible for PAPs. **Column B: Facility and Administration.** All overhead costs associated with line 8a and 8b are reported on line 8a. While there may be some overhead cost associated with the actual purchase of the drugs, these costs are generally minimal when compared to the total cost of the drugs.
	8B	**Line 11: Eligibility Services.** The cost of helping gain eligibility for PAPs is shown on line 11.

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

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

ISSUE	TABLES AFFECTED	TREATMENT
Clinical dispensing of drugs	description	Many pharmaceuticals, ranging from vaccines to allergy shots to family planning shots or pills, are dispensed in the clinic area of the CHC. This dispensing is considered to be a service attendant to the visit where it was ordered or, in the case of vaccinations, to be a community service. In most instances it is appropriate to charge for these services, though they are not considered to be encounters.
	3A/3B/4	If this is the only service the individual has received during the year, they are not counted as patients.
	5	These services are not counted as separate visits.
	6	Because these are not visits, they are not counted on Table 6.
	8A	Costs are reported on line 8b – pharmaceuticals. In the case of vaccines obtained at no cost through the Vaccines For Children program, the value may be reported on line 18 – donated services and supplies.
	9D	Full charges, collections, allowances and discounts are reported as appropriate. Note that it is *not appropriate* to charge for a pharmaceutical that has been donated, though an administration and/or dispensing fee *is* appropriate. Note that Medicare has separate flu vaccine rules.
	9E	Do not show any amount, even though GAAP might suggest another treatment for the value.
Adult Day Health Care (ADHC)	description	ADHC programs are recognized by Medicare, Medicaid and certain other third party payors. They involve caring for an infirm, frail elderly patient during the day to permit family members to work, and to avoid the institutionalization of and preserve the health of the patient. They are quite expensive and may involve extraordinary PMPM capitation payments, though are thought to be cost effective compared to institutionalization. If patients are covered by both Medicare and Medicaid treat as in Medi-Medi, below.
	5	When a provider does a formal, separately billable, examination of a patient at the ADHC facility, it is treated as any other medical visit. The nursing, observation, monitoring, and dispensing of medication services which are bundled together to form an ADHC service are *not* counted as a visit for the purposes of reporting on this table.
	9D	ADHC charges and collections are reported. Because of Medicaid FQHC procedures it is possible that there will also be significant positive or negative allowances. See also Medi-Medi below.
Medi-Medi Cross-Over	description	Some individuals are eligible for both Medicare and Medicaid coverage. In this case, Medicare is primary and billed first. After Medicare pays its (usually FQHC) fee, the remainder is billed to Medicaid which pays the difference between its FQHC rate and what Medicare paid.

ISSUE	TABLES AFFECTED	TREATMENT
	4	Patients are reported on line 9, Medicare. *Do not* report as Medicaid!
	9D	While initially the entire charge shows as a Medicare charge, after Medicare makes its payment, the remaining amount is re-classified to Medicaid. This means that *eventually* the charges and collections will be the same, though for any given twelve month period the cash positions will probably not net out. In most cases a large portion of the total charge will transfer to Medicaid where it will be received and/or written off as an allowance.
Certain grant supported clinical care programs: BCCCP, Title X, , etc. (These are fee-for service or fee-per-visit programs only.)	description	Some programs pay providers on a fee-for-service or fee-per visit basis under a contract which may or may not also have a cap on total payments per year. They cover a very narrow range of services. Breast and Cervical Cancer Control and Family Planning programs are the most common, but there are others.
	4	These are *not* insurance programs. They pay for a service, but the patient is to be classified according to their primary health insurance carrier. Most of these programs do not serve insured patients, so most of the patients are reported on line 7 as uninsured.
	9D	While the patient is uninsured, there *is* an "other public" payor for the service. The clinic's usual and customary charge for the service is reported on line 7 in column A, and the payment is reported in column B. Since the payment will almost always be different than the charge, the difference is shown as an allowance in column D.
	9E	The grant or contract *is not shown on Table 9E.* It is fully accounted for on Table 9D.
State or local safety net programs	description	These are programs which pay for a wide range of clinical services for uninsured patients, generally those under some income limit set by the program. They may pay based on a negotiated fee-for-service, or fee-per-visit. They may also pay "cents on the dollar" based on a cost report, in which case they are generally referred to as an "uncompensated care" program.
	4	While patients may need to qualify for eligibility, these programs are not considered to be public insurance. Patients served are almost always to be counted on line 7 as uninsured.
	9D	The charges are to be considered charges directly to the patient (reported on line 13, column A). If the patient pays any co-payment, it is reported in column B. If they are responsible for a co-payment but do not pay it, it remains a receivable until it collected or is written off as a bad-debt in column f. All the rest of the charge (or all of the charge if there is no co-payment) is reported as a sliding discount in Column E.
	9E	The total amount received during the calendar year is reported on line 6a.

ISSUE	TABLES AFFECTED	TREATMENT
Workers Compensation	4	Workers Compensation is a form of *liability insurance for employers*, not a *health insurance for employees*. Patient's whose bills are being paid by Workers Compensation should have a related insurance that is what is reported on Table 4 (even if it is not being billed or cannot be billed by the CHC.) In general, if they had an employer paid / work-place based health insurance plan they would be reported on line 11. If they do not have *any* health insurance, they are reported on line 7.
	9D	Charges, collections and allowances for Workers Compensation covered services are reported on line 10.
Tricare, Trigon, Veterans Administration, Public Employees Insurance, etc.	4	While there are many individuals whose insurance premium is paid for by a government, ranging from military and dependents to school teachers to congressmen and HRSA staff, these are all considered to be private insurances. They are reported on line 11, *not on line 10a.*
	9D	Charges, collections and allowances are reported on lines 10 – 12, *not on lines 7 – 9.*
Contract sites ***(In-scope sites in schools, workplaces, jails, etc.)***	description	Some CHCs have included in their scope of service a site in a school a workplace, a jail, or some other location where they are contracted to provide services to (students / employees / inmates / etc.) at a flat rate per session or other similar rate *which is not based on the volume of work performed.* The agreement generally stipulates whether and under what circumstances the clinic may bill third parties.
	4	**Lines 1-6 – income:** In general, income should be obtained from the patients. In prisons, it may be assumed that all are below poverty (line 1). In schools, income should be that of the parent or unknown or, in the case of minor consent services, below poverty. In the workplace, income is the patient's family income or, if not known, "unknown" (Line 5). **Lines 7-12 – insurance:** Record the actual form of insurance the patient has. Do not consider the agency with whom the clinic is contracted to be an insurer. (Schools and jails are not "other public" insurance.)
	5	Count all encounters as appropriate. Do not reduce or reclassify FTEs for travel time.
	8A	Costs will generally be considered as medical (lines 1-3) unless other services (mental health, case management, etc) are being provided. *Do not report on line 12—"other related services"*
	9D	*Unless the encounter is being charged to a third party such as Medicaid* the clinic's usual and customary charges will appear on line 10, column A. The amount paid by the contractor is shown in column B. The difference (positive or negative) is reported in column D.
	9E	*Contract revenue is not reported on Table 9E.*

ISSUE	TABLES AFFECTED	TREATMENT
S-CHIP	4	**Medicaid:** If S-CHIP is handled through Medicaid and the enrollees are identifiable, they are reported on line 8b. *If it is not possible to differentiate S-CHIP from regular Medicaid,* the enrollees are reported on line 8a with all other Medicaid patients. **Non-Medicaid:** S-CHIP enrollees in states which do not use Medicaid are reported as "Other Public S-CHIP" on line 10b. Note that, even if the plan is administered through a commercial insurance plan, the enrollees are *not reported on line 11.* *For information about the type of S-CHIP Program in your state: http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=compare&category=Medicaid+%26+SCHIP&subcategory=SCHIP&topic=SCHIP+Program+Type*
	9D	**Medicaid:** Report on lines 1 – 3 as appropriate. **Non-Medicaid:** Report on lines 7 – 9 as appropriate. *Do not report on lines 10 – 12 even if the plan is administered by a commercial insurance company.*
Carve-outs	description	**Relevant to capitated managed care only.** Grantee has a capitated contract with an HMO which stipulates that one set of CPT codes will be covered by the capitation regardless of how often the service is accessed, and another set of codes which the HMO will pay for on a fee-for-service basis whenever it is appropriate. Most common carve-outs involve lab, radiology and pharmacy, but specific specialty care or diagnoses (e.g., perinatal care) may also be carved out.
	9C	**Lines 1a/1b.** The actual capitation received from the HMO is reported on line 1a. The additional amounts received as a result of the carve-outs are reported on line 1b. **Lines 5a/5b.** The cost of delivering the capitated services are reported on line 5a; the costs of delivering the carved-out services are reported on 5b. The costs of the carved out services are generally calculated *based on* the associated charges, but are generally not just equal to those charges. **Lines 8a/8b, 10a/10b.** Member months and enrollees are counted *only* on the capitated lines (lines 8a and 10a) **Lines 9a/9b.** The encounters for the capitated patients are counted on line 9a. No encounters are reported for the carved out services if the are a part of another encounter (e.g., the lab part) but encounters *are* reported if the *service* (e.g. prenatal care or HIV treatment) is carved out.

ISSUE	TABLES AFFECTED	TREATMENT
	9D	**Lines 2a/b, 5a/b, 8a/b, 11a/b.** Capitation payments are reported on the "a" lines, carve out payments are reported on the "b" lines. The numbers will in general be the same as on Table 9C.
(Migrant) Vouchers	description	**Voucher Programs** have traditionally been an exclusive part of the Migrant and Seasonal Farmworker program, though in recent years some Homeless and even CHC programs have made use of the mechanism. In this system, the center identifies services that are needed by its patients which cannot be provided by their in-house staff. Vouchers are written to authorize a third party provider to deliver the services, and voucher is returned to the grantee for payment. Payment is generally at less than the providers full fee, but is consistent with other payors such as Medicaid.
	3a, 3b, 4	**Patients are counted** even if the only service that they receive is a vouchered service, provided that these services would make the patient eligible for inclusion if the Center provided them. Thus a vouchered Taxi ride would *not* make the patient "countable" because transportation services are not counted on Table 5.
	5	**Column A:** There is no way to account for the time of the voucher providers. As a result, zero FTEs are reported with regard to these services. If there is a provider who works *at* the center, the FTE of *that* provider *is* counted. For example, the one-day-a-week family practitioner would be reported as 0.20 FTEs on line 1. But the 125 vouchered visits to FPs would not result in an additional count on line 1. **Column B:** Count all visits that are paid for by voucher. DO NOT count visits where the referral is to a provider who is not paid in full for the service (i.e., a "voucher" to a doctor who donates five visits per week does NOT generate a visit that is counted on Table 5.
	6	**Diagnoses / Services.** The Voucher program is expected to receive from the provider a bill similar to a HCFA-1500 which lists the services and diagnoses. These are to be tracked by the center and reported on Table 6.
	8a	**Cost of Vouchered Services.** The costs are reported on the appropriate line. Medical vouchers are reported on Line 1, not Line 3. Report *only* those costs paid directly by the grantee. **Discounts.** Virtually all clinical providers are paid less than their full fee. Some grantees like to report the amount of these discounts as "donated services". *While this is not required,* grantees may report the difference between the voucher provider's full fee and the contracted voucher payment as a donated service on line 18, column D.

ISSUE	TABLES AFFECTED	TREATMENT
	9d	**Column A: Charges.** Report the full charge that the provider shows on their HCFA-1500 as the charge 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 a nominal or other fee, show this in column B. **Column E: Sliding Discounts.** Show the difference between the full charge and the amount that the patient was *supposed to pay* in Column E. Do not show the full amount in Column E if the patient was supposed to make a payment to the center and failed to do so. **Column F: Bad Debt.** Show any amount (such as a nominal fee) that the patient was supposed to pay but failed to pay. Bad debts are recognized consistent with the center's financial policies. Amounts not paid may be considered a bad debt in 30 days or in a year – whatever is the center's policy.

ISSUE	TABLES AFFECTED	TREATMENT
Incarcerated Patients	description	Some grantees contract with jails and prisons to provide health services to inmates. These arrangements can vary in terms of the contractual arrangement and location for providing health services to patients.
	4	Income must be verified or reported as unknown. Individuals receiving health services under this contract is not considered to have insurance. The patient must be classified according to their primary health insurance carrier regardless of whether the services will be billed to the insurer.
	9D	The patient's services are reimbursed by the jail/prison. For purposes of reporting, there *is* an "other public" payor for the service. The clinic's usual and customary charge for the service is reported on line 7 in column A, and the payment is reported in column B. Since the payment will almost always be different than the charge, the difference is shown as an allowance in column D.
	9E	The grant or contract *is not shown on Table 9E.* It is fully accounted for on Table 9D.