Uniform Data System Calendar Year 2017 Reporting

Bureau of Primary Health Care

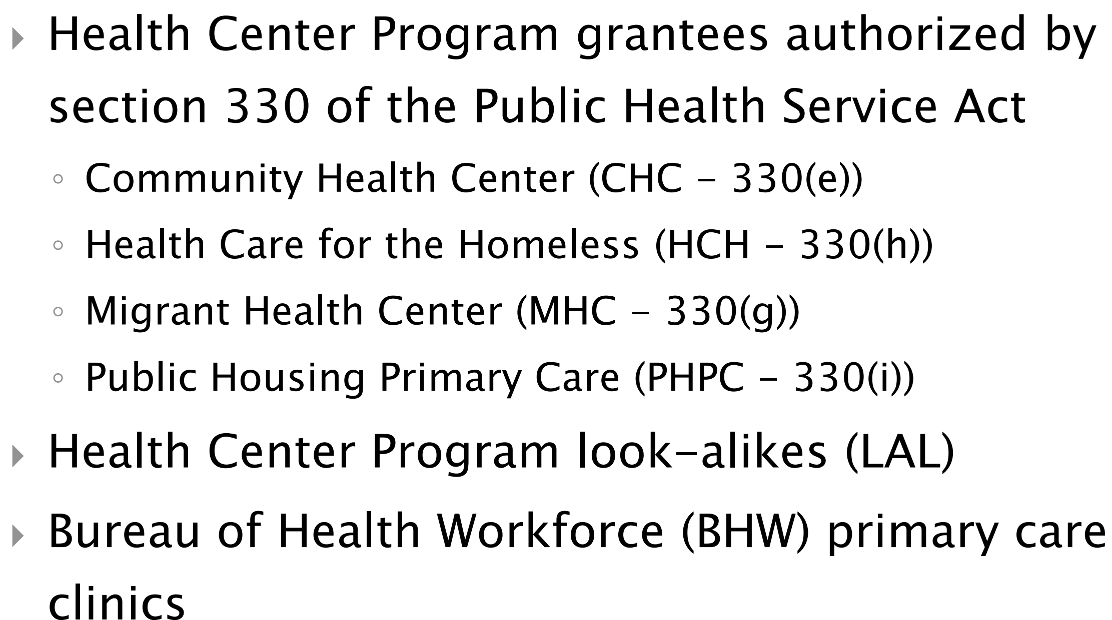
Agenda

- Introduction to the Uniform Data System (UDS): Who, What, When, Where, Why
- 2017 UDS Changes and 2018 UDS Proposed Changes
- UDS Modernization
- Step-by-Step UDS Table Instructions and Definitions
- Strategies for Successful Reporting
- Assistance Available to Help Complete the UDS

Introduction to UDS

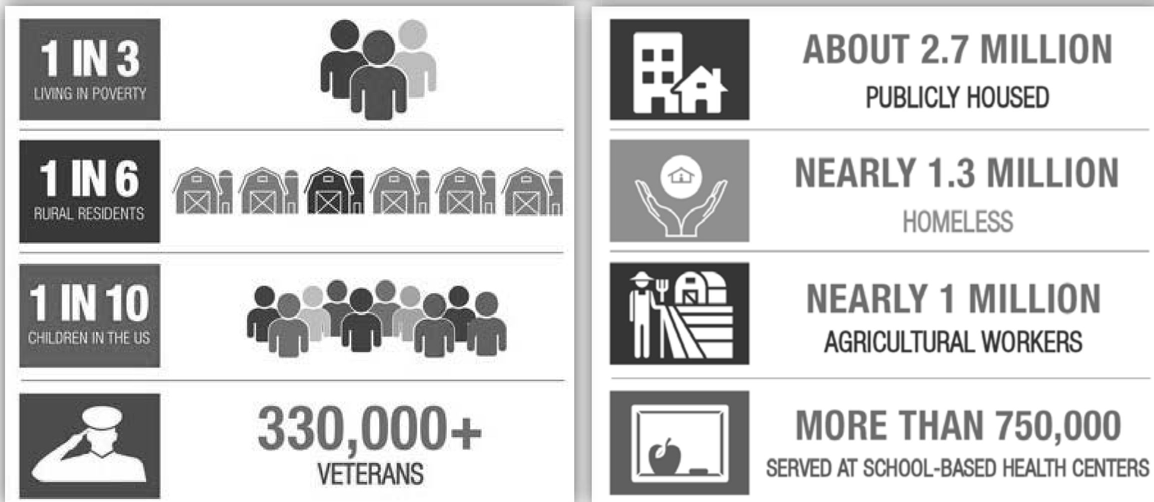
Who, What, When, Where and Why

Who Reports the UDS



- Health Center Program grantees authorized by section 330 of the Public Health Service Act
  - Community Health Center (CHC - 330(e))
  - Health Care for the Homeless (HCH – 330(h))
  - Migrant Health Center (MHC - 330(g))
  - Public Housing Primary Care (PHPC - 330(i))
- Health Center Program look-alikes (LAL)
- Bureau of Health Workforce (BHW) primary care clinics

National Impact/Community Focus



In-Scope Activities

- Report all "in-scope" activities in the health center's Notice of Award/designation
  - All related staff, services, patients, visits, income/revenue, expenses/costs
  - Do not include sites or services that are not approved
- Report on activities that occurred during the period from January 1, 2017–December 31, 2017
  - Calendar year reporting—not based on grant year or fiscal year
  - Activities funded or designated before October 2017

What is Reported

- A detailed picture of your health center using:
  - Twelve tables of demographic, clinical, operational, and financial data
  - Two forms of health information technology (HIT), telehealth, and other data elements

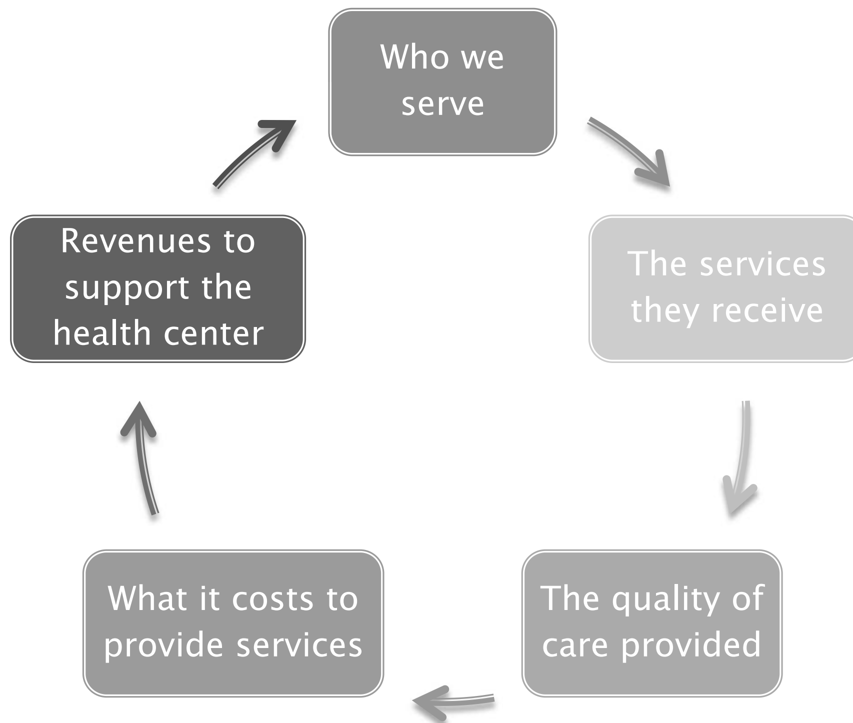
What is Reported	Table(s)
Patients served and their demographic characteristics	ZIP Code, 3A, 3B, 4
Types and quantities of services provided	5, 6A
Staffing mix and tenure	5, 5A
Quality of care, health outcomes, and disparities	6A, 6B, 7
Costs of providing services	8A
Revenue sources	9D, 9E
HIT capabilities, electronic health record (EHR) interoperability, Meaningful Use leveraging	HIT Form
Telehealth, medication-assisted treatment (MAT), and outreach and enrollment assists	Other Form

Tables are Interrelated

- How many of you are here with colleagues from your center?
- How many of you work on the UDS with others from your center?
- How many of you work in teams that cross departments?

In order to best approach the UDS Report, it is best for you to work with others to understand how the tables fit together

How the Tables are Interrelated



Components of the UDS Report

- Universal Report—completed by reporting health centers
- Grant Report(s)—completed by grantees that receive 330 grants under multiple program funding

Table	**Universal Report** if you are: 330-funded program LAL BHW primary care clinic	Also report **Grant Report(s)** if you receive 330 grants under multiple program authorities: CHC (330 (e)) HCH (330 (h)) MHC (330 (g)) PHPC (330 (i))
ZIP Code	Yes	No
3A, 3B, 4	Yes	Yes
5	Yes	Yes, but patients and visits only
5A	Yes	No
6A	Yes	Yes
6B, 7, 8A, 9D, 9E	Yes	No

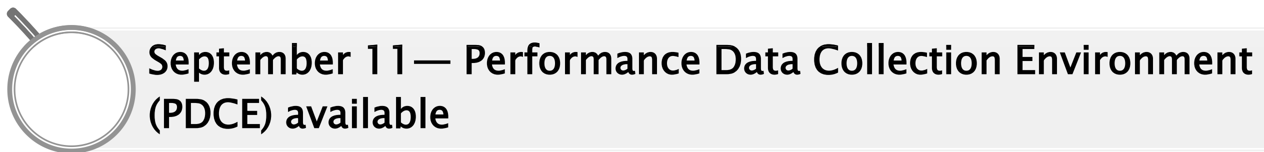
Where to Report

- Report through Electronic Handbook (EHB) web-based data collection system https://grants3.hrsa.gov/2010/WebEPSExternal//Interface/common/accesscontrol/login.aspx
- Authorized staff can work on the UDS
  - Multiple people can work at the same time as long as they are updating different tables
- Acknowledge that data was reviewed for accuracy and validated prior to submission
  - EHB includes a summary of incomplete tables and questions about the data reported

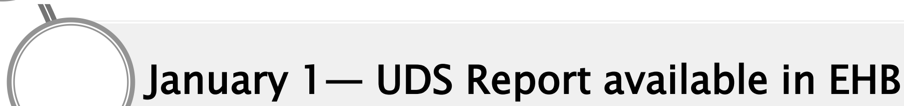
Notes about EHB

- EHB table format may look slightly different than tables in the manual
- The Data Audit Report (DAR) needs to be run when tables are marked as complete to identify system questions (edits) about the data reported
  - You must correct or explain each edit on the DAR, *not* in the comments section available on each table

When to Report: Important Dates



September 11— Performance Data Collection Environment (PDCE) available



January 1— UDS Report available in EHB

February 15— Due Date

February 15 – March 31— Review period

- Work with your assigned UDS reviewer

March 31— All corrected submissions must be finalized

- No further changes made after this date

Why do we report the UDS?

- Comply with legislative and regulatory requirements
- Inform Health Resources and Services Administration (HRSA), Congress, and the public about health center performance and operations
- Identify and measure trends over time
- Reward effective programs and services
- Support quality improvement at the health center
- Target needed interventions
- Compare health center performance with national benchmarks and quality standards

Changes to UDS Reporting

Changes by Table

2017 Changes: Tables 6B and 7

Tables 6B and 7: Continue to align UDS Clinical Quality Measures (eCQMs) with the electronic CQMs used by the Centers for Medicare & Medicaid Services (CMS)

- Use the **January 2017 Addendum eReporting update** for 2017 reporting
  - Specifications included at the CMS eCQI Resource Center
    - Link: https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ecqms?field_year_value=2&keys=

Note: Major differences between 2016 and 2017 will be outlined later in presentation

2017 Changes: Appendix E Other Data Elements *(New)*

- Collects some data previously collected on HIT Form:
  - Medication-assisted treatment (MAT)
    - Note: Opioid treatment prescribing privileges have been extended beyond physicians to include certain qualified nurse practitioners and physician assistants
  - Use of telehealth
- Outreach and enrollment assists by a trained assister
  - Note: Definition of assists is unchanged and assists still do not count as visits on the UDS tables

2018 Proposed Changes

- Retire the reporting of Hemoglobin A1c less than 8% *(Table 7)*
- Remove the patient-centered medical home (PCMH) recognition question *(HIT Form)*
- Enhance the questions about telehealth *(Other Data Form)*

Performance Data
Collection Environment

- <Play video>

- Suma Nair PhD, MS, RD
- Director, Office of Quality Improvement

New: Performance Data Collection Environment

Available September 11–December 31

Step-by-Step Instructions

Unduplicated Count

Patients Defined—Unduplicated

- People who have at least one reportable visit* during the calendar year
  - On the demographic tables: ZIP Code Table, Table 3A, and in each section of Tables 3B and 4, count each patient <u>once and only once</u>
    - Even if the patient received more than one type of service or had more than one visit
    - Patients are "unduplicated" on these tables—do not report the same patient twice

** A visit determines who to count as a patient and will be further described on Table 5*

Count Once and Only Once

- Table 3A, total on Line 39, must equal the totals from the ZIP Code Table and each section from Tables 3B and 4 to provide an unduplicated count of patients

Patients Defined– by Service

- Also report these patients on Tables 5 and 6A only <u>once for each type of service or diagnosis</u> received during the year
  - Table 5—Has seven service categories: medical, dental, mental health, substance abuse, other professional, vision, and enabling services
  - Table 6A—There are multiple diagnoses and services

Example of Unduplicated Patient Count

- A patient comes in three times during the year: once for medical, once for dental, and once for vision services. Count the patient once on:
  - Each demographic table and section (ZIP Code, Tables 3A, 3B, and 4) AND
  - Table 5 as a medical patient AND
  - Table 5 as a dental patient AND
  - Table 5 as a vision patient
- Note: Patients will also be considered for clinical tables, described later

ZIP Code Table

Patients by ZIP Code by
Primary Medical Insurance

Patients by ZIP Code

ZIP Code (a)	None/Uninsured (b)	Medicaid/ CHIP/ Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
<system allows insertion of rows for more ZIP Codes>					
Other ZIP Codes					
Unknown Residence					
Total					

Patients by ZIP Code

- List all ZIP codes with 11 or more patients in Column A
  - Aggregate ZIP codes with 10 or fewer patients as “other”
- Report each ZIP code **by primary medical insurance**
  - Apply same rules used for reporting patients by insurance on Table 4 (totals must be equal)

Considerations for Reporting Patients by ZIP Code

- For patients experiencing homelessness, use the ZIP code of service location if no address is obtained
- For migratory agricultural workers, use the ZIP code where the patient was housed when they received care
- Use current United States (U.S.) residency ZIP code for people from other countries who reside in the U.S.
- These data provide current geographic service area of health centers and are updated yearly on UDS Mapper at http://www.udsmapper.org/

UDS Edit Check: Patient Counts

What to look for and possible solutions

Common edit: Patient numbers do not agree for Medicaid on ZIP Code Table and Table 4.

UDS Edit Check: Patient Counts

What to look for and possible solutions

Common edit: Patient numbers do not agree for Medicaid on ZIP Code Table and Table 4.

What to look for:

- Insurance categories across the two tables must equal
- Edit may appear for other insurance categories

Possible solutions:

- Correct errors:
  - ✗ Neglecting to combine Medicaid, CHIP, and Other Public on ZIP Code Table
  - ✗ Reporting patients with multiple insurance under different categories across tables
- Explain:
  - ✓ Patient total by insurance categories across the two tables must equal (edit is not explainable)

ZIP Code Table and Table 4

ZIP Code Table:

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

Table 4:

	Principal Third Party Medical Insurance
7	None/Uninsured
8a	Regular Medicaid (Title XIX)
8b	CHIP Medicaid
8	Total Medicaid (Sum lines 8a+8b)
9a	Dually Eligible (Medicare and Medicaid)
9	Medicare (Inclusive of dually eligible and other Title XVIII beneficiaries)
10a	Other Public Insurance Non-CHIP Specify:
10b	Other Public Insurance CHIP
10	Total Public Insurance (Sum lines 10a+10b)
11	Private Insurance
12	Total (Sum lines 7+8+9+10+11)

Table 3A

Patients by Age and by Sex Assigned at Birth

Patients by Age and by Sex Assigned at Birth

Line	Age Groups	Male Patients (a)	Female Patients (b)
1	Under age 1		
2	Age 1		
3	Age 2		
4	Age 3		
5	Age 4		
6	Age 5		
7	Age 6		
8	Age 7		
9	Age 8		
10	Age 9		
11	Age 10		
12	Age 11		
13	Age 12		
14	Age 13		
15	Age 14		
16	Age 15		
17	Age 16		
18	Age 17		
19	Age 18		
20	Age 19		
21	Age 20		
22	Age 21		
23	Age 22		
24	Age 23		
25	Age 24		
26	Ages 25-29		
27	Ages 30-34		
28	Ages 35-39		
29	Ages 40-44		
30	Ages 45-49		
31	Ages 50-54		
32	Ages 55-59		
33	Ages 60-64		
34	Ages 65-69		
35	Ages 70-74		
36	Ages 75-79		
37	Ages 80-84		
38	Age 85 and over		
39	**Total Patients (Sum lines 1-38)**		

Patients by Age and by Sex Assigned at Birth

- Report the number of patients by age and by sex
  - Use patient’s sex at birth or on a birth certificate
  - Use **age as of June 30**
    - Note: The non-prenatal and non-childhood immunization portions of Tables 6B and 7 define age as of January 1

National Statistics—2016 Rollup

Line	Age Groups	Male Patients (a)	Female Patients (b)	All Patients
1	Under age 1	331,726	317,190	648,916
2	Age 1	224,025	213,809	437,834
3	Age 2	214,223	204,584	418,807
4	Age 3	224,044	216,498	440,542
5	Age 4	239,973	232,808	472,781
6	Age 5	242,912	233,782	476,694
7	Age 6	231,696	222,702	454,398
8	Age 7	231,241	222,017	453,258
9	Age 8	232,360	223,561	455,921
10	Age 9	225,719	216,452	442,171
11	Age 10	213,453	204,666	418,119
12	Age 11	217,527	211,330	428,857
13	Age 12	213,031	206,224	419,255
14	Age 13	199,554	197,825	397,379
15	Age 14	198,282	206,469	404,751
16	Age 15	194,305	216,283	410,588
17	Age 16	191,012	226,714	417,726
18	Age 17	178,655	229,330	407,985
Subtotal	Patients (Sum Lines 1-18)	4,003,738	4,002,244	8,005,982
19	Age 18	147,648	223,720	371,368
20	Age 19	113,808	208,438	322,246
21	Age 20	105,977	210,365	316,342
22	Age 21	104,968	217,864	322,832
23	Age 22	109,093	227,310	336,403
24	Age 23	112,922	236,216	349,138
25	Age 24	117,180	244,310	361,490
26	Ages 25-29	623,120	1,244,596	1,867,716
27	Ages 30-34	642,200	1,184,980	1,827,180
28	Ages 35-39	639,288	1,083,171	1,722,459
29	Ages 40-44	613,498	964,819	1,578,317
30	Ages 45-49	669,165	950,730	1,619,895
31	Ages 50-54	740,045	970,986	1,711,031
32	Ages 55-59	721,580	919,546	1,641,126
33	Ages 60-64	588,409	770,041	1,358,450
Subtotal	Patients (Sum Lines 19-33)	6,048,901	9,657,092	15,705,993
34	Ages 65-69	372,389	513,972	886,361
35	Ages 70-74	217,903	307,974	525,877
36	Ages 75-79	137,365	202,315	339,680
37	Ages 80-84	80,838	129,311	210,149
38	Age 85 and over	61,569	124,685	186,254
Subtotal	Patients (Sum Lines 34-38)	870,064	1,278,257	2,148,321
39	**Total Patients (Sum lines 1-38)**	10,922,703	14,937,593	25,860,296
	% of Total	42.24%	57.76%	

Table 3B

Demographic Characteristics

- Hispanic or Latino Ethnicity and Race
- Language Preference
- Sexual Orientation
- Gender Identity

Demographic Characteristics

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

Line	Patients by Language	Number (a)
12.	Patients Best Served in a Language Other Than English	

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

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

Ethnicity, Race, and Language

- Report patients by ethnicity and race (lines 1-8)
  - Self-reported by patients
  - If patient did not choose Hispanic or Latino BUT chose a race, report them in Column B
  - Report patients of multiple races on Line 6, “More than one race”
  - If race is unreported, report on Line 7
  - Only report patients who do not report race OR ethnicity in Column C
- Report patients best served in a language other than English on Line 12
  - Only this line may be estimated

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

Line	Patients by Language
12.	Patients Best Served in a Language Other Than English

Sexual Orientation and Gender Identity

- Report patients by their sexual orientation and by their gender identity
  - Self-reported by all patients or their caregivers
- Important to identify and reduce health disparities and promote culturally competent care in health centers
  - Aligned with the Office of National Coordinator for Health Information Technology (ONC) certification program

Sexual Orientation and Gender Identity (SOGI) Line Clarification

Description	Line	Report patients response of "Chose not to Disclose"	Report patients who chose "Don't Know" or "Other", and where data is missing (include minors, patients who did not respond, and if no system was in place to capture data)
Sexual Orientation	17 – Don't know		√
	18 – Chose not to disclose	√	
Gender Identity	24 – Other		√
	25 – Chose not to disclose	√	

Considerations for SOGI Reporting

- You should have established data collection systems to capture this information
  - First year data (2016) shows this information was not collected by most health centers
- If you did not collect SOGI data from patients, explain the reason in Table 3B Comments
- The National LGBT Health Education Center can help http://www.lgbthealtheducation.org

National Statistics—2016 Rollup

Line	Patients by Sexual Orientation	Number (a)	% of Total
13.	Lesbian or Gay	125,772	0.49%
14.	Straight (not lesbian or gay)	4,073,054	15.75%
15.	Bisexual	50,941	0.20%
16.	Something else	43,948	0.17%
17.	Don't know	19,941,060	77.11%
18.	Chose not to disclose	1,625,521	6.29%
19.	Total Patients (Sum Lines 13 to 18)	25,860,296	100.00%

Line	Patients by Gender Identity	Number (a)	% of Total
20.	Male	3,617,287	13.99%
21.	Female	5,064,052	19.58%
22.	Transgender Male/Female-to-Male	20,975	0.08%
23.	Transgender Female/Male-to-Female	15,826	0.06%
24.	Other	16,248,894	62.83%
25.	Chose not to disclose	893,262	3.45%
26.	Total Patients (Sum Lines 20 to 25)	25,860,296	100.00%

UDS Edit Check: Gender Identity
What to look for and possible solutions

Common edit: All patients by gender identity have been reported as male or female.

UDS Edit Check: Gender Identity
What to look for and possible solutions

What to look for:

- Record patient's self-reported gender identity
- Edit may appear for all patients reported as 'straight' for sexual orientation, or when all patients are in one category

Possible solutions:

- Correct errors:
  - ✗ Using patient's sex assigned at birth to identify gender
  - ✗ Assigning patients to one category for missing data
- Explain:
  - ✓ All patients self-reported gender
  - ✓ If data is missing, report patients on Line 24, Other

Table 4

Selected Patient Characteristics

Income as a Percent of Poverty Guideline
Principal Third-Party Medical Insurance
Managed Care Utilization
Special Populations

Line	Characteristic	Number of Patients (a)
Income as Percent of Poverty Guideline		
1.	100% and below	
2.	101 - 150%	
3.	151 - 200%	
4.	Over 200%	
5.	Unknown	
6.	**Total (Sum lines 1-5)**	

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

Line	Payer Category	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	Total (e)
13a.	Capitated Member months					
13b.	Fee-for-service Member months					
13c.	**Total Member months (Sum Lines 13a + 13b)**					

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

Patients by Income (Lines 1-6)

- Report patients by household income ranges based on annual Federal Poverty Guidelines on Lines 1-4
- Report patients with unknown income on Line 5

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

Patients by Income Considerations

- Collect and update income annually
  - Verified income is necessary to qualify for sliding discounts
  - Report most recent family income
  - May be self-declared if consistent with Board-approved policy
- Do not assume patients are at or below poverty if they are homeless, migrant, or agricultural workers or are on Medicaid
  - But, if patients were verified to have no income, report at or below poverty

National Statistics—2016 Rollup

Line	Characteristic	Number of Patients (a)	% of Total	% of Known
Income	as Percent of	Poverty Guideline		
1	100% and below	13,083,637	*50.6%*	*70.0%*
2	101 - 150%	2,840,294	*11.0%*	*15.2%*
3	151 - 200%	1,256,848	*4.9%*	*6.7%*
4	Over 200%	1,503,914	*5.8%*	*8.0%*
5	Unknown	7,175,603	*27.7%*	
6	**Total (Sum lines 1-5)**	25,860,296	*100.0%*	

Principal Third-Party Medical Insurance, Lines 7-12

- Report primary source of <u>medical</u> insurance for all patients by age range

Columns= Age Ranges

Rows = Primary Medical Insurance

	Principal Third Party Medical Insurance	0-17 Years Old (a)	18 and Older (b)
7	**None/Uninsured**		
8a	Regular Medicaid (Title XIX)		
8b	CHIP Medicaid		
8	**Total Medicaid (Sum lines 8a+8b)**		
9a	Dually Eligible (Medicare and Medicaid)		
9	**Medicare** (Inclusive of dually eligible and other Title XVIII beneficiaries)		
10a	Other Public Insurance Non-CHIP Specify:		
10b	Other Public Insurance CHIP		
10	**Total Public Insurance (Sum lines 10a+10b)**		
11	**Private Insurance**		
12	**Total (Sum lines 7+8+9+10+11)**		

Medical Insurance Reporting Considerations

- Report medical insurance as of the last visit of the year *regardless of whether the patient received medical care*
- Primary medical insurance is the insurance normally billed first for medical services
- 330 grant funds are not a form of insurance

UDS Edit Check: Age Ranges Not Equal

What to look for and possible solutions

Common edit: Total patients ages 0-17 years on Table 4, Line 12, Column A is not equal to the sum of Lines 1-18 on Table 3A.

UDS Edit Check: Age Ranges Not Equal

What to look for and possible solutions

Common edit: Total patients ages 0–17 years on Table 4, Line 12, Column A, is not equal to the sum of Lines 1–18 on Table 3A.

What to look for:

- Total patients by insurance reports aggregate age ranges 0–17 and 18 and older
- These must tie to detailed total on 3A
- Edit may appear for Table 4, Column B compared to Lines 19–38 on Table 3A

Possible solutions:

- Correct errors:
  - ✗ There is no "unknown" insurance — identify all patients' primary medical insurance status
- Explain:
  - ✓ Patient counts by age ranges across tables must be equal (edit is not explainable)
  - ✓ Use age as of June 30 on both tables

Insurance Categories: Line 7

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

- **None/Uninsured (Line 7)**
  - Patients who do not have medical insurance at their last visit
  - May include patients whose services are reimbursed through a grant, contract, or uncompensated care fund
  - Do not assume and count as uninsured:
    - Patients experiencing homelessness or seen at a school-based clinic
    - Services not covered by insurance

Insurance Categories: Lines 8a,8b,10b

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

- **Regular Medicaid (Line 8a)**
  - Report Medicaid patients
  - Include Medicaid managed care programs run by commercial insurers
  - Include patients with all forms of state-expanded Medicaid
- **Children's Health Insurance Program (CHIP) (Lines 8b or 10b)**
  - Report CHIP provided through:
    - Medicaid on Line 8b
    - Commercial carrier outside of Medicaid on Line 10b
  - Do not report CHIP as private insurance
  - CHIP varies from state to state—some with different names
  - If unable to distinguish between regular Medicaid and CHIP Medicaid, classify patients on Line 8a, regular Medicaid

Insurance Categories: Lines 9, 10a

- **Medicare (Line 9)**
  - Report patients covered by Medicare
  - Include Medicare, Medicare Advantage, MediGap, and Dually Eligible
  - Report dually eligible patients on Line 9 AND on Line 9a
- **Other Public Insurance Non-CHIP (Line 10a)**
  - Report state and/or local government insurance that covers a broad set of benefits
  - Do not include:
    - Federal or state exchanges
    - Programs with limited benefits, such as family planning (Title X); Early Prevention, Screening, Detection, and Treatment (EPDST); Breast and Cervical Cancer Control Program (BCCCP), etc.

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

Insurance Categories: Line 11

- **Private Insurance (Line 11)**
  - Report patients covered by commercial insurance (sold by for-profit and not-for-profit companies)
  - Include insurance purchased for public employees or retirees, such as Tricare, Trigon, or the Federal Employees Benefits Program
  - Include insurance sold on federal or state exchanges
  - Do not include patients on workers' compensation—it is a liability insurance
    - Report according to medical insurance patient has; if they do not have medical insurance, report as uninsured on Line 7

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

National Statistics—2016 Rollup

Line	Principal Third Party Medical Insurance	0-17 Years Old (a)	18 and Older (b)	Total	%
7.	**None/Uninsured**	1,044,251	5,014,875	6,059,126	*23.43%*
8a.	Regular Medicaid (Title XIX)	5,763,790	6,780,028	12,543,818	*48.51%*
8b.	CHIP Medicaid	152,102	19,535	171,637	*0.66%*
8.	**Total Medicaid (Sum lines 8a+8b)**	**5,915,892**	**6,799,563**	**12,715,455**	*49.17%*
9a.	Dually Eligible (Medicare and Medicaid)	2,232	937,260	939,492	*3.63%*
9.	**Medicare** (Inclusive of dually eligible and other Title XVIII beneficiaries)	8,680	2,375,643	2,384,323	*9.22%*
10a.	Other Public Insurance Non-CHIP Specify:	18,754	99,032	117,786	*0.46%*
10b.	Other Public Insurance CHIP	109,541	25,865	135,406	*0.52%*
10.	**Total Public Insurance (Sum lines 10a+10b)**	128,295	124,897	253,192	*0.98%*
11.	**Private Insurance**	908,864	3,539,336	4,448,200	*17.20%*
12.	**Total (Sum lines 7+8+9+10+11)**	**8,005,982**	**17,854,314**	**25,860,296**	*100.00%*

Managed Care Utilization, Lines 13a–13c

- Report patient member months in managed care plans
- Do NOT count as managed care:
  - Primary care case management (PCCM)
  - PCMH demonstration grant
  - Patients enrolled for non-medical services only (e.g., dental, mental health)
  - Patients in plans who can receive care from other providers

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

Special Populations—Agricultural Workers or Dependents

- Report number of agricultural workers on Line 16 even if you do not receive the targeted funding for that population
- Lines 14 and 15 are only completed by MHC grantees
- Status must be verified at least every 2 years
- Definitions:
  - Migratory—An individual, including aged or disabled former agricultural workers, who establishes a temporary home for purposes of seasonal agricultural employment
  - Seasonal—An individual who does not establish a temporary home for the purpose of seasonal agricultural employment

Line	Special Populations	Number of Patients (a)
14.	Migratory (330g grantees only)	
15.	Seasonal (330g grantees only)	
16.	**Total Agricultural Workers or Dependents**(All Health Centers Report This Line)	

Sample Questions to Identify Agricultural Workers or Dependents

1. In the last 2 years, have you or anyone in your family been *employed as a worker* in any type of agriculture (farm work) like planting; picking; preparing the soil; packinghouse; driving a truck for any type of farm work; working with farm animals such as cows, chickens, etc.? ***Yes or No***
2. In the last 2 years, have you or a member of your family lived away from home in order to work in any type of agriculture (farm work)? ***Yes or No***
3. Have you or a member of your family stopped migrating to work in agriculture (farm work) because of a disability or age (too old to do the work)? ***Yes or No***

Source: http://www.ncfh.org/administrative.html
Website: http://www.ncfh.org/

Special Populations—Homeless

- Report number of patients who are experiencing homelessness on Line 23 even if you do not receive the targeted funding for that population
- Include individuals who experienced homelessness at time of any service provided during the year
- Include patients in permanent supportive housing
- Lines 17-22 are only completed by HCH grantees
- Shelter arrangements (Lines 17-22):
  - Report where they are housed as of first visit during the year for housing status
  - If institutionalized, report where patient will spend the night after release
  - Continue to count as homeless on Line 21 for 12 months after last visit while homeless

Line	Special Populations	Number of Patients (a)
17.	Homeless Shelter (330h grantees only)	
18.	Transitional (330h grantees only)	
19.	Doubling Up (330h grantees only)	
20.	Street (330h grantees only)	
21.	Other (330h grantees only)	
22.	Unknown (330h grantees only)	
23.	**Total Homeless** (All Health Centers Report This Line)	

Sample Questions to Identify Housing Status

Please check the statement that best describes your housing situation:

- ❑ I live in my home, which I rent, lease, or own
- ❑ I am staying with a series of friends and/or extended family members on a temporary basis
- ❑ I am staying in supportive or transitional housing (such as a sober living facility or recovery home)
- ❑ I live in a public or private facility that provides temporary shelters (such as a shelter, mission, single room occupancy facility, or motel)
- ❑ I have been released from an institution (such as jail or hospital) without stable housing to return to
- ❑ I live on the streets, in a car, park, sidewalk, in an abandoned building, or any unstable or non-permanent situation
- ❑ I live in a foster care environment

Source: https://www.nhchc.org/wp-content/uploads/2016/10/ask-code-policy-brief-final.pdf

Website: https://www.nhchc.org/

Other Special Populations

- Report number of special population patients (if any) on Lines 24 and 25 even if you do not receive the targeted funding for that population
  - Report patients who received primary care services at a school-based health center (Line 24)
  - Report patients who have been discharged from the uniformed services of the United States as veterans (Line 25)
    - Do not count active members of military or reserves
- Report total patients served at a health center located in or immediately accessible to a public housing site (Line 26)
  - Regardless of whether or not the patients are residents of public housing or the health center receives 330(i) funding

Line	Special Populations	Number of Patients (a)
24.	**Total School-Based Health Center Patients** (All Health Centers Report This Line)	
25.	**Total Veterans** (All Health Centers Report This Line)	
26.	**Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site** (All Health Centers Report This Line)	

Public Housing Line 26 Example

- A health center has 2 sites
- One is determined by the health center leadership (based on their own definition) to be immediately accessible to a public housing site and one is not
- The one immediately accessible saw 900 total patients, the one not accessible saw 1,100 patients
- Count on Line 26 = 900

Line	Special Populations	Number of Patients (a)
26.	**Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site** (All Health Centers Report This Line)	900

- Assistance:
  - Community Health Partners for Sustainability at http://www.chpfs.org
  - National Center for Health in Public Housing at http://www.nchph.org

Defining Visits and Providers

Staffing and Utilization

Countable Visits—Defined

- Documented
- One-on-one, face-to-face contact between a patient and a licensed or credentialed provider
  - Exception: Only behavioral health can count group visits and telemedicine
- Who exercises independent professional judgment in providing services
- *Only count visits that meet all these criteria*

Reportable Visit—Locations

- Must take place in the health center or at any other approved site or location
  - Count visits provided by both paid and volunteer staff
  - Include paid referral visits
  - Count when following current patients in a nursing home, hospital, or at home
    - Do not count if patient is first encountered at these locations unless the site is listed on Form 5B as being in your approved scope

Count Only One Visit Per

- Patient, per visit type, per day
- Provider, per patient, per day, regardless of the number of services provided
- Provider type
  - Exception: Two providers of same type at two different locations on the same day

Provider—Defined

- A provider:
  - Assumes primary responsibility for assessing the patient and documenting services in patient's record
  - Exercises independent judgement regarding the services provided, which must be in their field of training (licensure and credentialing)
- Allocate staff time by function among major service categories
  - Do not allocate clinical providers outside their clinical specialties
- Only those designated as "providers" in Appendix A of UDS Manual can generate visits for services—not all staff generate visits
- Providers may be employees of the health center, contracted (paid), or volunteers

Table 5

Staffing and Utilization

Full-Time Equivalents (FTEs)

Visits Rendered

Patients Served by Service Category

Table 5: Staffing and Utilization

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
1	Family Physicians			
2	General Practitioners			
3	Internists			
4	Obstetrician/Gynecologists			
5	Pediatricians			
7	Other Specialty Physicians			
8	**Total Physicians (Sum lines 1-7)**			
9a	Nurse Practitioners			
9b	Physician Assistants			
10	Certified Nurse Midwives			
10a	**Total NP, PA, and CNMs (Sum lines 9a - 10)**			
11	Nurses			
12	Other Medical Personnel			
13	Laboratory Personnel			
14	X-Ray Personnel			
15	**Total Medical (Sum lines 8+10a through 14)**			
16	Dentists			
17	Dental Hygienists			
17a	Dental Therapists			
18	Other Dental Personnel			
19	**Total Dental Services (Sum lines 16-18)**			
20a	Psychiatrists			
20a1	Licensed Clinical Psychologists			
20a2	Licensed Clinical Social Workers			
20b	Other Licensed Mental Health Providers			
20c	Other Mental Health Staff			
20	**Total Mental Health (Sum lines 20a-c)**			
21	**Substance Abuse Services**			
22	**Other Professional Services (specify__)**			
22a	Ophthalmologists			
22b	Optometrists			
22c	Other Vision Care Staff			
22d	**Total Vision Services (Sum lines 22a-c)**			
23	**Pharmacy Personnel**			
24	Case Managers			
25	Patient/Community Education Specialists			
26	Outreach Workers			
27	Transportation Staff			
27a	Eligibility Assistance Workers			
27b	Interpretation Staff			
27c	Community Health Workers			
28	Other Enabling Services (specify__)			
29	**Total Enabling Services (Sum lines 24-28)**			
29a	**Other Programs/Services (specify__)**			
29b	**Quality Improvement Staff**			
30a	Management and Support Staff			
30b	Fiscal and Billing Staff			
30c	IT Staff			
31	Facility Staff			
32	Patient Support Staff			
33	**Total Facility and Non-Clinical Support Staff (Sum lines 30a - 32)**			
34	**Grand Total (Sum lines 15+19+20+21+22+22d+23+29+29a+29b+33)**			

Staffing and Utilization—What to Report

Column A	Staff full-time equivalents (FTEs)
Column B	Visits by type of provider
Column C	Patients by seven service categories • Medical • Dental • Mental health • Substance abuse • Vision • Other professional • Enabling

Service categories on Table 5 have a direct relationship to cost categories on Table 8A. This will be discussed in the Table 8A section.

Who to Include in Full-Time Equivalent (FTE) Calculation

- Report all staff providing in-scope services in terms of an **annualized FTE**
  - Include employees, contracted staff, residents, interns, and volunteers
  - Do not include paid referral provider FTEs when working on a fee-for-service basis (paid by service, not by hours), but DO count their visits and patients!

Determining FTE, Column A

- **One full-time equivalent (FTE=1.0) describes staff who worked the equivalent of full-time for one year**
  - Health center defines the number of hours in full-time
  - Report FTE, not a head count or a census of staff as of end of year
  - Based on:
    - Employment contracts for clinicians and other exempt employees
      - Include paid time off, vacation, sick time, continuing education, "admin" time, etc.
    - Hours paid for non-exempt staff
      - Divide hours paid by 2,080 for 40-hour work weeks or by appropriate amount for other work weeks
      - The majority of staff are typically non-exempt employees
    - Hours worked for volunteers and locums (divided by fewer hours)

FTE by Function

- Also based on the part of the year the employee works
- Allocate staff by function/work performed, not job title
  - Do not parse out components of an interaction
  - Do not allocate administrative time supervising clinical staff, attending clinical meeting, or writing clinical protocol
  - Medical director's corporate time (only) can be allocated to non-clinical support services

For Example:
Report a 1.0 FTE medical assistant who works as a laboratory technician one day a week as follows:
0.80 FTE on Line 12, Other Medical Personnel
0.20 FTE on Line 13, Laboratory Personnel

Calculating FTE: Examples

Regular Employee	Volunteer, Locum, etc.
One full-time staff worked for 6 months of the year: 1. Calculate base hours for full-time: Total hours per year: 40 hours/week x 52 weeks = 2,080 hours 2. Calculate this staff person's paid hours: Total hours for 6 months: 40 hours/week x 26 weeks = 1,040 hours 3. Calculate FTE for this person: 1,040 hours/2,080 hours = **0.50 FTE**	Four individuals who had worked 1,040 hours scattered throughout the year: 1. Calculate base hours for full-time: Total hours per year: 40 hours/week x 52 weeks = 2,080 hours 2. Deduct unpaid benefits of 10 holidays, 12 sick days, 5 continuing medical education (CME) days, and 3 weeks vacation: 10+12+5+15 = 42 days * 8 hours = 336 2080-336 = 1,744 3. Calculate combined person hours: Total hours: 1,040 hours 4. Calculate FTE: 1,040 hours/1,744 hours = **0.60 FTE**

Specific Staff Considerations

- **Other Medical Personnel (Line 12)**: Include medical assistants, nurses' aides, unlicensed interns or residents, but do not report quality improvement (QI), medical records, patient support, or HIT/EHR staff here
- **Dental Therapists (Line 17a):** Only licensed in Maine, Minnesota, Vermont, and Alaska tribal lands
- **Other Professionals (Line 22)**: Include chiropractors, acupuncturists, physical, speech, and occupational therapists, nutritionists, podiatrists, etc.

Staff Considerations Continued

- **Community Health Workers (Line 27c):** Lay members of the community who provide outreach and education; include promotoras, health advisors, advocates, and representatives
- **Other Programs and Related Services (Line 29a)**: Include non-health care program staff (e.g., child care, adult day health, job training, housing programs)
- **Quality Improvement (QI) Staff (Line 29b)** : Staff who design and have oversight of QI systems; include QI staff, data specialists, statisticians, HIT including EHR designers, and those who design medical forms or conduct analysis of HIT data

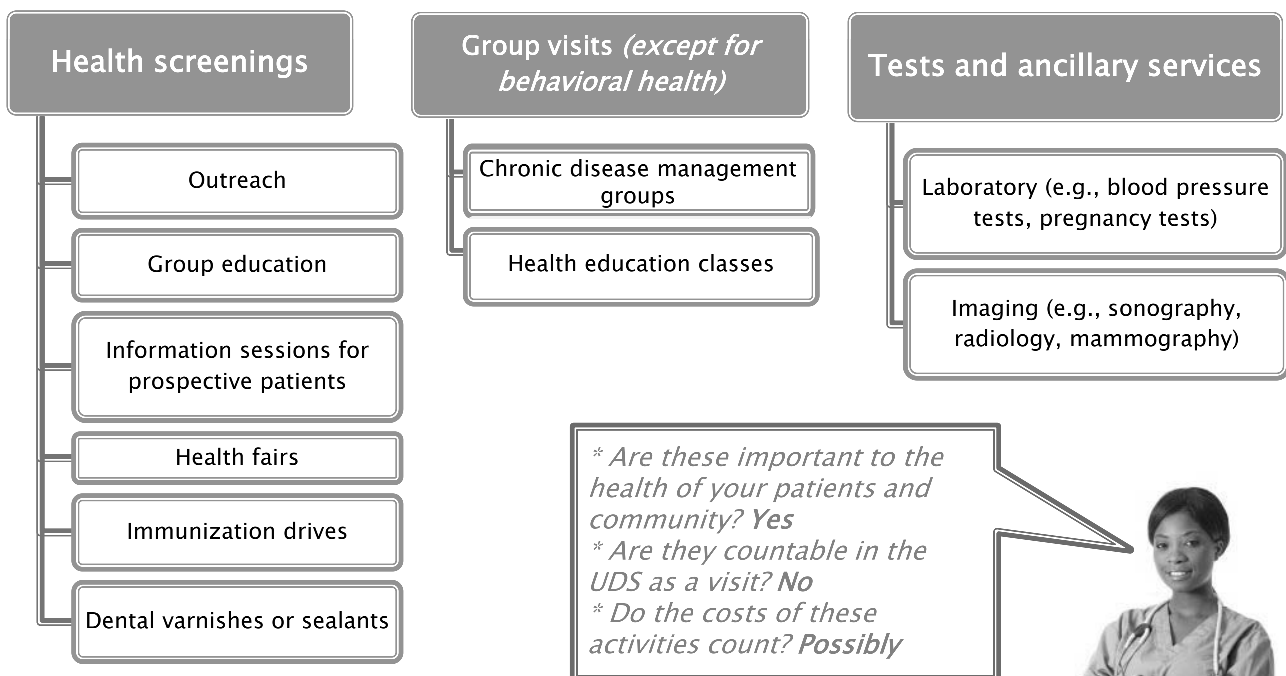
Staff Considerations

- **IT Staff (Line 30c)**: Technology and information systems staff supporting maintenance and operation of computing systems and those managing hardware and software of HIT
  - Report data entry, help desk, and technical assistance in the category of service they support, not here

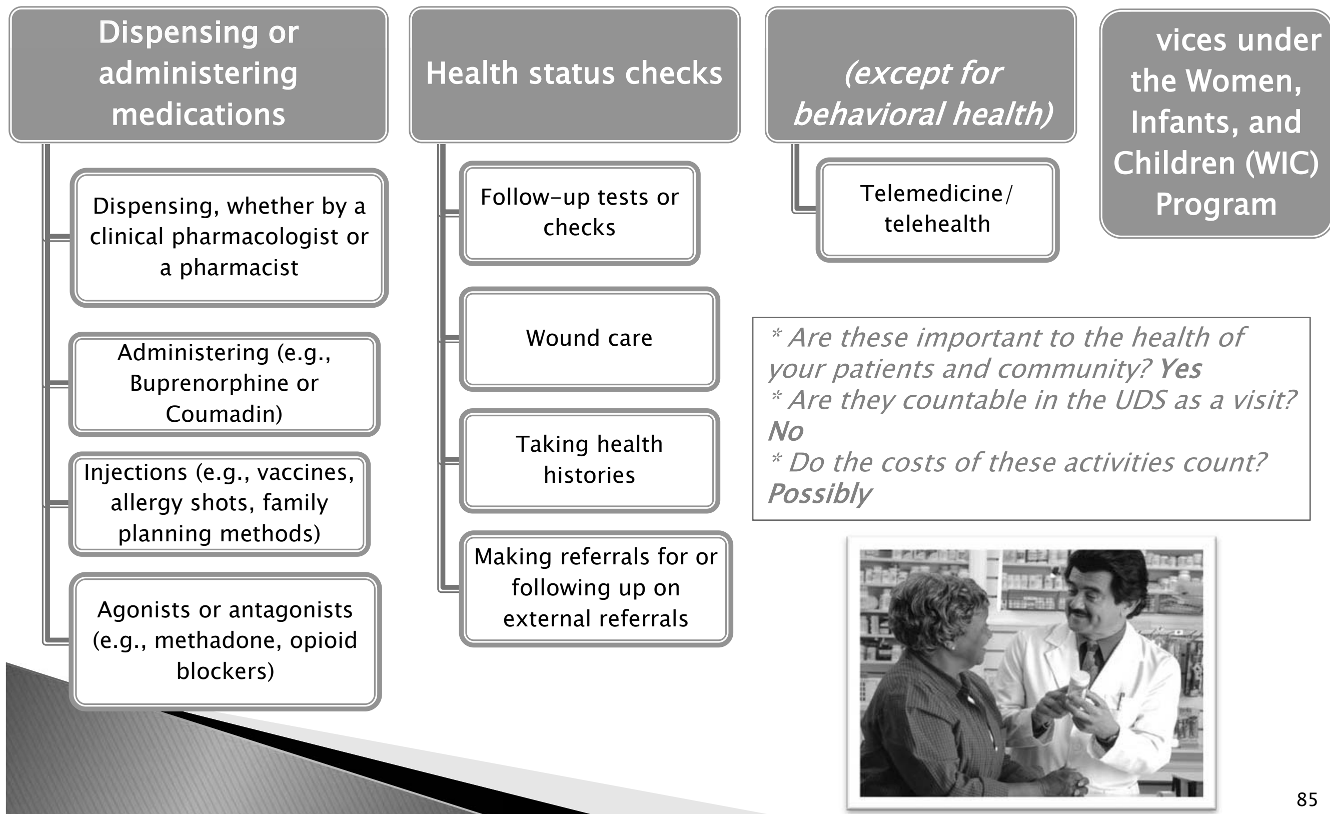
Counting Visits, Column B

- Report visits by service provider (including paid referral visits) that meet the definitions. Remember:
    - Visits must be
        1) documented,
        2) face-to-face and one-on-one (exception: group and telemedicine for behavioral health), and
        3) provided by a provider exercising independent, professional judgment (and licensed and/or credentialed to count a visit)
    - Not all staff generate visits (the visits column is greyed out)
    - Not all services are counted as visits
    - A visit may consist of multiple services, but only report one visit

Services and Persons Not Reported



Other Services and Persons Not Reported



Other Visit Considerations

- **Nurses**: Must meet <u>all</u> the visit definition requirements
  - Common visits that might be counted: Triage, nurse evaluation of patient's medical condition AND patient not seen by another provider, home health care
  - Do not count drug or vaccine administration, other shots, tests, blood draws, or visits where the patient sees another medical provider as a nurse visit
- **Students**: Do not count services of students, but count those by a licensed provider
- **MAT**: Credit the visit to the credentialed medical or psychiatric staff providing treatment (not as substance abuse)

Counting Patients, Column C

- **Report patients by *service category***
- Report an unduplicated count of patients who received at least one countable visit in the service category
- The same patient may be counted in multiple service categories but only once per category

UDS Edit Check: Visits per Patient
What to look for and possible solutions

Common edit: Medical visits per medical patient varies substantially from national average. CY (4.68); PY National Average (3.13).

UDS Edit Check: Visits per Patient

What to look for and possible solutions

Common edit: Medical visits per medical patient varies substantially from national average. CY (4.68); PY National Average (3.13).

What to look for:

- Calculate by service category: Column B (Visits) ÷ Column C (Patients)
- Nationally on average, patients are seen 3-4 times a year for medical care
- Similar edits may flag for other service categories if there is a large variance in visits per patient when compared to the national average

Possible solutions:

- Correct errors:
  - ✗ Reporting multiple visits per patient per day, for types or quantity of medical services
  - ✗ Reporting non-countable interactions as visits
  - ✗ Left out a site's visit activity
- Explain:
  - ✓ Situations that resulted in large number of return visits per patient
  - ✓ Limited staffing capacity to see patients more frequently

Table 5A

Tenure for Health Center Staff

Table 5A: Tenure

Line	Health Center Staff	Full and Part Time		Locum, On-Call, etc.	
		Persons (a)	Total Months (b)	Persons (c)	Total Months (d)
1	Family Physicians				
2	General Practitioners				
3	Internists				
4	Obstetrician/Gynecologists				
5	Pediatricians				
7	Other Specialty Physicians				
9a	Nurse Practitioners				
9b	Physician Assistants				
10	Certified Nurse Midwives				
11	Nurses				
16	Dentists				
17	Dental Hygienists				
17a	Dental Therapists				
20a	Psychiatrists				
20a1	Licensed Clinical Psychologists				
20a2	Licensed Clinical Social Workers				
20b	Other Licensed Mental Health Providers				
22a	Ophthalmologist				
22b	Optometrist				
30a1	Chief Executive Officer				
30a2	Chief Medical Officer				
30a3	Chief Financial Officer				
30a4	Chief Information Officer				

Report Persons

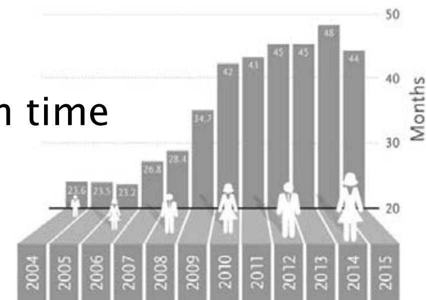
- Report persons and months based on census of staff employed on last day of year for the selected categories

Tenure = Months of Continuous Employment

- Persons (Columns A and C)
  - A head count (not FTE) of persons in their current position as of **December 31**
- Months (Columns B and D)
  - Number of consecutive months of service in current position

Two Categories

- Full- and part-time staff (Columns A and B)
  - Employees (full- and part-time or part-year)
  - Onsite contracted staff
  - National Health Service Corps assignees
- Other staff or consultants (Columns C and D)
  - Residents
  - Locum tenens
  - On-call providers
  - Offsite contract providers paid based on time
  - Volunteers
  - Non-clinical consultants



Tenure Reporting Considerations

- Include:
  - Staff who did not work on last day of year but have a scheduled commitment for the coming year
- Exclude:
  - Staff not employed at end of year
  - Paid referral providers (who work many hours but no regular schedule)
- Round persons and months up to a whole number
- Staff may be reported on more than one line if they hold more than one position at end of year
- Months may pre-date health center grant or look-alike designation

Tenure Reporting, Example

A physician has been (and continues to be) a pediatrician since January 1, 2014, and becomes medical director on July 13, 2017.

Count the provider with:

- 48 months as a pediatrician (Line 5) and
- 6 months as a medical director (Line 30a2)

UDS Edit Check: Tenure Increase

What to look for and possible solutions

Common edit: Tenure reported for full- and part-time staff on Line 16, Dentists, has increased by more than 12 months per person from the prior year.

UDS Edit Check: Tenure Increase

What to look for and possible solutions

Dentists, has increased by more than 12 months per person from the prior year.

What to look for:

- Compares total months per person by line to the prior year
- Check data when increases exceed one year tenure per person
- Edits may flag for other staff lines

Possible solutions:

- Correct errors:
  - ✗ Changing the category that the person is reported in
  - ✗ Inaccurate tracking of staff and their months
- Explain:
  - ✓ Had wrong start date entered in prior year

Table 6A

Selected Diagnoses and Services Rendered

Table 6A: Selected Diagnoses and Services

	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
Selected Infectious and Parasitic Diseases				
1-2.	**Symptomatic / Asymptomatic HIV**	**B20, B97.35, O98.7-, Z21**		
3	**Tuberculosis**	**A15- through A19-**		
4	**Sexually transmitted infections**	**A50- through A64- (exclude A63.0), M02.3-**		
4a.	**Hepatitis B**	**B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.51**		
4b.	**Hepatitis C**	**B17.10, B17.11, B18.2, B19.20, B19.21, Z22.52**		
Selected Diseases of the Respiratory System				
5	**Asthma**	**J45-**		
6	**Chronic obstructive pulmonary diseases**	**J40- through J44-, J47-**		
Selected Other Medical Conditions				
7	**Abnormal breast findings, female**	**C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.81, D05-, D48.6-, R92-**		
8	**Abnormal cervical findings**	**C53-, C79.82, D06-, R87.61-, R87.810, R87.820**		
9	**Diabetes mellitus**	**E08- through E13-, O24- (exclude O24.41-)**		
10	**Heart disease (selected)**	**I01-, I02- (exclude I02.9), I20- through I25-, I26- through I28-, I30- through I52-**		
11	**Hypertension**	**I10- through I15-**		
12	**Contact dermatitis and other eczema**	**L23- through L25-, L30- (exclude L30.1, L30.3, L30.4, L30.5), L55- through L59- (exclude L57.0 through L57.4)**		

*Excerpted from Table 6A

Selected Diagnoses and Services— Categories

- Medical Conditions:
  - Infections and Parasitic Diseases (Lines 1-4b)
  - Diseases of the Respiratory System (Lines 5-6)
  - Other Medical Diagnoses (Lines 7-14a)
  - Childhood Diagnoses (limited to ages 0 through 17) (Lines 15-17)
- Mental Health and Substance Abuse Diagnoses (Lines 18-20d)
- Diagnostic Tests/Screening/Preventive Services (Lines 21-26d)
- Dental Services (Lines 27-34)

Selected Diagnoses and Services Reporting

- Report the number of visits with the selected service or diagnosis in Column A
- Report the number of <u>unduplicated</u> patients receiving the service or with the diagnosis in Column B

Selected Diagnoses and Services Considerations

- **Report only diagnoses made by a medical, dental, mental health, substance abuse, or vision provider**
- Report only services provided as part of a countable visit
- If a patient has more than one reportable service or diagnosis during a visit, count each
- The same patient can have multiple visits during the year
- Do not count multiple services of same type conducted at one visit as separate visits (e.g., filling two teeth, different immunizations at same visit)

Counting Diagnosis and Services of a Patient Example

A patient was seen at the health center during the year for the following services:

- 1/12/17: Diagnosed by physician with hypertension; also got a flu shot
- 3/30/17: Further evaluation with nurse practitioner for hypertension; diagnosed with tobacco use; cessation counseling provided
- 12/11/17: Received emergency dental services from dentist

- Results:

Line	Category	Visits	Patient
11.	Hypertension	2	1
19a.	Tobacco use disorder	1	1
24a.	Seasonal Flu vaccine	1	1
26c.	Smoke and tobacco use cessation counseling	1	1
27.	Emergency Dental Services	1	1

Services Provided by Multiple Entities

- Count if:
  - Health center provider orders and performs the service
  - Test is ordered and paid for by the health center
  - Sample is collected at health center and sent to a reference lab for processing (regardless of payment)

- Do not count tests or services performed by other entities where the health center does not pay for the service

UDS Edit Check: Table 5 and 6A Dental

What to look for and possible solutions

Common edit: Total dental visits on Table 6A are less than or equal to the total dental visits reported on Table 5. This is unusual because dental visits often include more than one service, so on Table 6A each dental service would be counted on the corresponding line, but on Table 5 the combined services would be shown as one visit.

UDS Edit Check: Table 5 and 6A Dental

What to look for and possible solutions

dental visits reported on Table 5. This is unusual because dental visits often include more than one service, so on Table 6A each dental service would be counted on the corresponding line, but on Table 5 the combined services would be shown as one visit.

What to look for:

- Data on Table 6A relates to data on Table 5
- Review table and codes to ensure no data missing on Table 6A

Possible solutions:

- Correct errors:
  - ✗ Only one line on Table 6A is reflecting visits for multiple services provided at that visit (e.g., oral exam, sealant, fluoride)
  - ✗ Table 5 is reflecting multiple services conducted at one visit as multiple visits
- Explain:
  - ✓ Significant dental activity that has no corresponding dental code
  - ✓ Limited services provided to patients

Calculate Visits per Patients

- Learn more about your patients and identify potential errors in the report by calculating the average number of visits per patient
- Calculation:

Column A (Visits) ÷ Column B (Patients)

- The next 2 slides show averages using 2016 UDS national data
  - How does your health center compare?

National Statistics—2016 Rollup

	Diagnostic Category	Applicable ICD-10-CM Code	Diagnosis Regardless of Primacy (a)	Diagnosis (b)	Visits Per Patient
Selected Infectious and Parasitic Diseases					
1-2.	**Symptomatic / Asymptomatic HIV**	**B20, B97.35, O98.7-, Z21**	634,906	158,323	*4.01*
3	**Tuberculosis**	**A15- through A19-**	17,871	9,060	*1.97*
4	**Sexually transmitted infections**	**A50- through A64- (exclude A63.0), M02.3-**	307,214	214,478	*1.43*
4a.	**Hepatitis B**	**B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.51**	93,983	46,342	*2.03*
4b.	**Hepatitis C**	**B17.10, B17.11, B18.2, B19.20, B19.21, Z22.52**	475,220	206,587	*2.30*
Selected Diseases of the Respiratory System					
5	**Asthma**	**J45-**	2,184,904	1,196,242	*1.83*
6	**Chronic obstructive pulmonary diseases**	**J40- through J44-, J47-**	1,514,769	742,256	*2.04*
Selected Other Medical Conditions					
7	**Abnormal breast findings, female**	**C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.81, D05-, D48.6-, R92-**	172,073	108,729	*1.58*
8	**Abnormal cervical findings**	**C53-, C79.82, D06-, R87.61-, R87.810, R87.820**	268,245	168,903	*1.59*
9	**Diabetes mellitus**	**E08- through E13-, O24- (exclude O24.41-)**	7,699,943	2,283,360	*3.37*
10	**Heart disease (selected)**	**I01-, I02- (exclude I02.9), I20- through I25-, I26- through I28-, I30- through I52-**	1,761,974	710,638	*2.48*
11	**Hypertension**	**I10- through I15-**	10,995,226	4,335,639	*2.54*
12	**Contact dermatitis and other eczema**	**L23- through L25-, L30- (exclude L30.1, L30.3, L30.4, L30.5), L55- through L59- (exclude L57.0 through L57.4)**	886,358	687,780	*1.29*

*Excerpted from Table 6A

National Statistics—2016 Rollup

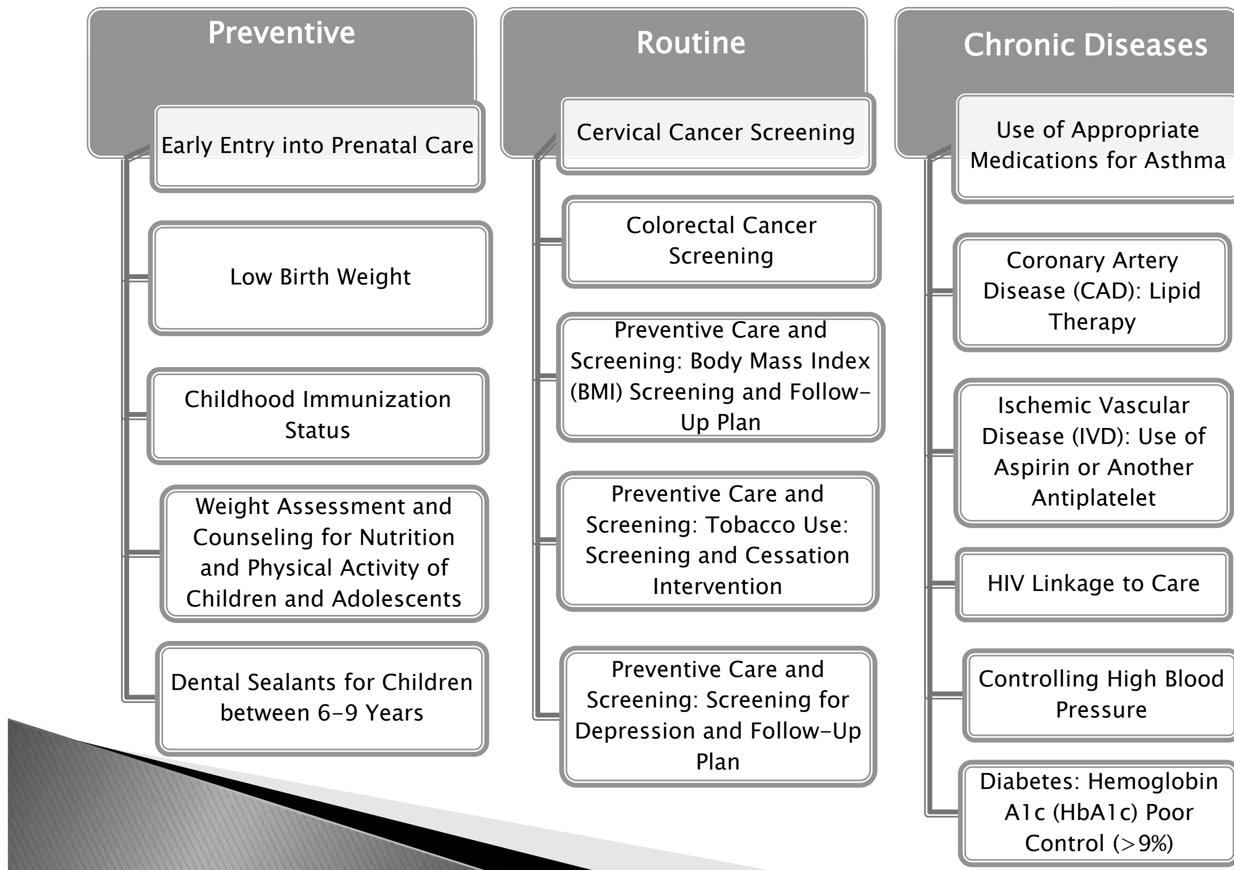
	Service Category	Applicable ICD-10-CM Code	Number of Visits (a)	Number of Patients (b)	Visits Per Patient
Selected Diagnostic Tests/Screening/Preventive Services					
21.	**HIV test**	**CPT – 4: 86689; 86701-86703; 87390-87391**	1,612,535	1,422,586	*1.13*
21a.	**Hepatitis B test**	**CPT-4: 86704, 86706, 87515-17**	639,999	558,040	*1.15*
21b.	**Hepatitis C test**	**CPT-4: 86803-04, 87520-22**	778,774	695,822	*1.12*
22.	**Mammogram**	**CPT-4: 77052, 77057 OR ICD-10" Z12.31**	612,017	561,269	*1.09*
23.	**Pap tests**	**CPT-4: 88141-88155; 88165-88167, 88174-88175 or ICD-10: Z01.41-, Z01.42, Z12.4**	2,096,335	1,951,006	*1.07*

*Excerpted from Table 6A

Tables 6B and 7

Clinical Measures

Types of Clinical Measures



Clinical Measure Reporting Format

Measure Description	Describes the quantifiable indicator to be evaluated
Denominator (Universe)	Patients who fit the detailed criteria described for inclusion in the measure
Numerator	Patients included in the denominator whose records meet the measurement standard for the measure
Exclusions/Exceptions	Patients not to be considered for the measure or included in the denominator
Specification Guidance	CMS measure guidance that assists with understanding and implementation of eCQMs
UDS Reporting Considerations	BPHC best practices and guidance to be applied to the measure

UDS and eCQMs

- Most measures align with eCQMs (measure numbers and links are provided to assist you)
- Major differences between UDS and eCQMs include:
  - Those noted under “UDS Reporting Considerations”
  - Visit types differences: UDS asks for patients who have had a medical visit (dental patients for the dental measure)
    - **Do not exclude** patients just because they were seen only for urgent care, family planning, or acute care or had only one visit at the health center
  - UDS measurement period is a fixed calendar year

ECQI Resource Center

- eCQM Link:

https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ecqms/2017-performance-period-epec-ecqms

2017 Performance Period

Secure | https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ecqms/2017-performance-period-epec-ecqms

Apps Imported From IE Bookmarks

eCQI Resource Center

The one-stop shop for the most current resources to support Electronic Clinical Quality Improvement.

CMS The Office of the National Coordinator for Health Information Technology

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Sections
2015 Performance Period EP eCQMs
2016 Performance Period EP eCQMs
2017 Performance Period EP/EC eCQMs
2018 Performance Period EP/EC eCQMs

2017 Perf P/EC eCQMs

Clinical Quality Measures in the 2016 update for Eligible Professionals.

Measure Name	CMS eCQM ID	Domain	NQF ID	Measure Steward	MIPS Quality ID	Addendum Notes	USHIK Version Links
ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range	CMS179v5	Patient Safety	None	Centers for Medicare & Medicaid Services (CMS)		Removed from Quality Payment Program	Version Detail Version Compare
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	CMS161v5	Effective Clinical Care	0104	PCPI(R) Foundation (PCPI[R])	107		Version Detail Version Compare
Anti-depressant	CMS128v5	Effective Clinical Care	0105	National Committee for	9		Version Detail

Tables 6B and 7

Prenatal Care
Delivery Outcomes

Prenatal and Birth Outcome Measures

- Report universe of prenatal patients, women who delivered, and their birth outcomes
- No sampling permitted
- Measures to report and major differences from prior year:

Table	Section	Description	eCQM	Major Differences from 2016 to 2017
6B	Lines 7-9	Early Entry into Prenatal Care	No eCQM	None
7	Part A	Low Birth Weight	No eCQM	None

Prenatal Patients by Age and Entry into Prenatal Care, Table 6B

Table 6B: Section A: Lines 1-6

0	Prenatal Care Provided by Referral Only (Check if Yes)	
Section A - Age Categories for Prenatal Patients: Demographic Characteristics of Prenatal Care Patients		
Line	**Age**	**Number of Patients (a)**
1	Less than 15 Years	
2	Ages 15-19	
3	Ages 20-24	
4	Ages 25-44	
5	Ages 45 and over	
6	**Total Patients (Sum lines 1-5)**	

Table 6B: Section B: Lines 7-9

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

Prenatal Patients

- Report all prenatal care patients who **received directly or were referred for prenatal care services.** Include women who were:
  - Provided all prenatal care by the health center, including delivery
  - Provided all prenatal care by the health center but were referred for delivery
  - Provided some prenatal care but were later referred for care and delivery
  - Diagnosed and referred with no prenatal care provided by the health center (for referral-only programs and certain high-risk referrals)

Prenatal Patients

- Report age as of **June 30**
- Report regardless of whether they began prenatal care at health center or were referred to it
- Mark the check box if your health center provides prenatal care to patients through direct referral only

Prenatal Patient Considerations

Include women who began prenatal care in the:

- Previous year, continued care, and delivered in the current reporting period
- Current year and who delivered during the current reporting year
- Current year but who will not deliver until the next reporting period
- Do not include patients who only had tests, vitamins, assessments, or education and did not have a prenatal care physical exam

Early Entry into Prenatal Care

Denominator	Women seen for prenatal care during the year • Report women in the trimester they <u>began</u> prenatal care (not when referral was made) • Count in Column A if care began at your health center or referred for care by your health center • Count in Column B if care began with another provider
Numerator	Women who began prenatal care during their first trimester (Line 7, Columns A+B)
Exclusions	None

Prenatal Care Reporting Considerations

eCQM Number	None
Major differences from prior year	None
Major differences from eCQM	None
Reminders	• In 2016, trimester of entry changed to be based on last menstrual period (vs. conception), end of the 2nd trimester changed from end of 26 week to end of 27 week, and 3rd trimester starts at 28 week • Total women by trimester of entry on Lines 7-9, Columns A + B, must equal total prenatal women reported on Line 6, Column A • Only report women who transferred into your care after seeing another provider in Column B • If you referred women to other providers for <u>all</u> their prenatal care, report the trimester of their first prenatal visit with the other provider in Column A • Include women who began prenatal care in 2016 and delivered in 2017

HIV Positive Pregnant Women and Deliveries by Health Center Providers

- **Table 7: Line 0**: Number of health center patients who are pregnant and are HIV positive
- **Table 7: Line 2**: Number of women who had deliveries performed by health center clinicians, including deliveries to non-health center patients (e.g., on-call, emergency deliveries)
- *Note: These counts are regardless of whether the health center provided prenatal care to the patients*

Section A: Deliveries and Birth Weight		
Line	**Description**	**Patients**
0	HIV Positive Pregnant Women	
2	Deliveries Performed by Health Center's Providers	

Low Birth Weight, Table 7, Section A

Line #	Race and Ethnicity	Who Delivered During the Year (1a)	Live Births: <1500 grams (1b)	1500–2499 grams (1c)	Live Births: ≥2500 grams (1d)
	Hispanic/Latino				
1a	Asian				
1b1	Native Hawaiian				
1b2	Other Pacific Islander				
1c	Black/African American				
1d	American Indian/Alaska Native				
1e	White				
1f	More than One Race				
1g	Unreported/Refused to Report Race				
	Subtotal Hispanic/Latino				
	Non-Hispanic/Latino				
2a	Asian				
2b1	Native Hawaiian				
2b2	Other Pacific Islander				
2c	Black/African American				
2d	American Indian/Alaska Native				
2e	White				
2f	More than One Race				
2g	Unreported/Refused to Report Race				
	Subtotal Non-Hispanic/Latino				
	Unreported/Refused to Report Ethnicity				
h	Unreported/Refused to Report Race and Ethnicity				
i	**Total**				

Women Who Delivered—Column 1a

- **Column 1a:** Prenatal care patients who delivered during the measurement year
  - Include delivery regardless of outcome
  - Do not include women with no documentation that delivery occurred
  - Do not include women who had a miscarriage
  - Even if the delivery is of twins or triplets or is a stillbirth, report only one woman as having delivered

Low Birth Weight

Denominator *(Columns 1b+1c+1d)*	Babies born during the measurement period to prenatal care patients
Numerator *(Columns 1b+1c)*	Babies born with a birth weight below normal (under 2,500 grams)
Exclusions	• Stillbirths (mother is counted on Table 6B, delivery is counted on Table 7, but birth weight is not counted) • Miscarriages (mother is counted only on Table 6B)

Low Birth Weight Reporting Considerations

eCQM Number	None
Major differences from prior year	None
Major differences from eCQM	None
Reminders	• Report babies according to their birth weight in grams: o *Very low (Column 1b) = Less than 1,500 grams* o *Low (Column 1c) = 1,500 grams through 2,499 grams* o *Normal (Column 1d) = 2,500 grams or greater* • The higher the percentage of babies born below normal birth weight, the poorer the outcome • Report race and ethnicity of mother and baby separately • Report all live births separately by birth weight • Report mothers in prenatal program and their babies, even if prenatal care or delivery was done by a non-health center provider • Prenatal Women ≠ Deliveries ≠ Birth Outcomes • Review outcomes against overall patient population mix

UDS Edit Check: Trimester of Entry

What to look for and possible solutions

Common edit: All prenatal patients are reported as having their first prenatal visit with another provider (Lines 7-9 Column B). Only report women who transferred into your care after seeing another provider in Column B. If your health center has referred women to other providers for all their prenatal care (no prenatal care at your center), report the trimester that they had the visit with the other provider, but report them in Column A.

UDS Edit Check: Trimester of Entry

What to look for and possible solutions

Common edit: All prenatal patients are reported as having their first prenatal visit with another provider (Lines 7-9 Column B). Only report women who transferred into your care after seeing another provider in Column B. If your health center has referred women to other providers for all their prenatal care (no prenatal care at your center), report the trimester that they had the visit with the other provider, but report them in Column A.

What to look for:

- For each prenatal care patient, determine who initiated prenatal care

Possible solutions:

- Correct errors:
  - ✗ Women referred out for all their prenatal care were reported in Column B but should be in Column A
- Explain:
  - ✓ All prenatal patients transferred **from** another organization to your providers

UDS Edit Check: Percent Deliveries

What to look for and possible solutions

Common edit: The total women who delivered on Table 7 seems high when compared to the total women in prenatal care on Table 6B.

UDS Edit Check: Percent Deliveries

What to look for and possible solutions

Common edit: The total women who delivered on Table 7 seems high when compared to the total women in prenatal care on Table 6B.

What to look for:

- Calculate women who delivered as a percent of prenatal patients:
  - Table 7, Line i, Column 1a ÷ Table 6B, Line 6, Column A
- Typical range is about 50-60% of women in program deliver
- Edit may appear for unusually high or low percent

Possible solutions:

- Correct errors:
  - ✗ Missing women in prenatal count but delivery included
  - ✗ Only including women who began and delivered in current year
  - ✗ Counting multiple babies born as separate women who delivered
  - ✗ For low percent, missing birth outcomes for significant number of women
- Explain:
  - ✓ Changes in prenatal program (e.g., your providers not taking new prenatal patients, external prenatal provider closed practice)

Tables 6B and 7

Non-Prenatal Measures Column Logic

Reporting Options

Reporting Column Logic

- **Universe (Denominator) (Column A)**: Identify all patients in the initial patient population (universe) and report this total
  - Universe is unique for each measure; defined in terms of characteristics such as age, gender, clinical condition, service provided
- **Number in Review (Column B)**: Report one of the following:
  - Universe
  - Reduced Universe—Number greater than or equal to 80% of universe
  - A **random** sample of 70 patient charts
    - Use only if you do not have at least 80% of all patient records in the HIT/EHR for the measure or if the missing cases would bias the findings
    - Note: Sampling can result in ineligibility for Health Center Quality Improvement Awards
- **Performance (Numerator) (Column C or F)**: Report the number of records (from Column B) that meet the measurement standard
  - The numerator divided by Column B is the percentage of patients meeting the measurement standard

Reporting of Reduced Universe

- **Example of using a reduced universe**
  - New location added that was not yet fully integrated into EHR system
  - It is a general practice site and sees a variety of patients of all ages
  - The site is still ramping up and accounts for less than 10% of your total practice
  - Since most of the data is in the EHR, report using a partial universe (since at least 80% of the records are present in the EHR)
  - See example numbers below

Example: Section C - Childhood Immunization Status				
Line	**Childhood Immunization Status**	**Total Patients with 2nd Birthday (a)**	**Number Charts Sampled or EHR total (b)**	**Number of Patients Immunized (c)**
10	MEASURE: Percentage of children 2 years of age who received age appropriate vaccines by their 2nd birthday	100	93	75

Table 6B

Quality of Care Measures
Lines 10-22

Quality of Care Measures

- Report on quality of care measures
- *"Process measures"* serve as a proxy for good long-term health outcomes
  - Patients who receive timely routine and preventive care are more likely to have improved health status

By identifying patients who use tobacco, we can provide cessation counseling and reduce the probability of cancer, asthma, emphysema, and other tobacco-related illnesses.

Table 6B: Measures to Report and Major Differences

	Description	eCQM	om 2016 to 2017
10	Childhood Immunization Status	CMS117v5	None
11	Cervical Cancer Screening	CMS124v5	Numerator = • Added concurrent cervical cytology/human papillomavirus (HPV) co-testing for those age 30 -64 performed in measurement period or the four years prior (retained women age 23-64 who had cervical cytology performed during measurement period or two years prior)
12	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	CMS155v5	None
13	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	CMS69v5	Numerator = • Deleted separate parameters for patients age 65 and older. Normal parameters are now age 18 years and older BMI was greater than or equal to 18.5 and less than 25 kg/m2
14a	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS138v5	None
16	Use of Appropriate Medications for Asthma	CMS126v5	Exclusions = • Now excludes patients with obstructive chronic bronchitis Numerator = • Dispensing of medications changed to ordering of medications

Table 6B: Measures to Report and Major Differences, continued

Line	Description	eCQM	Major Differences from 2016 to 2017
17	Coronary Artery Disease (CAD): Lipid Therapy	No eCQM	None
18	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	CMS164v5	Exclusions = • Now excludes patients using anticoagulant medications Numerator = • No longer specifies other antithrombotic. Changed to patients who had an active medication of aspirin or another antiplatelet
19	Colorectal Cancer Screening	CMS130v5	None
20	HIV Linkage to Care	No eCQM	None
21	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	CMS2v6	Numerator = • Screening is now required for depression, rather than clinical depression
22	Dental Sealants for Children between 6-9 Years	CMS277v0	None

Preventive Care Measures

Childhood Immunizations
Childhood Weight
Dental Sealants for Children

Childhood Immunizations

Table 6B, Line	Childhood Immunization Status	Total Patients with 2nd Birthday (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Immunized (c)
10	MEASURE: Percentage of children 2 years of age who received age appropriate vaccines by their 2nd birthday			

Childhood Immunizations

Denominator	Children who turn 2 years of age during the measurement period and who had a medical visit during the measurement period • Include children seen for acute or chronic conditions (not just those seen for well-child care)
Numerator	For each vaccine, children who were fully immunized, had documented history of illness, had a seropositive test result, or had an allergic reaction to the vaccine by their second birthday
Exclusions	None

Required Vaccinations

- ALL of the following vaccines are required:
  - 4 diphtheria, tetanus, and acellular pertussis (DTP/DTaP)
  - 3 polio (IPV)
  - 1 measles, mumps, rubella (MMR)
  - 3 H influenza type B (Hib)
  - 3 hepatitis B (Hep B)
  - 1 chicken pox VZV (Varicella)
  - 4 pneumococcal conjugate (PCV)
  - 1 hepatitis A (Hep A)
  - 2 or 3 rotavirus (RV)
  - 2 influenza (flu) vaccines

Childhood Immunizations Reporting Considerations

eCQM Number	CMS117v5
Major differences from prior year	None
Major differences from eCQM	None
Reminders	• Do not count notes that patient is "up to date." Record must list the dates of all immunizations and names of immunization agents • Good faith efforts do not meet the measurement standard, including: o Failure to bring patient in o Refusal for personal or religious reasons • Be sure to include patients: o Who turned two during the year (do not include other ages), even if they were not seen before they turned two o Whose only medical visit is for acute or urgent care

Childhood Weight

Table 6B, Line	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Total Patients Aged 3 through 17 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Counseling and BMI Documented (c)
12	MEASURE: Percentage of patients 3-17 years of age with a BMI percentile, *and* counseling on nutrition *and* physical activity documented			

Childhood Weight

Denominator	Patients 3 through 17 years of age with at least one medical visit during the measurement period
Numerator	Children and adolescents who had the following during the measurement period: • Their BMI percentile (not just BMI or height and weight) recorded ***and*** • Counseling for nutrition ***and*** • Counseling for physical activity All **three** elements must have occurred in order to meet the measurement standard
Exclusions	Patients who had a diagnosis of pregnancy during the measurement period

Childhood Weight Assessment Reporting Considerations

eCQM Number	CMS155v5
Major differences from prior year	None
Major differences from eCQM	• eCQM denominator is limited to outpatient visits with a primary care physician (PCP) or obstetrician / gynecologist (OB/GYN). UDS includes children seen by nurse practitioners and physician assistants • BMI, nutrition, and activity are calculated separately in the eCQM, but combined in the UDS to meet the measurement standard
Reminders	• Include children and adolescents in the evaluation of this measure if they had any medical visit with the health center during the year • Do not count well-child visits as automatically meeting the measurement standard

Dental Sealants for Children

Table 6B, Line	Dental Sealants for Children between 6-9 Years	Aged 6 through 9 at Moderate to High Risk for Caries (a)	Charts Sampled or EHR Total (b)	umber of Patients with Sealants to First Molars (c)
22	MEASURE: Percentage of children 6 through 9 years of age, at moderate to high risk of caries who received a sealant on a first permanent molar			

Dental Sealants for Children

Denominator	Children 6 through 9 years of age with an oral assessment or comprehensive or periodic oral evaluation dental visit and are at moderate to high risk for caries in the measurement period
Numerator	Children who received a sealant on a permanent first molar tooth during the measurement period
Exclusions	Children for whom all first permanent molars are non-sealable (i.e., molars are either decayed, filled, currently sealed, or un-erupted/missing)

Dental Sealants for Children Reporting Considerations

eCQM Number	CMS277v0
Major differences from prior year	None
Major differences from eCQM	• Note: Although draft eCQM reflects age 5 through 9 years of age, use age 6 through 9 as measure steward intended
Reminders	• Include patients who had a dental visit with the health center or with another dental provider through a paid referral • You must determine risk level, not count all dental patients of this age range in universe • Risk level is a finding at the patient-level, not a population-based factor such as low socio-economic status • If risk level or tooth placement is unknown for patients, pull a sample to help identify this information

Preventive Care Measures Commonalities

- What do these measures have in common?
  - Preventive care for children
  - Action required for all relevant patients (e.g., immunizations, sealants, counseling on nutrition, counseling on physical activity)
  - Multiple components that must all be met (e.g., all vaccinations, counseling on nutrition and on physical activity)

Routine Screening Measures

Cervical Cancer Screening
Colorectal Cancer Screening
Adult BMI
Tobacco Screening
Depression Screening

Cervical Cancer Screening

Table 6B, Line	Cervical Cancer Screening	Total Female Patients Aged 23 through 64 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Tested (c)
11	MEASURE: Percentage of women 23-64 years of age, who were screened for cervical cancer			

Cervical Cancer Screening

Denominator	Women 23 through 64 years of age with a medical visit during the measurement period
Numerator	Women with one or more screenings for cervical cancer. Either: • Cervical cytology during the measurement year or the two years prior to the measurement year • Women age 30-64 with cervical cytology/human papillomavirus (HPV) co-testing during the measurement year or four years prior • (Women must have been at least 21 at time of test)
Exclusions	Women who had a hysterectomy with no residual cervix

Cervical Cancer Screening Reporting Considerations

eCQM Number	CMS124v5
Major differences from prior year	Numerator = Added back concurrent cervical cytology/HPV co-testing for those age 30-64 performed in measurement period or the four years prior
Major differences from eCQM	None
Reminders	• Documentation in the medical record must include date of test, who performed it, and test result • Do not count in the numerator: o Referrals to third parties without documentation of results o Statements from patient that it was done—without documentation o Refusal of patient to have the test • Include women in the evaluation of this measure if they had any medical visit during the year, regardless of the nature of the visit • Include patients who were provided obstetrics / gynecological services elsewhere

Colorectal Cancer Screening

Table 6B, Line	Colorectal Cancer Screening	Total Patients Aged 50 through 75 (a)	Charts Sampled or EHR Total (b)	Number of Patients with Appropriate Screening for Colorectal Cancer (c)
19	MEASURE: Percentage of patients 50 through 75 years of age who had appropriate screening for colorectal cancer			

Colorectal Cancer Screening

Denominator	Patients 50 through 75 years of age with a medical visit during the measurement period
Numerator	Patients with one or more screenings for colorectal cancer. Appropriate screenings include: • Colonoscopy during the measurement period or the nine years prior to the measurement period • Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period • Fecal occult blood test (FOBT), including the fecal immunochemical test (FIT), during the measurement period
Exclusions	Patients with a diagnosis of colorectal cancer or a history of total colectomy

Colorectal Cancer Screening Reporting Considerations

eCQM Number	CMS130v5
Major differences from prior year	None
Major differences from eCQM	None
Reminders	• There are two FOBT test options: Guaiac fecal occult blood test (gFOBT) and the immunochemical-based fecal occult blood test (iFOBT - commonly known as a FIT test) • DNA colorectal cancer screening tests, such as Cologuard, do not meet the measurement standard

Adult BMI

Table 6B, Line	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate (c)
13	MEASURE: Percentage of patients 18 years of age and older with (1) BMI documented *and* (2) follow-up plan documented *if* BMI is outside normal parameters			

Adult BMI

Denominator	Patients 18 years of age or older on the date of the visit with at least one medical visit during the measurement year
Numerator	Patients with: 1. A documented BMI (not just height and weight) during their visit or during the previous six months of that visit, and 2. When the BMI is outside of normal parameters, a follow-up plan is documented during the visit or during the previous six months of the current visit
Exclusions	• Patients who are pregnant • Patients receiving palliative care • Patients who refuse measurement of height and/or weight or refuse follow-up • Patients with a documented medical reason

Adult BMI Reporting Considerations

eCQM Number	CMS69v5
Major differences from prior year	Numerator: Normal BMI parameters are now the same for all adults (No longer different for adults age 65 and older) Normal BMI for patients 18 and older is ≥ 18.5 and < 25
Major differences from eCQM	None
Reminders	• Patients with a documented medical reason, include: o Patients 65 or older for whom weight reduction/weight gain would complicate other underlying health conditions o Patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status • Include adults in the evaluation of this measure if they had any medical visit during the year, regardless of the nature of the visit • Measurement is required for all medical patients seen during the reporting year

Tobacco Screening

Table 6B, Line	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Assessed for Tobacco Use and Provided Intervention if a Tobacco User (c)
14a	MEASURE: Percentage of patients aged 18 years of age and older who (1) were screened for tobacco use one or more times within 24 months and *if* identified to be a tobacco user (2) received cessation counseling intervention			

Tobacco Screening

Denominator	Patients aged 18 years and older seen for at least two medical visits in the measurement year or at least one preventive medical visit during the measurement period
Numerator	Patients who 1. Were screened for tobacco use at least once within 24 months before the end of the measurement period, *and* 2. When identified to be a tobacco user, they received tobacco cessation intervention
Exclusions	Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason)

Tobacco Screening Reporting Considerations

eCQM Number	CMS138v5
Major differences from prior year	None
Major differences from eCQM	None
Reminders	• Remember to count in the numerator both patients with a negative screening result AND those with a positive screening who had cessation services provided • Include all forms of tobacco, but exclude e-cigarettes, in the screening • Tobacco cessation services include patients who: o Received tobacco use cessation counseling services, or o Received an order (a prescription or a recommendation to purchase an over the counter [OTC] product) for a tobacco use cessation medication, or o Are on (using) a tobacco use cessation agent

Depression Screening

Table 6B, Line	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Total Patients Aged 12 and Older (a)	Charts Sampled or EHR Total (b)	Number of Patients Screened for Depression and Follow-Up Plan Documented as Appropriate (c)
21	MEASURE: Percentage of patients 12 years of age and older who were (1) screened for depression with a standardized tool *and*, if screening was positive, (2) had a follow-up plan documented			

Depression Screening

Denominator	Patients aged 12 years and older with at least one medical visit during the measurement period
Numerator	Patients who: 1. Were screened for depression on the date of the visit using an age-appropriate standardized tool ***and***, 2. If screened positive for depression, a follow-up plan is documented on the date of the positive screen

Exclusions	• Patients with an active diagnosis for depression or a diagnosis of bipolar disorder
	• Patients:
	  • Who refuse to participate
	  • Who are in urgent or emergent situations
	  • Whose functional capacity or motivation to improve impacts the accuracy of results

Depression Screening Reporting Considerations

eCQM Number	CMS2v6
Major differences from prior year	Screening is now required for depression, rather than clinical depression
Major differences from eCQM	None
Reminders	• Patients who are in ongoing treatment for depression are not included in the universe • Note: PHQ-9 (patient health questionnaire) or another form of further screening as follow-up from a positive PHQ-2 <u>is</u> permitted • “Clinical depression” is also known as major depression or major depressive disorder and is not what the measure screens for • Depression can include situational or medication-induced depression • Remember to count in the numerator both patients with a negative screening result AND those with a positive screening who had a follow-up plan

Routine Screening Measures Commonalities

- What do these measures have in common?
  - Adult BMI, tobacco, depression require a follow-up plan if positive test result
    - Both negative screening result **and** positive screening result with follow-up count toward measurement standard
  - Look-back period is used for cervical cancer, colorectal cancer, and tobacco screening checks

Routine Screening Measures Commonalities, continued

- What do these measures have in common?
  - Adult BMI and depression screening must be done every year
  - Medical reasons for not screening is at the discretion of the provider and must be documented in the patient records (allowed for adult BMI, tobacco, depression only)

UDS Edit Check: Patients in Universe

What to look for and possible solutions

Common edit: You are reporting 115% of total possible medical patients in the universe for the Cervical Cancer Screening measure (Line 11, Column A). This appears high compared to estimated medical patients in the age group being measured.

UDS Edit Check: Patients in Universe

What to look for and possible solutions

Common edit: You are reporting 115% of total possible medical patients in the universe for the Cervical Cancer Screening measure (Line 11, Column A). This appears high compared to estimated medical patients in the age group being measured.

What to look for:

- Look at universe for reasonableness of total patients in universe
- Include medical patients of the age range and with the specific measure criteria in the count
- Edit may appear for high or low universes and for each of the clinical measures on Table 6B

Possible solutions:

- Correct errors:
  - ✗ Including non-medical patients, patients ages 21-23, or hysterectomies
  - ✗ Including only primary care patients
- Explain:
  - ✓ Confirm verified patients meet all criteria with date of birth as of January 1

Table 6B Chronic Disease-Related Measures

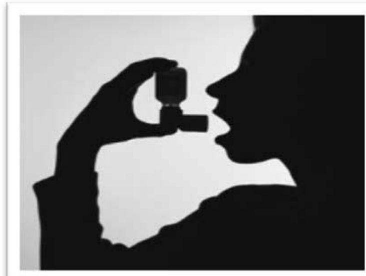
Asthma
CAD: Lipid Therapy
IVD: Aspirin Therapy
HIV Linkage to Care

Asthma

Table 6B, Line	Use of Appropriate Medications for Asthma	Total Patients Aged 5 through 64 with Persistent Asthma (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Acceptable Plan (c)
16	MEASURE: Percentage of patients 5 through 64 years of age identified as having persistent asthma and were appropriately ordered medication			

Asthma

Denominator	Patients 5 through 64 years of age with persistent asthma with a medical visit during the measurement period
Numerator	Patients who were ordered at least one prescription for a preferred therapy during the measurement period
Exclusions	Patients with an active diagnosis of emphysema, chronic obstructive pulmonary disease, obstructive chronic bronchitis, cystic fibrosis, or acute respiratory failure during the measurement period



Asthma Reporting Considerations

eCQM Number	CMS126v5
Major differences from prior year	Exclusions: Now also excludes patients with obstructive chronic bronchitis Numerator: “Dispensing” of medications changed to “ordering” of medications
Major differences from eCQM	Note: eCQM is no longer e-certified
Reminders	• Preferred therapy includes patients who: o Received a prescription for or were using an inhaled corticosteroid, *or* o Received a prescription for or were using an acceptable pharmacological agent, specifically inhaled steroid combinations, anti-asthmatic combinations, antibody inhibitor, leukotriene modifiers, mast cell stabilizers, or methylxanthines • Query system to identify only those patients with persistent asthma (not mild or intermittent asthma)

CAD: Lipid Therapy

Table 6B, Line	Coronary Artery Disease (CAD): Lipid Therapy	Total Patients Aged 18 and Older with CAD Diagnosis (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Prescribed A Lipid Lowering Therapy (c)
17	MEASURE: Percentage of patients 18 years of age and older with a diagnosis of CAD who were prescribed a lipid lowering therapy			

CAD: Lipid Therapy

Denominator	Patients 18 years of age and older with an active diagnosis of CAD or diagnosed as having had a myocardial infarction (MI) or had cardiac surgery in the past, with a medical visit during the measurement period and at least two medical visits ever
Numerator	Patients who received a prescription for or were provided or were taking lipid lowering medications during the measurement period
Exclusions	• Patients whose last low-density lipoprotein (LDL) lab test during the measurement year was less than 130 mg/dL • Patients with an allergy to, a history of adverse outcomes from, or intolerance to LDL lowering medications

CAD: Lipid Therapy Reporting Considerations

eCQM Number	None
Major differences from prior year	None
Major differences from eCQM	None
Reminders	• Include patients with CAD with no record of measurement year LDL lab test in the denominator, but do not include in the numerator • Do not count patients who are receiving a form of treatment other than pharmacologic treatment (e.g., therapeutic lifestyle changes) as meeting the measurement standard

IVD: Aspirin Therapy

Table 6B, Line	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Total Patients Aged 18 and Older with IVD Diagnosis or AMI, CABG, or PCI Procedure (a)	Charts Sampled or EHR Total (b)	Number of Patients with Documentation of Aspirin or Other Antiplatelet Therapy (c)
18	MEASURE: Percentage of patients 18 years of age and older with a diagnosis of IVD or AMI, CABG, or PCI procedure with aspirin or another antiplatelet			

Notes:
AMI = acute myocardial infarction
CABG = coronary artery bypass graft
PCI = percutaneous coronary interventions

IVD: Aspirin Therapy

Denominator	Patients 18 years of age and older with a medical visit during the measurement period who had an AMI, CABG, PCI during the 12 months prior to the measurement year or who had an active diagnosis of IVD during the measurement year
Numerator	Patients who an active medication (use) of aspirin or another antiplatelet during the measurement period
Exclusions	Patients who had documentation of use of anticoagulant medications at some point in time during the measurement period

IVD: Aspirin Therapy Reporting Considerations

eCQM Number	CMS164v5
Major differences from prior year	Exclusions = Now excludes patients using anticoagulant medications (e.g., warfarin, heparin, dalteparin) Numerator = No longer specifies other antithrombotic (e.g., clopidogrel, prasugrel). Changed to patients who had an active medication of aspirin or another antiplatelet
Major differences from eCQM	None
Reminders	• Include in the numerator patients who received a prescription for, were given, or were using aspirin or another antiplatelet drug • Be sure you are no longer counting antithrombotic (a broader classification of medications) toward measurement standard

HIV Linkage to Care

Table 6B, Line	HIV Linkage to Care	Total Patients First Diagnosed with HIV (a)	Charts Sampled or EHR Total (b)	Number of Patients Seen Within 90 Days of First Diagnosis of HIV (c)
20	MEASURE: Percentage of patients whose first ever HIV diagnosis was made by health center staff between October 1, of the prior year and September 30, of the measurement year and who were seen for follow-up treatment within 90 days of that first ever diagnosis			

HIV Linkage to Care

Denominator	Patients first diagnosed with HIV <u>*by the health center*</u> between October 1 of the prior year through September 30 of the current measurement year and who had at least one medical visit during the measurement period or prior year *Note: Timeframe for diagnosis is October 1, 2016, and September 30, 2017*
Numerator	Newly diagnosed HIV patients who received treatment <u>within 90 days of diagnosis</u>. Include patients who: • Were newly diagnosed by your health center providers • Had a medical visit with your health center provider who initiates treatment for HIV • Had a visit with a referral resource who initiates treatment for HIV
Exclusions	None

HIV Linkage to Care Reporting Considerations

eCQM Number	None
Major differences from prior year	None
Major differences from eCQM	None
Reminders	• Only include patients who have never before been diagnosed with HIV anywhere • Note that the identification of patients for this measure crosses years and may include prior year patients • To confirm HIV diagnosis, patient must receive a reactive initial HIV test confirmed by a positive supplemental HIV (blood) test • *Medical treatment must be initiated* within 90 days of HIV diagnosis, not just a referral made, education provided, or retesting conducted

Table 7 Chronic Disease-Related Measures

Hypertension
Diabetes
(Sections B and C)

Intermediate Outcome Measures

- Report on health outcome and disparities measures
- *"Intermediate outcome measures"* serve as a proxy for good long-term health outcomes
  - If measurable outcomes are improved, then later negative outcomes will be less likely

By controlling hypertension, we anticipate seeing fewer incidents of cardiovascular damage, heart attacks, and organ damage.

Table 7: Measures to Report and Major Differences

Section	Description	eCQM	Major Differences from 2016 to 2017
Part B	Controlling High Blood Pressure	CMS165v5	None
Part C	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	CMS122v5	None

Table 7 Disparities Format

	Hispanic/Latino (1)
1a.	Asian
1b1.	Native Hawaiian
1b2.	Other Pacific Islander
1c.	Black/African American
1d.	American Indian/Alaska Native
1e.	White
1f.	More Than One Race
1g.	Unreported/Refused to Report Race
Subtotal Hispanic/Latino	
Non-Hispanic/Latino (2)	
2a.	Asian
2b1.	Native Hawaiian
2b2.	Other Pacific Islander
2c.	Black/African American
2d.	American Indian/Alaska Native
2e.	White
2f.	More Than One Race
2g.	Unreported/Refused to Report Race
Subtotal Non-Hispanic/Latino	
Unreported/Refused to Report Ethnicity (3)	
h.	Unreported /Refused to Report Race and Ethnicity
i.	**Total**

- Outcome data are reported by race and ethnicity for:
  - Section A: Births
  - Section B: Hypertension
  - Section C: Diabetes
- Report in the corresponding section:
  - (1) Report Hispanic/Latino patients
  - (2) Report patients who are not Hispanic/Latino
  - (3) Report patients who do not report a race or an ethnicity

Hypertension, Table 7

	Section B: Controlling High Blood Pressure			
Line #	**Race and Ethnicity**	**Total Patients 18 through 85 Years of Age with Hypertension (2a)**	**Charts Sampled or EHR Total (2b)**	**Patients with HTN Controlled (2c)**
	Hispanic/Latino			
1a	Asian			
1b1	Native Hawaiian			
1b2	Other Pacific Islander			
1c	Black/African American			
1d	American Indian/Alaska Native			
1e	White			
1f	More than One Race			
1g	Unreported/Refused to Report Race			
	Subtotal Hispanic/Latino			
	Non-Hispanic/Latino			
2a	Asian			
2b1	Native Hawaiian			
2b2	Other Pacific Islander			
2c	Black/African American			
2d	American Indian/Alaska Native			
2e	White			
2f	More than One Race			
2g	Unreported/Refused to Report Race			
	Subtotal Non-Hispanic/Latino			
	Unreported/Refused to Report Ethnicity			
h	Unreported/Refused to Report Race and Ethnicity			
i	*Total*			

Hypertension

Denominator	Patients 18 through 85 years of age who had a diagnosis of essential hypertension within first six months of the measurement period or any time prior with a medical visit during the measurement period
Numerator	Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure (BP) less than 140 mmHg and diastolic BP less than 90 mmHg)
Exclusions	• Patients with evidence of end-stage renal disease (ESRD), dialysis, or renal transplant before or during the measurement period • Patients with a diagnosis of pregnancy during the measurement period

Hypertension Reporting Considerations

eCQM Number	CMS165v5
Major differences from prior year	None
Major differences from eCQM	None
Reminders	• Do not include patients in the denominator if initial diagnosis of hypertension was made after June 30th of measurement period • Include patients with no test during the year in the denominator, but do not include in the numerator o Report them in Columns 2a and 2b, but not in Column 2c • Review crude prevalence rates by taking number with hypertension by race and ethnicity (Table 7) divided by total patients of same race and ethnicity (Table 3B)

Diabetes, Table 7

Line #	Section C: Diabetes: Hemoglobin A1c Poor Control Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Charts Sampled or EHR Total (3b)	Patients with HbA1c <8% (3d1)	Patients with HbA1c >9% Or No Test During Year (3f)
	Hispanic/Latino				
1a	Asian				
1b1	Native Hawaiian				
1b2	Other Pacific Islander				
1c	Black/African American				
1d	American Indian/Alaska Native				
1e	White				
1f	More than One Race				
1g	Unreported/Refused to Report Race				
	Subtotal Hispanic/Latino				
	Non-Hispanic/Latino				
2a	Asian				
2b1	Native Hawaiian				
2b2	Other Pacific Islander				
2c	Black/African American				
2d	American Indian/Alaska Native				
2e	White				
2f	More than One Race				
2g	Unreported/Refused to Report Race				
	Subtotal Non-Hispanic/Latino				
	Unreported/Refused to Report Ethnicity				
h	Unreported/Refused to Report Race and Ethnicity				
i	*Total*				

Diabetes

Denominator	Patients 18 through 75 years of age with diabetes with a medical visit during the measurement period
Numerator	Patients whose most recent HbA1c level performed during the measurement year is greater than 9.0 percent *or* who had no test conducted during the measurement period
Exclusions	Patients with a diagnosis of secondary diabetes due to another condition (e.g., gestational or steroid-induced diabetes)

Diabetes Reporting Considerations

eCQM Number	CMS122v5
Major differences from prior year	None
Major differences from eCQM	• Report HbA1c levels as follows: o HbA1c less than 8 percent (Column 3d1) o HbA1c greater than 9 percent or no test during the year (Column 3f) (eCQM only reports this level)
Reminders	• Include patients with Type 1 or Type 2 diabetes • Include patients with diabetes regardless of when first diagnosed • Note: The higher the percentage of patients with Hba1c of 9 percent or over, the poorer the clinical performance • Usually Columns 3d1 + 3f will not equal Column 3b – this is because generally there are some patients with HbA1c between 8 and 9 percent (which is not reported) • Review crude prevalence rates by taking number with diabetes by race and ethnicity (Table 7) divided by total patients of same race and ethnicity (Table 3B)

Chronic Disease-Related Measures Commonalities

- What do these measures have in common?
  - Patients must have diagnosis
  - Some have a prescription component required to meet measurement standard (e.g., asthma, CAD, IVD)

UDS Edit Check: Prevalence Rates

What to look for and possible solutions

Common edit: The total number of Native Hawaiian patients with hypertension reported on Table 7 (120) is high compared to total Native Hawaiian patients reported on Table 3B (216).

UDS Edit Check: Prevalence Rates

What to look for and possible solutions

reported on Table 7 (120) is high compared to total Native Hawaiian patients reported on Table 3B (216).

What to look for:

- Table 7 race and ethnicity categories <u>**must**</u> align with Table 3B
  - Edit may appear on any category with high prevalence—check unusually high rates
- Do not default to the unreported race and ethnicity categories

Table/Section	Line, Column	Patient Number
3B, Native Hawaiian	Line 2a, Column D	216
7, Native Hawaiians with Hypertension	Lines 1b1 + 2b1, Column 2a	120
Overall Prevalence	**Hypertension**	**56%**

Possible solutions:

- Correct errors:
  - ✗ Race and ethnicity captured differently in patient registration and clinical EHR
- Explain:
  - ✓ Community factors that clearly address the high prevalence rates for the specific race or ethnicity

National Statistics—2015 vs. 2016

Quality of Care and Outcome Measures	CY 330	PY 330	CY LAL	PY LAL
Universes*				
Childhood Immunization Status	102%	88%	105%	93%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	88%	91%	93%	97%
Body Mass Index (BMI) Screening and Follow-up (Adult)	95%	97%	90%	97%
Tobacco Use: Screening and Cessation Intervention	76%	86%	76%	90%
Cervical Cancer Screening	93%	95%	96%	100%
Colorectal Cancer Screening	99%	98%	96%	98%
Screening for Clinical Depression and Follow-Up Plan	85%	89%	85%	92%
Dental Sealants for Children between 6-9 Years	70%	78%	74%	100%
Prevalence*				
Persistent Asthma	2%	3%	3%	4%
Coronary Artery Disease	2%	2%	2%	2%
Ischemic Vascular Disease	4%	3%	4%	3%
High Blood Pressure	26%	23%	26%	23%
Diabetes	14%	13%	15%	15%
New Diagnosis of HIV	0.04%	0.04%	0.04%	0.04%

** Estimated percent of patients based on average percent of medical care provided by health centers (85% for 330 grantees, 89% for look-alikes)*

Note: CY = 2016, PY = 2015

UDS Edit Check: Measurement Standard

What to look for and possible solutions

Common edit: A compliance rate of 100% is reported for the Patients Screened for Depression and Follow-Up measure, Line 21.

UDS Edit Check: Measurement Standard

What to look for and possible solutions

Common edit: A compliance rate of 100% is reported for the Patients Screened for Depression and Follow-Up measure, Line 21.

What to look for:

- Review count in Column C in relation to Column B
- Determine if the results are feasible based on program initiatives in this area
- Similar edits may appear for other clinical measures

Possible solutions:

- Correct errors:
  - ✗ Universe includes only those from a limited registry or system that only has patients who are part of a collaborative or initiative, so universe is missing patients
  - ✗ Sampling results were not randomized
- Explain:
  - ✓ Describe initiatives that your health center has engaged in to explain results
  - ✓ If total count is very small

National Statistics—2015 vs. 2016

Performance Measurement	CY 330	PY 330	CY LAL	PY LAL	Goal
Early Entry into Prenatal Care	74.1%	73.0%	70.1%	67.6%	77.9%
Low Birth Weight	7.8%	7.6%	7.7%	7.1%	7.8%
Childhood Immunization Status	42.8%	77.5%	49.0%	78.7%	-
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	62.9%	57.9%	70.5%	63.9%	-
Body Mass Index (BMI) Screening and Follow-up	62.5%	59.4%	58.4%	48.7%	-
Tobacco Use: Screening and Cessation Intervention	85.2%	82.8%	83.8%	80.8%	-
Screening for Clinical Depression and Follow-Up Plan	60.3%	50.6%	57.2%	52.4%	-
Cervical Cancer Screening	54.4%	56.0%	52.7%	58.2%	93.0%
Colorectal Cancer Screening	39.9%	38.3%	41.5%	36.4%	70.5%
Use of Appropriate Medications for Asthma	87.4%	84.1%	90.3%	83.7%	-
Coronary Artery Disease (CAD): Lipid Therapy	79.5%	77.9%	74.3%	76.4%	-
Ischemic Vascular Disease (IVD): Aspirin or Another Antithrombotic	78.4%	78.0%	80.8%	73.9%	-
HIV Linkage to Care	83.2%	74.7%	76.3%	90.6%	-
Controlling High Blood Pressure	62.4%	63.8%	63.0%	60.2%	61.2%
Diabetes: Hemoglobin A1c Poor Control	32.1%	29.8%	35.2%	33.1%	16.2%
Dental Sealants for Children between 6-9 Years	48.7%	42.4%	54.1%	32.6%	28.1%

Sources of Data: Aggregate 2016 UDS, Healthy People 2020
Note: CY = 2016, PY = 2015

Table 8A

Financial Costs

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
	s of Medical Care			
1.	Medical Staff			
2.	Lab and X-ray			
3.	Medical/Other Direct			
4.	**Total Medical Care Services** (Sum Lines 1- 3)			
	Financial Costs of Other Clinical Services			
5.	Dental			
6.	Mental Health			
7.	Substance Abuse			
8a.	Pharmacy not including pharmaceuticals			
8b.	Pharmaceuticals			
9.	Other Professional (Specify: ______)			
9a.	Vision			
10.	**Total Other Clinical Services** (Sum Lines 5 through 9a)			
	Financial Costs of Enabling and Other Services			
11a.	Case Management			
11b.	Transportation			
11c.	Outreach			
11d.	Patient and Community Education			
11e.	Eligibility Assistance			
11f.	Interpretation Services			
11g.	Other Enabling Services (Specify: _____)			
11h.	Community Health Workers			
11.	Total Enabling Services Cost (Sum Lines 11a through 11h)			
12.	Other Related Services (Specify:_______)			
12a.	Quality Improvement			
13.	**Total Enabling and Other Services** (Sum Lines 11, 12, and 12a)			
	Facility and Non-Clinical Support Services and Totals			
14.	Facility			
15.	Non-Clinical Support Services			
16.	**Total Facility and Non-Clinical Support Services** (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)			

Table 8A—Columns

(a)	Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
• Report accrued direct costs • Include costs of: o Staff o Fringe benefits o Supplies o Equipment o Depreciation o Related travel • Exclude bad debt	• Report allocation of facility and non-clinical support services o Allocate to all other cost centers (lines) o This column must equal Line 16, Column A	• Sum Columns A + B (done automatically in EHB)

Table 8A—Lines

Medical Care Lines 1-4

	Financial Costs of Medical Care
1.	Medical Staff
2.	Lab and X-ray
3.	Medical/Other Direct
4.	**Total Medical Care Services** (Sum Lines 1- 3)

- Separate medical staff (Line 1) from medical lab and X-ray (Line 2) and from other direct medical costs (Line 3)
  - This is the only category that separates costs
- Also include on Line 1:
  - Paid medical interns or residents
  - Vouchered or contracted medical services
- Report staff dedicated to HIT/EHR design and QI on Line 12a, not here, <u>but</u> include cost of medical HIT/EHR system (including depreciation on software and hardware, system training costs, and licensing fees) on Line 3

Table 8A—Lines

- Report direct expenses, including personnel (hired and contracted), benefits, supplies, and equipment together for each remaining service category

Other Clinical Lines 5-10

	Financial Costs of Other Clinical Services
5.	Dental
6.	Mental Health
7.	Substance Abuse
8a.	Pharmacy not including pharmaceuticals
8b.	Pharmaceuticals
9.	Other Professional (Specify: ______)
9a.	Vision
10.	**Total Other Clinical Services** (Sum Lines 5 through 9a)

Enabling and Other Services Lines 11a-13

	Financial Costs of Enabling and Other Services
11a.	Case Management
11b.	Transportation
11c.	Outreach
11d.	Patient and Community Education
11e.	Eligibility Assistance
11f.	Interpretation Services
11g.	Other Enabling Services (Specify: _____)
11h.	Community Health Workers
11.	Total Enabling Services Cost (Sum Lines 11a through 11h)
12.	Other Related Services (Specify:_______)
12a.	Quality Improvement
13.	**Total Enabling and Other Services** (Sum Lines 11, 12, and 12a)

Table 8A—Lines

Facility, Non-Clinical Support, and Totals Lines 14-19

	ical Support Services and Totals
14.	Facility
15.	Non-Clinical Support Services
16.	**Total Facility and Non-Clinical Support Services** (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)

- **Facility (Line 14):** Include health center’s rent or depreciation, mortgage interest payments, utilities, security, janitorial services, maintenance, etc.
  - Do not report Facilities Improvement Program/Capital Improvement Program costs
- **Non-Clinical Support Services (Line 15):** Include corporate administration, billing, collections, medical records, intake staff, facility and liability insurance, legal fees, and direct support costs (travel, supplies, etc.)
  - Include malpractice insurance in the service categories, not here

Specific Line Considerations

- **Pharmacy**-related considerations:
  - Report all pharmacy costs (including dispensing fees and "share of profit"), except the cost of pharmaceuticals, on Line 8a
  - Report pharmaceutical costs, including cost of 340(b) drugs, on Line 8b
  - Report pharmacy assistance program as eligibility assistance on Line 11e, not pharmacy
- Report space rented out within the health center, adult day health care, WIC, retail pharmacy to non-patients, etc., as **other related services** on Line 12

Specific Line Considerations

- Report **QI** program staff and HIT/EHR system development and analysis but not the cost of hardware, software, and training on Line 12a
- Report **donations** ("in-kind"), including services, facilities, supplies, pharmaceutical, and volunteers, on Line 18

Allocate Facility Costs

1. Distribute facility costs on Line 14, Column A to each cost center in Column B

- Base allocation on amount of <u>usable</u> square footage utilized by each cost center
  - Do not include common spaces, unless dedicated to a specific service area

Tips:
- Capture differences in costs per building separately, if possible (improvements, donated space, etc.).
- Allocate areas leased or rented to third parties on Line 12.

Allocate Non-Clinical Support Costs

2. Distribute non-clinical support costs on Line 15, Column A to each cost center in Column B

- Allocate after facility costs have been allocated to it
- Base allocation on actual use or straight line method *(proportion of net costs to each service category)*

Tip

Although contracted services do consume some administrative costs, they normally have a lower allocation of overhead.

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
	Financial Costs of Medical Care			
1.	Medical Staff	6,914,216,674	3,729,004,517	10,643,221,191
2.	Lab and X-ray	412,948,927	207,206,583	620,155,510
3.	Medical/Other Direct	1,306,091,741	694,858,509	2,000,950,250
4.	**Total Medical Care Services** (Sum Lines 1- 3)	**8,633,257,342**	4,631,069,609	**13,264,326,951**
	Financial Costs of Other Clinical Services			
5.	Dental	1,848,822,773	904,489,368	2,753,312,141
6.	Mental Health	962,491,965	471,802,628	1,434,294,593
7.	Substance Abuse	98,088,154	55,521,639	153,609,793
8a.	Pharmacy not including pharmaceuticals	638,672,978	317,233,088	955,906,066
8b.	Pharmaceuticals	1,491,482,507		1,491,482,507
9.	Other Professional (Specify: ______)	157,457,625	75,297,737	232,755,362
9a.	Vision	83,057,838	43,740,967	126,798,805
10.	**Total Other Clinical Services** (Sum Lines 5 through 9a)	**5,280,073,840**	1,868,085,427	**7,148,159,267**
	Financial Costs of Enabling and Other Services			
11a.	Case Management	432,569,333		432,569,333
11b.	Transportation	46,332,192		46,332,192
11c.	Outreach	155,451,112		155,451,112
11d.	Patient and Community Education	155,129,104		155,129,104
11e.	Eligibility Assistance	210,939,904		210,939,904
11f.	Interpretation Services	68,816,386		68,816,386
11g.	Other Enabling Services (Specify: _____)	32,498,058		32,498,058
11h.	Community Health Workers	39,081,639		39,081,639
11.	Total Enabling Services Cost (Sum Lines 11a through 11h)	**1,140,817,728**	**544,431,083**	**1,685,248,811**
12.	Other Related Services (Specify:_______)	489,802,512	176,894,896	666,697,408
12a.	Quality Improvement	170,750,245	76,677,931	247,428,176
13.	**Total Enabling and Other Services** (Sum Lines 11, 12, and 12a)	**1,801,370,485**	798,003,910	**2,599,374,395**
	Facility and Non-Clinical Support Services and Totals			
14.	Facility	1,699,731,974		
15.	Non-Clinical Support Services	5,597,426,972		
16.	**Total Facility and Non-Clinical Support Services** (Sum Lines 14 and 15)	7,297,158,946		
17.	**Total Accrued Costs** (Sum Lines 4 + 10 + 13 + 16)	**23,011,860,613**		**23,011,860,613**
18.	Value of Donated Facilities, Services, and Supplies (specify: _______)			505,499,055
19.	**Total With Donations** (Sum Lines 17 and 18)			**23,517,359,668**

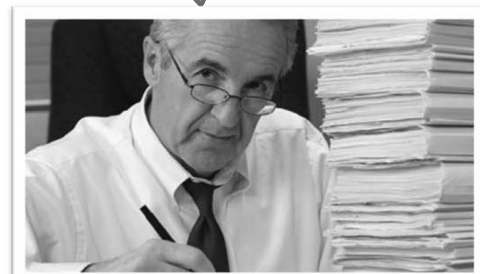
Allocation using national data: (4,631,069,609+1,868,085,427+798,003,910 = **7,297,158,946**)

Match Staff and Services with Costs

- Staff and services on Table 5 need to correspond with costs on Table 8A
- See Table 5 and 8A Crosswalk in Appendix B of UDS Manual
- Examples below

If a staff FTE is allocated across multiple service categories on Table 5, be sure to do the same on Table 8A.

Staff FTE on Table 5, Line:	Have Costs Reported on Table 8A, Line:
1–12: Medical Providers and Clinical Support Staff	1: Medical Staff
20a–20c: Mental Health	6: Mental Health
24–28: Enabling (e.g., case management, outreach, eligibility)	11a–11h: Enabling *Note: Cost categories on Table 8A are not in the same sequential order as they appear on Table 5*



UDS Edit Check: Cost per Visit
What to look for and possible solutions

Common edit: Mental health cost per visit is substantially different than the prior year. Current Year ($118.26); Prior Year ($85.64).

UDS Edit Check: Cost per Visit
What to look for and possible solutions

Common edit: Mental health cost per visit is substantially different than the prior year. Current Year ($118.26); Prior Year ($85.64).

What to look for:

- This evaluates the total mental health costs (Table 8A, Line 6, Column C) per mental health visit (Table 5, Line 20, Column B)
- Edits may flag for other service categories if there is a large difference

Possible solutions:

- Correct errors:
  - ✗ An expense item from the general ledger is mistakenly placed in the wrong service category
- Explain:
  - ✓ Change in service levels or change in types of services
  - ✓ For example: Adding a mental health worker who does prevention work would add a cost with no visits

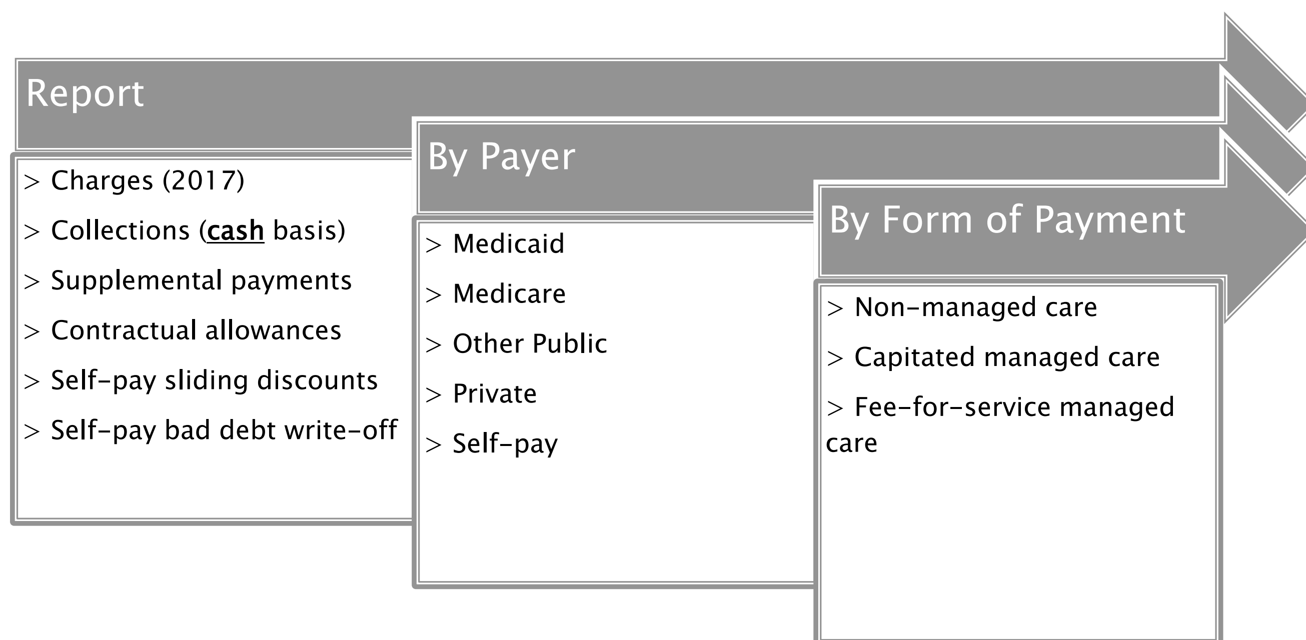
Table 9D

Patient-Related Revenue

				Retroactive Settlements, Receipts, and Paybacks (c)						
Line	**Payer Category**	**Full Charges This Period (a)**	**Amount Collected This Period (b)**	**Collection of Reconciliation/ Wrap-Around Current Year (c1)**	**Collection of Reconciliation/ Wrap-Around Previous Years (c2)**	**Collection of Other Payments: P4P, Risk Pools, Withholds, etc. (c3)**	**Penalty/ Payback (c4)**	**Allowances (d)**	**Sliding Discounts (e)**	**Bad Debt Write Off (f)**
1.	Medicaid Non-Managed Care									
2a.	Medicaid Managed Care (capitated)									
2b.	Medicaid Managed Care (fee-for-service)									
3.	**Total Medicaid** (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)									
8b.	Other Public, including Non-Medicaid CHIP (Managed Care fee-for-service)									
9.	**Total Other Public** (Lines 7 + 8a + 8b)									

				Retroactive Settlements, Receipts, and Paybacks (c)						
Line	**Payer Category**	**Full Charges This Period (a)**	**Amount Collected This Period (b)**	**Collection of Reconciliation/ Wrap-Around Current Year (c1)**	**Collection of Reconciliation/ Wrap-Around Previous Years (c2)**	**Collection of Other Payments: P4P, Risk Pools, Withholds, etc. (c3)**	**Penalty/ Payback (c4)**	**Allowances (d)**	**Sliding Discounts (e)**	**Bad Debt Write Off (f)**
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)									

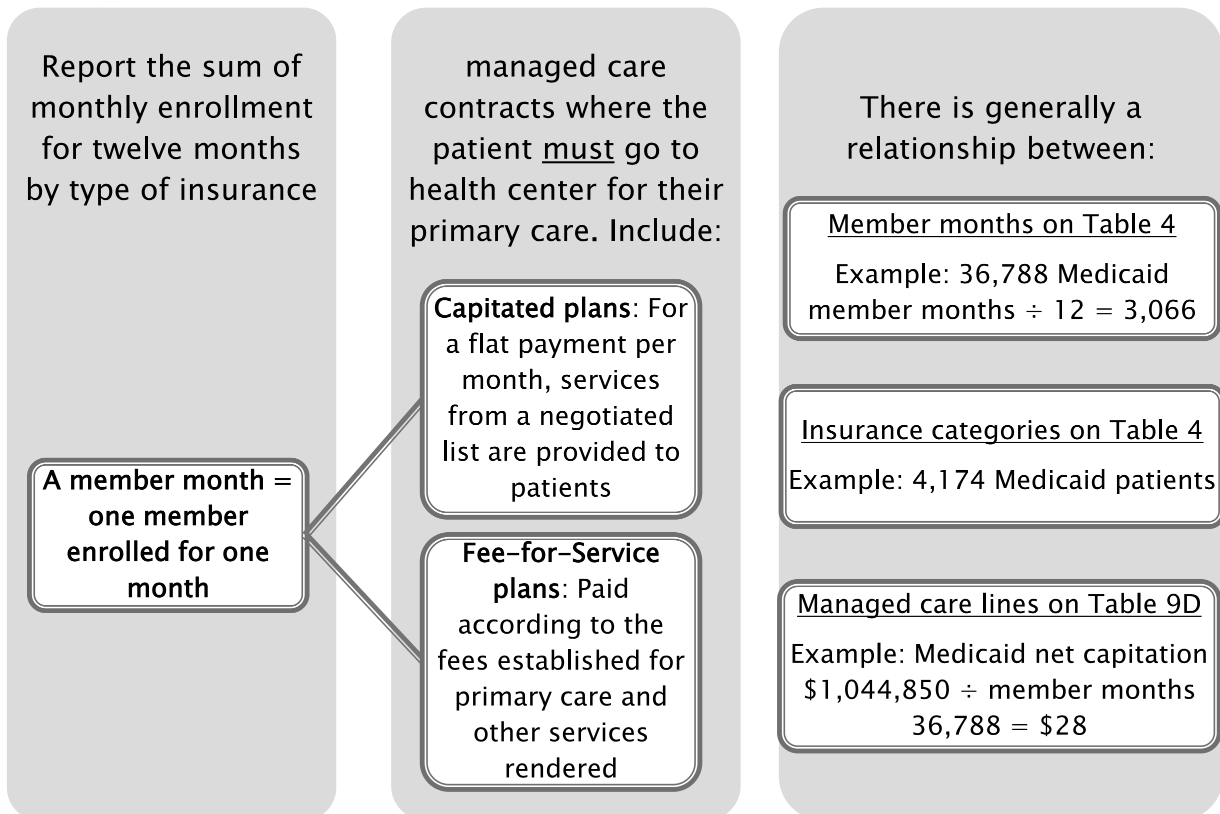
Patient-Related Revenue



Form of Payment

- Third-party payers may have three forms of payment
  - **Non-Managed Care ("Fee-for-Service")**: Payment for services charged (or global fee) on charge slip, encounter form, or bill at an agreed-upon rate (minus co-payments and deductibles)
  - **Managed Care (Capitated)**: Full charges reported, but payment covers list of services specified in contract for a one month period, regardless of volume
  - **Managed Care (Fee-for-Service)**: Same as non-managed care, except patients are assigned to doctor or clinic for primary care with payment made only when charges are reported
    - Include carved out charges and collections for capitated patients here
- Include "wrap-around" and reconciliation payments in Medicaid, Medicare, and CHIP programs

Managed Care Utilization Reporting Considerations



Payer Considerations

- Revenue generally relates to patient enrollment data on Table 4
- Table 9D exceptions:
  - Report state- or local-based programs that cover a specific service or disease (e.g., BCCCP, Title X) as Other Public
  - Classify charges and collections from contracts with schools, jails, head start, tribes, and workers' compensation as Private
  - Reclassify charges each payer is responsible for on the appropriate payer lines (e.g., Medi-Medi, co-payments, deductibles)

- Affordable Care Act reporting:
  - Medicaid expansion programs = Medicaid
  - State or federal exchanges = Private
- State or local indigent care programs = Self-pay, not Other Public

Full Charges this Period, Column A

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 Payments: P4P, Risk Pools, Withholds, etc. (c3)	Penalty/ Payback (c4)			

- Report total <u>billed</u> charges by payer source
  - Undiscounted, unadjusted, gross charges for services based on fee schedule
    - Include **all** service charges (e.g., medical, dental, mental health, vision, pharmacy including contract 340b pharmacy)
  - Do not include "charges" where no collection is attempted or expected (e.g., enabling services, donated pharmaceuticals, or free vaccines)
  - Do not include capitation or negotiated rate as charge amount
  - Do not include charges for Medicare G-codes
    - To learn more about CMS payment codes visit the CMS website

Collections this Period, Column B

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 Payments: P4P, Risk Pools, Withholds, etc. (c3)	Penalty/ Payback (c4)			

- Include all payments received in 2017 for services to patients
  - Capitation payments
  - Contracted payments
  - Payments from patients
  - Third-party insurance
  - Retroactive settlements, receipts, and payments
    - Include pay for performance, quality bonuses, and other incentive payments
- Do not include "meaningful use" payments from Medicaid and Medicare here—report on Table 9E

Retroactive Payments and Paybacks, Columns c1–c4

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

UDS Edit Check: Collections

What to look for and possible solutions

Common edit: A large change from the prior year in collections per medical + dental + mental health visit is reported. Current year ($217.90); prior year ($143.51).

UDS Edit Check: Collections

What to look for and possible solutions

Common edit: A large change from the prior year in collections per medical + dental + mental health visit is reported. Current year ($217.90); prior year ($143.51).

What to look for:

- Review average amount received for billable visits
  - *Collections*: Table 9D, Line 14, Column B
  - *Visits*: Table 5, Lines 15+19+20-11, Column B

Possible solutions:

- Correct errors:
  - ✗ Missing or other errors in reported income or visits
- Explain:
  - ✓ Receipt of an unusual payment that distorts the number
  - ✓ Change in billed services

UDS Edit Check: Retroactive Payments
What to look for and possible solutions

Common edit: Medicaid non-managed care net retroactive payments exceed 50% of Medicaid non-managed care collections.

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 Payments: P4P, Risk Pools, Withholds, etc. (c3)	Penalty/ Payback (c4)			

UDS Edit Check: Retroactive Payments
What to look for and possible solutions

Common edit: Medicaid non-managed care net retroactive payments exceed 50% of Medicaid non-managed care collections.

What to look for:

- Verify that Columns C1 through C4 are included in Column B and subtracted from Column D
- Edits may flag for any payer line

Possible solutions:

- Correct errors:
  - ✗ Did not include retroactive amounts (C Columns) in total collections (B Columns)
  - ✗ Only included retroactive amounts and other payments as total collection
- Explain:
  - ✓ Receipt of a large FQHC retroactive or court-ordered payment

Allowances, Column D

- Allowances are agreed upon reductions/write-offs in payment by a third-party payer
  - − Reduce by amount of retroactive payments in C1, C2, and C3
  - + Add paybacks reported in C4
- May result in a negative number
- Non-payment for services not covered/rejected by a third-party, deductibles, and co-payments due from patients are **not** allowances – Reclassify to second payer
- For managed care capitated lines (2a, 5a, 8a, and 11a) only, allowances equal the difference between charges and collections (since they do no typically carry a balance) Column D = A – B

Sliding Discounts, Line 13 Column E

- Report reductions in patient charges based on their ability to pay as a sliding discount
  - Only patients may be granted a sliding discount

- Based solely on the patient's documented income and family size (per federal poverty guidelines)
- Are generally applied at time of service
- ✓ May be applied:
  - To insured patients' co-payments, deductibles, and non-covered services
  - Only when charge has been reclassified from original charge line to self-pay
- ✗ May not be applied to past due amounts

Bad Debt Write-Off, Column F

- Only report **patient bad debt** (not third-party payer bad debt)
  - Report on Line 13
  - Third-party payer bad debt is not reported in the UDS
- Include amounts owed by patients considered to be uncollectable and formally written off during 2017, regardless of when service was provided
- Do not change bad debt to a sliding discount
- Discounts (e.g., to specific groups of patients, cash discounts) or forgiveness is not patient bad debt (or a sliding discount)

Sliding Discount Example

Line	Payer 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)	Other Payments: P4P, Risk Pools, Withholds, etc. (c3)	Penalty/ Payback (c4)			
13	Self Pay	$200	$10						$180	$10

An uninsured patient was seen at the health center. On the day of the service, the patient qualified for a sliding discount that required them to pay 10% of the service charge.

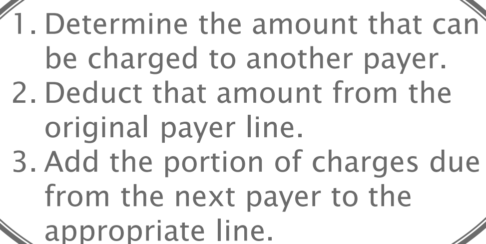
- The service's full charge is $200
- A fee of $20 was charged to the patient (10% of full charge)
- The patient paid $10
- The patient still owed $10 and this was written off by the health center

Reclassification of Charges

- It is essential to reclassify service charges that are unpaid in whole or in part by one payer if another payer is responsible for charges
  - Do not reclassify allowances
- Reclassify co-payments, deductibles, and charges for non-covered services rejected by third-party payers
- Show collections received by payer on the appropriate line

How to Reclassify Charges

- Reclassify charges in these situations:
  - When some part of the charge is not paid by the insurance company
    - And the patient has more than one insurance (e.g., dually-eligible)
    - Co-payments and deductibles owed by the patient



Example of Reclassifying Charges

Line	Payer Category	Reclassify Charge Full Charges This Period (a)	Amount Collected This Period (b)	Retroactive Settlements, Receipts, and Paybacks (c) Collection of Reconciliation /Wrap Around Current Year (c1)	Collection of Reconciliation /Wrap Around Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, Withholds, etc. (c3)	Penalty/ Payback (c4)	Allowances (d)	Sliding Discounts (e)	Bad Debt Write Off (f)
10	Private Non-Managed Care	~~$200~~ $170	$120					$50		
13	Self Pay	$30								

- Service charge = $200
  - Reduce the initial charge of $200 to private insurance by $30—this is the co-pay owed by the patient
  - Reclassify the $30 co-pay to self-pay charges
  - Report $170 with a $50 allowance on the private line
  - Report amount collected from private = $120 ($170-$50)

UDS Edit Check: Accounts Receivables

What to look for and possible solutions

Common edit: When we subtract collections (Column B) and adjustments (Column D) from your total Medicare charges (Column A), there is a large difference (51.96)%.

Full Charges This Period (a)	Amount Collected This Period (b)	Retroactive Settlements, Receipts, and Paybacks (c) Collection of Reconciliation /Wrap-Around Current Year (c1)	Collection of Reconciliation/ Wrap- Around Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, Withholds, etc. (c3)	Penalty/ Payback (c4)	Allowances (d)	Sliding Discounts (e)	Bad Debt Write Off (f)

UDS Edit Check: Accounts Receivables

What to look for and possible solutions

Common edit: When we subtract collections (Column B) and adjustments (Column D) from your total Medicare charges (Column A), there is a large difference (51.96)%.

What to look for:

- Eventually, charges should be collected or adjusted off
- Edits may flag for other payers if there is a large balance
- Check data when charges greatly exceed collections plus adjustments or vice-versa

Possible solutions:

- Correct errors:
  - ✗ Moving co-payment collections but not the charges
  - ✗ Failing to record allowances in a timely manner
- Explain:
  - ✓ Delay in billing to or processing payments from Medicare
  - ✓ Timing issue due to delay in credentialing or billing numbers for providers

UDS Edit Check: Collection/Write-off

What to look for and possible solutions

Common edit: More collections and write-offs are reported than charges for self-pay, Line 13. Please review that proper re-allocations of all deductibles and co-payments to the self-pay category are being done.

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 Payments: P4P, Risk Pools, Withholds, etc. (c3)	Penalty/ Payback (c4)			

UDS Edit Check: Collection/Write-off
What to look for and possible solutions

Common edit: More collections and write-offs are reported than charges for self-pay, Line 13. Please review that proper re-allocations of all deductibles and co-payments to the self-pay category are being done.

What to look for:

- Self-pay charges will be collected or written off as sliding discount or bad debt and some will still be owed at end of year (includes collections of prior year's charges)

Possible solutions:

- Correct errors:
  - ✘ Reporting co-pay as self-pay collection but failing to reclassify the charge to self-pay
  - ✘ Significant state or local indigent care program income reported as a sliding discount but failing to report charges
- Explain:
  - ✓ Concerted effort to collect outstanding receivables
  - ✓ Large amount of uncollectable bad debt write-offs from a prior year now written off

Table 9E

Other Revenue

Other Revenue

Line	Source	Amount (a)
BPHC Grants (Enter Amount Drawn Down - Consistent with PMS-272)		
1a	Migrant Health Center	
1b	Community Health Center	
1c	Health Care for the Homeless	
1e	Public Housing Primary Care	
1g	**Total Health Center (Sum lines 1a through 1e)**	
1j	Capital Improvement Program Grants(excluding ARRA)	
1k	Capital Development Grants, including School Based Health Center Capital Grants	
1	**Total BHPC Grants ((Sum Lines 1g +1j +1k)**	
Other Federal Grants		
2	Ryan White Part C HIV Early Intervention	
3	Other Federal Grants (specify:___)	
3a	Medicare and Medicaid EHR Incentive Payments for Eligible Providers	
5	**Total Other Federal Grants (Sum lines 2-3a)**	
Non-Federal Grants Or Contracts		
6	State Government Grants and Contracts (specify:____)	
6a	State/Local Indigent Care Programs (specify:____)	
7	Local Government Grants and Contracts (specify:____)	
8	Foundation/Private Grants and Contracts (specify:____)	
9	**Total Non-Federal Grants and Contracts (Sum lines 6+6a+7+8)**	
10	Other Revenue (Non-patient related revenue not reported elsewhere) (specify:____)	
11	**Total Revenue (Sum lines 1+5+9+10)**	

Other Revenue

- Report non-patient income received during 2017
  - BPHC grants
  - Other federal grants
  - Non-federal grants or contracts
  - Other non-patient-related revenue
- Report on a **cash** basis
- Include income that supported activities described in your scope of services
- Use the specify fields to clarify source of grants and contracts reported

Other Revenue

- Use "last party rule"
  - Report funds from the entity from which you received them
  - Do not report on the line of original source of funds

If your center received funds from another health center and they received the funds from the Indian Health Service (IHS), report the income on Line 8.

BPHC Grants, Lines 1a-1k

- Report **BPHC grants** drawn down in 2017
  - Report funds received directly from BPHC regardless of their end use
    - Include even if passed through to another agency
  - Include:
    - Health Center Program grants by type
    - Capital improvement grants
    - Capital development grants

BPHC Grants (Enter Amount Drawn Down - Consistent with PMS-272)	
1a	Migrant Health Center
1b	Community Health Center
1c	Health Care for the Homeless
1e	Public Housing Primary Care
1g	**Total Health Center (Sum lines 1a through 1e)**
1j	Capital Improvement Program Grants(excluding ARRA)
1k	Capital Development Grants, including School Based Health Center Capital Grants
1	**Total BHPC Grants ((Sum Lines 1g +1j +1k)**

Other Federal Sources, Lines 2-5

- **Ryan White Part C Funds, Line 2**
  - Part A is usually reported on Line 7, Local
  - Part B is usually reported on Line 6, State
  - Report Part D as Other Federal, Line 3
- **Other Federal Grants, Line 3**
  - Grants received directly from the federal government, other than BPHC
  - Include grants that are paid directly from the U.S. Treasury
- **Medicare and Medicaid EHR Incentive Payments for Eligible Providers, Line 3a**
  - Report Meaningful Use funds
  - Include funds paid to providers and turned over to the health center (only exception to the last party rule)

State and Local, Lines 6 and 7

- **State, Line 6 and Local, Line 7**
  - From state or local governments—Line 6 and 7, respectively
  - Report non-health service delivery grants (e.g., WIC, outreach)
  - Do not include indigent care programs here
  - Do not include fee-for-service payments (e.g., family planning and cancer detection programs)—report these on Table 9D

Private and Other, Lines 8 and 10

- **Foundation/Private Grants or Contracts, Line 8**
  - From foundations or private organizations (e.g., another health center, a primary care association)
- **Other Revenue, Line 10**
  - Report other cash unrelated to charge-based services
    - Do not report in-kind or non-monetary donations here
  - Include contributions, fundraising income, rents, sales, interest income, patient record fees, pharmacy sales to the public, etc.
    - Do not report net income from pharmacy here-report charges and collections on Table 9D

State/Local Indigent Care Programs

Table	Line	Report
4	7	Patient as uninsured • Not other public
9D	13	Charges, collections, bad debt (if any) as self-pay, balance not owed by patient as sliding fee
9E	6a	Funds received from state and local program that subsidize/pay for health care (general) services to uninsured and IHS PL 93-638 Compact funds • Based on a current or prior level of service or lump sum per visit (not fee-for-service) • Private contracts with tribes are to be reported as private, on Table 9D • Do not report these funds on both Tables 9D and 9E

UDS Edit Check: Surplus/Deficit

What to look for and possible solutions

Common edit: When comparing cash income to accrued expenses a large surplus or deficit is reported. Surplus or deficit = $ (1,335,591); percent surplus or deficit (6.78)%.

UDS Edit Check: Surplus/Deficit

What to look for and possible solutions

Common edit: When comparing cash income to accrued expenses a large surplus or deficit is reported. Surplus or deficit = $ (1,335,591); percent surplus or deficit (6.78)%.

What to look for:

- Compare cash income from patient services (Table 9D, Line 14, Column B) and other sources (Table 9E, Line 11, Column A) to total accrued costs (Table 8A, Line 17, Column C) and calculate a percent gain or loss

Possible solutions:

- Correct errors:
  - ✖ If number is large, make sure you had a large increase or decrease in net worth
  - ✖ This is an indicator of cash flow and may be triggered by a typo
- Explain:
  - ✓ If you received a large lump sum retro payment during the year
  - ✓ Significant billing and collection delay (e.g., staff turnover)
  - ✓ Your center experienced a large profit or loss
  - ✓ Large change in grants

Strategies for Success

Parting Instructions

Adhere to definitions and instructions in the UDS Manual.

Address edits in EHB by correcting issues or providing good, detailed explanations. *"The number is correct"* is not a sufficient response.

Check your data before you submit!

Work as a team (tables are interrelated).

Review last year's reviewer letter and work with your reviewer to correct your report.

Timeline Reminders

WHO	WHAT	WHERE	WHEN
Health centers funded or designated **prior to October 1**	Activities from **January 1, 2017–December 31, 2017,** in scope of project	Through EHB **starting January 1, 2018**	**By** February 15, 2018, with a review period between February 15, 2018, and March 31, 2018

Reporting Assistance

- Regional in-person UDS trainings
- **Manual**, tables, fact sheets, webinars, data, online training modules, modernization efforts, and other technical assistance materials, including PALs
  - http://www.bphcdata.net
  - http://bphc.hrsa.gov/datareporting/index.html
  - https://bphc.hrsa.gov/datareporting/reporting/udsmodernization.html
- **Telephone and e-mail support line for reporting questions and use of UDS data**
  - **866-UDS-HELP (866-837-4357) or e-mail:** udshelp330@bphcdata.net
- Technical support from a UDS reviewer during the review period

Additional System Resources

- EHB Access (PDCE, UDS submission, and reports)
  - https://grants3.hrsa.gov/2010/WebEPSExternal/Interface/common/accesscontrol/login.aspx
- UDS Mapper
  - http://www.udsmapper.org/contact-us.cfm
- EHB Support (see handout)
  - HRSA Call Center for EHB access and roles: 877-464-4772 or http://www.hrsa.gov/about/contact/ehbhelp.aspx
  - BPHC Help Desk for EHB system issues: 877-974-2742 or
  - http://www.hrsa.gov/about/contact/bphc.aspx

Program Resources

- National Cooperative Agreements
  - http://bphc.hrsa.gov/qualityimprovement/supportnetworks/ncapca/natlagreement.html
- Primary Care Associations/Primary Care Offices
  - http://bphc.hrsa.gov/qualityimprovement/supportnetworks/ncapca/associations.html
- National Association of Community Health Centers
  - http://www.nachc.org/

National Cooperative Agreements

- **Health information technology**
  - Health Information Technology, Evaluation, and Quality (HITEQ): hiteqcenter.org
- **Public housing**
  - Community Health Partners for Sustainability: http://www.chpfs.org
  - National Center for Health in Public Housing: http://www.nchph.org
- **Sexual orientation and gender identity**
  - National LGBT Health Education Center: http://www.lgbthealtheducation.org
- **Oral health**
  - National Network for Oral Health Access: http://www.nnoha.org
- **Agricultural workers**
  - Migrant Clinicians Network: http://www.migrantclinician.org
  - National Center for Farmworker Health: http://www.ncfh.org
- **Homeless**
  - National Health Care for the Homeless Council: http://www. nhchc.org
  - Corporation for Supportive Housing: http://www.csh.org

Performance Measure Resources

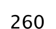
- eCQI Resource Center
  - https://ecqi.healthit.gov/ep
- Clinical Quality Measures
  - https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html
- United States Health Information Knowledgebase (USHIK)
  - https://ushik.org/QualityMeasuresListing?system=mu&stage=Stage%202&sortField=570&sortDirection=ascending&resultsPerPage=100&filter590=April+2014+EH&filter590=July+2014+EP&enableAsynchronousLoading=true
- National Quality Forum
  - http://www.qualityforum.org/QPS/QPSTool.aspx
- ONC Issue Tracking System (OITS) for eCQM inquiries
  - https://oncprojecttracking.healthit.gov/support/projects/CQM

Performance Measure Resources, continued

- Healthy People 2020
  - http://healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=8
- Adjusted Quartile Ranking
  - https://bphc.hrsa.gov/datareporting/reporting/ranking.html
- Million Hearts Hypertension Control Change Package
  - http://millionhearts.hhs.gov/Docs/HTN_Change_Package.pdf
- U.S. Preventive Services Task Force
  - https://www.uspreventiveservicestaskforce.org/
- CDC National Center for Health Statistics State Facts
  - http://www.cdc.gov/nchs/fastats/map_page.htm
- Health Center Quality Improvement Awards
  - https://bphc.hrsa.gov/programopportunities/fundingopportunities/quality/index.html

Discussion

- Are there issues that you have encountered related to UDS that you would like to share (state-specific reporting, consensus on handling issues, etc.)?
- Are there any final questions that you would like to discuss before we leave today?



Thank you!

Remember to call the UDS Support Line if you have additional content questions:

1-866-UDS-HELP

or

1-866-837-4357

udshelp330@bphcdata.net

Thank you for attending this training and for all of your hard work to provide comprehensive and accurate data to BPHC!