Question	Primary Table	Answer	References
What prep can we do now in the next 6 weeks in prep for the app going live? Like run data checks to see if their 'true' or good to use??	All	To be addressed Dec. 3	
How do we deal with discrepancies between the summary data and UDS+?	All	For CY2024 reporting that will take place in early 2025, you do not have to worry about this! There WILL be discrepancies, for many reasons, but primarily because the UDS+ submission will only include medical patients or patients from your primary system. So, if you use multiple systems or have subs or have dental program that's not included, then discrepancy is expected!	https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/uds-2024-submission-requirements.pdf
If we have multiple section 330 grants do we have to submit patient demographics via UDS+ for each grant?	All	I don't believe so, no. The UDS+ IG includes special population information (including granular information required by those with multiple grants) within its existing data elements, so it appears that the detail will just be submitted in bulk, including that granular information for those for whom it's applicable.	https://fhir.org/guides/hrsa/uds-plus/ Refer to extension definitions (13.0.4) UDS+ Individualized Sessions Registration: https://forms.office.com/pages/responsepage.aspx?id=YSZl7iDhjEqs_ICzVbYzon-LIujjZZ9PgwKGogDIKiNUNkVDU0pRVkdNSzU4VUtKUURRNldJS1JUQy4u&route=shorturl
Recommendations on how to provide much needed street outreach and healthcare and being able to provide comprehensive UDS data.	All	Great question-- let's talk more about the challenges here, of which I am sure there are many many. To be addressed further on Dec. 3	https://nhchc.org/
How much of UDS is referenced in an OSV?	All	Anecdotally, health centers are typically asked to share at least some UDS tables to their OSV reviewer and the reviewer want to see if health centers utilize their UDS data in meaningful ways - like patient demographics to inform board member composition, zip codes to ensure they are serving their service area, sliding scale fee and associated nominal charges are reflective of what the patient population would deem reasonable, staffing levels for number of patients served, etc. Others have shared that many health centers use the UDS to tell the story of their population to the reviewers during an opening conference, especially for quality indicators.	
Is it considered a negative to have a large number in the 'other' category for zip code patients?	ZIP	Not necessarily, though I could see it bringing up questions about service area.	
Why are the race categories so different from the Census, who have added the MENA (Middle Eastern/North African) and collapsed Ethnicity and Race together? Why are those for Asian and Pacific Islanders so specific while the others aren't?	Table 3B	Why indeed! My understanding is that it is because the census has been on a relatively slow updating process (e.g., the 1997 standards from OMB has been the primary guidance for most of the last 25 years), and efforts to update within individual programs, etc. are piecemeal, but requirements were laid out in the Affordable Care Act. Those are just now becoming requirements, and because the UDS is updated every year it takes a year or two for changes to be reflected in the reporting from health centers.	Helpful overview here: https://aspe.hhs.gov/reports/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-disability-0 Additional information: https://minorityhealth.hhs.gov/explanation-data-standards-race-ethnicity-sex-primary-language-and-disability

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Should patients with Emergency Medicaid be reported as “None/Uninsured” or “Other Public Insurance (Non-Chip)?	Table 4	On Table 4, patients with Emergency Medicaid are uninsured, they are NOT Other Public. On Table 9D, any revenue from emergency Medicaid is reported on Medicaid, non-managed care, Line 1.	DO NOT report public programs that reimburse for ***selected*** services, such as the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program; Breast and Cervical Cancer Early Detection Program (BCCEDP); or Title X, as a patient’s primary medical insurance. Page 42 of 2024 UDS Manual: Include patients covered by “state-only” programs covering individuals who are ineligible for federal matching funds (e.g., undocumented persons, pregnant patients) and paid through Medicaid, if they cannot otherwise be identified as having another insurance.
Define how migrant workers and farmworkers are identified differently?	Table 4	They are not! Migrant health care, MHC in UDS parlance, refers to agricultural and farm workers as defined in the manual.	Page 46 of the 2024 UDS Manual: For either migratory or seasonal agricultural workers, report patients who meet the definition of agriculture as farming in all its branches, as defined by the Office of Management and Budget (OMB)-developed North American Industry Classification System (NAICS), and include seasonal workers included in codes 111 and 112 and all sub-codes therein, including sub-codes 1151 and 1152. https://www.census.gov/naics/
Is it considered a negative to have a large number of Commecial insurance?	Table 4	Nope-- you should report patients by the insurance that they have and it's fine if they have commercial insurance.	
We have a CMO who spends a 25% FTE as a clinician and .75% of admin. With what i learned, i would count the CMO full FTE and visits in medical portion of table 5 and not split the time within admin category?	Table 5	That's correct.	"For medical directors or other personnel whose time is split between clinical and non-clinical activities, report here only that portion of their FTE corresponding to the corporate management function. (See limits on non-clinical time under Personnel Full-Time Equivalents.)" Page 62 of the 2024 UDS Manual.
Can you please give a few examples of a Countable Nurse visit for table 5?	Table 5	As it relates to Line 11, primary examples are triage and home visits where the nurse goes to an existing patient's home and includes evaluation/ assessment.	https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/uds-nurse-visits.pdf
Can we count telephonic visits?	Table 5	To be addressed Dec. 3	
Which contractors are reported as FTEs and which are not?	Table 5	Contractors paid based on time (by the hour or by a set time commitment) DO have FTEs reported in Column A of Table 5. Contractors who are not paid by the hour and are instead paid FFS or some other encounter basis do NOT have their FTE counted (but do have their visits/ patients counted).	Page 184 of the 2024 UDS Manual provides more information!
Who are the providers who can have countable visits?	Table 5	To be addressed Dec. 3	Appendix A on Page 178 of the 2024 UDS Manual helps with this!
How to count prenatal visits in the Group Centering Program?	Table 5	Assuming this if referring to counting on Table 5, these group centering sessions would not be countable visits on that table as group visits don't count outside of behavioral health.	Regarding group visits, refer to Page 19 of the 2024 UDS Manual.
for 6A line 21, if staff did not use CPT Code HIV testing but you did order testing and received results can you report tests on this line?	Table 6A	To be addressed Dec. 3	

Question	Primary Table	Answer	References
How might health centers want to submit requests for changes in the eCQMs?	Table 6B	Send to the measure stewards!	Appendix H on page 220 of the 2024 UDS Manual
Will the Clinical Quality Measures ever go back to the “UDS Medical” definition or will podiatry and psychiatry patients be included in medical measures for the foreseeable future?	Table 6B	I don't believe so, no. There are many reasons for this, but I think there are two primary reasons: 1. Aligning with national standards (hopefully) reduces overall reporting burden by not requiring that health centers/ vendors/ others write totally separate reports/ logic for the UDS. Further it ideally makes the data more comparable with other similar data reporting. 2. The vision of the health center program is to provide comprehensive patient-centered care, which I think means that patients have as many of their needs as possible addressed by the health center. This means that, in part, the vision is that a patient seen for dental care is also referred to the medical department for their other needs, and vice versa.	"Standardized countable visits reporting (Completed in 2020): Testing whether health centers can collect and report UDS countable visits using eCQM standards from the National Library of Medicine. In general, testing found that transitioning to complete alignment with CMS eCQMs would lower average performance rates by a few percentage points. However, the improvements in data reliability, consistency of reporting across health centers, and burden reduction outweigh the impact of short-term changes to performance rates" from UDS modernization page: https://bphc.hrsa.gov/data-reporting/uds-training-and-technical-assistance/uniform-data-system-uds-modernization-initiative
For the Adult BMI measure- because some dental visits can pull a patient into this measure, our dental providers are struggling with the follow up piece of the measure being out of their scope. Can the follow up piece just be a simple “check box” indicating that they recommend the patient discuss this with their PCP?	Table 6B	Yes, as long as checking that box actually triggers the information to be recorded in your system.	
How to report donated space?	Table 8A	Value it using fair value of what it would cost to rent the space, based on similar space, and report on Line 18, Column C of Table 8A	Report the estimated reasonable acquisition cost of donated personnel, supplies, services, space rental, and estimated depreciation for the use of donated equipment. -- Page 152 of the 2024 UDS Manual
With the UDS app opening up Jan 1st, how do we handle the revenue side of things, since we're likely not going to have that finalized that soon after year's end?	Table 9D	To be addressed Dec. 3	
can you clarify again on table 9 - column D - Adjustments. can you clarify time period for it. adjustments made in 2024 or for visits in 2024	Table 9D	To be addressed Dec. 3	
Do you report MCVR Liabilities in Table 9D?	Table 9D	Because these are reductions in reimbursement, as opposed to cash paid out from the health center, this will be reflected just as reduced reimbursements. No payback is reported, and adjustments are increased-- so it will appear that there is large outstanding A/R, that's ok.	From CHCANYS: NYS Medicaid liabilities are paid back in the following way: Recoupments will be automatically deducted at a rate of 15% from each Medicaid payment weekly until the total owed amount is fully repaid. Any remaining balance after 10 weeks will begin to accrue interest at the Prime rate plus 2%. (For recent audit recoupments, CHCANYS had this interest waived, but future recoupments may have this interest.) The 15% recoupment rate may be increased if necessary to ensure full repayment within one year.

Question	Primary Table	Answer	References
How to count/track referrals?		Let's discuss which table this is asking about, or what examples? To be addressed further on Dec. 3	