National
Family Planning
& Reproductive Health Association

FREQUENTLY ASKED QUESTIONS

FEDERAL REPORTING GUIDANCE FOR FQHCs PROVIDING TITLE X FAMILY PLANNING SERVICES

Purpose:

To support complete and accurate reporting through the Family Planning Annual Report (FPAR) and Uniform Data System (UDS) by addressing frequent questions and concerns raised by federally qualified health center (FQHC) who provide Title X services. Please also refer to **Appendix A** for a detailed crosswalk of FPAR and UDS data elements.

Disclaimer: The NFPRHA-produced document is intended for general guidance and informational purposes only. NFPRHA recommends that FQHCs that provide Title X services should communicate directly with their Title X grantee or the Office of Population Affairs (OPA), as appropriate, about specific questions related to FPAR reporting. Health centers requiring UDS reporting assistance should contact HRSA's Bureau of Primary Health Care by phone at 1-866-UDS-HELP (866-837-4357) or e-mail at udshelp330@bphcdata.net.

How should my FPAR data compare to my UDS data?

FPAR captures services relating only to patients that received family planning services, while UDS captures patients that received a broad range of medical and specialty care services rendered by a health center, including dental, vision, and emergency care. For this reason, along with the fact that FPAR and UDS are separate reporting systems with separate guidelines that are sometimes not in direct alignment, data submitted for these reports likely will not match. For entities that are dual Section 330 and Title X grantees, OPA and HRSA do not attempt to do data matching between FPAR and UDS reports.

How do I count unduplicated users for FPAR (Table 1, *Unduplicated Number of Family Planning Users by Age Group and Sex*)?

OPA defines a family planning user as an individual who has at least one family planning encounter at a Title X service site during the reporting period. Title X projects may only count the same, unduplicated individual once during a reporting period (i.e., the calendar year).

FQHCs that provide Title X services should strive to account for every patient that meets the definition of a "family planning user" — even those patients for which Title X funds were not used to pay for the family planning services received (e.g., patients with commercial insurance or Medicaid), including patients that receive integrated family planning services as part of a regular health center visit.

Example: A patient with commercial insurance receives a well-woman visit, which included a discussion of her reproductive life plan (to ensure that testing and any treatments provided were aligned with the patient's current and future plans) and provision of oral contraceptive pills. The health center bills the patient's insurance provider and receives full reimbursement for care delivered. This patient should have a Clinic Visit Record (CVR) created and be reported in FPAR, as she received Title X family planning services.

The number of patients that a health center reports to FPAR will be a subset of patients they report in Tables 3A and 3B of UDS. Health centers only should report health center patients that received family planning services (as defined in FPAR) to FPAR. It may be possible to identify many of these patients using ICD10 Z30/Z31 diagnosis codes, though this depends on how rigorously these codes are used by health center staff.

Example: A health center reported 1,600 family planning users to FPAR in 2018, of which 1,472 (92%) were female and 128 (8%) were male. In its 2018 UDS submission, the same health center reported 8,000 patients, 4,400 (55%) female patients and 3,600 (45%) male patients. It also reported to UDS that 1,250 patients had a contraceptive management ICD-10 code (Z30-) in 2018, lower than the number of female users reported to FPAR because some patients received family planning services outside the scope of Z30/Z31 codes and some patients were missing these codes in their electronic health records (EHR).

Can an unduplicated user (as reported in FPAR) also be counted for UDS reporting?

UDS defines a patient as a person who has at least one reportable visit – including medical or dental services – during the reporting year. Patients who meet the FPAR definition of a "user" and the UDS definition of a "patient" are reported in both FPAR and UDS. Reporting such data to each report does not result in a FQHC that provides Title X services "double counting" or receiving

"double" credit for services provided. Rather, it ensures that both OPA and HRSA receive accurate information on services provided to health center patients during the reporting period.

Do we need to report income level and family size for all unduplicated users (or just those without insurance)?

FPAR requires that Title X projects report family income data for *all* users – not just those patients without third-party insurance – because of the function this data serves for OPA. OPA ultimately uses income level data to monitor the Title X program's role in supporting the health care safety net for individuals who confront financial barriers. Because income level is reported as a percentage of the HHS Poverty Guidelines in Table 4, Title X projects collect patients' current income and family size. Patients for which income level is unknown are reported as "Unknown/not reported."

Though UDS requires that health centers report family income data for all patients (in Table 4), many health centers report a considerable number of users with unknown incomes (approximately 28% of patients nationally in 2017). Health centers that are accustomed to reporting high proportions of users with unknown incomes consequently may encounter challenges when striving to capture family income data for family planning users for FPAR reporting. If there are high levels of unknown/not reported values in any FPAR table, including Table 4, OPA will require the grantee to revisit these issues during validation processes and include notes that confirm the values entered and explain why high levels of unknowns were reported.

Of note, HRSA allows each health center's Board of Directors to define "income" (in policy), provided that definition is consistent with the Health Center Program Compliance Manual. As a result, family income data collected by health centers using a definition of "income" that is different from the definition used by OPA for FPAR likely will not match family income data collected for FPAR.

How do I count encounters for FPAR (Table 13, *Number of Full-Time Equivalent Clinical Services Providers and Family Planning Encounters by Type of Provider*)?

OPA defines an "encounter" as a documented, face-to-face contact between an individual and a provider that takes place at a Title X service site. There are two types of family planning encounters: (1) family planning encounters with a "Clinical Services Provider"; and (2) family planning encounters with an "Other Services Provider. The type of family planning provider who delivers the care, regardless of the services rendered, determines the type of family planning encounter.

In FPAR, a "provider" includes any health center staff person that exercises independent judgment when providing family planning and related preventive health services to a patient who wishes to avoid unintended pregnancy or achieve intended pregnancy, including female, male, or non-binary patients. This provider must document services provided during the family planning encounter in the patient's medical record.

How does counting encounters in FPAR compare to how visits are counted for UDS reporting?

Counting encounters for FPAR is different than determining visits for UDS (in Table 5). Within UDS, "visits" are defined as documented individual, face-to-face contacts between a patient and a *licensed or credentialed provider*. While FPAR's definition of a "provider" includes "Clinical Service Providers" and "Other Service Providers," the UDS's definition is more limited. See Appendix A for a side-by-side comparison of the types of professionals that fall under each report's definition of provider. Most notably, FPAR allows health centers to report documented encounters with a licensed practical nurse, certified nurse assistant, health educator, social worker, or clinic aide.

Can health centers report when a patient comes in for a laboratory tests as an encounter in FPAR?

Lab tests, in and of themselves, do not constitute a family planning encounter in FPAR unless there is face-to-face contact between the patient and the provider (see definition in the FPAR-UDS Data Element Crosswalk), the provider documents the encounter in the patient's record, and the tests are accompanied by counseling or education related to avoiding unintended pregnancy or achieving intended pregnancy.

How do I calculate Clinical Services Provider FTEs (Table 13) for FPAR? How does this compare to UDS reporting?

Within FPAR, health centers report the time that each type of Clinical Services Provider (e.g., physician; physician assistant/nurse practitioner/certified nurse midwife; registered nurse with an expanded scope of practice) is involved providing Title X-funded services (i.e., serving patients who are reported as family planning users). Time is reported as full-time equivalent (FTE) units, where an FTE of 1.0 describes a staff person who works the health center's equivalent of a full-time schedule for 1 year.

Example: A health center has two women's health nurse practitioners dedicated to providing Title X family planning services; one works 5 full days weekly, the other works 4 full days weekly. While these clinicians do not create a CVR for every patient they serve – some patients do not meet the definition of a "family planning user" – CVRs are created for most patients. Additionally, one full-time licensed practical nurse (LPN) provides support. This health center will report 1.8 FTE Clinical Service Providers for the two nurse practitioners. The LPN's time is reported in the "Other Services Provider" category.

This calculation is less clear-cut for FQHC that deliver Title X family planning services as part of integrated patient visits. Because integrated visits are reported as encounters to FPAR, the time that Clinical Services Providers spend on these encounters also are reported.

Example: If a full-time primary care physician has 2,500 regular health center visits each year, of which 500 visits are integrated family planning visits, the FQHC would report 0.2 FTE (500 visits / 2,500 visits = 0.2 FTE) to FPAR. There is no need to pro-rate provider time spent on integrated family planning visits in order to account for the proportion of time spent on family planning services versus other health services.

FPAR and UDS are separate reporting systems with separate guidelines, so health centers likely will report different FTE estimates to OPA and HRSA, respectively. Most notably, in Table 5 of the UDS, health centers report FTE values for all paid staff, volunteers, contracted personnel, interns, residents, and preceptors that carry out activities that are within the scope of their HRSA grant project—a scope that is much broader than that of their Title X project. In addition, when calculating FTEs for UDS, health centers report FTE units by major service category and do not combine staff to create an aggregate number for "Clinical Service Providers."

What do I count when reporting collections from patients (Table 14, *Revenue Report*) in FPAR?

When reporting collections from patients in FPAR, health centers report the total amount of funds collected directly from patients for services provided within the scope of the Title X project, including fees (as determined by the health center's Title X sliding fee scale, when applied) and co-payments. Patient donations are not be reported as "Collections" in FPAR, but, instead, as "Other Revenue," another field in Table 14.

UDS requires that health centers report all charges and collections for which the patient is responsible as "Self-pay" in Table 9D. This amount includes charges and collections for deductibles and co-payments collected from patients for *all* services that are within the health center's HRSA grant project scope, including Title X-supported family planning services. When reporting patient collections for family planning encounters to both FPAR and UDS, FQHCs that provide Title X family planning services are not "double counting" collections.

What do I count when reporting collections from third-party payers (Table 14)?

In Table 14 of FPAR, health centers report all funds that were reimbursed by third-party payers for any services provided within the scope of their Title X projects, including reimbursements from Medicaid (either directly by Medicaid or indirectly through a fiscal intermediary or a health maintenance organization), Medicare, Children's Health Insurance Program, other public health insurance, and private (i.e., commercial) health insurance. These payer-specific amounts are separated and reported as "Amount Prepaid" and "Amount Not Prepaid," where "pre-paid" funds include capitated managed care arrangements (e.g., capitated Medicare, Medicaid, and private managed care contracts). All revenues received after the date of service, even under managed care arrangements, are reported as "Amount Not Prepaid."

Table 9D of the UDS has five payer categories for patient-related revenue: Medicaid, Medicare, Other Public, Private, and Self-Pay. Except for the "Self-Pay" category (described above), each

category has three sub-categories: "Non-managed care," "Capitated managed care," and "Fee-for-service managed care." Within the appropriate categories and sub-categories, FQHCs that provide Title X family planning services report all revenues for *all* services that are within the health center's HRSA grant project scope, including Title X-supported family planning services. When reporting third-party payer reimbursements for family planning encounters to both FPAR and UDS, FQHCs that provide Title X family planning services are not "double counting" revenues.

There is misalignment between FPAR and UDS guidance around categorizing revenues. FPAR requests Medicaid and CHIP revenues separately on Table 14, while UDS allows reporting of Medicaid-funded CHIP revenues together with regular Medicaid revenues. In addition, FPAR requests that grantees report revenues that supported Title X projects from federal programs such as Title V, Title XX, and TANF as such; however, UDS advises grantees to report such revenues as coming from the entity from which the health center received them. HRSA calls this the "last party rule," which states that "Grant and contract funds should always be reported based on the entity from which the health center received them, regardless of their origin." For example, funds awarded by the state for maternal and child health services usually include a mixture of Federal funds, such as Title V, and state funds. Nonetheless, report these as state grants.[1] Additional guidance is needed to resolve these discrepancies and ease burden of reporting revenue by dual Section 330 and Title X grantees.

[1] HRSA Bureau of Primary Health Care (2017). Uniform Data System Reporting Instructions for Calendar Year 2018 UDS Data. Rockville, MD: HRSA Bureau of Primary Health Care.

Appendix A
Reporting Encounters by Service Providers

Key Can be reported as an encounter Cannot be reported as an encounter	Family Planning Annual Report		Uniform Data System	
	Clinical Services Provider	Other Service Provider	Provider	Non-Provider
	Visits with both categories of providers can be reported; however, to be reportable, staff person must offer education, counseling, referral, or follow-up services relating to the patient's potential or adopted method of contraception, general reproductive health, or infertility treatment.		*Only visits with providers can be reported. Visits where the patient does not see a provider cannot be reported as "Medical Care Services."*	
Physicians	X		X	
Licensed medical residents	X		X	
Nurse practitioners	X		X	
Physician assistants	X		X	
Certified nurse midwives	X		X	
Clinical nurse specialists	X		X	
Public health nurses		X	X	
Visiting nurses		X	X	
Registered nurses		X	X	
Licensed practical nurses		X		X
Nurse aides/ assistants		X		X
Clinic aides/ medical assistants		X		X
Unlicensed interns and residents		X		X
Laboratory technicians		X		X
Phlebotomists		X		X
Social workers		X		X*
Case managers		X		X*
Care/ referral coordinators		X		X*
Family planning counselors		X		X*
Health educators		X		X*
Outreach workers		X		X

*Provision of enabling services by these professionals can be reported in UDS as "Enabling Services" (not "Medical Care Services"). Such services include case management, interpretation, transportation, and other mechanisms to link patients to preventive medical care services and necessary treatments.

References

HRSA Bureau of Primary Health Care (2017). Uniform Data System Reporting Instructions for Calendar Year 2018 UDS Data. Rockville, MD: HRSA Bureau of Primary Health Care. Available at: https://bphc.hrsa.gov/sites/default/files/bphc/datareporting/reporting/2018-uds-reporting-manual.pdf.

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