

HRSA
Health Resources & Services Administration

Uniform Data System (UDS) Reporting Requirements

Annual Training

Calendar Year (CY) 2026

Vision: Healthy Communities, Healthy People



UDS Reporting Requirements

AGENDA

- ❑ Welcome and Logistics
- ❑ Overview of the Uniformed Data System (UDS)
- ❑ Overview of Tables and Forms
- ❑ Tips for Success
- ❑ Review of Available Technical Assistance (TA)
- ❑ Closing

Overview of the UDS

Key Facts About UDS Reporting

Health centers, look-alikes (LALs), and certain Bureau of Health Workforce (BHW) recipients funded or designated before Oct. 2026 all complete a UDS Report.

The UDS includes 11 tables and 2 forms that provide an annual snapshot of all in-scope activities reported on the Universal Report and, if applicable, Grant Reports.

The UDS Report is completed in the Performance Report in the Electronic Handbooks (EHBs).

The UDS is legislatively mandated as part of the Health Center Program and is used for program monitoring and improvement.

All health centers complete their UDS Report between Jan. 1 and Feb. 15, 2027; the report covers health center services in the calendar year from Jan. 1 to Dec. 31, 2026.

HRSA Health Center Program

Value of the UDS



Demonstrate Services

Demonstrates the scope of the Health Center Program, including type of services, volume, and outcomes, for each calendar year.



Identify Trends

Allows stakeholders to understand how each health center and health centers in aggregate have changed year over year.



Communicate Importance

Demonstrates to administrators and the public the impact of the Health Center Program.



Inform Consistently

Provides consistent, reliable data over time, supporting evaluation of progress, decision-making, identification of gaps, and improvement strategies.

HRSA Health Center Program

Overview of UDS Report

Four Primary Sections, Eleven Tables, and Two Forms



Patient Profile

ZIP Code: by Medical insurance
Table 3A: Age, sex
Table 3B: Race, ethnicity, limited English proficiency
Table 4: Income, medical insurance, special medically underserved populations



Clinical Services and Outcomes

Table 5: Personnel, visits, and patients
Table 6A: Selected services and diagnoses
Table 6B: Clinical quality measures (CQMs)
Table 7: Clinical outcome measures



Financial Performance

Table 8A: Financial costs
Table 9D: Accrued patient service–related charges, collections, adjustments, bad debt, pharmacy, and incentives
Table 9E: Other accrued revenue



Other Forms

Appendix C: Health Information Technology (Health IT) Capabilities and Other Data Elements (ODE)
Appendix D: Workforce

HRSA Health Center Program

Health Center Program Grants and Designations

- **Some health centers have a single Health Center Program funding type, also called a section 330 award:** Community Health Center (CHC) funding, Homeless Population (HP) funding(h), Migratory and Seasonal Agricultural Workers (MSAW) funding (g), or Residents of Public Housing (RPH) funding (i).
- **Some health centers have more than one Health Center Program award:** these health centers have two or more awards, in any combination of CHC, HP, MSAW, and/or RPH.
- **Some health centers have a Health Center Program Look-alike (LAL) designation. Health Centers may also be BHW award recipients.** LALs do not receive Section 330 award funding.

Additional definitions can be found on the Health Resources and Services Administration's (HRSA's) "What is a Health Center?" page.

HRSA Health Center Program

Overview of UDS Reporting Requirement

Universal Report

- Reported by *all* health centers.
- Includes full UDS Report, 11 tables and 2 forms.
- All patients, services, and related information within the calendar year that are in the health center scope of project are reported.
- All health centers that only have a single Health Center Program award, LAL designation, or BHW award will report just a Universal Report.

Grant Report

- Reported by those health centers with **additional** Health Center Program 330 awards, such as MSAW, HP, and RPH.
  - **This is *in addition* to the Universal Report, for those with the grant.**
- Report subset of the full UDS Report: 5 tables and no forms.
  - Tables 3A, 3B, 4, and 6A, as well as patients and visits on Table 5, are reported.
  - Reporting is specific to the scope of each additional 330 grant.

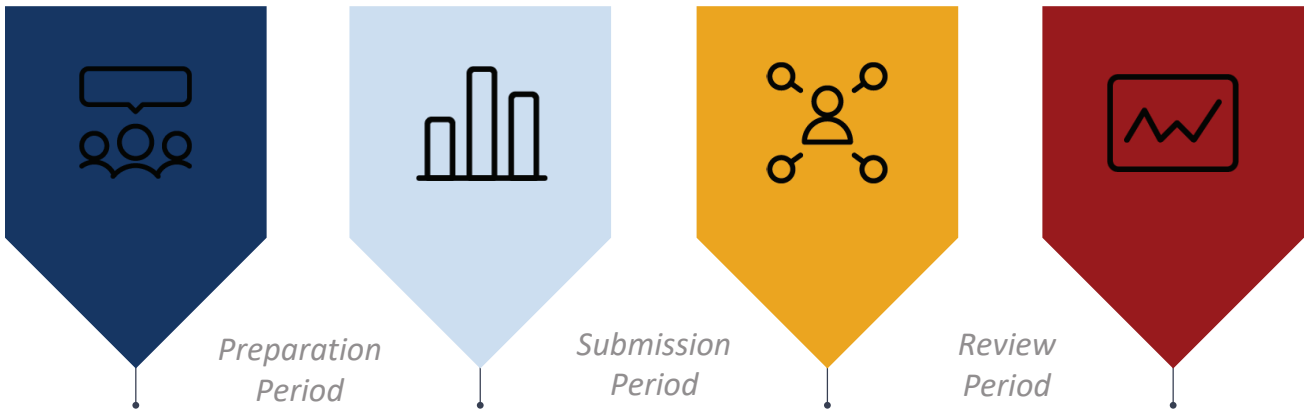
Overview of Universal Reporting Requirement vs. Grant Reporting Requirement

Table	Data Reported	Universal Report	Grant Reports
Service Area			
Patients by ZIP Code Table: Patients by ZIP Code	Patients served reported by ZIP code and by primary third-party medical insurance source, if any	X	
Patient Profile			
Table 3A: Patients by Age and by Sex	Patients by age and by sex	X	X
Table 3B: Demographic Characteristics	Patients by race, ethnicity, and limited English proficiency	X	X
Table 4: Selected Patient Characteristics	Patients by income (as measured by percentage of the federal poverty guidelines [FPG]) and primary third-party medical insurance and the number of special medically underserved population patients receiving services	X	X
Staffing and Utilization			
Table 5: Staffing and Utilization	The annualized full-time equivalent (FTE) of program personnel by position, in-person and virtual visits by provider type, and patients by service type	X	Partial (excludes FTE)
Clinical			
Table 6A: Selected Diagnoses and Services Rendered	Visits and patients for selected medical, mental health, substance use disorder (SUD), vision, dental, patient support, and upstream drivers of health diagnoses and services	X	X
Table 6B: Quality of Care Measures	Clinical quality of care measures	X	
Table 7: Health Outcomes	Health outcome measures	X	
Financial			
Table 8A: Financial Costs	Direct and indirect expenses by cost categories	X	
Table 9D: Accrued Patient Service Revenue	Full charges, collections, and adjustments by payer type; bad debt write-offs and allowances; pharmacy revenue; and third-party incentives	X	
Table 9E: Other Accrued Revenue	Other, non–patient service revenue	X	
Other			
Appendix C: Health Information Technology (Health IT) Capabilities and Other Data Elements Form	Health IT capabilities, including the use of electronic health record (EHR) information, medications for opioid use disorder (MOUD), telehealth, alternative payment models (APM), and voluntary family planning	X	
Appendix D: Workforce Form	Health center workforce training and use of satisfaction surveys for provider and other personnel	X	

This table from pages 11–12 of the 2026 UDS Manual provides a detailed overview.

HRSA Health Center Program

Reporting Timeline



Preparation Period

Fall

Preliminary Reporting Environment (PRE) opens November 2026

Submission Period

Jan. 1, 2027

UDS Report is available in EHBs

Review Period

Feb. 15, 2027

Deadline for each health center to submit UDS Report in EHBs

Outlier Period

Mar. 31, 2027

Last day for UDS data changes as part of review process

HRSA Health Center Program

Administering Program Conditions and Questionable Ratings

Health centers must demonstrate program compliance with these requirements:

- The health center has a system in place to collect and organize data related to the HRSA-approved scope of project, as required to meet U.S. Department of Health and Human Services (HHS) reporting requirements, including those data elements for UDS reporting; and
- The health center submits timely, accurate, and complete UDS reports in accordance with HRSA instructions and submits any other required HHS and Health Center Program reports.

At the end of the review period, all tables and forms need to be marked as acceptable or questionable. If any table is rated as questionable, the health center will not be eligible for Community health Quality Recognition (CHQR) badges.

A questionable rating means that:

- Data do not align with the reporting requirements in the 2026 UDS Manual.
- Data are missing or incomplete.
- Data do not capture the whole health center scope of project.
- There is a significant outlier that cannot be explained.

Key Definitions

Understanding Terms Foundational to the UDS



HRSA Health Center Program



Health Center Scope

UDS Definition: Health center scope of project is a defined set of approved service sites, services, providers, service area, and medically underserved populations served by a health center.

- Only services within the **health center scope of project**, meaning the scope of your health center program award (or LAL designation), or required by your BHW award, are reported in the health center's UDS Report.
- For some, all sites and services are within the health center scope of project. For others, the health center scope of project is a subset of the larger organization.
  - It is important to understand your health center scope of project to report correctly.
  - In-scope services for your health center are on your Form 5A. Sites within your health center scope of project are listed on your Form 5B.

Example of Health Center Scope

- Mercy Care is an organization with five sites that offers primary care, mental health and substance use disorder, dental, and care coordination.
- All of these sites and services are listed on Form 5A and Form 5B and included in the health center award.
- They don't have a parent company or umbrella organization.
- **All of Mercy Care's sites and services are in-scope.**

- Hope Health is a health center within a larger health system.
- The health center has several sites that provide mostly primary care to about 6,000 patients. The larger health system serves 60,000 patients and includes emergency departments, surgical, oncology, labor and delivery, and more.
- Hope Health has just three sites on their Form 5B.
- **Only the services from Form 5A provided at the sites listed on Form 5B are in-scope—not the whole health system!**



Health Center Patient

UDS Definition: A person who had at least one countable visit and is reported on Table 5 in one or more service categories during the calendar year.

- The patient profile tables (ZIP Code Table and Tables 3A, 3B, and 4) provide an **unduplicated count of health center patients**.
  - In the patient profile tables, **each patient is counted once** regardless of the number of visits or services received.
  - All patients must be included in the patient demographic tables by their demographic characteristics.
- Individuals with contact with the health center who **don't** meet this definition of health center patient are **not counted anywhere on the UDS**.
- Health center patients are reported on all service and clinical tables for which they meet the criteria.



Countable Visit

UDS Definition: Encounters between a patient and a licensed or credentialed provider who exercises independent professional judgment in providing services that are individualized to the patient and documented in the patient's record are countable visits, reported on Table 5.

- Visits can be **clinic (in-person) or virtual**; the requirements to be countable are the same for each.
- Only **certain personnel are classified as providers** and can therefore generate countable visits.
  - Appendix A of the UDS Manual specifies which personnel (by line on Table 5) can be providers in the UDS.
  - Page 64 spells out Personnel lines that cannot have visits.
- A countable visit in *any* service category on Table 5 determines if someone is a health center patient in the UDS.
  - Starting on page 52 of the UDS Manual, personnel categories are outlined by the different service categories reported in the UDS.
- An encounter is a countable visit when it is **one-to-one with a provider and a patient**.
  - Exception: Mental health (MH) and substance use disorder (SUD) (Lines 20a–21) allow group visits.

HRSA Health Center Program

We will review more examples and details about countable visits and health center patients when we get to Table 5.

Keep the Big Picture in Mind

Include Health Center Scope
Determine what sites and services are within your health center scope of project.

Identify Patients Served in Your Health Center Scope
Only include individuals who had at least one UDS countable visit (on Table 5) in the calendar year as a patient.

Report Patient Characteristics
Demographic information must be captured and reported for all unduplicated health center patients (Tables ZIP, 3A, 3B, and 4).



Report Services Patients Received
Services and clinical tables (Tables 5, 6A, 6B, and 7) reflect *only* and *all* countable services provided to health center patients. The forms are also limited to health center patients, except where specified!

Report Financials
Financial tables (Tables 8A, 9D, and 9E) include *only* and *all* accrued costs and revenue for services reflected in all other tables and the UDS as a whole.

Complete Forms
Health IT and ODE Form and Workforce Form

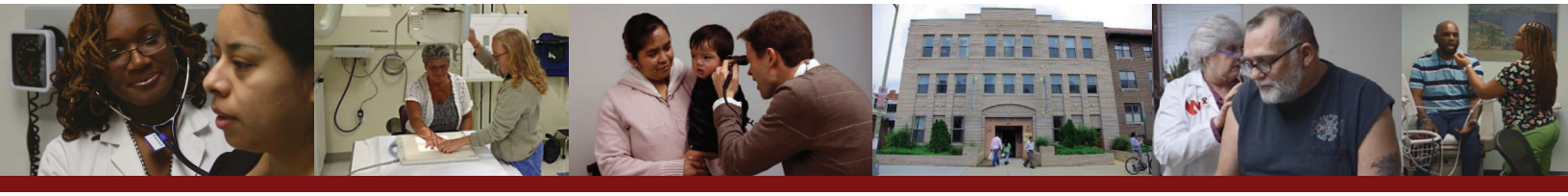
HRSA Health Center Program

Overview of the UDS Tables and Forms

Understanding What Data Are Reported and Why



HRSA Health Center Program



ZIP Code Table and Tables 3A, 3B, and 4

Understanding Who You Are Serving

HRSA Health Center Program

ZIP Code Table

Patients by ZIP Code and Primary Medical Insurance

No Changes for Calendar Year (CY) 2026 Reporting

Overview of Patients by ZIP Code Table

In the rows, report unduplicated patients by their ZIP code of residence. Enter a ZIP code or import a list.

For any ZIP code with 11 or more patients, list it on its own row. For ZIP codes with 10 or fewer patients, combine the count of patients from these ZIP codes on the "Other ZIP Codes" line.

Use the patient's local address for migratory and seasonal agricultural workers, people in a carceral facility, and those from other countries who reside in the United States; use the ZIP code where service was provided for the homeless population without an identified address.

In the columns, report unduplicated patients by their primary medical insurance as of the last visit of the year.

ZIP Code (A)	None/Uninsured (B)	Medicaid/ CHIP/Other Public (C)	Medicare (D)	Private (E)	Total Patients (F)
Other ZIP Codes					
Unknown Residence					
Total					

CHIP = Children's Health Insurance Program

Excerpt from ZIP Code Table

Helpful Tips for Patient ZIP Code Table

On the ZIP code table, **Medicaid, CHIP, and Other Public are combined** and reported in Column C.

ZIP Code (A)	None/Uninsured (B)	Medicaid/ CHIP/Other Public (C)	Medicare (D)	Private (E)	Total Patients (F)
Other ZIP Codes					
Unknown Residence					
Total					

There is **not an "unknown" category** for primary medical insurance. Primary medical insurance must be recorded for all patients as of their last visit in the calendar year.

Total patients must equal total patients reported on the other patient characteristics tables (with the exceptions noted earlier).

Table 3A

Patients by Age and Sex

No Changes for CY 2026 Reporting

Overview of Patients by Age and Sex Table

Table 3A, Lines 1–39

In the rows, report an unduplicated count of patients by age as of December 31 of the calendar year (2026).

In the columns, report the sex of the patients as listed on the birth certificate.

There is **not an "unknown" category** for age or sex. The health center must collect the age and sex of all patients.

Total patients must equal total patients reported on the other patient characteristics tables (with the exceptions noted earlier).

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		
…	…		
26	Ages 25–29		
27	Ages 30–34		
28	Ages 35–39		
29	Ages 40–44		
30	Ages 45–49		
31	Ages 50–54		
32	Ages 55–59		
33	Ages 60–64		
34	Ages 65–69		
35	Ages 70–74		
36	Ages 75–79		
37	Ages 80–84		
38	Age 85 and over		
39	**Total Patients** (Sum of Lines 1–38)		

Excerpt from Table 3A

HRSA Health Center Program

Table 3B

Demographic Characteristics: Race, Ethnicity, and Limited English Proficiency

No Changes for CY 2026 Reporting

Patients by Race and Ethnicity

Table 3B, Lines 1a–8

	Patients by Race and Hispanic, Latino/a, or Spanish Ethnicity									
Line	Patients by Race	Yes, Mexican, Mexican American, Chicano/a (A1)	Yes, Puerto Rican (A2)	Yes, Cuban (A3)	Yes, Another Hispanic, Latino/a, or Spanish Origin (A4)	Yes, Hispanic, Latino/a, Spanish Origin, Combined (A5)	Total Hispanic, Latino/a, or Spanish Origin (A) (Sum Columns A1+A2+A3+ A4+A5)	Not Hispanic, Latino/a, or Spanish Origin (B)	Unreported / Chose Not to Disclose Ethnicity (C)	Total (D) (Sum Columns A+B+C)
1a	Asian Indian									
1b	Chinese									
1c	Filipino									
1d	Japanese									
1e	Korean									
1f	Vietnamese									
1g	Other Asian									
1	Total Asian (Sum Lines 1a+1b+1c+1d+1e+1f+1g)									
2a	Native Hawaiian									
2b	Other Pacific Islander									
2c	Guamanian or Chamorro									
2d	Samoan									
2	Total Native Hawaiian/Other Pacific Islander (Sum Lines 2a+2b+2c+2d)									
3	Black or African American									
4	American Indian/Alaska Native									
5	White									
6	More than one race									
7	Unreported/Chose not to disclose race									
8	**Total Patients** (Sum of Lines 1 + 2 + 3 to 7)									

HRSA Health Center Program

Patient Race

Table 3B, Lines 1a–8

In the rows, report unduplicated patients by race.

There are subcategories for Asian and Other Pacific Islander:

- Asian: Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Other Asian
- Native Hawaiian/Other Pacific Islander: Native Hawaiian, Other Pacific Islander, Guamanian or Chamorro, Samoan

Line	Patients by Race
1a	Asian Indian
1b	Chinese
1c	Filipino
1d	Japanese
1e	Korean
1f	Vietnamese
1g	Other Asian
1	Total Asian (Sum Lines 1a+1b+1c+1d+1e+1f+1g)
2a	Native Hawaiian
2b	Other Pacific Islander
2c	Guamanian or Chamorro
2d	Samoan
2	Total Native Hawaiian/Other Pacific Islander (Sum Lines 2a+2b+2c+2d)
3	Black or African American
4	American Indian/Alaska Native
5	White
6	More than one race
7	Unreported/Chose not to disclose race
8	**Total Patients** (Sum of Lines 1 + 2 + 3 to 7)

Excerpt from Table 3B

HRSA Health Center Program

Tips on Patient Race

Table 3B, Lines 1a–8

Line	Patients by Race
1a	Asian Indian
1b	Chinese
1c	Filipino
1d	Japanese
1e	Korean
1f	Vietnamese
1g	Other Asian
1	Total Asian (Sum Lines 1a+1b+1c+1d+1e+1f+1g)
2a	Native Hawaiian
2b	Other Pacific Islander
2c	Guamanian or Chamorro
2d	Samoan
2	Total Native Hawaiian/Other Pacific Islander (Sum Lines 2a+2b+2c+2d)
3	Black or African American
4	American Indian/Alaska Native
5	White
6	More than one race
7	Unreported/Chose not to disclose race
8	**Total Patients** (Sum of Lines 1 + 2 + 3 to 7)

Excerpt from Table 3B

If a **patient identified or selected multiple races**, report on Line 6, "More than one race."

If a patient **does not report or chooses not to disclose their race**, report on Line 7, "Unreported/Chose not to disclose race."

Total patients **must equal** total patients reported on the other patient characteristics tables (with the exceptions noted earlier).

Patient Ethnicity

Table 3B, Columns A1–D

Line	Patients by Race	Yes, Mexican, Mexican American, Chicano/a (A1)	Yes, Puerto Rican (A2)	Yes, Cuban (A3)	Yes, Another Hispanic, Latino/a, or Spanish Origin (A4)	Yes, Hispanic, Latino/a, Spanish Origin, Combined (A5)	Total Hispanic, Latino/a, or Spanish Origin (A) (Sum Columns A1+A2+A3 +A4+A5)	Not Hispanic, Latino/a, or Spanish Origin (B)	Unreported / Chose Not to Disclose Ethnicity (C)	Total (D) (Sum Columns A+B+C)

In the columns, report patients by ethnicity.

There are subcategories for Hispanic, Latino/a, or Spanish origin:

- Mexican, Mexican American, Chicano/a; Puerto Rican; Cuban
- Another Hispanic, Latino/a, or Spanish Origin
- Hispanic, Latino/a, Spanish Origin, Combined

Tips on Patient Ethnicity

Table 3B, Columns 1a–8

If a patient identified as **another Hispanic culture or origin not listed as a subcategory** (Columns A1, A2, or A3), report in Column A4.
Note: this means your health center **is collecting** more granular ethnicity categories not listed in Columns A1–A3.

If a patient **identified as Hispanic, Latino/a, or Spanish origin but for whom granularity of ethnicity is not known**, or the patient **selected more than one ethnicity**, report in Column A5.

If race is known but ethnicity is not, report in Column B, Not Hispanic, Latino/a, or Spanish Origin.

Line	Patients by Race	Yes, Mexican, Mexican American, Chicano/a (A1)	Yes, Puerto Rican (A2)	Yes, Cuban (A3)	Yes, Another Hispanic, Latino/a, or Spanish Origin (A4)	Yes, Hispanic, Latino/a, Spanish Origin, Combined (A5)	Total Hispanic, Latino/a, or Spanish Origin (A) (Sum Columns A1+A2+A3 +A4+A5)	Not Hispanic, Latino/a, or Spanish Origin (B)	Unreported / Chose Not to Disclose Ethnicity (C)	Total (D) (Sum Columns A+B+C)

Race and Ethnicity Classifications

- The current UDS race and ethnicity classifications are based on the Office of Management and Budget (OMB) guidance issued before 2025, titled "U.S. Department of Health and Human Services Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status."

Patients with Limited English Proficiency

Table 3B, Line 12

Line	Patients with Limited English Proficiency	Number (A)
12	Patients with Limited English Proficiency	

Excerpt from Table 3B

Report patients **with limited English proficiency** on Line 12.

Include those patients who were served in a second language by a bilingual provider or a third-party interpreter and those who may have brought their own interpreter.

If the patient's **primary language is not English**, then they are reported on this line. This line does not discern between written and spoken preference; it could be either or both.

Because Line 12, patients with limited English proficiency, is a subset of total patients, this number **does not need to equal** total patients reported on the other patient characteristics tables.

Table 4

Selected Patient Characteristics: Income, Third-Party Medical Insurance, and Special Medically Underserved Populations

Summary of Changes to Table 4

- Removed: Managed Care Member Months (Lines 13a, 13b, 13c)

Income as a Percentage of Poverty Guideline

Table 4, Lines 1–6

Report all patients by income as a percentage of federal poverty guidelines on Lines 1–5. Report each patient's most recent income within 12 months prior to the last calendar year visit.

Report income based on federal poverty guidelines. Note: this means information on income and family/household size will need to be collected.

If the health center **did not collect or capture information** on a patient's income, report on Line 5, "Unknown." Note: **Self-declaration of income from patients is acceptable** as long as that is consistent with the health center's governing board-approved policies and procedures.

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

Total patients **must equal** total patients reported on the other patient profile tables (with the exceptions noted earlier).

Primary Medical Insurance

Table 4, Lines 7–12

Line	Primary Third-Party Medical Insurance	0–17 Years Old (A)	18 and Older (B)
7	**None/Uninsured**		
8a	Medicaid (Title XIX)		
8b	CHIP Medicaid		
8	**Total Medicaid** (Line 8a + 8b)		
9a	Dually Eligible (Medicare and Medicaid)		
9	**Medicare** (Inclusive of dually eligible and other Title XVIII beneficiaries)		
10a	Other Public Insurance (Non-CHIP) (specify___)		
10b	Other Public Insurance CHIP		
10	**Total Public Insurance** (Line 10a + 10b)		
11	**Private Insurance**		
12	**TOTAL** (Sum of Lines 7 + 8 + 9 +10 +11)		

In the rows, report all unduplicated patients by primary medical insurance on Lines 7–11.

- Use medical insurance at the patient's last visit in the year.
- Only comprehensive, portable medical insurance is counted on this table.

In the columns, report patients by their age into two categories: 0–17 years old and 18 and older, based on their age on December 31, 2026.

Tips on Primary Medical Insurance

Line	Primary Third-Party Medical Insurance	Description
7	**None/Uninsured**	Patient without insurance at last visit (includes uninsured patients for whom the health center may be reimbursed through grant, contract, or fund).
8a	Medicaid (Title XIX)	Medicaid and Medicaid managed care programs, including those administered by commercial insurers.
8b	CHIP Medicaid	CHIP administered and paid by Medicaid, report on Line 8b.
8	**Total Medicaid** (Line 8a + 8b)	
9a	Dually Eligible (Medicare and Medicaid)	Subset of Medicare patients who also have Medicaid coverage. They have Medicare and Medicaid and are reported on both Lines 9a and 9.
9	**Medicare** (Inclusive of dually eligible and other Title XVIII beneficiaries)	Include Medicare, Medicare Advantage, and Dually Eligible.
10a	Other Public Insurance (Non-CHIP) (specify___)	State and/or local government insurance that covers a broad set of services. Do not include patients whose services were paid for by grant programs reimbursing limited benefits, such as Title X or the Breast and Cervical Cancer Early Detection Program (BCCEDP). Often these patients are uninsured and should be reported on Line 7 if they do not have comprehensive coverage.
10b	Other Public Insurance CHIP	CHIP administered and reimbursed by another payer (i.e., a commercial carrier) outside of Medicaid, report on Line 10b.
10	**Total Public Insurance** (Line 10a + 10b)	
11	**Private Insurance**	Commercial insurance (employer, insurance purchased on the federal or state exchanges, and insurance purchased for public employees or retirees).
12	**TOTAL** (Sum of Lines 7 + 8 + 9 +10 +11)	

Tips on Primary Medical Insurance

There is **not** an “unknown” category for primary medical insurance. All patients must have their primary medical insurance information captured by the health center.

Total patients **must equal** total patients reported on the other patient characteristics tables (with the exceptions noted earlier).



It is helpful to **understand how CHIP is administered in your state** to determine where to report patients with CHIP. Contact your state Primary Care Association for more information.

Many states have limited CHIP coverage for individuals 18 and older, so the numbers in Column B for CHIP are often much lower than the number of children with CHIP reported in Column A.

Relationships Between Table 4 and Table 9D

Primary Medical Insurance: Charges and collections by payer on Table 9D (Accrued Patient Related Revenue) are related to the classification of patients by primary medical insurance on Table 4. One exception is Other Public Charges and Table 4 Other Public.

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

Line	Payer Category
3	**Total Medicaid**
6	**Total Medicare**
9	**Total Other Public** (specify__)
12	**Total Private**
13	**Total Self-Pay**
14	**Total** (Sum of Lines 3 + 6 + 9 + 12 + 13)

Relationships Between Table 4 and Table 9D

Revenue sources on Table 9D are generally aligned with patient insurance reported on Table 4.

If there is a reason the relationship would look unusual, include an explanation in your UDS submission on Table 9D.

Primary Medical Insurance on Table 4, Line:	Have Revenue Reported on Table 9D, Line:
7: Uninsured—No medical insurance at last visit (includes patients whose service is reimbursed through grant, contract, or indigent care funds)	13: Self-Pay—Include co-pays and deductibles, state and local indigent care programs (do not include revenues from programs with limited benefits; see Other Public, Lines 7–9)
8a and 8b: Medicaid and Medicaid CHIP (includes Medicaid managed care programs and all forms of state-expanded Medicaid)	1–3: Medicaid (includes Medicaid expansion)
9: Medicare (includes Medicare Advantage)	4–6: Medicare
9a: Dually eligible (Medicare and Medicaid)	4–6: Medicare, initially, with balance reallocated to Medicaid
10a: Other Public non-CHIP—State and local government insurance that covers primary care	7–9: Other Public—Include patient service revenue from programs with limited benefits, such as voluntary family planning (Title X), Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), and BCCEDP
10b: Other Public CHIP (private carrier outside Medicaid)	7–9: Other Public
11: Private—Commercial insurance, including insurance purchased from state or federal exchanges (do not include workers' compensation coverage as health insurance—it is a liability insurance)	10–12: Private—Charges and collections from contracts with private (commercial) carriers, private schools, Head Start, workers' compensation, and state and federal exchanges

Special Medically Underserved Populations

Table 4, Lines 14–26

Line	Special Medically Underserved Populations	Number of Patients (A)
14	Migratory Agricultural Workers and Their Family Members (330g recipients only)	
15	Seasonal Agricultural Workers and Their Family Members (330g recipients only)	
16	**Total Migratory and Seasonal Agricultural Workers and Their Family Members** (All health centers report this line.)	
17	Homeless Shelter (330h recipients only)	
18	Transitional (330h recipients only)	
19	Doubling Up (330h recipients only)	
20	Street (330h recipients only)	
21a	Permanent Supportive Housing (330h recipients only)	
21	Other (330h recipients only)	
22	Unknown (330h recipients only)	
23	**Total Homeless Population** (All health centers report this line.)	
24	**Total School-Based Service Site Patients** (All health centers report this line.)	
25	**Total Veterans** (All health centers report this line.)	
26	**Total Residents of Public Housing** [1] (All health centers report this line.)	

Report the count of patients from the special medically underserved populations listed.

Patients can be reported in more than one category, as appropriate.

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

Health centers that receive funding from section 330(g) MSAW and section 330(h) HP must provide additional information on their migratory and seasonal agricultural employment and/or housing characteristics.

[1] Patients who are served at a health center located in or immediately accessible to a public housing site

HRSA Health Center Program

Special Medically Underserved Populations

Table 4, Lines 14–16, Migratory and Seasonal Agricultural Workers and Their Family Members

All health centers report the number of patients seen during the calendar year who were migratory and seasonal agricultural workers, family members of migratory and seasonal agricultural workers, or aged or disabled former migratory agricultural workers on Line 16.

Only health centers that receive section 330(g) (MSAW) funding provide separate totals for migratory and seasonal agricultural workers on Lines 14 and 15.

Line	Special Medically Underserved Populations	Number of Patients (A)
14	Migratory Agricultural Workers and Their Family Members (330g recipients only)	
15	Seasonal Agricultural Workers and Their Family Members (330g recipients only)	
16	**Total Migratory and Seasonal Agricultural Workers and Their Family Members** (All health centers report this line.)	

Special Medically Underserved Populations

Table 4, Lines 17–23, Homeless Population

Line	Special Medically Underserved Populations	Number of Patients (A)
17	Homeless Shelter (330h recipients only)	
18	Transitional (330h recipients only)	
19	Doubling Up (330h recipients only)	
20	Street (330h recipients only)	
21a	Permanent Supportive Housing (330h recipients only)	
21	Other (330h recipients only)	
22	Unknown (330h recipients only)	
23	**Total Homeless Population** (All health centers report this line.)	

Only health centers that receive section 330(h) (HP) funding provide separate totals for patients by housing location on Lines 17 through 22. Housing status is based on the housing arrangement at the first visit during the calendar year when the patient is identified as homeless.

All health centers report the total number of patients seen and known to have been homeless at any time during the calendar year, even if their housing situation changed during the year, on Line 23.

Special Medically Underserved Populations

Table 4, Line 25, Veterans

Line	Special Medically Underserved Populations	Number of Patients (A)
25	**Total Veterans** (All health centers report this line.)	

All health centers report the total number of patients who served in the active military, naval, or air service on Line 25. Also include patients who served in the National Guard or Reserves on active-duty status.

Reporting should **exclude** Veterans for non-U.S. military forces. **Do not** report military members who served on active duty (full-time status in their military capacity) at the time of their last visit during the year.

To support accuracy in collecting data on Veteran status, the U.S. Department of Veterans Affairs recommends simply asking patients "**Have you served in the United States military, armed forces, or uniformed services? (yes/ no)**". The question can be expanded to clarify "This includes: Air Force, Army, Coast Guard, Marines, Navy, Space Force, National Guard, Reserves, or the U.S. Public Health Service (PHS) and National Oceanic and Atmospheric Administration."

Special Medically Underserved Populations

Table 4, Line 24, School-Based Service Site Patients

This reporting is a **site-based measure**. Health centers capture information on the total number of patients served at their school-based service site(s).

Report patients with **countable visits within any of the service categories** (medical, dental, mental health, SUD, other professional, vision, or patient support) who:

- Are seen in a school-based service site (as documented on Form 5B).
- Are seen in an in-scope mobile unit parked on the grounds of a school (preschool through high school).

Does your health center have a school-based service site documented on Form 5B?

If yes, you will likely report data on Line 24.

If no, you will have a 0 on Line 24.

Line	Special Medically Underserved Populations	Number of Patients (A)
24	**Total School-Based Service Site Patients** (All health centers report this line.)	

Special Medically Underserved Populations

Table 4, Line 26, Residents of Public Housing

Line	Special Medically Underserved Populations	Number of Patients (A)
26	**Total Residents of Public Housing** [1] (All health centers report this line.)	

This measure is a **site-based measure**. This requires you to provide a count of all patients based on the health center service delivery site's proximity to public housing.

Report **all patients seen at a service delivery site that meets the statutory definition for the RPH funding (located in or immediately accessible to public housing)**, regardless of whether the patients are residents of public housing or the health center receives funding under section 330(i) (RPH). **Immediately accessible** means that the service site is within or adjacent to the public housing and the no physical barriers (for example, a highway or river) exist that prevent this medically underserved population from accessing the service site.

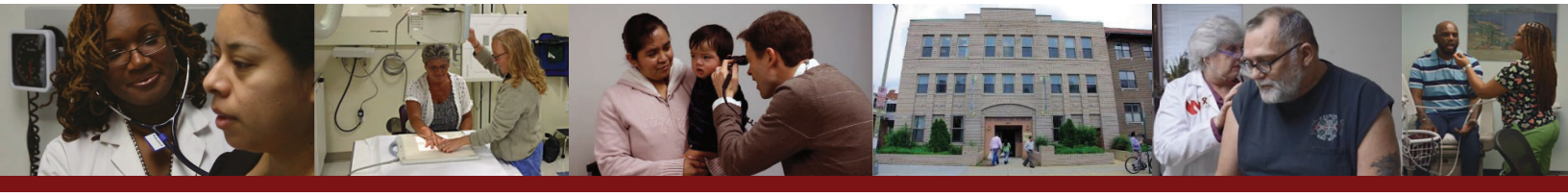
Does your health center have a site(s) located in or immediately accessible to public housing?

If yes, you will likely report data on Line 26.

If no, you will have a 0 on Line 26.

Key Resources to Assist with Reporting Patient Profile Tables

1. Pages 24–49 of the 2026 UDS Manual
2. UDS Reporting Webinars: Understanding UDS Patient Characteristics Tables for Quality Improvement
3. Clinical resources on the UDS TA site
4. UDS Support Center: 866-UDS-HELP or udshelp330@bphcdata.net



Tables 5, 6A, 6B, and 7

Understanding Services Provided and Their Outcomes

HRSA Health Center Program

Table 5

Full-Time Equivalents (FTEs), Visits, and Patients

Summary of Changes to Table 5

- Removed Selected Service Detail Addendum
- Updates to Existing Lines:
  - Other Licensed Mental Health Providers (Line 20b): Additional MH personnel types added as drop-down options
  - Enabling Services (Line 29) renamed to Total Patient Support Services
    - Patient support service categories have also been reordered and renamed.
  - Total Facility and Non-Clinical Support Services (Line 33) renamed to Total Facility and Support Services Personnel
  - Quality Improvement personnel should be reported on Information Technology Personnel (Line 30c). Quality Improvement Personnel (Line 29b) has been removed.

Table 5: Staffing and Utilization Lines 1–22

Line	Personnel by Major Service Category	FTEs (A)	Clinic Visits (B)	Virtual Visits (B2)	Patients (C)
1	Family Physicians				
2	General Practitioners				
3	Internists				
4	Obstetrician/Gynecologists				
5	Pediatricians				
7	Other Specialty Physicians				
8	**Total Physicians** (Lines 1–7)				
9a	Nurse Practitioners				
9b	Physician Assistants/Associates				
10	Certified Nurse Midwives				
10a	**Total NPs, PAs, and CNMs** (Lines 9a–10)				
11	Nurses				
12	Other Medical Personnel				
13	Laboratory Personnel				
14	X-ray Personnel				
15	**Total Medical Care Services** (Lines 8 + 10a through 14)				
16	Dentists				
17	Dental Hygienists				
17a	Dental Therapists				
18	Other Dental Personnel				
19	**Total Dental Services** (Lines 16–18)				
20a	Psychiatrists				
20a1	Licensed Clinical Psychologists				
20a2	Licensed Clinical Social Workers				
20b	Other Licensed Mental Health Providers • Family Therapists • Psychiatric Mental Health Nurse Practitioners • Psychiatric Mental Health Registered Nurses • Other Licensed Mental Health Providers (specify___)				
20c	Other Mental Health Personnel				
20	**Total Mental Health Services** (Lines 20a–c)				
21	**Substance Use Disorder Services**				
22	**Other Professional Services** • Audiologists • Chiropractors • Community and Behavioral Health Aides/Practitioners (CHA/Ps and BHA/Ps) • Podiatrists • Registered Dietitians, including Dietitians and Nutritionists • Therapists, including Massage, Occupational, Physical, Respiratory, and Speech Therapists and Speech Pathologists • Traditional Medicine Providers, including Acupuncturists and Naturopaths • Other professional services (specify__)				

Table 5: Staffing and Utilization
Lines 22a–34

Line	Personnel by Major Service Category	FTEs (A)	Clinic Visits (B)	Virtual Visits (B2)	Patients (C)
22a	Ophthalmologists				
22b	Optometrists				
22c	Other Vision Care Personnel				
22d	**Total Vision Services** (Lines 22a–c)				
23a	Pharmacists				
23b	Clinical Pharmacists				
23c	Pharmacist Technicians				
23d	Other Pharmacy Personnel				
23	**Pharmacy Personnel** (Lines 23a-d)				
24	Case Managers				
25	Health Education Specialists				
26a	Eligibility Assistance Services Personnel				
26b	Outreach Services Personnel				
26c	Transportation Services Personnel				
27b	Language Assistance Services Personnel				
28a	Community Health Workers				
28b	Other Patient Support Services Personnel (specify___)				
29	**Total Patient Support Services** (Lines 24–28b)				
29a	**Other Programs and Services** (specify ___)				
30a	Management and Support Personnel				
30b	Fiscal and Billing Personnel				
30c	Information Technology Personnel				
31	Facility Personnel				
32	Patient Registration and Health Records Personnel				
33	**Total Facility and Support Services Personnel** (Lines 30a–32)				
34	**Grand Total** (Lines 15+19+20+21+22+22d+23+29+29a+33)				

Service Categories That *Can* Have Countable Visits

Examples of Some Provider Types in Each

Medical (Lines 1–15):
Physicians, Nurse Practitioners (NPs), Physician Assistants (PAs), Midwives, Nurses

Dental (Lines 16–19):
Dentists, Dental Hygienists

MH (Lines 20a–20c, 20) and SUD (Line 21): Psychiatrists, Psychologists, Clinical Social Workers, Psychiatric NPs or PAs

Other Professional (Line 22):
Audiologists, Chiropractors, Podiatrists, Nutritionists

Vision (Lines 22a–22d):
Ophthalmologists, Optometrists

Patient Support Services (Lines 24–29): Case Managers, Health Education Specialists

- *Note that these are just a few of the provider types in each, and that these service categories **also** have non-provider personnel.*

HRSA Health Center Program

Service Categories That Do *Not* Have Countable Visits

Examples of Personnel FTEs in Each



Pharmacy (Lines 23a–23d)

Pharmacists, Clinical Pharmacists, Pharmacy Techs



Other Programs and Services (Line 29a)

Head Start, Healthy Start, Program of All-Inclusive Care for the Elderly (PACE), AmeriCorps, Food Pantry, Women, Infants, and Children (WIC)



Facility and Support Services (Lines 30a–32)

Management, Finance, Billing, Information Technology (IT), Front Desk, Call Center

Four Columns of Table 5



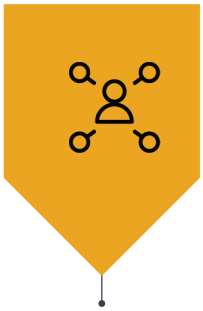
Column A: FTEs

Calculated FTE of in-scope personnel, reported in the area in which they provide services/have duties



Column B: Clinic Visits

The number of in-person countable visits for each personnel category during the calendar year



Column B2: Telehealth Visits

The number of telehealth countable visits for each personnel category during the calendar year



Column C: Patients

The number of patients for whom visits are reported in the given service area

Reporting Personnel on Table 5

Table 5 includes personnel FTE for all individuals who worked in programs and activities that are within Form 5A of the health center's scope of project for all service delivery sites included in Form 5B.

Report all personnel in terms of annualized FTEs.

Reporting Personnel FTEs

Table 5

Personnel are reported by position (line) and service category (set of lines) on Table 5.

To determine where given personnel are reported, consider the following:

- Licensed providers are reported on the line of their licensure.
- Personnel who are in positions that don't have licensure or who are not working in the area of their licensure are reported based on primary job duties.
- Report FTE based on function.

Example: A family physician should be reported as a family physician, even if they work in a pediatric setting.

Example: A nurse who primarily provides case management or care coordination should be reported as a case manager.

- *Only* personnel reported on certain lines can generate visits—those lines noted as "providers" in Appendix A of the UDS Manual.
- Non-provider lines are grayed out in Columns B and B2.
- Encounters with personnel on non-provider lines cannot be reported as visits elsewhere.
  - Said another way, contacts with non-providers are not countable visits.

Where Do These Personnel Go on Table 5?

A nurse at the health center does communication triage; responsibilities include contacting patients to schedule follow-up or referrals, responding to patient messages by phone or secure messaging, and doing warm handoffs via phone between primary care and mental health and SUD.

This nurse's FTE is reported in Column A, on either *Nurse* (Line 11), if part of the medical team, *or* on *Case Manager* (Line 24) if they do this for an assigned group of patients such as patients with high-risk scores or patients with diabetes.

These services do *not* meet the definition of countable visits, so there are no related visits reported on Table 5.

The health center contracts with a local organization to have someone come in 16 hours a month to assist with Medicaid and Marketplace enrollment for patients in need of insurance.

This contracted personnel's FTE is reported on Eligibility Assistance, Line 26a, in Column A, based on hours paid. This is *not* a provider line, so there are no related visits reported on Table 5.

The health center has a staff member who tables at local events and works with organizations in the community to provide some services (like education or taking blood pressures).

This staff person's FTE is reported on *Outreach,* Line 26b, Column A.

This is *not* a provider line, so there are no related visits reported on Table 5.

Calculating FTEs for Column A



Employees with full benefits

One full-time staff person worked for 6 months of the year:

Calculate base hours for full-time:

Total hours per year: 40 hours/week × 52 weeks = 2,080 hours

Calculate this staff person's paid hours:

Total hours for 6 months: 40 hours/week × 26 weeks = 1,040 hours

Calculate FTE for this person:

1,040 hours/2,080 hours = **0.50 FTE**



Employees with no or reduced benefits

Together, four individuals worked 1,040 hours scattered throughout the year:

Calculate base hours for full-time:

Total hours per year: 40 hours/week × 52 weeks = 2,080 hours

Deduct benefits (10 holidays, 12 sick days, 5 continuing medical education [CME] days, and 3 weeks' vacation):

10 + 12 + 5 + 15 = 42 days × 8 hours = 336

2,080 – 336 = 1,744

Calculate combined person hours: Total hours: 1,040 hours

Calculate FTE: 1,040 hours/1,744 hours = **0.60 FTE**

Important Key: FTE and visit reporting on Table 5 ties closely to costs on Table 8A.

Excerpt of Table 5

Line	Personnel by Major Service Category	FTEs (a)
16	Dentists	
17	Dental Hygienists	
17a	Dental Therapists	
18	Other Dental Personnel	
19	**Total Dental Services** (Lines 16–18)	
20a	Psychiatrists	
20a1	Licensed Clinical Psychologists	
20a2	Licensed Clinical Social Workers	
20b	Other Licensed Mental Health Providers · Family Therapists · Psychiatric Mental Health Nurse Practitioners · Psychiatric Mental Health Registered Nurses · Other Licensed Mental Health Providers (specify ___)	
20c	Other Mental Health Personnel	
20	**Total Mental Health Services** (Lines 20a–c)	
21	**Substance Use Disorder Services**	

Excerpt of Table 8A

Line	Cost Center	Accrued Cost (a)
	Financial Costs of Medical Care	
…	…	
	Financial Costs of Other Clinical Services	
5	Dental	
6	Mental Health	
7	Substance Use Disorder	
8a	Pharmacy (not including pharmaceuticals)	
8b	Pharmaceuticals	
…	…	

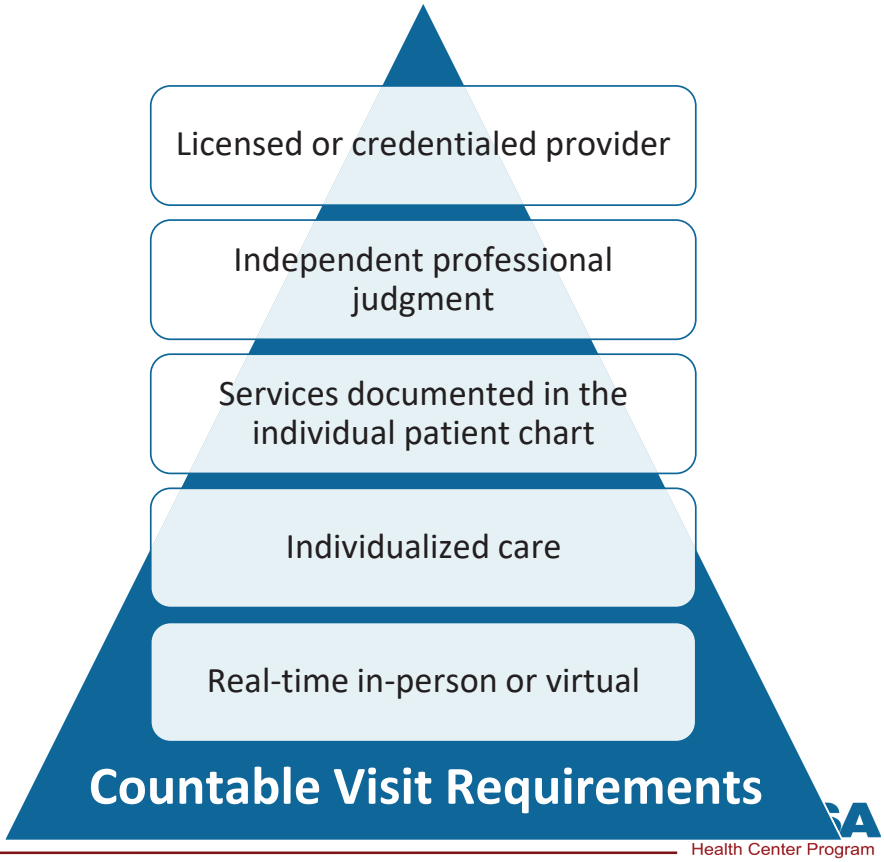
Reporting Visits on Table 5

The definition of a UDS countable visit determines who to count as a patient here on Table 5 and on all other tables that include health center patients.

A *patient* on the UDS is someone who has a *countable visit* in any service category on Table 5.

Remember, this definition and its relationship across tables are **central** to accurate reporting.

Only those who have had a countable visit here are reported on patient profile tables!



Reporting Visits

Table 5



- Visits must be provided at the health center site or at another approved location (or via telehealth).
- Count visits provided by paid, contracted, *and* volunteer providers.
- Include completed referral visits paid for by the health center.
- Count when *following* ***current*** *patients* in a nursing home, hospital, or at home.
- Do **not** count if patient is **first encountered** at a location *not* listed on Form 5B as part of your health center scope of project.

Differentiating Columns B and B2



Clinic Visits (Column B)

Report *in-person contact* between provider and patient that meets all the requirements for countable visits.



Virtual Visits (Column B2)

Report *virtual contact* between provider and patient that meets all the requirements for countable visits.

Must be provided using interactive, *synchronous* audio and/or video telecommunication systems that permit *real-time communication* between the provider and a patient.

Identification of virtual visits typically requires relevant codes, such as CPT, HCPCS, modifiers, or Place of Service codes.

Guidance for Multiple Visits in One Day

1

On any given day, a patient may have only one visit per service category per provider counted on the UDS.

- Remember, service categories that have countable visits are Medical, Dental, MH, SUD, Other Professional, Vision, and Patient Support.

2

If multiple providers in a single service category (e.g., two medical providers) deliver multiple services at the *same location* on a single day, count only one visit.

3

If services are provided by *two different providers* located at *two different sites* on the same day, count two visits.

- A virtual visit and a clinic visit are considered to be two different sites and may both be counted as visits, even when they occur on the same day.

Contacts That Do Not, Alone, Count as Visits

Screenings or Outreach	Group Visits	Tests/Ancillary Services	Dispensing/ Administering Medications	Health Status Checks
Information sessions for prospective patients	Patient education classes	Drawing blood	Dispensing medications from a pharmacy	Follow-up tests or checks
Health presentations to community groups	Health education classes	Laboratory	Giving injections	Follow-up wound care
Immunization drives	*Exception: behavioral health group visits*	Imaging	Providing narcotic agonists or antagonists or a mix	Taking health histories

Reporting Patients on Table 5

Each individual who has a countable visit in Column B and/or Column B2 of Table 5 is a health center patient on the UDS.

Counting Patients in Column C

Unduplicated patient counts are reported for each service category with visits on Table 5.

Patients are included *only* in service categories on Table 5 in which they had a countable visit in the year.



If a visit is counted in Column B or B2, the patient *must* be reported in Column C of Table 5.

Only those patients reported in Column C on Table 5 are included in the unduplicated patient count on patient profile tables and on clinical care tables.

Table 6A

Selected Diagnoses and Services Rendered

Summary of Changes to Table 6A

- Removals:
  - Selected Diagnoses: Line 6a, Respiratory conditions related to COVID-19; Line 7, Abnormal breast findings, female; Line 8, Abnormal cervical findings; Line 12, Contact dermatitis and other eczema
  - Selected Services: Line 21c, Novel coronavirus (SARS-CoV-2) diagnostic test; Line 21d, Novel coronavirus (SARS-COV-2) antibody test; Line 22, Mammogram; Line 23, Pap test; Line 30, Sealants; Line 33, Oral surgery (extractions and other surgical procedures); Line 34, Rehabilitative services (Endo, Perio, Prostho, Ortho)
- Updates to Existing Lines:
  - Line 26, "Health supervision of infant or child (ages 0 through 11)" has been renamed "Well child visit (ages 0 through 11)."
  - Codes updated as of July 2026.
- Additions/New Lines:
  - Line 9a: Diabetes mellitus type 1
  - Line 20g: Intellectual and developmental disabilities
  - Line 26g: Autism spectrum disorder (ASD) screening
  - Line 35: Case management
  - Line 36: Eligibility assistance
  - Line 37: Transportation
  - Line 38: Language assistance services
  - Line 39: Upstream drivers of health screening
  - Line 40: Food insecurity
  - Line 41: Housing instability
  - Line 42: Financial insecurity
  - Some elements of the Other Data Elements Form outreach and enrollment assists have been added to the Selected Patient Support Services and Selected Upstream Drivers of Health Services section.

Table 6A: Selected Diagnoses and Services Rendered

Example Diagnoses: Lines 1–6a

Line	Diagnostic Category	Applicable ICD-10-CM Code or Value Set Object Identifier (OID)	Number of Visits by Diagnosis Regardless of Primacy (A)	Number of Patients with Diagnosis (B)
	Selected Infectious and Parasitic Diseases			
1–2	Symptomatic/Asymptomatic human immunodeficiency virus (HIV)	**ICD-10:** B20, B97.35, Z21 **OID:** 2.16.840.1.113883.3.464.1003.120.11.1007, 2.16.840.1.113883.3.464.1003.120.11.1010		
3	Tuberculosis	**ICD-10:** A15- through A19-, B90-, J65 **OID:** 2.16.840.1.113762.1.4.1222.44		
4	Sexually transmitted infections (gonococcal infections and venereal diseases)	**ICD-10:** A50- through A64-		
4a	Hepatitis B	**ICD-10:** B16.0 through B16.2, B16.9, B18.0, B18.1, B19.1- **OID:** 2.16.840.1.113883.3.67.1.101.1.271		
4b	Hepatitis C	**ICD-10:** B17.1-, B18.2, B19.2-		
4c	Novel coronavirus (SARS-CoV-2) disease	**ICD-10:** U07.1 **OID**: 2.16.840.1.113762.1.4.1248.139		
4d	Long COVID	**ICD-10:** U09, U09.9 **OID:** 2.16.840.1.113762.1.4.1178.98		
	Selected Diseases of the Respiratory System			
5	Asthma	**ICD-10:** J45- **OID:** 2.16.840.1.113762.1.4.1222.1471		
6	Chronic lower respiratory diseases	**ICD-10:** J40 (count J40 only when code U07.1 ***is not*** present), J41- through J44-, J47-, J4A-		

Table 6A: Selected Diagnoses and Services Rendered

Example Services Rendered: Lines 21–24

Line	Service Category	Applicable ICD-10-CM, CPT-4/I/PLA, or HCPCS, SNOMED CT, or OID Code	Number of Visits (A)	Number of Patients (B)
	Selected Diagnostic Tests/Screening/Preventive Services			
21	HIV test	**CPT-4:** 86689, 86701 through 86703, 87389 through 87391, 87534 through 87539, 87806 **HCPCS**: G0432, G0433, G0435, G0475 **OID:** 2.16.840.1.113762.1.4.1056.50		
21a	Hepatitis B test	**CPT-4:** 80074, 86704 through 86707, 87340, 87341, 87350, 87467, 87912 **HCPCS:** G0499		
21b	Hepatitis C test	**CPT-4**: 80074, 86803, 86804, 87520 through 87522, 87902 **HCPCS:** G0472		
21e	Pre-Exposure Prophylaxis (PrEP)-associated prescribing and management	**ICD-10**: Z29.81		
24	Selected immunizations: hepatitis A; haemophilus influenzae B (HiB); pneumococcal, diphtheria, tetanus, pertussis (DTaP) (DTP) (DT); measles, mumps, rubella (MMR); poliovirus; varicella; hepatitis B	**CPT-4**: 90371, 90389, 90396, 90632, 90633, 90634, 90636, 90644, 90645, 90646, 90647, 90648, 90670, 90671, 90677, 90684, 90696, 90697, 90698, 90700, 90701, 90702, 90703, 90704, 90705, 90706, 90707, 90708, 90710, 90712, 90713, 90714, 90715, 90716, 90720, 90721, 90723, 90732, 90739, 90740, 90743, 90744, 90745, 90746, 90747, 90748		

Table 6A



Captures selected **diagnoses and services provided to health center patients** (those reported on patient profile tables)—*do not* include activities provided to the general public.

Report all visits and patients meeting the specified criteria (diagnosis or service, and relevant codes) in the calendar year.

Diagnoses are reported where the indicated diagnosis is listed as part of a countable visit.

- Diagnoses are Lines 1 through 20g.

Services and procedures are counted when *provided at any point during the year to a health center patient and documented in that patient's chart*.

- Services and procedures are Lines 21 through 42.

Key Notes for Table 6A

Column A describes the **total number of visits** at which the service/test/diagnosis was present and coded to the patients in Column B.

Only report **tests** or **procedures** that are:

- **Performed by the health center**, *or*
- Not performed by the health center but **paid for by the health center**, *or*
- Not performed by the health center or paid for by the health center **but ordered by the health center, and results are returned to the health center provider to evaluate and follow up with the patient based on results**.

Table 6A: *New* Lines

Lines 9a, 20g, and 26g

Line 9a: Diabetes mellitus type 1

- Identify the number of patients with type 1 diabetes.
- Patients with type 1 diabetes will be reported on both Line 9 (Diabetes) and Line 9a (Diabetes mellitus type 1).

Line 20g: Intellectual and developmental disabilities

- Capture the number of patients with intellectual and developmental disabilities.

Line 26g: Autism spectrum disorder (ASD) screening

- Capture the proportion of patients screened for ASD.

Question 16 in the frequently asked questions (FAQ) section for Table 6A covers using the codes provided.

Table 6A: *New* Lines

Selected Patient Support Services, Lines 35–38

Line	Service Category
	Selected Patient Support Services
35	Case management
36	Eligibility assistance
37	Transportation
38	Language assistance services

- Four new metrics were added as Lines 35–38 to capture the number of patients receiving case management services, eligibility assistance, transportation, and language assistance services.

Table 6A: *New* Lines

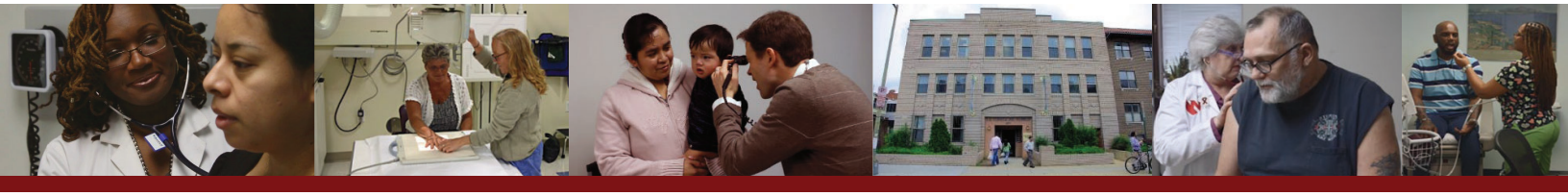
Selected Upstream Drivers of Health Services, Lines 39–42

	Selected Upstream Drivers of Health Services
39	Upstream drivers of health screening
40	Food insecurity
41	Housing instability
42	Financial insecurity

- Four new metrics were added as Lines 39–42 to identify the number of patients who are screened for and receive services addressing upstream drivers of health.
- These or similar measures were previously included in the Other Data Elements Form and are now being elevated to the core reporting set.

Remember that all reporting on Table 6A is limited to health center patients.

Patients must have a countable visit on Table 5 and be included in unduplicated patients on demographic tables to be counted on Table 6A.



Forms

Understanding More About How and What Your Health Center Does

HRSA Health Center Program

Summary of Changes to the Forms

Removals

- Removed: Questions 1a, 1a2, 1a3, 1c, 1c1, and 10
- Removed: Questions 11, 11a, 12, 12a, and 12b (aspects of these questions have been incorporated into Table 6A)

Additions

- Three questions on alternative payment models (APM) have been added as Questions 17–19.
- A question has been added to learn if health centers provide services that use puberty blockers, sex hormones, or surgical procedures to individuals under 19 years of age (Question 20).

Updates

- The former Health Information Technology (Health IT) Capabilities Form and Other Data Elements (ODE) Form have been consolidated into a single form. The combined form has been renamed to Health Center Health IT Capabilities and Other Data Elements Form. Instructions can be found in Appendix C of the UDS Manual.

Health Center Health IT Capabilities and ODE Form

Health center's Health IT capabilities, prescription medication monitoring, medications for opioid use disorder, voluntary family planning, telehealth, and value-based purchasing contracts



HRSA Health Center Program

Health Center Health IT Capabilities and ODE Form

Appendix C

A series of questions that assess:

- EHR adoption and use in your health center
- Prescription medication monitoring
- Medications for opioid use disorder (MOUD)
- Voluntary family planning
- Telehealth services
- Value-based purchasing (VBP) contracts

Note

Appendix C is formerly Appendix D: Health IT Capabilities (or the Health IT form) combined with Appendix E: ODE.

Certain questions from the ODE form were moved here, and the appendix itself was removed. Migrated questions include:

- MOUD
- Telehealth
- Voluntary family planning

New questions were added:

- APM (three new questions)
- Sex-rejecting services and procedures (one new question)

Much of the information on the Health IT form can be gathered and entered into the PRE in the fall, with the exception of the upstream drivers of health screening.

Reporting on Health IT and ODE, Appendix C

EHR Use, Prescription Monitoring and MOUD, Telehealth Use

EHR

Questions 1 and 4–5:
Report your health center's EHR usage, as well as

- If you switched to your current EHR in the past calendar year.
- Information sharing among key providers/settings and patient engagement.

Prescription Monitoring and MOUD

Question 13:
Report if your health center uses a statewide Prescription Drug Monitoring Program database to streamline access to information on patients' controlled substance prescriptions.

Question 14 *(moved):*
Report on providers eligible to treat MOUD and how many health center patients received MOUD.

Telehealth

Question 15:

- Report whether your health center provided telehealth services.
- Report who you used telehealth to communicate with, what technology was used, and what services were delivered remotely.
- If your health center does not provide telehealth services, report why.

Reporting on Health IT and ODE, Appendix C

Patient Screening Needs, VBP, and Sex-Rejecting Services and Procedures

Voluntary Family Planning

Question 16:
Report patients screened for voluntary family planning, including contraceptive methods.

- This should only be the number of patients who **completed** a standardized screener.

Value-Based Purchases (VBP)

Questions 17–19 (*New*):
Report on payer arrangements, APM, and revenue tied to VBP.

Sex-Rejecting Services and Procedures

Question 20 (*New*):
Report if your health center provides sex-rejecting services and procedures. Options are: Yes, No, and Not Applicable.

Workforce Form

Appendix D



HRSA Health Center Program

Workforce Form

Appendix D

The Workforce Form collects information related to workforce training and staffing models, including health professional education and/or training and personnel satisfaction surveys.

Professional Education and Training

Questions 1–4:

- Report health professional training and/or education occurring in the health center by personnel category.
- Report training, whether it is pre-graduate/certificate or post-graduate.
- Report preceptor and support staff for training.
- Note: This is *not* internal staff training such as continuing education, CMEs, or first aid training.

Personnel Satisfaction Surveys

Questions 5–6:

- Report provider satisfaction survey frequency.
- Report general personnel satisfaction survey frequency.
- Refer to Appendix A regarding who is considered a provider.
- Note: This is satisfaction of the health center's personnel, not patient satisfaction surveys.

Professional Education/Training Reporting

Workforce Form, Appendix D Reporting Considerations

Extent of health professional education/training provided by the health center and satisfaction surveys

Training

- Refers to a formal agreement with an institution, not scenarios of informal shadowing.
- Include non–health-center individuals trained by your health center.

Pre-Graduate/Certificate Training

- Includes student clinical rotations or externships.

Post-Graduate Training

- Includes a residency, fellowship, or practicum.

Examples	Where should you report?
A health center hosts a family medicine resident for a 12-month rotation starting July 2026.	This resident is reported in Line 1a, Column B, as a family physician doing post-graduate training.
A health center provides a clinical internship site for an NP student for 16 weeks during the spring 2026 semester.	This NP is reported on Line 2 in Column A as an NP doing pre-graduate training.
A health center had a health policy graduate student intern with the health center's data analytics team for 6 weeks during the summer of 2026.	This graduate student is reported on Line 25 in Column A (pre-graduate/certificate).

Key Resources to Assist with Reporting Forms

1. Pages 199–209 of the 2026 UDS Manual
2. UDS Reporting Webinars
3. Appendices resources on the UDS TA Site
4. UDS Support Center: 866-UDS-HELP or udshelp330@bphcdata.net

Tables 6B and 7

Quality of Care Measures



HRSA Health Center Program

Summary of Changes to Tables 6B and 7

- Updates:
  - Alignment with latest electronic clinical quality measures (eCQMs).
  - Childhood Immunization Status: reporting is voluntary.
  - Breast Cancer Screening: denominator age range changed to 42–74 years of age.
  - HIV Screening: denominator updated to patients 15–65 years of age at the start of the measurement period without an HIV diagnosis prior to the start of the measurement period.
  - Screening for Depression and Follow-Up: numerator has been revised to include an active depression medication overlapping the date of the qualifying encounter.
  - Sealant Receipt on Permanent First Molars: replaced the dental sealants for children between 6–9 years measure.
- Additions/New Lines:
  - Falls: Screening for Future Fall Risk (Line 24).

Understanding CQM Reporting

Tables 6B and 7 Are Both CQM Tables



HRSA Health Center Program

Key Information About CQMs

- Measures are defined centrally.
- eCQMs are standardized measures that are designed to use data from electronic health record (EHR) and other Health IT systems for reporting.
- UDS CQMs align with eCQMs wherever possible.
- eCQMs are updated annually, by measure stewards. For most measures, 2026 is v14.
- UDS measures that are eCQMs align with the annual updates.
- Those annual updates sometimes have impact on reporting.
- There is one eCQM newly required on the UDS this year: Fall Risk Screenings (CMS139v14).
- This measure will be reported on Line 24.

Components of Each Clinical Measure

DENOMINATOR

- Identifies the group of patients that the measure is looking at when determining who meets the numerators.
- Equal to the initial population identified in the CQM.
- Reported in Column A (and B).

NUMERATOR

- The number of patients from the denominator who met the service, event, or outcomes requirements.
- Each patient in the denominator is assessed to determine whether they meet the numerator.
- Reported in Column C (or F).

- **EXCLUSIONS** Patients who meet exclusion criteria are not to be considered for the measure. They are removed from the denominator before determining whether numerator criteria are met.
- **EXCEPTIONS** Patients who do meet denominator criteria but do not meet numerator criteria and meet any of the exceptions criteria are removed from the denominator (and not included in the numerator).

Table 6B: Quality of Care Measures

Lines 10–12

Excerpt from Table 6B

Line	Childhood Immunization Status	Total Patients with 2nd Birthday (A)	Number of Records Reviewed (B)	Number of Patients Immunized (C)
10	MEASURE: Percentage of children 2 years of age who received age- appropriate vaccines by their 2nd birthday			

Line	Cervical Cancer Screening	Total Female Patients Aged 24 through 64 (A)	Number of Records Reviewed (B)	Number of Patients Tested (C)
11	MEASURE: Percentage of women 24–64 years of age who were screened for cervical cancer			
Line	**Breast Cancer Screeningas**	**Total Female Patients Aged 42 through 74 (A)**	**Number of Records Reviewed (B)**	**Number of Patients with Mammogram (C)**
11a	MEASURE: Percentage of women 42–74 years of age who had a mammogram to screen for breast cancer			

Line	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Total Patients Aged 3 through 17 (A)	Number of Records Reviewed (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			

BMI: Body Mass Index

Table 7: Health Outcomes

Section B: Controlling High Blood Pressure

Excerpt from Table 7

Line	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2A)	Number of Records Reviewed (2B)	Patients with Hypertension Controlled (2C)
	Mexican, Mexican American, Chicano/a			
1a1m	Asian Indian			
1a2m	Chinese			
1a3m	Filipino			
1a4m	Japanese			
1a5m	Korean			
1a6m	Vietnamese			
1a7m	Other Asian			
1b1m	Native Hawaiian			
1b2m	Other Pacific Islander			
1b3m	Guamanian or Chamorro			
1b4m	Samoan			
1cm	Black or African American			
1dm	American Indian/Alaska Native			
1em	White			
1fm	More than One Race			
1gm	Unreported/Chose Not to Disclose Race			
	Subtotal Mexican, Mexican American, Chicano/a			
	Puerto Rican			
1a1p	Asian Indian			
1a2p	Chinese			
1a3p	Filipino			
1a4p	Japanese			
1a5p	Korean			
1a6p	Vietnamese			
1a7p	Other Asian			
1b1p	Native Hawaiian			
1b2p	Other Pacific Islander			
1b3p	Guamanian or Chamorro			
1b4p	Samoan			
1cp	Black or African American			
1dp	American Indian/Alaska Native			
1ep	White			
1fp	More than One Race			
1gp	Unreported/Chose Not to Disclose Race			
	Subtotal Puerto Rican			

What Is Reported in the Denominator of Each Measure?

- **Column A** and **Column B** of Table 6B are limited to the patients in the measure denominator.
- In **limited situations** where the health center doesn't have access to the full set of data needed *to assess numerator*, health centers can report 80 percent or more of Column A in Column B.



HRSA Health Center Program

Eligibility for Each CQM

For someone to be included in a measure denominator…

1. They must have a countable visit on Table 5.

Remember, no one is included as a patient anywhere on the UDS without having a visit counted somewhere on Table 5.



2. They must have an encounter that meets the measure's qualifying encounter specifications.

3. They must *not* meet any of the denominator exclusions or exceptions.

4. Then, only once someone is included in the denominator are they evaluated for the numerator.

HRSA Health Center Program

New CQM on Table 6B

Fall Risk Measure (CMS139v14), reported on Line 24.

Table 6B: *New* Measure

Fall Risk Screening (CMS139v14)

- This eCQM will measure the number of patients aged 65 and older who were screened for future fall risk.
- Report this measure on Table 6B, Line 24.

Line	Falls: Screening for Future Fall Risk	Total Patients Aged 65 and Older (A)	Number of Records Reviewed (B)	Number of Patients Screened for Future Fall Risk (C)
24	MEASURE: Percentage of patients 65 years of age and older who were screened for future fall risk			

Excerpt from Table 6B

Components of the Fall Risk Screening Measure

CMS139v14

DENOMINATOR

- Patients aged 65 years and older at the start of the measurement period with at least one qualifying encounter during the measurement period.

Value sets for qualifying encounters can be found on the Value Set Authority Center (VSAC) website.

NUMERATOR

- Patients who were screened for future fall risk at least once within the measurement period.

OID for Fall Risk Screening: 2.16.840.1.113883.3.464.1003.118.12.1028

EXCLUSIONS

- Patients who were in hospice care for any part of the measurement period.

EXCEPTIONS

- None.

Tables 6B and 7: Screening and Preventive Care Measures

Cancer Screening eCQMs

Breast Cancer Screening (CMS125v14)

Percentage of women 40–74* years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period (October 1, two years prior to the end of the measurement period).

*This is a change from CY 2025 reporting (50–74).

Estimated 56 percent of patients with mammogram

Cervical Cancer Screening (CMS124v14)

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

- Women aged 21–64 who had cervical cytology performed with the last 3 years
- Women aged 30–64 who had cervical human papillomavirus testing performed within the last 5 years

Estimated 57 percent of patients tested

Colorectal Cancer Screening (CMS130v14)

Percentage of adults 45–75 years of age who had appropriate screening for colorectal cancer

Appropriate screenings:

- Fecal occult blood test
- Stool DNA with fecal immunochemical test
- Flexible sigmoidoscopy
- CT colonography
- Colonoscopy

Estimated 45 percent of patients with appropriate screening for colorectal cancer

More detailed information about each measure at the links above.
Data Source: 2025 UDS

HRSA Health Center Program

Preventive Care and Screening eCQMs

Preventive Care and Screening Body Mass Index (BMI) Screening and Follow-Up Plan (CMS69v14)

Percentage of patients aged 18 years and older with a BMI documented during the most recent visit or during the measurement period *and* who had a follow-up plan documented if BMI was outside of normal parameters.

Estimated 70 percent of patients with BMI charted and follow-up plan documented as appropriate

Tobacco Use: Screening and Cessation Intervention (CMS138v14)

Percentage of patients aged 12 years and older who were screened for tobacco use one or more times during the measurement period *and* who received tobacco cessation intervention during the measurement period or in the six months prior if identified as a tobacco user.

Estimated 85 percent of patients assessed for tobacco use and provided intervention if a tobacco user

Screening for Depression and Follow-Up Plan (CMS2v15)

Percentage of patients aged 12 years and older screened for depression on the date of the visit or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool *and* if positive a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter or an active depression medication overlaps the date of the qualifying encounter.

Estimated 75 percent of patients screened for depression and follow-up plan documented as appropriate

More detailed information about each measure at the links above.
Data Source: 2025 UDS

HRSA Health Center Program

Other Screening eCQMs

HIV Screening (CMS349v8)

Percentage of patients aged 15–65 at the start of the measurement period who were between 15–65 years old when tested for HIV.

Estimated 55 percent of patients tested for HIV

***New* Falls: Screening for Future Fall Risk (CMS139v14)**

Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.

More detailed information about each measure at the links above.
Data Source: 2025 UDS

HRSA Health Center Program

Tables 6B and 7: Maternal Care and Children's Health



HRSA
Health Center Program

Prenatal Care Reporting

Prenatal care is a requirement of the health center program.

- It must be provided directly by health center staff or by formal referral.
- And it is expected that all health centers have processes in place to track and collect those data.

Prenatal and Birth Outcome Measures



Health center patients who **initiate prenatal care with the health center or its referral network** are included in the **Prenatal section of Table 6B** *and* tracked and reported in the **Delivery and Birth Outcomes section of Table 7**.

Prenatal care initiated with "the health center or its referral network" refers to:

- Prenatal care initiated with the health center directly *or*
- Prenatal care initiated with a provider/entity with which the health center has *formal* ***contractual*** *agreements* (as indicated in Column 2 of Form 5A) *or*
- Prenatal care initiated with a provider/entity with which the health center has *formal written* ***referral*** *arrangements* (as indicated in Column 3 of Form 5A).

Table 6B: Quality of Care Measures

Line 0, Section A (Lines 1–6), and Section B (Lines 7–9)

0	**Prenatal Care Provided by Referral Only (Check if Yes)**	

Line 0: Check this box if your health center provides prenatal care *only by referral.*

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 of Lines 1–5)**	

Lines 1–6: Report all prenatal care patients by their age as of Dec. 31, 2026—not age when prenatal care began! Note that patients may be included in prenatal counts two years in a row if their care crossed years; they would be reported as a different age in each.

Line	Early Entry into Prenatal Care	Patients Having First Visit with Health Center (A)	Patients Having First Visit with Another Provider (B)
7	First Trimester		
8	Second Trimester		
9	Third Trimester		

Lines 7–9 Columns A and B: Report all prenatal care patients by the trimester they began prenatal care (first comprehensive prenatal visit), in Column A if care *began at your health center* (including any patient you may have referred out for care) or in Column B if care *began with another provider* and was then transferred into your health center's care.

Knowledge Check!



A patient visits the health center in 2025 (countable visit) and has a positive pregnancy test. They are referred out for care through the health center's formal referral network. They deliver in 2026 *but* are not seen at the health center for a countable visit in 2026.

Should the patient in the following scenario be reported on the UDS? And if so, what table(s) will they be reported on?

a) This is *not* a patient and would not be reported on the 2026 UDS.
b) This *is* a patient and would be reported on Tables 6B, 7, and the patient profile tables.
c) This *is* a prenatal patient and would *only* be reported on Tables 6B and 7.

Knowledge Check!



A patient visits the health center in 2025 (countable visit) and has a positive pregnancy test. They are referred out for care through the health center's formal referral network. They deliver in 2026 *but* are not seen at the health center for a countable visit in 2026.

Should the patient in the following scenario be reported on the UDS? And if so, what table(s) will they be reported on?

a) This is *not* a patient and would not be reported on the 2026 UDS.
b) This *is* a patient and would be reported on Tables 6B, 7, and the patient profile tables.
c) **This *is* a prenatal patient and would *only* be reported on Tables 6B and 7.**

Table 7: Health Outcomes

Lines 0 and 2

Line	Description	Patients (A)
0	HIV-Positive Pregnant Women	
2	Deliveries Performed by Health Center's Providers	

- **Line 0:** Number of health center patients who are pregnant women and HIV positive regardless of whether or not they received prenatal care from the health center.
  - This cell is a count of the patients who had *both* HIV and a pregnancy in the year. The health center does not need to have provided prenatal care to the patient.
- **Line 2:** Number of deliveries performed by health center clinicians, including deliveries to non–health center patients.
  - Deliveries performed by health center clinicians means that the provider was working on behalf of the health center when the delivery was done.

Table 7: Health Outcomes

Section A: Deliveries and Birth Weight

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1A)	Live Births: <1500 grams (1B)	Live Births: 1500–2499 grams (1C)	Live Births: ≥2500 grams (1D)
	Mexican, Mexican American, Chicano/a				
1a1m	Asian Indian				
1a2m	Chinese				
1a3m	Filipino				
1a4m	Japanese				
1a5m	Korean				
1a6m	Vietnamese				
1a7m	Other Asian				
1b1m	Native Hawaiian				
1b2m	Other Pacific Islander				
1b3m	Guamanian or Chamorro				
1b4m	Samoan				
1cm	Black or African American				
1dm	American Indian/Alaska Native				
1em	White				
1fm	More than One Race				
1gm	Unreported/Chose Not to Disclose Race				
	Subtotal Mexican, Mexican American, Chicano/a				
	Puerto Rican				
1a1p	Asian Indian				
1a2p	Chinese				
1a3p	Filipino				
1a4p	Japanese				
1a5p	Korean				
1a6p	Vietnamese				
1a7p	Other Asian				
1b1p	Native Hawaiian				

Deliveries and Birth Outcomes

Table 7, Lines 1a1m through h, Columns 1A through 1D

Deliveries

- **Column 1A:** Report prenatal care *patients who delivered* during the year (*exclude miscarriages*) *by their race and ethnicity*.
  - Report only one patient as having delivered for multiple births.
  - Report deliveries for all prenatal patients who delivered in the year, including those referred for prenatal care and/or whose delivery was not done by the health center.
  - Report stillbirths as a delivery in column 1A.

Birth Weights

- **Columns 1B–1D:** Report each live birth by *birth weight* (exclude stillbirths) *and by race and ethnicity of baby*.
  - Count twins as two births, triplets as three, etc.
  - Normal birth weight: Column 1D (≥ 2,500 grams).
  - Low birth weight: Column 1C (1,500–2,499 grams).
  - Very low birth weight: Column 1B (< 1,500 grams).

- Delivery and birth weight information can come from delivering provider, hospital, data exchange, or the patient themselves.
- If birth weight is recorded but race and ethnicity are not, report the baby on Line h by their birth weight.
- In the average year, deliveries will *not* equal birth weights, as there will be some multiples or stillbirths.

Children's Health eCQMs

Childhood Immunization Status (CMS117v14)*

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

*This measure is optional for CY 2026 reporting.

Estimated 30 percent of patients immunized

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (CMS155v14)

Percentage of patients 13–17 years of age who had an outpatient visit with a primary care physician or obstetrician/gynecologist and who had evidence of the following during the measurement period:

- Documented height, weight, and BMI
- Documented counseling for nutrition
- And documented counseling for physical activity

Estimated 75 percent of patients assessed and counseled

More detailed information about each measure at the links above.
Data Source: 2025 UDS

HRSA Health Center Program

Sealant Receipt on Permanent First Molars (SFM-CH-A)

- The dental sealants for children between 6–9 years measure has been replaced with **a new measure with two rates** for sealant receipt on permanent first molars.
- **Measure:** Percentage of children 10 years of age who have ever received sealants on permanent first molar teeth.
- **Denominator:** Children who turn 10 years of age during the measurement period and had at least one qualifying encounter during the measurement period, as specified by the measure criteria.
- **Numerator 1 (Line 22a):** Children who received a sealant on at least one permanent first molar tooth in the 48 months prior to their 10th birthday.
- **Numerator 2 (Line 22b):** Children who received sealants on all four permanent first molars in the 48 months prior to the 10th birthday.
- **Denominator Exclusions:** Children who have received treatment (restorations, extractions, endodontic, prosthodontic, and other dental treatments) on all four permanent first molars in the 48 months prior to the 10th birthday.
- **Denominator Exceptions:** None

Line	Sealant Receipt on Permanent First Molars	Total Patients with 10th Birthday (A)	Number of Records Reviewed (B)	Number of Patients with Sealants to First Molars (C)
22a	MEASURE: Percentage of children who have ever **received at least one sealant on a permanent first molar tooth**			
22b	MEASURE: Percentage of children who have **received sealants on all four permanent first molar teeth**			

Tables 6B and 7: Disease Management CQMs

Heart Health eCQMs

Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (CMS347v9)

Percentage of patients at high risk of cardiovascular events who were prescribed or were on statin therapy:

- All patients previously diagnosed with or who currently have diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD) or have ever had ASCVD procedure, or
- Patients 20–75 years of age who ever had a low-density lipoprotein cholesterol ≥ 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia, or
- Patients 40–75 years of age with diabetes, or
- Patients 40–75 years of age with a 10-year ASCVD risk score ≥ 20 percent

Estimated 79 percent of patients prescribed or on statin therapy

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

Percentage of patients 18+ years of age with documented use of aspirin or another antiplatelet during the measurement period diagnosed with:

- Acute myocardial infarction, or who had a coronary artery bypass graft or percutaneous coronary interventions in the 12 months prior to the measurement period or
- Who had an active diagnosis of IVD during the measurement period

Estimated 73 percent of patients with documentation of aspirin or other antiplatelet

Controlling High Blood Pressure (CMS165v14)

Percentage of patients 18–85 years of age with diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure was adequately controlled (<140/90 mmHg) during the measurement period

Note: Report by race and ethnicity.

Estimated 69 percent of patients with controlled blood pressure

More detailed information about each measure at the links above.
Data Source: 2025 UDS

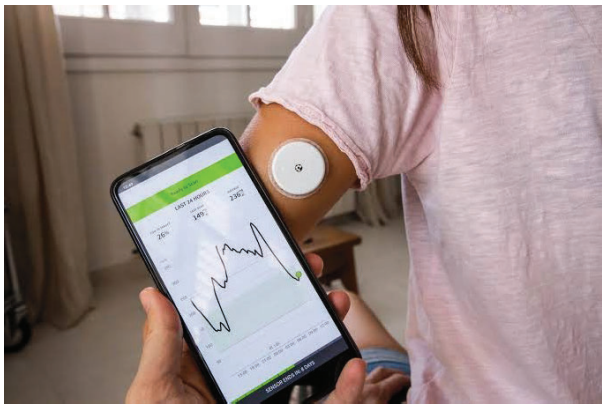
HRSA Health Center Program

Diabetes Management eCQM

Diabetes: Glycemic Status Assessment Greater Than 9% (CMS122v14)
Percentage of patients 18–75 years of age with diabetes who had a glycemic status assessment (hemoglobin A1c or glucose management indicator) greater than 9.0% during the measurement period

Notes: Report by race and ethnicity. The lower the number, the better performance.

Estimated 26 percent of patients with glycemic status assessment greater than 9 percent



More detailed information about each measure at the links above.
Data Source: 2025 UDS

HIV Linkage to Care CQM

HIV Linkage to Care (*Not* an eCQM; UDS specific!)
Percentage of patients *newly* diagnosed with HIV who were seen for follow-up treatment within 30 days of diagnosis.

Estimated 81 percent of patients seen within 30 days of first diagnosis of HIV.



More detailed information about each measure at the links above.
Data Source: 2025 UDS

HRSA Health Center Program

Mental Health and Substance Use Disorder eCQMs

Depression Remission at Twelve Months (CMS159v14)

Percentage of patients aged 12 years and older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event

Estimated 16 percent of patients who reached remission



Initiation and Engagement of SUD Treatment (CMS137v14)

Percentage of patients 13 years of age and older with a new SUD episode who received the following (two rates are reported):

a. Percentage of patients who initiated treatment, including either an intervention or medication for the treatment of SUD, within 14 days of the new SUD episode

b. Percentage of patients who engaged in ongoing treatment, including two additional interventions or medication treatment events for SUD, or one long-acting medication event for the treatment of SUD, within 34 days of the initiation

Estimated 25 percent of patients who received initial SUD treatment

Estimated 9 percent of patients who engaged in ongoing SUD treatment

More detailed information about each measure at the links above.
Data Source: 2025 UDS

HRSA Health Center Program

Accessing Full eCQM Specifications

New resource: Navigating CQMs



Example: *New* Screening for Future Fall Risk

Denominator: Patients aged 65 years and older at the beginning of the measurement period with at least one qualifying encounter during the measurement period, as specified in the measure criteria

Question: What screening tools can be used for this measure? What are the relevant codes?

Line	Falls: Screening for Future Fall Risk	Total Patients Aged 65 and Older (A)	Number of Records Reviewed (B)	Number of Patients Screened for Future Fall Risk (C)
24	MEASURE: Percentage of patients 65 years of age and older who were screened for future fall risk			

Step 1: Access the Measure Specifications (Two Ways)

1) Click the link next to the measure name in the UDS Manual.
2) Visit the eCQI Resource Center, select “Eligible Clinician eCQMs,” search for the measure, then click on the “Specifications and Data Elements” tab, and finally the HTML file.

Title	CMS eCQM ID	CBE ID*	MIPS Quality ID
Falls: Screening for Future Fall Risk	CMS139v14	Not Applicable	318



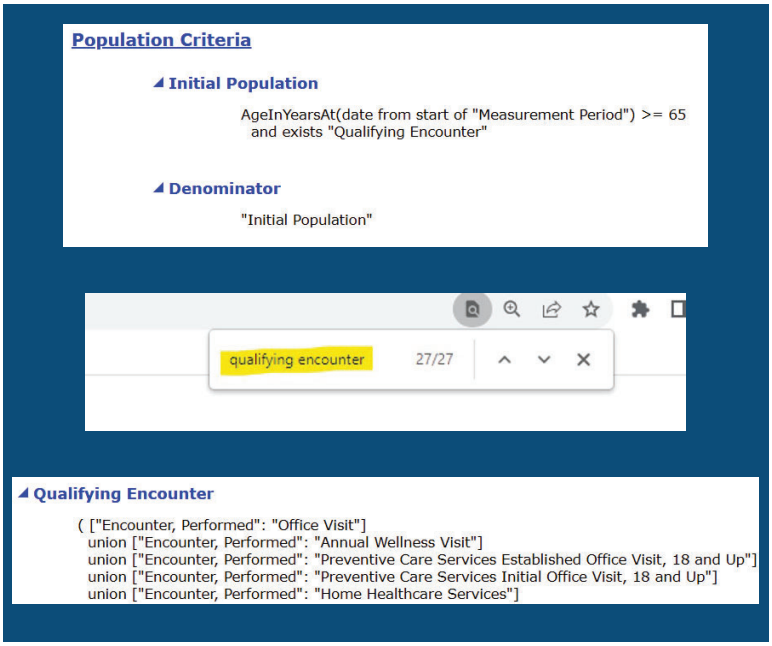
Step 2: Read Specifications to Determine Denominator Criteria

To be included in the **initial population**, someone must have a **qualifying encounter during the measurement period** and be 65 years of age or older at the start of the measurement period.

The measure specifications show that the **denominator criteria** for this measure is equal to the "initial population."

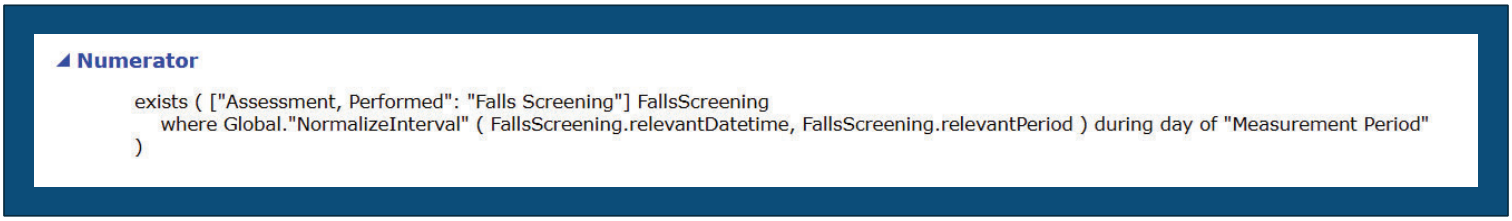
To determine what defines a **qualifying encounter**, search for the phrase using Ctrl + F.

A subset of the Qualifying Encounters for this measure are pictured to the right.

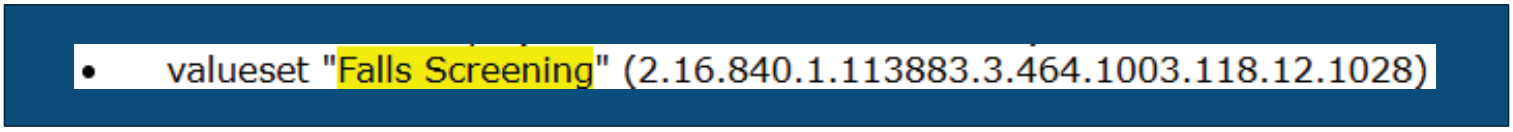


Step 3: Identify Numerator Criteria and OID

Use Ctrl + F to search for “Numerator”.

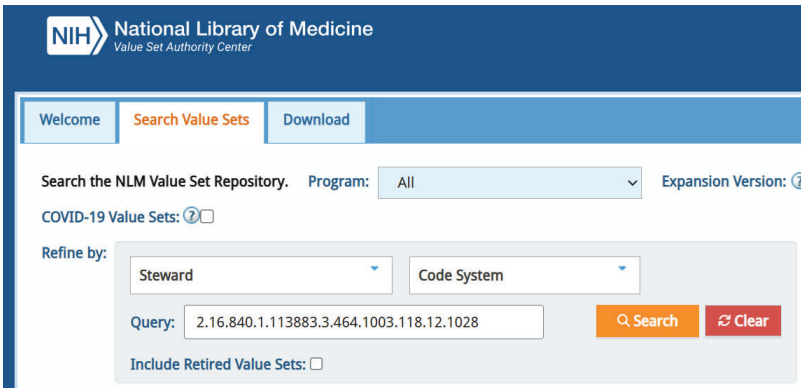


Use Ctrl + F to search for “Falls Screening” (under “Terminology” heading).



The long string of numbers is the relevant OID, which we will use in the next step!

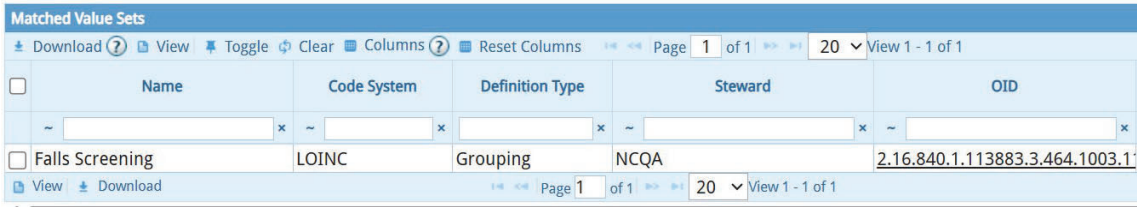
Step 4: Search for the Value Set



VSAC webpage

On the VSAC webpage, select "Search Value Sets," then paste the OID from the eCQI Resource Center into the Query line and click "Search."

Select the search result, then click "Download."



HRSA Health Center Program

Step 5: Access the Expansion List

In the Excel file you download, the second tab is called “Expansion List.” This tab will contain the specific codes within the Value Set (column labeled “Code”). One (or more) of these codes will need to be in the patient’s chart to meet the numerator criteria for the Fall Risk measure.

NIH National Library of Medicine
Value Set Authority Center

Value Set Name	Falls Screening	
Code	**Description**	**Code System**
52552-7	Falls in the past year	LOINC
57254-5	Standardized fall risk assessment was conducted during assessment period [CMS Assessment]	LOINC
59454-9	History of falling; immediate or within 3 months [Morse Fall Scale]	LOINC
73830-2	Fall risk assessment	LOINC

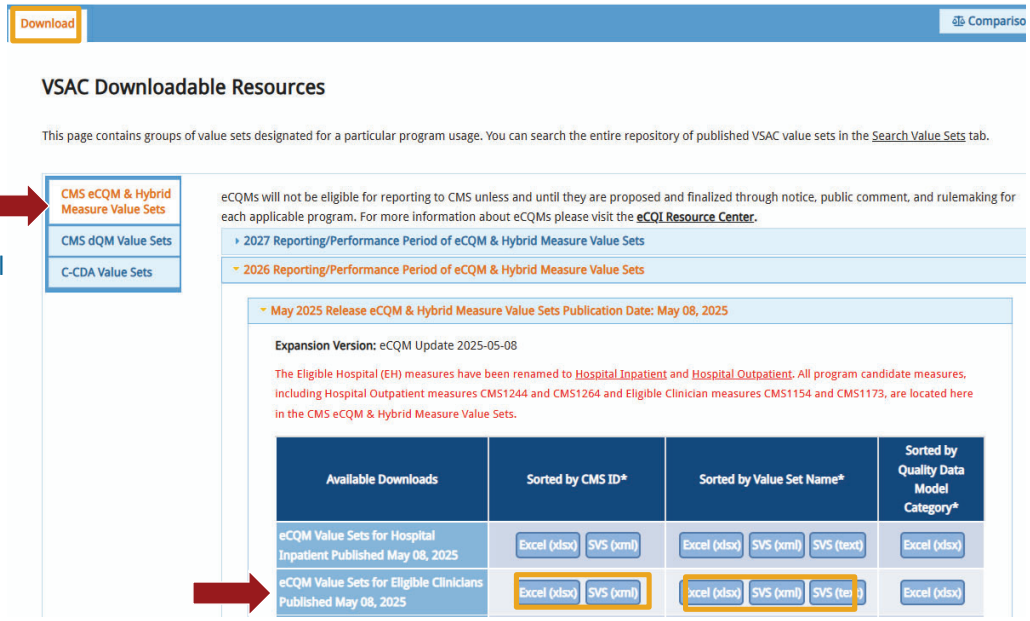
HRSA Health Center Program

Tip: Accessing Codes for All Measures

Download all codes from the VSAC site: Once you are logged in, go to Download tab → 2026 Reporting → eCQM Value Sets for Eligible Clinicians

Two download options:

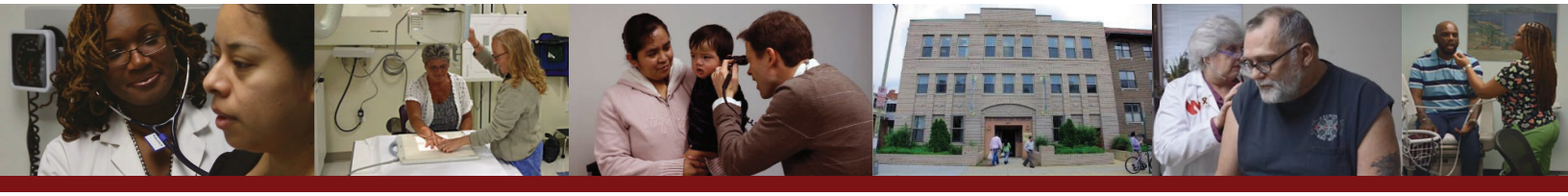
- ➔ Download Excel **Sorted by CMS ID** to get the full set for each measure—you'll match the CMS # from the UDS Manual to the CMS # on the tabs of the downloaded spreadsheet. There are more measures in the spreadsheet than there are in the UDS.
- ➔ Download Excel **Sorted by Value Set Name** to find codes for only certain value sets. (Remember, value sets are the defined components of each measure.)



Key Resources to Assist with Reporting Operational and Clinical Tables

1. Pages 50–70 (Operational) and pages 71-136 (Clinical)of the 2026 UDS Manual
2. UDS Reporting Webinars: The Foundation of the UDS and Clinical Tables Series
3. Clinical resources on the UDS TA site
4. UDS Support Center: 866-UDS-HELP or udshelp330@bphcdata.net

HRSA Health Center Program



Tables 8A, 9D, and 9E

Understanding Costs and Revenues within Health Center Scope

HRSA Health Center Program

Overview of Financial Tables

- **Table 8A:** Accrued costs for all activities attributable to the calendar year that are within the health center's approved scope of project

- **Table 9D:** Accrued patient service revenue in accordance with generally accepted accounting principles (GAAP) for health care entities, including charges, collections, contractual adjustments, sliding fee discounts, waived and reduced fee deductions, bad debt write-offs and allowances, pharmacy revenue, and incentive revenue attributable to the calendar year

- **Table 9E:** Accrued non–patient service revenue, including grants, contracts, and other funds recognized in the calendar year from sources supporting the approved federal scope of project.

Table 8A

Financial Costs

Summary of Changes to Table 8A

Removals

- Removed: Allocation of Facility and Non–Clinical Support Services (Column B)
- Removed: Medical/Other Direct Costs (Line 3)
- Removed: Detailed Costs for Each Patient Support Service Type (Lines 11a–11h)
  - Costs have been consolidated into Line 11.
- Removed: Quality Improvement (Line 12a)
- Removed: Value of Donated Facilities, Devices, and Supplies (Line 18)

Updates

- Column A, Accrued Costs, has been replaced with Personnel Costs (Column A1).
- Total Cost After Allocation of Facility and Non-Clinical Support Services (Column C) renamed to Total Accrued Costs (Column A), and will include the combined total of Column A1, Personnel Costs, and Column A2, Other Costs.
- Lines 11 and 13 renamed to Patient Support Services.
- Non-Clinical Support Services (Line 15) renamed to Other Support Costs.
- Total Accrued Costs (Line 17) renamed to Total Health Center Costs.

Table 8A: Financial Costs

Lines 1–17

Line	Cost Center	Personnel Costs (A1)	Other Costs (A2)	Total Accrued Costs (A)
	Medical Care			
1	Medical Care			
2	Medical Laboratory and X-ray			
4	**Total Medical Care Services** (Sum of Lines 1 + 2)			
	Other Clinical Services			
5	Dental			
6	Mental Health			
7	Substance Use Disorder			
8a	Pharmacy (not including pharmaceuticals)			
8b	Pharmaceuticals			
9	Other Professional (specify___)			
9a	Vision			
10	**Total Other Clinical Services** (Sum of Lines 5 through 9a)			
	Patient Support Services and Other Programs			
11	Patient Support Services			
12	Other Programs and Services (specify ___)			
13	**Total Patient Support and Other Program Services** (Sum of Lines 11 + 12)			
	Facility and Support Services			
14	Facility			
14a	Information Technology			
15	Other Support Costs			
16	**Total Facility and Support Services Costs** (Sum of Lines 14 + 14a + 15)			
17	**Total Health Center Costs** (Sum of Lines 4 + 10 + 13 + 16)			

Financial Costs

Financial costs are reported across three columns (Columns A1, A2, and A), captured in Lines 1–16.



Cost Center (Lines 1–16)

Cost centers for four sections: Medical, Other Clinical, Patient Support Services and Other Programs, and Facility and Support Services.



Personnel Costs (Column A1)

Report the accrued personnel salaries, their fringe benefits, and the labor cost of personnel under contract (1099–NEC).



Other Costs (Column A2)

Report the accrued costs for all other direct (non-personnel) costs, such as supplies, training, travel, and purchased services.



Total Accrued Costs (Column A)

Sum of Columns A1 + A2; represents full cost.

HRSA Health Center Program

Costs by Cost Center

There Are Four Cost Center Sections

Medical Care (Lines 1–4)
Other Clinical Services (Lines 5–10)
Patient Support Services and Other Programs (Lines 11–13)
Facility and Support Services (Lines 14–16)

- Each represents a service area/cost center. In that line, report direct expenses including personnel and fringe benefits (A1) and purchased services, supplies, and minor equipment (A2).
- Align personnel and fringe costs reported in Column A1 with FTE and services reported on Table 5.
- If an individual's FTE is split across multiple lines of Table 5, the same allocation must be used on this table.
  - Only allocate FTE (and costs) across multiple lines when the personnel are scheduled separately and this accounts for a substantial portion of their time.
- Health centers should be able to reconcile the FTEs with personnel costs in a worksheet or other reports.

Tables 5 and 8A Crosswalk

Critically important to complete these tables together!

Excerpt of Table 8A

Line	Cost Center	Personnel Costs (A1)
	Medical Care	
1	Medical Care	
2	Medical Laboratory and X-ray	
4	**Total Medical Care Services** (Sum of Lines 1 + 2)	
	Other Clinical Services	
5	Dental	
6	Mental Health	
7	Substance Use Disorder	

Excerpt of Table 5

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

Tables 5 and 8A Crosswalk

Critically important to complete these tables together!

Excerpt of Table 8A

Line	Cost Center	Personnel Costs (A1)	Other Costs (A2)	Total Accrued Costs (A)
	Patient Support Services and Other Programs			
11	Patient Support Services			
12	Other Programs and Services (specify ___)			
13	**Total Patient Support and Other Program Services** (Sum of Lines 11 + 12)			
	Facility and Support Services			
14	Facility			
14a	Information Technology			
15	Other Support Costs			
16	**Total Facility and Support Services Costs** (Sum of Lines 14 + 14a + 15)			
17	**Total Health Center Costs** (Sum of Lines 4 + 10 + 13 + 16)			

Excerpt of Table 5

Line	Personnel by Major Service Category	FTEs (A)
24	Case Managers	
25	Health Education Specialists	
26a	Eligibility Assistance Services Personnel	
27a	Outreach Services Personnel	
27b	Transportation Services Personnel	
27c	Language Assistance Services Personnel	
28a	Community Health Workers	
28b	Other Patient Support Services Personnel (specify___)	
29	**Total Patient Support Services** (Lines 24–28b)	
29a	**Other Programs and Services** (specify ___)	
30a	Management and Support Personnel	
30b	Fiscal and Billing Personnel	
30c	Information Technology Personnel	
31	Facility Personnel	
32	Patient Registration and Health Records Personnel	
33	**Total Facility and Support Services Personnel** (Lines 30a–32)	
34	**Grand Total** (Lines 15+19+20+21+22+22d+23+29+29a+29b+33)	

HRSA Health Center Program

Examples of Aligning Table 5 and Table 8A

A health center has a psychiatric MH NP who treats patients with alcohol use disorder and opioid use disorder.

The health center reports this staff member on Table 5, Line 20b (Other Licensed Mental Health Providers); the costs for these staff need to be on Table 8A, Line 6 (Mental Health), Column A1.

A nurse does communication triage, including responding to messages and doing follow-up (discussed on Table 5).

The health center decided this nurse belongs on Table 5, Line 11 (Nurses), based on duties; the costs for this nurse must be reported on Table 8A, Line 1, Medical Care, Column A1.

A health center employs a quality improvement (QI) specialist.

QI staff are reported on Table 5, Line 30c (Information Technology Personnel). Personnel costs are reported on Table 8A, Line 14a (Information Technology) in Column A1.

Examples of Aligning Tables 5 and 8A: Poll #1

A health center employs care coordinators and covers van vouchers for patient rides. Where is this activity reported on Tables 5/8A? (Check all that apply.)

A. FTE are reported on Table 5, Line 24, Case Managers. On Table 8A, their salaries are reported on Line 11, Patient Support Services, in Column A1.

B. FTE are reported on Table 5, Line 28b, Other Patient Support Services. On Table 8A, their salaries are reported on Line 11, Patient Support Services, in Column A1.

C. Vouchers are reported on Table 8A, Line 11, Column A2.

D. Vouchers are not reported on the UDS.

Examples of Aligning Tables 5 and 8A: Poll #1 Answer

A health center employs care coordinators and covers van vouchers for patient rides. Where is this activity reported on Tables 5/8A? (Check all that apply.)

A. FTE are reported on Table 5, Line 24, Case Managers. On Table 8A, their salaries are reported on Line 11, Patient Support Services, in Column A1.

B. FTE are reported on Table 5, Line 28b, Other Patient Support Services. On Table 8A, their salaries are reported on Line 11, Patient Support Services, in Column A1.

C. Vouchers are reported on Table 8A, Line 11, Column A2.

D. Vouchers are not reported on the UDS.

Examples of Aligning Tables 5 and 8A: Poll #2

A health center contracts with an external imaging group to read X-rays on a fee-for-service (FFS) basis. Where is this activity reported on Tables 5/8A?

A. FTE are reported on Table 5, Line 14 (X-Ray Personnel). Costs are reported on Table 8A, Line 2 (Medical Laboratory and X-Ray), Column A2 (Other Costs).

B. FTE are reported on Table 5, Line 14 (X-Ray Personnel). Costs are reported on Table 8A, Line 2 (Medical Laboratory and X-Ray), Column A1 (Personnel Costs).

C. No FTE are reported on Table 5. Costs are reported on Table 8A, Line 2 (Medical Laboratory and X-Ray), Column A2 (Other Costs).

D. No FTE are reported on Table 5. Costs are reported on Table 8A, Line 2 (Medical Laboratory and X-Ray), Column A1 (Personnel Costs).

Examples of Aligning Tables 5 and 8A: Poll #2 Answer

A health center contracts with an external imaging group to read X-rays on a fee-for-service (FFS) basis. Where is this activity reported on Tables 5/8A?

A. FTE are reported on Table 5, Line 14 (X-Ray Personnel). Costs are reported on Table 8A, Line 2 (Medical Laboratory and X-Ray), Column A2 (Other Costs).

B. FTE are reported on Table 5, Line 14 (X-Ray Personnel). Costs are reported on Table 8A, Line 2 (Medical Laboratory and X-Ray), Column A1 (Personnel Costs).

C. No FTE are reported on Table 5. Costs are reported on Table 8A, Line 2 (Medical Laboratory and X-Ray), Column A2 (Other Costs).

D. No FTE are reported on Table 5. Costs are reported on Table 8A, Line 2 (Medical Laboratory and X-Ray), Column A1 (Personnel Costs).

Reporting Pharmacy Costs on Table 8A

Pharmacy (not including pharmaceuticals) (Line 8a)

- Report all accrued pharmacy costs (not including pharmaceuticals) on Line 8a: personnel costs in Column A1 and other costs in Column A2.
- In Column A1, include direct salaries, fringe, and hourly FTE contracts.
  - Exclude the cost of personnel engaged in helping patients become eligible for free pharmaceuticals, pharmacy assistance programs. Report as Patient Support Services.
- In Column A2, include 340B dispensing fees, inventory, and ordering fees.
- If a contract pharmacy retains a share of profit or dispensing fee, that fee must still be captured as a cost in Column A2.
- Check that Line 8a correlates with personnel reported on Lines 23a–23d on Table 5.

Pharmaceuticals (Line 8b)

- Report all pharmaceutical costs on Line 8b, Column A2. Column A1 is grayed out for Line 8b.
- Include medications and vaccines administered directly on-site at the health center.
- Report the full gross cost of 340B medications purchased by or on behalf of the health center. This applies whether the health center pays in full or uses net-settled billing mechanisms.
- If a contract pharmacy pays for replenishment and deducts the cost from receipt balances, you must still extract and report the **full accrued medication cost** on Line 8b.

Reporting of Overhead Costs

- Overhead Allocation is no longer included on Table 8A in a separate column. Overhead costs are contained in Lines 14, 14a, and 15, Facility and Support Services.
- The exception to this rule is for **Line 12, Other Programs and Services**. Report costs of facilities and other direct costs for Other Programs in Column A2.
- Do *not* allocate Health IT/EHR to cost centers! All Health IT/EHR costs are to be reported on Line 14a, Information Technology.

Facility and Support Services Costs

Table 8A, Lines 14, 14a, and 15

Line	Personnel Costs (A1) Examples	Other Costs (A2) Examples
Facility, Line 14	Facility-related personnel costs, associated with personnel reported on Table 5, Line 31	All other direct facility costs, such as contracts paid on a FFS basis, security, groundskeeping, rent on leased units, janitorial services, maintenance, etc.
Information Technology, Line 14a	Health IT/EHR, QI, programming, technical and IT-related services personnel costs, associated with personnel reported on Table 5, Line 30c	All other direct costs for the provision of IT and QI services ***EHR/IT costs are reported here and no longer allocated to medical, dental, etc.**
Other Support Costs, Line 15	Central support services, senior leadership, management, fiscal, billing and collections, and registration personnel costs, associated with FTE reported on Table 5, Lines 30a, 30b, and 32	Corporate costs (e.g., liability insurance not including malpractice, audits, legal fees, publications, printing), supplies, travel, central support services contracts paid FFS

Total Facility and Support Service Costs, Line 16: Automatically calculates the sum of Lines 14 + 14a + 15.

Table 9D

Accrued Patient Service Revenue

Summary of Changes to Table 9D

Removals

- Removed: Retroactive Settlements, Receipts, and Paybacks (Columns C1–C4)
- Removed: Payer Category details related to third-party payers
- Removed: Sliding Fee Discounts (Column E)
- Removed: Bad Debt Write-Off (Column F)

Updates

- Reporting on Table 9D has shifted from reporting on a cash basis to an accrual basis. The title of Table 9D is renamed to Accrued Patient Service Revenue.

Additions

- New column added for Net Patient Service Revenue (Charges Less Adjustments), Column G.
- New line for Net Patient Service Revenue Before Other Patient Service Revenue, Line 16.
- A new line has been added to Table 9D: Bad Debt Write-Offs and Allowances, Line 15 (reported in Column G) for patient and third-party payer bad debt write-offs.
- A new line has been added to reflect all Pharmacy Net Patient Service Revenue, Line 17 (reported in Column G).
- A new line has been added for Third-Party Incentive Revenue, Line 18 (reported in Column G).

Table 9D: Accrued Patient Service Revenue

Lines 3–19

Line	Payer Category	Charges (A)	Collections (B)	Adjustments (D)	Net Patient Service Revenue (Charges Less Adjustments) (G)
3	**Total Medicaid**				
6	**Total Medicare**				
9	**Total Other Public** (specify__)				
12	**Total Private**				
13	**Total Self-Pay**				
14	**Total** (Sum of Lines 3 + 6 + 9 + 12 + 13)				
15	**Bad Debt Write-Offs and Allowances**				
16	**Net Patient Service Revenue Before Other Patient Service Revenue** (Sum of Line 14, Column G less Line 15, Column G)				
	Other Patient Service Revenue				
17	**Pharmacy Net Patient Service Revenue**				
18	**Third-Party Incentive Revenue**				
19	**Total Net Patient Service Revenue** (Sum of Lines 16 + 17 + 18)				

Understanding Where Revenue Is Reported

Table 9D

Patient service revenue from third-party payers and patients, including:

- FFS reimbursement
- Per member per month or capitated payments
- Incentive or quality payments, shared saving distributions
- Payments from patients
- Payments for service paid via a grant, but on a FFS basis
- Pharmacy revenue for patient services
- Bad debt write-offs and allowances

Table 9E

Non–patient service revenue, including grants, contracts, and other funds from sources supporting the health center scope of project, including:

- Health Center Program awards, including additional awards from HRSA's Bureau of Primary Health Care (BPHC)
- Other federal grant or contract funding, such as Ryan White, Title X
- Grant revenue from state, local, and private entities
- Indigent care funding
- Other revenue not from patient services, such as fundraising, interest revenue, rent from tenants, patient health records fees, individual monetary donations, receipts from vending machines, etc.

Reporting Table 9D, Patient Service Revenue

Columns

Charges, Collections, Adjustments

- **Column A:** Charges for patient services in the calendar year, according to fee schedule
- **Column B:** Collections (e.g., payments, reimbursements) received in the year regardless of the date of services
- **Column D:** Contractual adjustments posted/accrued in the calendar year
- **Column G:** Net Patient Service Revenue

Lines

By Payer

- **Line 3:** Medicaid
- **Line 6:** Medicare
- **Line 9:** Other Public
- **Lines 12:** Private
- **Line 13:** Self-Pay

Other Patient Service Revenue

- **Line 15:** Bad Debt Write-Offs and Allowances
- **Line 16:** Net Patient Service Revenue Before Other Patient Service Revenue
- **Line 17:** Pharmacy Revenue
- **Line 18:** Third-Party Incentive Revenue
- **Line 19:** Total Net Patient Service Revenue, should equal the amount reported on the health center's internal financial statements, assuming all appropriate adjustments have been recorded.

Charges, Collections, Adjustments, and Net Service Revenue

Table 9D columns are where charges, collections, and adjustments are reported as accrued revenue during the calendar year.

Column A: Charges

Charges (A)	Collections (B)	Adjustments (D)	Net Patient Service Revenue (Charges Less Adjustments) (G)

- **Column A: Charges:** Total accrued, gross charges across all services, reported on the payer category:
  - Undiscounted, unadjusted, gross charges for services by payer
  - Based on health center fee schedule, typically based on CPT codes
  - Charges for services provided during the calendar year
- Do not include:
  - Pharmaceuticals dispensed in-house or through 340B contract pharmacy (Report those on Line 17, column G.)
  - Pharmacy charges (Only report net pharmacy revenue, charges less contractual adjustments.)

Reclassifying Charges

Services may be charged to and paid for by more than one source. Report amounts charged to each payer accordingly, reclassifying any part of the charge as needed.

- Report the gross charge by the primary insurer on their payer line, alongside the negotiated contractual adjustment (Column D).
- Shift the unadjusted remaining balance to the secondary payer's row.
- Once the secondary payer settles, repeat for a third if one exists.
- Any final balance must move to Line 13, Self-Pay.
- If a health center's systems do not handle reclassification automatically, the health center must manually transfer portions of the charge from the original payer line.

Form of Receipt

The fee-for-service (FFS) and managed care data are consolidated and reported on the total line for each payer.

- Medicaid (Line 3)
- Medicare (Line 6)
- Other Public (Line 9)
- Private (Line 12)

Report all forms of payment, including:

- Non-managed care FFS
- Capitated managed care
- FFS managed care
- Combined capitation and FFS

Column B: Collections

Charges (A)	Collections (B)	Adjustments (D)	Net Patient Service Revenue (Charges Less Adjustments) (G)

Column B: Collections: Include **all patient service receipts** for CY 2026, regardless of the date of service the payment applies to:

- Managed care FFS and monthly capitation payments
- Case management fees received
- Contracted payments
- Payments from patients
- Third-party insurance payer payments
- Cost report settlements, wraparound receipts, and other payments

Do not include:

- Pharmaceuticals dispensed in-house or through 340B contract pharmacy (report those on Line 17, Column G)
- Third-party incentives (such as for conducting certain screenings or improving on CQMs (report those on Line 18, Column G)

Column D: Adjustments

Charges (A)	Collections (B)	Adjustments (D)	Net Patient Service Revenue (Charges Less Adjustments) (G)

Column D: Adjustments: Contractual reductions in payment by a third-party payer (Lines 3, 6, 9, and 12). Also include sliding fee discounts and any waivers or reduction in fees under Self-Pay (Line 13). Be sure to account for any year-end adjustments necessary to recognize accounts receivable balances and net revenue.

Do not include:

- Transfers or charges to secondary or subsequent payers
- Amounts for which another third-party payer or patient is billed
- Other patient service revenue (e.g., pharmacy and incentive payments)
- Refunds or paybacks for overpayment or penalty paybacks that are recouped by withholding payments

Column G: Net Patient Service Revenue (Charges Less Adjustments)

Charges (A)	Collections (B)	Adjustments (D)	Net Patient Service Revenue (Charges Less Adjustments) (G)

Column G: Net Patient Service Revenue: Full charges minus adjustments recognized in the calendar year.

- Line 14: Net patient service revenue (Line 14) before bad debt write-offs and allowances (Line 15) and other patient service revenue (Lines 17+18)
  - Equals charges (Column A) less adjustments (Column D) for all payers
- Line 16: Net patient service revenue (Line 16) before other patient service revenue (Lines 17+18)
  - Equals patient service revenue by payer total (Line 14, Column G) less bad debt write-offs and allowances (Line 15, Column G)
- Line 19: Total net patient service revenue: sum of net patient service revenue (Line 16) plus pharmacy net revenue (Line 17) and third-party incentive net revenue (Line 18)

Table 9D: Revenue Timing

- **Charges** in Column A are to be reported based on the **date of service** that occurred in CY 2026.
- **Collections** and **adjustments** (Columns B and D) are reported based on **posting date** (which is typically the date the payment is received or posted and the health center received an explanation of benefits or similar document outlining reimbursement details) and limited to transactions posted in CY 2026.
- This acknowledges that there is likely to be some timing difference between the columns.
- Charges minus collections minus adjustments should reasonably approximate the change in accounts receivable from the beginning of the year to the end of the year.

Table 9D Rows:
Payer Categories and Other Patient Service Revenue

Lines 3–13 align with primary payers, which needs to align with the payer the claim was submitted to and origin of the payment.

Net revenue from pharmacy is now reported on Line 17 and incentive payments are now reported on Line 18.

Payer Categories for Patient Service Revenue

Report charges (Column A), related collections (Column B), and related adjustments (Column D) associated with all services billed to and paid for by:

Medicaid (Line 3)

- Medicaid (Title XIX), including:
- Medicaid managed care
- CHIP through Medicaid
- Medicaid portion for dually eligible patients
- EPSDT
- Portion of Medicaid share of cost program
- Medicaid administered adult day health care (ADHC) or PACE

Medicare (Line 6)

- Includes health center pharmacy, ADHC, or PACE

Other Public (Line 9)

- CHIP, when *not* administered by Medicaid
- Public programs that pay for limited services, such as BCCEDP, BCCP, or Title X
- State- or county-run insurance plans that are not Medicaid
- Service contracts with carceral facilities, public schools, or other public entities

Private (Line 12)

- Insurance purchased by patients and/or their employers, including insurance purchased on insurance exchanges
- Tricare, Trigon, Federal Employees Health Benefits Program, or workers' compensation
- Private organizations that contract for patient services

Self-Pay (Line 13)

Portion that the patient is responsible for or that is not covered by a third-party payer

- Includes co-pay, deductibles, or full charge
- Indigent care charge portion

*Remember, reimbursement or payment **may** or **may not** be the same as the patient's primary medical insurance.*

HRSA Health Center Program

Relationship Between Insurance on Table 4 and Revenue on Table 9D

- Revenue sources on Table 9D are generally aligned with patient insurance reported on Table 4.
- If there is a reason the relationship would look unusual, include an explanation in your UDS submission on Table 9D.

Primary Medical Insurance on Table 4, Line:	Have Revenue Reported on Table 9D, Line:
7: Uninsured—No medical insurance at last visit (includes patients whose service is reimbursed through grant, contract, or indigent care funds, workers' compensation if the patient has no other medical insurance)	13: Self-Pay—Include co-pays and deductibles, patient responsible charges for uncovered services, state and local indigent care programs **(do not include revenues from programs with limited benefits; See Other Public, Line 9)**
8a and 8b: Medicaid and Medicaid CHIP (includes Medicaid managed care programs and all forms of state-expanded Medicaid)	**3: Medicaid** (includes Medicaid expansion)
9: Medicare (includes Medicare Advantage)	**6: Medicare**
9a: Dually eligible (Medicare and Medicaid)	**6: Medicare**, initially, with balance reallocated to Medicaid, so typically revenue on both lines
10a: Other Public non-CHIP—State and local government insurance that covers primary care	**9: Other Public**—State or local government insurance revenue that is not Medicaid; also patient service revenue from programs with limited benefits, such as family planning (Title X), EPSDT, BCCEDP or BCCP, etc.
10b: Other Public CHIP (carrier outside Medicaid)	**9: Other Public**
11: Private—Private (commercial) insurance, including insurance purchased from state or federal exchanges (Do not include workers' compensation coverage as health insurance—it is a liability insurance.)	**12: Private**—Charges and collections from contracts with private carriers, private schools, carceral facilities, Head Start, workers' compensation, and state and federal exchanges

Total Self-Pay, Line 13

Self-Pay Sliding Fee: discount applied based on patient's ability to pay

- Use the health center's sliding fee discount program and schedule.
- In Column D, sliding discounts applied to co-payments and deductibles after the patient's balance has been reclassified to Self-Pay.
- Includes prompt pay discounts, hardship discounts, or fee waiver program discounts given to a sliding fee patient.
- Do not include bad debt in Column D. All bad debt is reported on Line 15, Column G.

Other Self-Pay: reporting where the patient is responsible for payment

- Includes uninsured, full-pay, self-pay patients.
- Insured patients responsible for co-payments or non-covered service charges.
- Includes prompt pay discounts.
- Exclude state or local indigent care programs that subsidized services rendered to uninsured patients—on a service-specific basis (e.g., FFS). Report those receipts on Table 9D as Other Public.

Pharmacy Net Patient Service Revenue (Line 17)

Report net revenue for the calendar year associated with pharmaceuticals dispensed to health center patients on Line 17, Column G.

Include both in-house pharmacies and contract pharmacies.

Do *not* separate by payer or include any pharmacy revenue on Lines 3, 6, 9, or 12 of Table 9D.

Report pharmacy revenue on a full accrual basis. Charges are recognized on the date or service minus any corresponding adjustments including bad debt.

There are common limitations on a health center's ability to report pharmacy service net revenue on a full accrual basis from all sources, which are discussed in Appendix B. At a minimum, health centers should report pharmacy net revenue using the same method used in its most recent GAAP-compliant audit and financial statements.

Third-Party Incentive Revenue (Line 18)

Report managed care pool distributions, pay for performance, incentive payments, and quality bonuses on Line 18, Column G.

- Includes third-party incentive revenue earned from any payer.
- Includes managed care risk pool distributions.
- Does not include case management revenue (report on third-party payer rows, Lines 3, 6, 9, and 12).
- Report net incentive revenue by either a full accrual or cash receipts method.
  - *Because advance notice of incentive income is generally not given, incentive revenue may be recognized on a cash basis.*



Table 9E

Other Accrued Revenue

Summary of Changes to Table 9E

Removals

- Removed: Health Center funding grant sources (Lines 1a–1e); other BPHC funding detail lines (Lines 1k–1q)
  - Reporting is now combined into a single total on Line 1.

Updates

- Reporting on Table 9E has shifted from reporting on a cash basis to an accrual basis. Table 9E is renamed Other Accrued Revenue.
- State and local indigent care programs (Line 6a) will include revenue for only those indigent care grant programs that *do not* reimburse on a service-specific basis.

Table 9E: Other Accrued Revenue

Full Table (Lines 1–11)

Line	Source	Revenue (A)
	HRSA's BPHC Grants	
1	**Total Health Center BPHC Grants**	
	Other Federal Grants	
5	**Total Other Federal Grants (specify _____)**	
	Non-Federal Grants or Contracts	
6	State Government Grants and Contracts (specify_____)	
6a	State/Local Indigent Care Programs (specify _____)	
7	Local Government Grants and Contracts (specify_____)	
8	Foundation/Private Grants and Contracts (specify_____)	
9	**Total Non-Federal Grants and Contracts** (Sum of Lines 6 + 6a + 7 + 8)	
10	**Other Revenue** (non–patient service revenue not reported elsewhere) (specify _____)	
11	**Total Revenue** (Sum of Lines 1 + 5 + 9 + 10)	

Other Accrued Revenue

Table 9E

- Report **non–patient service revenue** recognized in the calendar year.
  - Include grants, contracts, and other funds from sources supporting the approved federal scope of project.
  - Report funds by the entity from which the health center received them (called the last party rule).
    - For example, a screening program for latent tuberculosis may be funded by a city health department, with the funds originating from the Centers for Disease Control and Prevention (CDC). The health center receives the money from the city health department and therefore reports the funding on Line 7, Local Government.
  - Complete "specify" fields where they appear, clearly explaining what's included in the line. Spell out acronyms that are not well known.
- The total amount reported on Tables 9E and 9D represents total revenue supporting the health center's scope of services.

This table is reported on an **accrual basis**—amount recognized on the health center's financial statements or its GAAP-compliant audit.

Report accrued revenue for conditional grants, such as BPHC Health Center Program award(s), as earned once the grant conditions are satisfied.

HRSA's BPHC Grants and Other Federal Grants Lines

Table 9E, Lines 1 and 5

- **HRSA's BPHC Grants (Line 1):** Funds your health center received directly from BPHC, including funds passed through to another agency.
  - Include 330 grant(s) (Section 330 [Health Center Program] grants), quality improvement fund (QIF) awards, amounts the health center received and passed through to another Health Center Program recipient, and capital development grants.
- **Other Federal Grants (Line 5):** Grants and contracts directly from the federal government other than BPHC.
  - Include BHW, Ryan White Part C, the Indian Health Services, Department of Housing and Urban Development, CDC, Substance Abuse and Mental Health Services Administration, Congressionally Directed Spending, and others.
  - Use the "specify" field to detail the names and amounts for all Other Federal revenue.
  - *Do not* report QIF awards here.

Non-Federal Grants Revenue Categories

Table 9E, Lines 6–9

- **Line 6: State Government Grants and Contracts:** Accrued revenue recognized from a state (e.g., state public health grant, screening grant from the state)
- **Line 6a: State/Local Indigent Care Programs:** Accrued revenue recognized from state/local indigent care programs that subsidize services rendered to patients who are uninsured (e.g., New Mexico Tobacco Tax Program)
- **Line 7: Local Government Grants and Contracts:** Accrued revenue recognized from a local government (e.g., city or town), taxing district, or sovereign tribal entity
- **Line 8: Foundation and Private Grants and Contracts:** Accrued revenue recognized from foundations and private organizations (e.g., hospital, United Way, private university)

	Non-Federal Grants or Contracts	
6	State Government Grants and Contracts (specify_____)	
6a	State/Local Indigent Care Programs (specify _____)	
7	Local Government Grants and Contracts (specify_____)	
8	Foundation/Private Grants and Contracts (specify_____)	
9	**Total Non-Federal Grants and Contracts** (Sum of Lines 6 + 6a + 7 + 8)	

Other Revenue

Table 9E, Line 10

Other Revenue: Miscellaneous non–patient service–related accrued revenues, including monetary donations, medical record fees, and vending machine revenue.



Other Revenue on Line 10 *includes*:

- Cash donations
- Fundraising and pledges
- Interest income
- Rent revenue
- Public/retail pharmacy revenue for non–health center patients (not 340B)
- Gains on asset sales and loan forgiveness
- Employee retention credit



Other Revenue on Line 10 does *not* include:

- Bad debt recovery
- 340B revenue
- Payer quality incentives
- In-kind or other monetary donations
- Investment losses
- Loan proceeds
- Payments that belong elsewhere on Table 9E

Common Revenue Examples

The health center was awarded Behavioral Health Service Expansion and expanded hours additional awards from BPHC.

HRSA's BPHC Grants, Table 9E, Line 1

Do *not* report on Line 5, Other Federal.

The health center received funds from their Primary Care Association for workforce development.

Table 9E, Line 8, Foundation/Private Grants and Contracts

Health center received $50,000 in a state-awarded Rural Health Transformation program fund.

Table 9E, Line 6, State Government Grants and Contracts

Note: Don't forget to use the "specify" field.

Key Considerations for 2026 Financial Tables Reporting

While there are significant changes to the financial tables this year, there are still key comparisons to keep in mind for data quality checks!

Similar to the prior year:

- **FTE-to-Cost Alignment:** Ensure personnel classifications on Table 5 match personnel cost centers on Table 8A.
- **Insurance-to-Payer Mix:** The proportion of your patient profile mix on Table 4 should show similarities to your payer mix on Table 9D.

The key consideration is that the financial tables are intended to align with GAAP reporting so that the total net revenue, total cost, and total net income should equal or be close to the amounts shown for the federal project on the center's financial statements.



Key Considerations for 2026 Financial Tables Reporting

Pharmacy Impacts

While the change to accrual accounting may not impact financial table totals significantly, moving pharmacy to its own line will! This will impact charges per patient and collections per patient. Report pharmacy separate from payers on Table 9D and ensure pharmacy costs are fully accounted for on Table 8A.

Total In-Scope Revenue

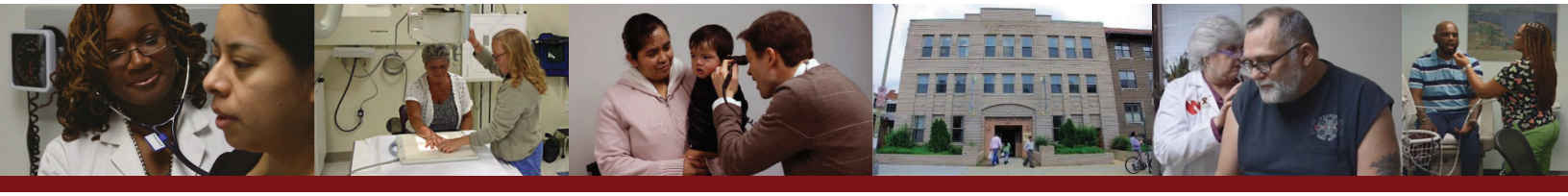
Total accrued revenue is the combined sum of patient services and non-patient operations (Table 9D + Table 9E). These will now tie more closely to financial statements!

Removal of Overhead

Administrative and facility expenses remain entirely contained within Lines 14, 14a, and 15 of Table 8A (except for Other Programs). Expect your clinical line-item costs per visit to look lower than in prior years because central overhead is no longer layered on top of them.

Key Resources to Assist with Reporting Financial Tables

1. Pages 148–177 of the 2026 UDS Manual
2. UDS Reporting Webinars : Reporting UDS Financial and Operational Tables
3. Financial resources on the UDS TA site
4. UDS Support Center: 866-UDS-HELP or udshelp330@bphcdata.net



Wrapping Up

Setting Up for Success

HRSA Health Center Program

Setting Up For Success



Resources | Support | Tips | Closing

UDS Technical Assistance Resources

UDS TA site includes:

- UDS Manual
- Final Program Assistance Letter
- Training Schedule
- Reporting Guidance
- Resource links for each section of the UDS Report organized by topic



Announcement

Community Health Quality Recognition (CHQR) badges, eligibility, and criteria for Calendar Year (CY) 2026-2027

View CHQR badges, eligibility, and criteria on the CHQR Overview webpage. Eligibility and criteria updates will take effect for the 2025 UDS reporting period. 2025 UDS data will determine CY26 CHQR badges.

2025 UDS Data Available

View the 2025 UDS data on the HRSA Data Warehouse

Featured resources

- 2026 UDS Proposed PAL (PDF - 529 KB)
  An overview of the proposed updates to 2026 UDS reporting.
- 2025 UDS Manual (PDF - 4 MB)
  Provides health centers with detailed reporting instructions and example data tables that support CY25 UDS Reporting.
- 2025 UDS Final Changes Program Assistance Letter (PAL) (PDF - 283 KB)
  An overview of the final updates to 2025 UDS reporting
- 2025 UDS Proposed PAL (PDF - 267 KB)
  An overview of the proposed updates to 2025 UDS reporting
- 2024 UDS Manual – Health Center Data Reporting Requirements (PDF - 3 MB)
  Includes reporting requirements and resources to assist with CY24 UDS reporting.
- 2024 UDS Final PAL (PDF - 202 KB)
  An overview of final updates to CY24 UDS reporting

HRSA Health Center Program

UDS Reporting Trainings

Understanding UDS Patient Characteristics Tables for Quality Improvement
September 17, 2026, 2–3:30 p.m. ET

The Foundation of the UDS: Counting Visits
October 1, 2026, 2–3:30 p.m. ET

UDS Clinical Tables Part 1: Screening and Preventive Care Measures
October 15, 2026, 2–3:30 p.m. ET

UDS Clinical Tables Part 2: Maternal Care and Children's Health
October 20, 2026, 2–3:30 p.m. ET

UDS Clinical Tables Part 3: Disease Management
October 29, 2026, 2–3:30 p.m. ET

Preliminary Reporting Environment (PRE)
November 4, 2026, 2–3:30 p.m. ET

Reporting UDS Financial and Operational Tables
November 12, 2026, 2–3:30 p.m. ET

Strategies for Successful Submission
January 14, 2027, 2–3:30 p.m. ET

Recordings will be available on the HRSA TA Reporting Training Schedule website, if you are not able to join live.

Tips for Success

Start with Personnel on Table 5.

Determining which personnel are providers is the first step to accurately identifying countable visits and accurately capturing costs.

Align costs with Table 5.

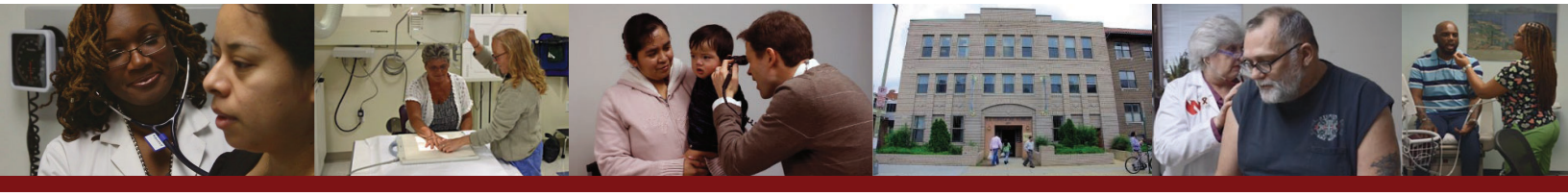
Determining where staff and services are reported on Table 5 is the determining factor for cost allocation on Table 8A.



Countable visits create health center patients.

Those who had countable visits are your health center patients for the year. Only when someone meets this criterion are they counted elsewhere in the UDS.

Health Center patients compose counts of services, diagnoses, and measures throughout.



Q&A

What questions do you have?

Connect with HRSA

Learn more about our agency at:

www.HRSA.gov

FOLLOW US: