Uniform Data System

2026 MANUAL

Health Center Data Reporting Requirements

HRSA
Health Center Program

For Reports Due February 15, 2027

Bureau of Primary Health Care (BPHC)

Uniform Data System Reporting Requirements for 2026 Health Center Data

Bureau of Primary Health Care

Uniform Data System Reporting Requirements

For Calendar Year 2026 UDS Data

For help contact: 866-837-4357 (866-UDS-HELP), BPHC Contact Form, https://bphc.hrsa.gov/data-reporting/uds-training-and-technical-assistance, or udshelp330@bphcdata.net

Health Resources and Services Administration

Bureau of Primary Health Care

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Changes and Highlights to the Reporting Requirements

Key changes from the 2025 calendar year reporting to the 2026 calendar year reporting are included at the start of each Table and Form instruction section and highlighted in gold color for ease of locating.

Note: Items highlighted in blue emphasize key foundational reporting guidance.

For users printing in black and white or using screen readers, key changes are also labeled at the beginning of each instruction section as "Changes," and foundational guidance is labeled as "Guidance," in addition to being highlighted in color.

Introduction

This manual describes the annual Uniform Data System (UDS) reporting requirements. The following entities must complete the UDS Report:

- All health centers that receive federal award funds ("recipients") under the Health Center Program authorized by section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b) ("section 330"), as amended
- All health center look-alikes designated by HRSA under the Health Center Program authorized by 42 U.S.C. 1395x(aa)(4)(A)(ii) and 42 U.S.C. 1396d(l)(2)(B)(ii)
- Certain health centers funded under HRSA's Bureau of Health Workforce (BHW)

Unless otherwise noted, for the rest of this manual, the term "health center" will refer to all the entities listed above.

ABOUT THE UDS

The UDS is a standard data set that is reported each year by each health center and, thus, gives consistent information across health centers. These unduplicated data describe the entire scope of the Health Center Program project for the calendar year and include patient characteristics, services provided, clinical processes and health outcomes, patients' use of services, staffing, costs, and revenues.

HRSA routinely reports these data and related analyses. These data are available to health centers in HRSA's Electronic Handbooks (EHBs), the Freedom of Information Act (FOIA) Electronic Reading Room, and to the public through HRSA's data.HRSA.gov website.[1] Please refer to Appendix E: Health Center Resources for resources that may be helpful for completing the UDS Report.

WHAT THIS MANUAL INCLUDES

This manual includes reporting guidance and resources to help with completion of the calendar year 2026 UDS Report **due February 15, 2027**.

- **Reporting requirements** include the approved UDS changes for the calendar year. The 2026 Program Assistance Letter (PAL) gives an overview of key changes.
- **A list of personnel** by service category and by job title who may be eligible to produce countable "visits" for the UDS is shown in Appendix A.
- **Issues that affect multiple tables** are addressed in Appendix B.
- **Resources** and supports to help health centers, including links to electronic clinical quality measures (eCQMs) and national programs crosswalk, are offered in Appendix E.
- **A glossary** of key terms is available in Appendix F.
- **Acronyms** used throughout the UDS Manual are defined in Appendix G.

[1] In accordance with the Freedom of Information Act (Exemption 4), HRSA's BPHC does not publicly share proprietary business information at the health center level.

General Instructions

WHAT TO SUBMIT

The UDS includes two parts that health centers must submit through the Electronic Handbooks (EHBs):

1) **Universal Report:** All health centers complete the Universal Report, which is an unduplicated count of activities for all patients served by the health center during the calendar year, regardless of funding source. It consists of the UDS tables, the Health Information Technology (Health IT) Capabilities and Other Data Elements Form, and the Workforce Form.
2) **Grant Report:** Health centers that receive HRSA's BPHC Health Center Program awards under multiple funding types also complete separate Grant Reports for each special medically underserved population: Migratory and Seasonal Agricultural Workers (MSAW) (330(g)) funding, Homeless Population (HP) (330(h)) funding, and/or Residents of Public Housing (RPH) (330(i)) funding. Include services provided to patients in the special medically underserved population grant count, regardless of the source of funding for those services.

- Each Grant Report is a subset of the patients reported on the Universal Report for Tables 3A, 3B, 4, 6A, and part of Table 5.
- Grant Reports are only completed for the part of the health center program that falls within the scope of a project funded under a particular funding authority. No value in a Grant Report cell may be larger than the same cell in the Universal Report.
- A Grant Report is not required for Community Health Center (CHC) (330(e)) funding type, since these activities make up a large part of the Universal Report.

The EHBs reporting system automatically identifies and gives forms for all the reports needed to meet the reporting requirements. Please contact Health Center Program Support through the BPHC Contact Form or at 877-464-4772 if there appear to be errors or issues accessing the reporting system.

WHAT IS INCLUDED

The UDS includes 11 tables and 2 forms that give demographic, clinical, operational, and financial data. Health centers must complete the following:

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

Table	Data Reported	Universal Report	Grant Reports
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	

Note: Grant Reports are NOT completed for tables and forms that are grayed out in the last column of this table.

The UDS Support Center is available to give guidance, technical assistance and resources about the UDS data and reporting requirements. Contact the Support Center at **1-866-UDS-HELP,** udshelp330@bphcdata.net, or the BPHC Contact Form.

CALENDAR YEAR REPORTING

Who Reports UDS	What Is Reported	How to Report	When to Report
• All health centers funded or designated, in whole or in part, before **October 1, 2026**, including New Access Point (NAP) recipients, mergers, and acquisitions.	• Approved in-scope activities from **January 1 through December 31, 2026.** • Report even if no grant funds were drawn down for some or all funding types during the calendar year.	• Through the Electronic Handbooks (EHBs) starting **January 1, 2027.** • The Preliminary Reporting Environment (PRE) and offline tools are available in **Fall 2026**.	• **January 1 through February 15, 2027.** UDS Reports are to be submitted **by February 15, 2027.** • UDS Report reviews are conducted, and necessary revisions are made from **February 15 through March 31, 2027**.

The UDS is a calendar year report. Health centers must report all in-scope activities for the entire calendar year.

- Health centers whose designation or funding begins, either in whole or in part, on or after January 1 will report on the calendar year. No UDS Report is filed if the health center was funded or designated for the first time **on or after** October 1 of the calendar year.
- Health centers with a fiscal year or grant period other than January 1 to December 31 will still report on the calendar year, NOT on their fiscal or grant year.
- Look-alike health centers that were funded and became a 330 recipient **before** October 1, 2026, will report for the entire year using a recipient UDS Report.
- Health centers whose designation or funding ends during the calendar year must still complete the UDS Report for the calendar year.

Use the BPHC Contact Form, email udshelp330@bphcdata.net, or call 877-464-4772 for questions about the UDS reporting requirements.

IN-SCOPE REPORTING

Submit data that show all activities in the HRSA health center scope of project, as defined in approved applications and shown in the official Notice of Award/Designation.

DO NOT report data for activities, programs and/or service delivery sites that are outside of the HRSA-approved scope of project.

- If the health center brings services into its approved scope of project at any time during the calendar year, the health center must include data for those services in its UDS Report for the full calendar year.
- If the health center brings service delivery sites into its approved scope of project during the calendar year, the health center must include data for the new service delivery sites in its UDS Report for the period beginning on the date of the scope change or the New Access Point (NAP) site implementation date.

DUE DATES, HOW TO SUBMIT, AND REVISIONS

Submit a complete and accurate UDS Report through EHBs between January 1 and **February 15, 2027, 11:59 p.m. local time**. Refer to Appendix E: Health Center Resources for help.

The Preliminary Reporting Environment (PRE) offers early access to the EHBs in the fall. This allows health centers to:

- Enter available UDS data,
- Find potential data reporting problems, and
- Make use of more preparation time to compile UDS data.

Data present in the PRE on December 31 are automatically transferred to the annual UDS reporting environment, which opens January 1.

To log in to the EHBs, use your Login.gov account and two-factor authentication. Visit the EHBs Help and Knowledge Base for more information on Login.gov. The EHBs supports standard web browsers[2] and provides electronic forms necessary to complete the UDS Report. EHBs has offline report templates that can be downloaded. For more information on these tools, visit the UDS Technical Assistance Reporting Guidance webpage.

Health centers must appoint one person as the UDS contact. The UDS contact receives all communications about the UDS Report. This person makes sure that the report is submitted on time, corrections to the report are made, and appropriate comments are included. **Be sure the UDS contact information in the EHBs is current to ensure receipt of important UDS-related communications.**

Health centers grant individual personnel "view" or "edit" privileges to the UDS in the EHBs, each using separate, individualized login credentials. These privileges apply to the whole report, not just specific tables or forms. Each authorized user can work on the tables and forms in sections, saving their progress online.

The EHBs routinely checks for questionable data until you submit. EHBs provides a summary of complete tables and forms and a list of audit questions. Health center personnel must address each audit finding, even if it does not appear to apply to the health center's unique circumstances. If data are correct as reported, clearly explain why, such as any unique circumstances, in table comments.

The chief executive officer (CEO) or project director usually submits the UDS Report. Submission authority may be delegated to an alternate in the EHBs. **The submitter must acknowledge that the health center reviewed and verified the accuracy and validity of the data.** Submit only a complete and accurate report.

Between February 15 and March 31, 2027, a Health Center Program UDS Reviewer will assess your submission and, as needed, help you revise the report. The UDS Reviewer sends communications and data change requests through EHBs via a non-HRSA.gov email address to the health center's UDS contact. Communicate directly with

[2] While most web browsers should work with the EHBs, it is certified to work with the browsers mentioned in the EHBs' recommended settings, which are available on the EHBs website.

the UDS Reviewer during this time to address their questions within the assigned timeframe. Final, corrected submissions are due no later than March 31, 2027.

Before finalization, the UDS Reviewer will evaluate the submission and determine if data elements or table should be rated questionable. This will happen when the final data:

- Does not align with UDS reporting requirements in the UDS manual (for example, not reporting charges based on the health center's fee schedule, not aligned with specification/definitions of clinical quality measures [CQMs]).
- Is missing or incomplete (for example, required data are not collected or tracked, system failures, natural disaster impacts).
- Does not capture the whole health center scope of project (for example, missing data from an entire site or including out-of-scope activities).
- Is a significant outlier that cannot be explained (for example, extremely high visits-per-patient counts with no context provided).

HRSA may grant a reporting exemption under extraordinary circumstances, such as the physical destruction of a health center. Health centers must ask for exemptions via the BPHC Contact Form or at 877-464-4772.

Failure to submit an accurate and complete UDS Report by February 15, 2027, 11:59 p.m. (local time) may result in a condition being placed on your award. Additional restrictions are possible, such as a requirement to obtain HRSA prior approval to draw down awarded funds from the Federal Financial Report (FFR) and limits on future funding.

Note: Keep a backup of the health center UDS Report, documentation, and files for at least 3 years.

FAQ FOR THE GENERAL INSTRUCTIONS

1. **When do we complete a Universal Report and when do we complete a Grant Report?**

   All health centers complete the Universal Report. Health centers that receive funds under **only one** Health Center Program funding type complete the Universal Report and no Grant Reports (i.e., CHC only, HP only, MSAW only, or RPH only). Look-alikes and certain health centers funded by BHW complete the Universal Report and not a Grant Report.

   Health centers who received **more than one** type of Health Center Program funding complete a Universal Report for the combined projects and separate Grant Reports for their MSAW, HP, and RPH funding grant(s), as appropriate.

   Examples include:

   - A CHC recipient that also has HP funding completes a Universal Report for all CHC and HP in-scope activities. They will also complete a Grant Report for all activities for the HP, regardless of the award that supports any specific activity (i.e., CHC or HP). The health center would NOT complete a Grant Report for the CHC funding.
   - A CHC recipient that also has MSAW and HP funding completes a Universal Report, a Grant Report for the HP funding, and a Grant Report for the MSAW funding.
   - An HP recipient that also receives RPH funding completes a Universal Report and two Grant Reports—one for the HP funding and one for the RPH funding.
   - An HP recipient that receives no other Health Center Program funding will file a Universal Report and will NOT file a Grant Report.

2. **When reporting on special medically underserved population funding types, do we report *only* the services provided to patients using HP, MSAW, or RPH grant funds on the Grant Report?**

   No. Report all HP, MSAW, or RPH patients who received in-scope services, regardless of the funding source. For example, if homeless population patients receive medical services in the 330(h)-supported homeless medical van, report this activity on the Homeless Population Grant Report tables. If homeless population patients receive dental services at the clinic, where 330(h) funds are not used, this activity would still be reported on the Homeless Population Grant Report tables regardless of the dental funding source.

3. **We had a service delivery site that closed and services that were removed during the calendar year, and they are no longer in-scope. Do we report data from the service delivery site or services that were removed from the scope of project on the UDS Report?**

   Yes. If services or service delivery sites are removed from your scope of project during the calendar year, report on all activities (patients, services, visits, clinical care, personnel, revenue, and costs) that were in-scope up until the date HRSA acknowledged their removal from your approved scope of project.

4. **We added a new service delivery site to our scope of project. What should we do to report the activity of this new service delivery site on the UDS Report?**

   Health centers must submit data for all approved in-scope activities, as shown in the Notice of Award/Designation when a new service delivery site is added, as listed on Form 5B: Service Sites. If your health center added a new service delivery site, either through a change in scope (CIS) request or through an additional award, you will need to submit data for approved in-scope activities based on the site start date.

5. **Is activity at a non-approved service delivery site or location included on the UDS Report?**

   No. Only report patients and services provided at your health center's approved service delivery sites (e.g., clinics, schools, homeless shelters), as listed on Form 5B, or in other locations that DO NOT meet HRSA's site criteria but are included in the health center's approved scope of project (e.g., health center patients' home visits for primary care or the provider rounds on hospitalized health center patients), as shown on Form 5C: Other Activities/Locations.

6. **What should we do if a data breach impacts our ability to complete an accurate UDS Report by February 15?**

   Health centers still need to complete the UDS Report to the best of their ability with the data they have. Contact Health Center Program Support via the BPHC Contact Form, udshelp330@bphcdata.net, or 877-464-4772 to discuss the circumstances of the breach. Additionally, clearly explain missing data and its impact on any affected tables using the EHBs UDS *Report Comment* field.

Instructions for Counting Visits, Patients, and Providers

Health centers serve many individuals in different ways. NOT all individuals and their encounters are reported in the UDS Report, and not all health center personnel count as providers. The following section defines countable visits, patients, and providers for the UDS.

COUNTABLE VISITS

Visits determine who to count as a patient on the Patients by ZIP Code Table and Tables 3A, 3B, 4, 5, 6A, 6B, and 7, and in the corresponding activity reported throughout the UDS Report. Report visits by type of provider on Table 5 and for selected diagnoses and selected services on Table 6A. Use the following guidance to determine if an interaction fully meets the countable visit definition.

Countable visits are encounters between a patient and a licensed or credentialed provider[3] who exercises independent professional judgment in providing services that are:

- Documented,
- Individualized,[4] and
- In-person or virtual.[5]

Count only visits that meet **all** these criteria.

Each component of the visit definition is further outlined in the "UDS Countable Visit Guidance" file found on the Staffing and Utilization resources webpage.

Below are definitions and criteria for reporting visits. Table 5 further clarifies the definitions. See Clinic Visits, Column B.

Documentation

Health centers must use a system that permits ready retrieval of current patient data. Documents may be paper or electronic, but must record the service and associated patient information. The patient health record does NOT have to describe all details of the service. It should include service, procedure, and diagnostic code(s), setting of service, decision making of necessity and appropriateness, examination or assessment, and time spent on the date of visit.

[3] For services that do not have a central credentialing body, the term "licensed or credentialed provider" refers to a provider hired by the health center to conduct those patient services within the scope of their duties.
[4] An exception is allowed for mental health or substance use disorder visits, which may be conducted in a group setting.
[5] Virtual services are delivered using telehealth. For purposes of the Health Center Program, telehealth is defined as the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, health administration, and public health. Within the context of the Health Center Program scope of project, telehealth is NOT a service or a service delivery method requiring specific HRSA approval; rather, telehealth is a mechanism or means for delivering a health service to health center patients using telecommunications technology or equipment. When counting visits, only consider interactive, synchronous audio and/or video telecommunication systems that permit real-time communication between a distant provider and a patient.

Independent Professional Judgment

Providers must act on their own, not assist another provider, when serving the patient.

Independent professional judgment is the use of the professional skills gained through formal training and experience and unique to that provider or other similarly or more intensively trained providers.

Behavioral Health Group Visits

The only group visit that may be counted is a mental health or substance use disorder (SUD) visit (mental health and SUD might be referred to as "behavioral health") conducted in a group setting with the service documented in each participating patient's health record.

Examples include family therapy or counseling sessions, group mental health counseling, and group SUD counseling.

Other considerations:

- The health center normally records applicable charges for each patient, even if another grant or contract covers the costs.
- If only one patient is billed (for example, when a family member who is not the patient takes part in a patient's counseling session), count the visit for only that one patient.
- DO NOT count group medical or health education visits.

Location of Services Provided

A visit must take place in:

- Health centers' approved service delivery sites (e.g., clinics, schools, homeless shelters), as listed on Form 5B
- Other locations that DO NOT meet HRSA's site criteria but are included in the health center's scope of project (e.g., hospitals, nursing homes, extended care facilities, health center patient home visits for primary care, or the provider rounds on hospitalized health center patients), as referenced on Form 5C

In addition, virtual visits may occur from other locations, as long as they otherwise meet the definition of a UDS countable visit and are performed at an approved service delivery site or under the health center's approved scope of project. See instructions for Virtual Visits.

Inpatient visit considerations:

- Count only one inpatient visit per patient per service category per day, regardless of how many clinic providers see the patient or how often they do so.
- Visits include encounters with an existing patient who has been hospitalized, when health center medical personnel "**follow**" the patient during the hospital stay as the provider of record or when they provide care to the patient on behalf of the provider of record. This applies only when the health center pays their medical personnel who "follow" patients for the specific service.
- When a patient's *first* encounter is in a hospital, in respite care, or in a similar facility that is **not an approved service delivery site in Form 5B**, do not count the patient or any of the services provided at the facility for that patient.

Counting Multiple Visits by Category of Service

Multiple visits occur when a patient has more than one visit with the health center in a day (in-person and/or virtual).

Count only one visit per patient per service category per provider per location in a single day, regardless of the types or number of services provided, as described in the table that follows.

Other considerations:

- If multiple medical providers in a single category deliver multiple services to a patient on a single day:
  - Count **only one** visit if the services are performed at the same service delivery site.
  - Count only one visit, even if third-party payers may recognize these as separate billable services. This is typically credited to the provider performing the highest level of or most care, although the health center needs to make this determination for itself.
  - For example, count only one visit for a patient who had a medical visit with a physician associate and another medical visit with an internist on the same day, at the same service delivery site.
- Count two visits performed on the same day if the services are performed by two **different providers** of the same service category type who are located at and assigned to two **different service delivery sites**.
  - For example, this lets patients who are in challenging environments receive services outside the health center from a licensed or credentialed health center provider and receive services again on the same day at the health center from a different licensed or credentialed provider.
  - For example, patients seen at a health center service delivery site by one provider and then seen on the same day at the hospital by another health center provider.
  - For example, patients seen in-person at a health center service delivery site and seen for a virtual visit on the same day, only if the assigned service delivery location and the providers are different.

Maximum Number of Visits per Patient per Day per Service Category at the Same Service Delivery Site

# of Visits	Service Category	Provider Examples
1	Medical	Physician, nurse practitioner, physician assistant/associate, certified nurse midwife, nurse
1	Dental	Dentist, dental hygienist, dental therapist
1	Mental health	Psychiatrist, licensed clinical psychologist, licensed clinical social worker, board-certified psychiatric mental health nurse practitioner, other licensed or unlicensed mental health providers
1	Substance use disorder	Alcohol and SUD specialist, psychologist, social worker
1 for each provider type	Other professional	Nutritionist, podiatrist, speech therapist, acupuncturist
1	Vision	Ophthalmologist, optometrist
1 for each provider type	Patient support services	Case manager, health educator

PATIENT

Patients are people who have at least one countable visit during the calendar year. The term "patient" applies to everyone who receives clinic (in-person) or virtual visits in any of the seven service categories, NOT just those who receive medical services (who are referred to as "medical patients"). When patients are included in the UDS Report, they are to be reported in corresponding sections only once, as described below.

The Universal Report includes all patients who had at least one visit during the calendar year within the scope of project supported by the health center grant or designation.

Report each patient only once on:

- Patients by ZIP Code Table,
- Tables 3A and 3B, and
- Each section of Table 4.

This applies even if they received more than one service (e.g., medical, dental, patient support) or received services supported by more than one funding type (i.e., section 330(g), section 330(h), section 330(i)).

Report these patients and their visits on:

- Tables 5 and 6A for each type of service (e.g., medical, dental, patient support) received during the calendar year.

Also report these patients:

- As applicable, for each of the clinical quality measures (CQMs) on Tables 6B and 7.

For each Grant Report, only include patients who had at least one countable visit during the calendar year within the scope of project activities supported by the specific section 330 funding type, even if the specific service is not paid for by the grant. Patient counts on the Grant Report may not exceed the count in the same cell of the Universal Report.

Services and Individuals NOT Reported on the UDS Report

Some services **DO NOT count as a visit** for UDS reporting, even though they are critical to the overall provision of care to an individual or a community.

DO NOT count as a patient someone who receives **only** the services described in the table below, and DO NOT count the activity as a UDS countable visit.

Note: Although these services do not qualify as UDS countable visits, their data may be needed in CQM reporting.

If an individual receives **other services** that fully meet the countable visit definition (i.e., the services need independent professional judgment from a health center provider, and those services are documented), they should be considered a patient of the health center.

Health screenings or outreach services	• DO NOT count screenings (e.g., COVID-19, blood pressure, diabetes)
	• DO NOT count outreach as countable visits, including:
	  ○ Information sessions for prospective patients.
	  ○ Health presentations to community groups.
	  ○ Information presentations about available health services at the center.
	  ○ Services conducted at health fairs.
	  ○ Immunization drives.
	  ○ Services provided to groups, such as dental varnishes or sealants provided at schools.
	  ○ Similar public health efforts that often occur as part of community activities that involve conducting outreach or group education.

Group visits that are not mental health or substance use disorder–focused	• DO NOT count visits conducted in a group setting, including:
	  ○ Patient education.
	  ○ Health education classes (e.g., people with diabetes learning about nutrition).

Tests and other ancillary services	• DO NOT count services needed to do tests, such as drawing blood or collecting urine, and other ancillary services, including:
	  ○ Laboratory tests (e.g., infectious diseases, purified protein derivatives [PPDs], pregnancy, Hemoglobin A1c [HbA1c]).
	  ○ Measurements (e.g., blood pressure, height, weight, sonography).
	  ○ Imaging (e.g., radiology, mammography, retinography, computerized axial tomography [CT]).

Dispensing or administering medications	• DO NOT count dispensing medications, including dispensing from a pharmacy or administering medications (e.g., buprenorphine, warfarin). • DO NOT count giving any injection (e.g., vaccinations, allergy shots, contraceptives), regardless of education provided at the same time. • DO NOT count providing narcotic agonists or antagonists or mixes of these, regardless of whether the patient is assessed at the time of the dispensing and regardless of whether these medications are dispensed regularly.
Health status checks	• DO NOT count follow-up tests or checks (e.g., patients returning for glycemic status tests or blood pressure checks). • DO NOT count follow-up wound care to assess healing or to change a dressing. • DO NOT count taking health histories. • DO NOT count making referrals for or following up on external referrals. • DO NOT include phone, patient portal, or other remote contact used for health status check follow-up.
Services under the Women, Infants, and Children (WIC) program	• DO NOT count a person whose only contact with a health center is to receive services (including nutrition) under a WIC program.

PROVIDER

Only personnel designated as a "provider" can generate countable visits for purposes of UDS reporting. A provider exercises independent professional judgment in the provision of services to the patient, assumes primary responsibility for assessing and/or treating the patient for the care provided at the visit, and documents services in the patient's health record.

Visits must be provided by an individual classified as a "provider" for UDS purposes. NOT all health center personnel who interact with patients are classified as a provider, and NOT all services by a provider are countable as visits. See Services and Individuals NOT Reported on the UDS Report. Appendix A gives a list of various health center personnel and the status of each as a provider or non-provider for UDS reporting purposes.

Visits provided by contractors who are **paid for by or billed through the health center** are counted in the UDS if they meet all visit criteria. These include outpatient or inpatient specialty care. In these instances, the patient's health record must include full visit documentation or a visit summary with all appropriate documentation and, at a minimum, procedure and diagnostic codes.

Considerations in counting providers and their activities:

- Except for physicians and dentists, allocate personnel (as full-time equivalent [FTE]) by role on Table 5 among the major service categories based on time dedicated to each position.
- Providers may be employees of the health center, contracted personnel, or volunteers.

- Contracted providers who *are paid for their time* by the health center with grant funds or program income and who are part of the scope of project, serve health center patients, and document their services in the health center's records count as providers; report their FTE and these providers' activities (patients, visits, revenue).
- Contracted providers who *are paid for specific visits or services* with grant funds or program income, where the services are within the scope of the project and included in Column II of Form 5A, and report patient visits to the direct recipient of a HRSA's BPHC or BHW grant or designation do not have a time basis for their services; do not report an FTE for them, but report these providers' activities (patients, visits, revenue).
- Volunteers who serve patients at the health center's service delivery sites under the supervision of health center's personnel and document their services and time in the health center's records count as providers; report their FTE and these providers' activities (patients, visits, revenue).
- DO NOT count visits by providers who see patients under a formal external *unpaid referral* arrangement (Form 5A, Column III) with the health center.
- Report physicians according to the specialty in which they are board certified. If a physician has multiple board certifications, report their FTE and visits under the specialty in which they are working. FTE and visits for physicians with multiple board certifications should be allocated and reported according to the specialty they are practicing at any given time.
- For services that do not have a central credentialing body, the term "licensed or credentialed provider" refers to a provider hired by the health center to conduct those patient services within the scope of their duties.
- Appendix A lists personnel by service category and indicates if they are considered a "provider."
- Only one provider receives credit for a visit, even when two or more providers are present and take part in the visit (see Counting Multiple Visits by Category of Service).
- In cases where a preceptor (or attending physician) is supervising a licensed resident, only the licensed resident or fellow receives credit for countable visits. (See Appendix B for further instruction on counting interns and residents.)
- When health center personnel are following a patient in the hospital or at an extended care facility, the primary health center personnel in attendance during the inpatient visit is the provider who receives credit for the visit, even if other personnel are present.
- Table 5 further clarifies these definitions. See Instructions for Table 5: Staffing and Utilization.

FAQ FOR THE INSTRUCTIONS FOR COUNTING VISITS, PATIENTS, AND PROVIDERS

1. **What level of documentation is needed for emergency, hospital, or respite services? Can we count the visit if the record is incomplete?**

   A patient receiving documented emergency services counts even if some parts of the patient health record are incomplete. Providers who see their established patients at a hospital or respite care facility and make a note in the institutional file can satisfy this criterion by including a summary discharge or interim note showing activities for each of the visit dates.

2. **Do we exclude from the UDS Report a patient who died during the calendar year?**

   No. If a patient was seen before their death during the calendar year, include the patient and their visits in all applicable areas of the UDS Report, including their demographics, services, and clinical care details.

3. Do we credit a visit to the nurse assisting a physician?

No. For example, a nurse assisting a physician during a physical examination by taking vital signs, recording a history, or drawing a blood sample does NOT receive credit as a separate visit. Visits that the nurse performs independently, and that fully meet countable visit criteria, may be credited to the nurse. Countable medical visits usually involve one of the "Evaluation and Management" billing codes (99202–99205 or 99211–99215) or one of the preventive medicine codes (99381–99387, 99391–99397).

4. Two different medical providers treated the patient at the health center on the same day. Can we count both?

No. Only count one visit per service category when care is provided at the same location. For example, only count one medical visit if an obstetrician/gynecologist (OB/GYN) provides prenatal care to a patient at the health center and a nurse practitioner treats that same patient's hypertension at the same location on the same day. Other examples may include: a family physician and a pediatrician who both see a child or a dental hygienist and a dentist who both see a patient on the same day.

Instructions for Patients by ZIP Code Table

The Patients by ZIP Code Table collects data on patients' geographic residence by ZIP code[6] and by primary medical insurance.

The text directly below contains changes to the Patients by ZIP Code Table from 2025 calendar year reporting to 2026 calendar year reporting:

There are no key changes to this table.

This marks the conclusion of changes to the Patients by ZIP Code Table from 2025 calendar year reporting to 2026 calendar year reporting.

PATIENTS BY ZIP CODE

All health centers must report patient's ZIP code of residence and primary medical insurance.

- Report the number of patients served by ZIP code and primary medical insurance.
- This information helps HRSA's BPHC identify areas served by health centers, service area overlaps, and possible geographic areas of unmet need.
- Update ZIP code information for patients each calendar year using the patients' most recent ZIP code on file.

ZIP Code of Specific Groups

For health centers serving patients without residence information, such as individuals from homeless populations or transient groups, follow the instructions below:

Homeless population	• Report the ZIP code of the service delivery site or mobile unit on the day of the visit as a proxy for homeless population patients served when the patient's residence ZIP code location is unavailable. • If the patient is staying at a shelter or otherwise has an address, use the ZIP code of that location. • If the patient is living in permanent supportive housing or doubled up, report that location as the ZIP code. • DO NOT use the address of an identified contact person who facilitates communication with the patient.
Patients who are migratory and seasonal agricultural workers	• Report the ZIP code of where the patient lived *when* they received care from the health center. Migratory agricultural workers (as opposed to seasonal agricultural workers) may have both a temporary address, where they live when working, and a permanent or "downstream" address. • Report the ZIP code for the location (fixed service delivery site or mobile camp) where patients received services, for those whose ZIP code is unavailable (e.g., living in cars or on the land).
Patients who are foreign nationals	• Report the current ZIP codes for people from other countries who live in the United States either permanently or temporarily. • Report "Other ZIP Code" in cases where patients have a permanent residence outside the country, if they have no temporary address in the United States.

[6] The geographic residence of patients served during the calendar year should generally align with the ZIP codes recorded in the health center scope of project.

Unknown ZIP Code

In rare instances, for patients whose residence is not known or for whom a proxy ZIP code is not available, report residence in the "Unknown Residence" category.

Ten or Fewer Patients in ZIP Code

To ease the burden of reporting, combine and report patients from ZIP codes that have **10 or fewer** patients in the "Other ZIP Codes" category.

INSTRUCTIONS FOR PATIENTS BY MEDICAL INSURANCE

- Report the patient's ZIP code by their **primary medical insurance, if any, as of their last visit during the calendar year**.
- Report primary medical insurance for all patients, regardless of the services they receive or where they receive services. This includes patients who did not receive medical care, such as dental-only or mental health-only patients, as well as patients whose medical insurance did not cover the service.
- DO NOT report children as Uninsured unless they are receiving minor consent services or their family/household is uninsured.
- DO NOT report patients as Uninsured simply because they are receiving a service that is not covered by health insurance.

Insurance Categories Considerations

Primary medical insurance is the insurance plan that the health center would typically bill first for medical services, even if that insurance pays for none or only a part of the visit. Specific rules guide reporting:

- Report the patient by their medical insurance, even if the health center does not bill the specified insurance or the patient does not receive medical services.
- Report only third-party insurance that patients carry. Section 330 grant awards used to serve special medically underserved populations (e.g., MSAW, HP, RPH) are NOT a form of medical insurance.
- Report patients living in residential substance use programs, college dormitories, or military barracks by their primary medical insurance. Use the corresponding ZIP code of the residential program, dormitory, or barrack.

None/Uninsured (Column B)

- Report justice-involved patients as Uninsured (whether they were seen in the correctional facility or at the health center), unless the health center is able to seek reimbursement from Medicaid or other insurance under applicable federal and state policies. Use the ZIP code of the carceral facility.
- Report otherwise uninsured patients whose care is paid for by state or local government indigent care programs as Uninsured.

Medicaid/CHIP/Other Public (Column C)

- The categories for this table are slightly different from those on Table 4; this table combines Medicaid, Children's Health Insurance Program (CHIP), and Other Public into one category.
- Report Medicaid and CHIP patients enrolled in a plan administered by a private insurance company as Medicaid/CHIP/Other Public.

Medicare (Column D)

- Report patients who have both Medicare and Medicaid (dually eligible) as Medicare patients, because Medicare is billed before Medicaid.
    - The exception to the Medicare-first rule is the Medicare-enrolled patient who is still working and insured by both an employer-based plan and Medicare. In this case, the primary health insurance is the employer-based plan, which is billed first.
- Report Medicare administered by a private insurance company as Medicare.

Private (Column E)

- Report patients who received insurance through the Health Insurance Marketplace as Private.

FAQ FOR PATIENTS BY ZIP CODE TABLE

1. **Do we need to collect information on and report the ZIP code of all our patients?**

   Yes. Although health centers report residence by ZIP code for all patients, some centers may draw patients from multiple ZIP codes outside of their normal service area. To ease the burden of reporting, combine ZIP codes with 10 or fewer patients in the "Other" category.

2. **Do we need to collect information on and report the primary medical insurance of all our patients?**

   Yes. Although the ZIP code of a patient may be "Unknown", medical insurance information *must* be obtained for every individual counted as a patient.

3. **If a patient did not receive medical care, do we still need their medical insurance information? What about dental patients?**

   Yes. This information is about patients' primary medical insurance resources, not billing. Obtain medical insurance information for **all** patients, even dental-only patients. For example, if a patient received only mental health services, collect their primary medical insurance and report it.

4. **How do we report patients by insurance when we DO NOT bill that form of insurance?**

   You should collect primary medical insurance information for all patients, even if their insurance will not be billed. For example, report patients enrolled in Medicaid but assigned to another primary care provider as Medicaid, and report patients with private insurance for which the health center's providers have not been credentialed as Private.

5. **How do we report patients by insurance who have their care subsidized by an indigent care program?**

   Report patients as Uninsured when their care is subsidized by a state or local government indigent care program and they have no other primary medical insurance. Examples include New Jersey's Uncompensated Care Program, New York's Public Goods Pool Funding, and Colorado's Indigent Care Program.

6. **We see children at local schools. Do we report these patients?**

   Report children served as part of the approved scope of project at school-based service sites, including mobile units parked on school grounds and portable clinical care at a school. Report these patients only if they had a countable visit and have completed the clinic intake or patient registration process that includes family/household income, ZIP code of residence by primary medical insurance, and other patient characteristics, as required.

PATIENTS BY ZIP CODE TABLE

Calendar Year: January 1, 2026, through December 31, 2026

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

Note: The actual output from the EHBs will display ZIP codes entered by the health center in Column A.

Patients by ZIP Code Table Cross-Table Considerations:

- Patients by ZIP Code Table and Tables 3A, 3B, and 4 describe the same patients and the totals must be equal.
- The number of patients by insurance source reported on the Patients by ZIP Code Table must be consistent with the number of patients by insurance category reported on Table 4.

Instructions for Tables 3A and 3B

Tables 3A and 3B collect demographic data (age, sex, race, ethnicity, and limited English proficiency) for patients who received services during the calendar year. This information must be collected from patients first as part of the patient registration or intake process and updated or confirmed each year thereafter.

Table 3A: Patients by Age and by Sex – Instructions

Table 3A gives an unduplicated count of each patient's age and sex.

The text directly below contains changes to Table 3A from 2025 calendar year reporting to 2026 calendar year reporting:

There are no key changes to this table.

This marks the conclusion of changes to Table 3A from 2025 calendar year reporting to 2026 calendar year reporting.

- Report the number of patients by appropriate categories for age and sex.
- Use the individual's **age on December 31, 2026**.
- Report the date of birth and sex[7] listed on the birth certificate for all patients.
- There is no "Unknown" or "Other" category on this table.

Note: On the non-prenatal parts of Tables 6B and 7, age is defined differently by measure. Thus, the numbers on Table 3A may not be the same as those on Tables 6B and 7.

[7] "Sex" refers to an individual's immutable biological classification as either male or female.

Table 3B: Demographic Characteristics – Instructions

Table 3B gives an unduplicated count of patients by demographic characteristics.

The text directly below contains changes to Table 3B from 2025 calendar year reporting to 2026 calendar year reporting:

There are no key changes to this table.

This marks the conclusion of changes to Table 3B from 2025 calendar year reporting to 2026 calendar year reporting.

Report the number of patients by their self-identified race, ethnicity, and limited English proficiency.

PATIENTS BY HISPANIC, LATINO/A, OR SPANISH ETHNICITY AND RACE (LINES 1–8)

Table 3B displays the race and ethnicity of the patient population in a matrix format.

Hispanic, Latino/a, or Spanish Ethnicity

Report whether patients consider themselves to be of Hispanic, Latino/a, or Spanish ethnicity, regardless of their race.

Columns A1–A5 (Hispanic, Latino/a, or Spanish Origin)	Column B (Not Hispanic, Latino/a, or Spanish Origin)	Column C (Unreported/Chose Not to Disclose Ethnicity)
• Report the number of patients of Mexican, including Mexican American and Chicano/a (Column A1), Puerto Rican (Column A2), Cuban (Column A3), another Spanish culture or origin (Column A4), or Hispanic, Latino/a, or Spanish origin combined (Column A5), broken out by their racial identification. Include in this count Hispanic, Latino/a, or Spanish origin patients born in the United States or another country. • Report patients who are of Hispanic, Latino/a, or Spanish origin but for whom granularity of ethnicity is not known, as well as patients who select more than one ethnicity, in Column A5 (e.g., Mexican and Puerto Rican). • Report patients who self-report as being of Hispanic, Latino/a, or Spanish ethnicity but DO NOT separately select a race on Line 7, as "Unreported/Chose not to disclose race." Health centers should not default these patients to any other category. • DO NOT include patients from Portugal, Brazil, or Haiti whose ethnicity is not otherwise tied to the Spanish language, unless they self-identify as being of Hispanic, Latino/a, or Spanish origin.	• Report the number of patients who indicate that they are NOT of Hispanic, Latino/a, or Spanish origin. • If a patient self-reported a race but has not made a selection for the Hispanic/Not Hispanic, Latino/a, or Spanish origin question, presume that the patient is NOT of Hispanic, Latino/a, or Spanish origin.	• Report on Line 7 only those patients who left the entire race and Hispanic, Latino/a, or Spanish ethnicity part of the intake form blank or those who indicated that they choose not to share these data. Only one cell is available in this column. **Note:** Column C is grayed out on all race lines except for the "Unreported/Chose not to disclose race" line.

Race

All patients must be classified in one of the racial categories.

- Report patients in one of 16 race categories:
  - Asian, Line 1, as Asian Indian (Line 1a), Chinese (Line 1b), Filipino (Line 1c), Japanese (Line 1d), Korean (Line 1e), Vietnamese (Line 1f), or Other Asian (Line 1g)
  - Native Hawaiian/Other Pacific Islander, Line 2, as Native Hawaiian (Line 2a), Other Pacific Islander (Line 2b), Guamanian or Chamorro (Line 2c), or Samoan (Line 2d)
  - Black or African American, Line 3
  - American Indian/Alaska Native, Line 4
  - White, Line 5
  - More than one race, Line 6
  - Unreported/Chose not to disclose race, Line 7
- Patients categorized as "Asian/Asian American/Pacific Islander" in other systems are reported on the UDS in one of five distinct categories:
  - **Asian (Line 1):** Patients having ancestry in any of the original peoples of Asia, Southeast Asia, or the Indian subcontinent, including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Indonesia, Thailand, or Vietnam.
    - Include in the Other Asian category (Line 1g):
      - Patients who are Asian, but for whom the granularity of their ancestry is not known.
      - Patients who select more than one of the Asian subcategories listed (e.g., Chinese and Filipino).
  - **Native Hawaiian (Line 2a):** Patients having ancestry in any of the original peoples of Hawai'i.
  - **Other Pacific Islander (Line 2b):** Patients having ancestry in any of the original peoples of Tonga, Palau, Chuuk, Yap, Kosrae, Ebeye, Pohnpei, or other Pacific Islands in Melanesia or Oceana.
    - Include in the Other Pacific Islander category (Line 2b):
      - Patients who are of other Pacific Islands not reported on Lines 2a, 2c, or 2d.
      - Patients who are of other Pacific Islands for whom the granularity of their ancestry is not known.
      - Patients who select more than one of the Pacific Islander subcategories listed (e.g., Chuuk and Guamanian).
  - **Guamanian or Chamorro (Line 2c):** Patients having ancestry in any of the original peoples of the Northern Mariana Islands, Guam, Saipan, Tinian, Rota, or other Mariana Islands in Micronesia.
  - **Samoan (Line 2d):** Patients having ancestry in any of the original peoples of the Samoan Islands, Savai'i, Manono, Upolu, Tutuila, Pola Island, Aunu'u, or other Samoan Islands in American Samoa or Polynesia.
- **Black or African American (Line 3):** Patients having ancestry in any of the original peoples of Africa, not including North Africa.
- **American Indian/Alaska Native (Line 4):** Patients having ancestry in any of the original peoples of North, South, and Central America and who have tribal affiliation or community attachment.

- **White (Line 5):** Patients having ancestry in any of the original peoples of Europe, the Middle East, or North Africa.
- **More than one race (Line 6):** Use this line only if your system captures multiple races and the patient has chosen two or more races. This is usually done with an intake form that lists the races and tells the patient to "check one or more" or "check all that apply."
  - DO NOT report on this line:
    - Patients who select multiple Asian races (Lines 1a–1f).
    - Patients who select multiple Native Hawaiian/Other Pacific Islander races (Lines 2a–2c).
    - Hispanic, Latino/a, or Spanish people who DO NOT select a race (Column A).
  - DO NOT include "more than one race" as an option on your intake form.
  - DO NOT include ethnicity as a race. Capture ethnicity separately.
- **Unreported/Chose not to disclose race (Line 7):** Report patients who did not provide their race, including when information was sought but not found or asked but unknown.
  - Include in the "Unreported/Chose not to disclose race" category (Line 7):
    - Hispanic, Latino/a, or Spanish people who DO NOT select a race.
- Report patients who self-report their race but DO NOT indicate that they are of Hispanic, Latino/a, or Spanish origin in Column B as NOT of Hispanic, Latino/a, or Spanish origin on the proper race line.

PATIENTS WITH LIMITED ENGLISH PROFICIENCY (LINE 12)

This section of Table 3B identifies the patients who may have limited English proficiency.

- Report on Line 12 the number of patients with limited English proficiency, including those who are best served in sign language. This line does not discern between written and spoken preference; it could be either or both.
- Include those patients who were served in a second language by a bilingual provider, a third-party interpreter, and those who may have brought their own interpreter or translator.
- Include patients who are best served in a language other than English, even when the health center is in an area where a language other than English is the dominant language, such as Puerto Rico or the Pacific Islands.

FAQ FOR TABLES 3A AND 3B

1. **Our health center collects different race and ethnicity data than required by the UDS. Why are the data collected at this level?**

   The UDS classifications are consistent with the guidance issued by the Office of Management and Budget (OMB) 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." These standards govern the categories used to collect and present federal data on race and ethnicity. Before 2025 and before implementation of OMB's Statistical Policy Directive No. 15 (SPD 15), OMB required at least five categories (White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander) for race. While the revised SPD 15 requirements, first developed in 1977, took effect on March 28, 2024, U.S. Department of Health and Human Services (HHS) agencies have until September 28, 2029, to come into full compliance. HRSA is working with health centers and health information technology vendors supporting health centers to meet the added reporting requirements. For now,

HRSA remains aligned with the earlier requirements. HHS data standards that were in place before 2025 and used for the reporting of race and ethnicity for Table 3B are based on the disaggregation of the OMB standard.

2. Do we have to report the race and ethnicity of all our patients?

Yes. Health centers whose data systems DO NOT support such reporting must enhance their systems to permit the required level of reporting, rather than using the "Unreported/Chose not to disclose" categories.

3. How are patients of Hispanic, Latino/a, or Spanish ethnicity reported?

Race and ethnicity data appear in a matrix on Table 3B. Report patients' ethnicity in one of the detail columns A1–A5 and report them on Lines 1–7 based on their race. If only Hispanic, Latino/a, or Spanish ethnicity is known, report these patients in Columns A1–A5 on Line 7 as having an "unreported" racial identification, and update your data system to permit the collection of both race and ethnicity for future reporting. If a patient self-identifies as of Hispanic, Latino/a, or Spanish origin with no distinction within the subcategories listed (Mexican, Mexican American, Chicano/a, Puerto Rican, Cuban, another Spanish origin), report the patient in Column A5. Also report patients who report more than one ethnicity (e.g., Hispanic and other Spanish origin) in Column A5.

4. Can we have a choice on our registration form of "more than one race"?

No. To count patients as being of "more than one race," they must have the option of checking two or more boxes under race and must have indeed checked more than one. Do not include "more than one race" as an option on registration forms.

5. How are patients who receive different types of services or use more than one of our health center's service delivery sites reported? For example, how do we report a patient who receives both medical and dental services or a patient who receives primary care from one service delivery site but gets prenatal care at another?

The Patients by ZIP Code Table and Tables 3A, 3B, and 4 each give an unduplicated patient count. Count each individual who has at least one visit reported on Table 5 only once on the Patients by ZIP Code Table and Tables 3A, 3B, and 4, regardless of the type or number of services they receive or where they receive them. We define visits in detail in the Instructions for Tables that Report Visits, Patients, and Providers section. Note the following:

DO NOT count individuals who:

- receive Women, Infants, and Children (WIC) services and no other services at the health center as patients on Table 3A or 3B (or anywhere in the UDS).
- only receive imaging or lab services or whose only service was an immunization or screening test as patients on Table 3A or 3B (or anywhere in the UDS).
- only receive health status checks and health screenings as patients on Table 3A or 3B (or anywhere in the UDS).

6. We have multiple, separate data systems. How do we include their data on these tables?

It is the health center's responsibility to make sure data are not duplicated. Count patients only once, regardless of the number of different types of services they receive. This may require downloading and merging data from each system to remove duplicates or checking them manually. This can be a time-consuming process and should start as soon as the year ends to ensure there is enough time for completion

before the submission due date. Health centers can also reach out to their state or territory Primary Care Association or Health Center Controlled Network for technical assistance.

TABLE 3A: PATIENTS BY AGE AND BY SEX

Calendar Year: January 1, 2026, through December 31, 2026

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

Table 3A Cross-Table Considerations:

- Table 3A, Line 39 = Table 3B, Line 8, Column D = total patients on the Patients by ZIP Code Table = Table 4, Lines 6 and 12.
- If you submit Grant Reports, the total number of patients reported on each grant table must be less than or equal to the corresponding number on the Universal Report for each cell.

TABLE 3B: DEMOGRAPHIC CHARACTERISTICS

Calendar Year: January 1, 2026, through December 31, 2026

	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)									

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

Table 3B Cross-Table Considerations:

- Table 3B, Line 8 = Table 3A, Line 39 = Patients by ZIP Code Table = Table 4, Lines 6 and 12.
- Tables 3B and 7 both report patients by race and Hispanic, Latino/a, or Spanish ethnicity. The data sources for identifying race and ethnicity for the two tables should be the same, and the number of patients reported on Table 7 by race and ethnicity cannot exceed the number of patients in the same category on Table 3B.
- If you submit Grant Reports, the total number of patients reported on each grant table must be less than or equal to the corresponding number on the Universal Report for each cell.

Instructions for Table 4: Selected Patient Characteristics

Table 4 collects descriptive data on selected characteristics of health center patients.

The text directly below contains changes to Table 4 from 2025 calendar year reporting to 2026 calendar year reporting:

Key changes have been made to Table 4, as outlined below:

- Managed care utilization (Lines 13a–13c) is no longer reported.

This marks the conclusion of changes to Table 4 from 2025 calendar year reporting to 2026 calendar year reporting.

INCOME AS A PERCENTAGE OF POVERTY GUIDELINE (LINES 1–6)

Report **all** patients (not only patients eligible for a sliding fee discount) based on their most current income data, which must have been collected at or within 12 months of the last calendar year visit.

- Determine a patient's income relative to the 2026 federal poverty guidelines (FPG).
- Report patients by income, as defined by the health center's governing board policy consistent with the Health Center Program Compliance Manual.
- Children, except for emancipated minors or those presenting for minor consent services, should be classified using their family's/household's income.
- Report patients whose information was not collected at or within 12 months of their last visit in the calendar year on Line 5 as "Unknown."
- Use self-declared income for patients if this is consistent with the health center's governing board–approved policies and procedures. If income information is not consistent with the health center's board policy, report the patient as having "Unknown" income.
- DO NOT allocate patients with "Unknown" income to the other income groups.
- DO NOT classify a patient who is in the homeless population, is a migratory and seasonal agricultural worker, or is on Medicaid as having income below the FPG based on these factors alone.

PRIMARY THIRD-PARTY MEDICAL INSURANCE (LINES 7–12)

This part of the table reports data on patients classified by their age and primary source of insurance for **medical** care. Health centers must collect medical insurance information each calendar year from **all** patients to maximize third-party payments. Note that there is **NO** "Unknown" insurance classification on this table. DO NOT report other forms of insurance, such as dental, mental health, or vision coverage. Also note that states often rename federal insurance programs, such as the Children's Health Insurance Program (CHIP) and Medicaid.

- Report the primary **medical** insurance patients had at the time of their last visit, regardless of whether that insurance was billed or paid for any or all of the services delivered.

Note: Presume a patient with Medicaid, Private, or Other Public dental insurance to have the same kind of medical insurance. If a dental patient **does not** have dental insurance, DO NOT assume that they are uninsured for medical care. Instead, obtain this information from the patient.

- Patient primary medical insurance is classified into seven types, as shown on the following pages.

- In rare instances, a patient may have insurance that the health center cannot or does not bill. Even in these instances, report the patient as being insured and report the type of insurance.
- Patients are divided into two age groups: 0–17 (Column A) and 18 and older (Column B) based on their age on December 31, 2026 (consistent with ages reported on Table 3A).
- DO NOT report public programs that reimburse selected services, such as the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program; Breast and Cervical Cancer Early Detection Program (BCCEDP); Title X; or AIDS Drug Assistance Program, as a patient's primary medical insurance.

Note: Report the revenue from public programs that reimburse for selected services as Other Public payers on Table 9D.

None/Uninsured (Line 7)

Report patients who did NOT have medical insurance at the time of their last visit on Line 7. This may include patients who were insured earlier in the year and patients whose visit was paid for by a third-party source that was not insurance, such as EPSDT, BCCEDP, Title X, or some state or local safety net or indigent care programs. Some considerations:

- Report a minor receiving services with parental consent under the family's/household's insurance.
- Report children seen in a school-based service site under their parent's health insurance. This information must be obtained if they are included in the UDS Report. Report emancipated minors or patients seeking minor consent services allowed by the state, such as voluntary family planning or mental health services, as Uninsured if they DO NOT have access to the family's/household's insurance information.
- Patients served in correctional facilities may be classified as Uninsured unless insurance, such as Medicaid or Medicare, is documented, in which case report them on that insurance line.
- DO NOT assume that patients in facilities other than correctional, such as residential substance use programs, college dormitories, and military barracks are uninsured. Instead, obtain insurance information from the patient.
- DO NOT report patients as Uninsured if they have medical insurance that did not pay for their visit. Report them with the primary medical insurance they have.
- DO NOT report patients seen for dental care who have dental insurance as Uninsured.

Medicaid (Line 8a)

Report patients covered by state-run programs operating under the guidelines of Titles XIX and XXI of the Social Security Act.

- Include Medicaid programs known by state-specific names (e.g., California's "Medi-Cal" program).
- Include patients covered by "state-only" programs covering individuals who are ineligible for federal matching funds (e.g., pregnant women) and paid through Medicaid, if they cannot otherwise be identified as having another insurance.
- Report patients enrolled in both Medicaid and Medicare on Lines 9 (Medicare) **and** 9a (Dually Eligible), but not on Line 8a (Medicaid).
- Report patients who are enrolled in Medicaid but receive services through a managed care plan administered by a private insurer that contracts with the state Medicaid agency on Line 8a (Medicaid), not as privately

insured (Line 11). This also applies in states that have a Medicaid waiver letting Medicaid funds be used to buy private insurance for services.

- Report as Medicaid (Line 8a) Medicaid expansion programs (such as state premium aid programs) that use Medicaid funds to help patients buy their insurance through exchanges if it is possible to identify them.

CHIP Medicaid (Line 8b)

Report patients covered by CHIP provided through the state's Medicaid program.

- In states that use Medicaid to administer CHIP, it may be difficult to distinguish between Medicaid and CHIP Medicaid. There may also be variation at the county level. In some states, the distinction is clear (e.g., they have different cards, a plan code, or a program identifier embedded in a membership number). Obtain information on coding practice from the state and/or county.
- If there is no way to distinguish between Medicaid and CHIP coverage when both are administered through Medicaid, classify all covered patients as Medicaid (Line 8a).

Medicare (Line 9)

Report patients with the following primary medical insurance on Line 9, Medicare, **only**. Include:

- Patients covered by the federal insurance program for the aged, blind, and disabled (Title XVIII of the Social Security Act).
- Patients who have Medicare and a private ("Medigap") insurance.
- Patients enrolled in "Medicare Advantage" products, even if their services were covered by a private insurance company.

Report patients who have Medicare and Medicaid ("dually eligible") on Line 9 **and** on Line 9a (Dually Eligible).

Report Medicare-enrolled patients who are insured by both an employer-based plan and Medicare as Private Insurance on Line 11, because the employer-based insurance plan is billed first. DO NOT include them as Medicare on Line 9 or Dually Eligible on Line 9a.

Dually Eligible (Medicare and Medicaid) (Line 9a)

Report patients with both Medicare and Medicaid insurance on Line 9a **and** include them on Line 9. Line 9a (Dually Eligible) is a subset of Line 9 (Medicare).

- Include patients who are dually eligible and enrolled in both Medicare and Medicaid.
- Include patients who are enrolled in Dual Eligible Special Needs Plans.
- DO NOT include Medicare gap "Medigap" (supplemental insurance plan) enrollees on Line 9a. Report patients who buy Medicare gap insurance as Medicare patients (Line 9).

Other Public Insurance (Non-CHIP) (Line 10a)

Report state and/or local government programs that provide a broad set of benefits for eligible individuals. Include any public-paid or subsidized private insurance not reported elsewhere on Table 4.

- DO NOT report any CHIP, Medicaid, or Medicare patients on Line 10a.
- DO NOT report uninsured individuals whose visit may be covered by a public source with limited benefits, such as Title X, EPSDT, BCCEDP, or AIDS Drug Assistance Program.

Note: Public programs that reimburse for selected services, such as Title X, EPSDT, BCCEDP, or AIDS Drug Assistance Program are, however, considered Other Public payers on Table 9D.

- DO NOT include patients covered by workers' compensation (which is liability insurance for the employer—not health insurance for the patient).

Other Public Insurance CHIP (Line 10b)

Report patients on the Other Public Insurance CHIP line in states where CHIP is contracted through a private third-party payer.

- Report CHIP programs that are run through the private sector, often administered through health maintenance organizations (HMOs). Coverage may appear to be a private insurance plan (such as Blue Cross/Blue Shield) but is funded through CHIP and is to be counted on Line 10b.
- Report CHIP patients who are on plans administered by coordinated care organizations (CCOs).
- DO NOT report CHIP as Private Insurance on Line 11.

Private Insurance (Line 11)

Report patients with health insurance provided by private (commercial) and not-for-profit companies.

- Individuals may obtain insurance through employers or on their own.
- Include patients who buy insurance through the federal or state exchanges.
- In states using Medicaid expansion to support the purchase of insurance through exchanges, report patients covered under these plans on Line 8a (Medicaid). Report patients who are not identifiable as Medicaid patients on Line 11 (Private Insurance).
- Private insurance includes insurance bought for public employees or retirees, such as Tricare, Trigon, or the Federal Employees Benefits Program.
- DO NOT report patients enrolled in "Medicare Advantage" as Private (Line 11). Report them as having Medicare (Line 9).

SPECIAL MEDICALLY UNDERSERVED POPULATIONS (LINES 14–26)

This section collects a count of patients from special medically underserved populations (specifically, migratory and seasonal agricultural workers and their family members, homeless populations, and residents of public housing[8]), patients served by school-based service sites, and patients who are Veterans. Recipients who receive funding from section 330(g) (MSAW) and section 330(h) (HP) must give more information on their migratory and seasonal agricultural employment and/or housing characteristics.

- All health centers report these populations, regardless of whether they receive special medically underserved population funding through section 330(g), (h), or (i).
- Patients can be reported in more than one category (e.g., a patient can be reported as both Veteran and homeless).

[8] "Residents of public housing" refers to patients who are served at a health center located in or immediately accessible to a public housing site. Public housing includes public housing agency-developed, -owned, or -assisted low-income housing, including mixed-finance projects but excludes housing units with no public housing agency support other than Section 8 housing vouchers (Section 330(i) of the PHS Act).

Total Migratory and Seasonal Agricultural Workers and Their Family Members (MSAWs) (Lines 14–16)

Total Migratory and Seasonal Agricultural Workers and Their Family Members, Line 16: Report the total number of patients seen during the calendar year who were MSAWs, their family members, or aged or disabled former migratory agricultural workers (as described in the statute section 330(g)(1)(B)). All health centers must report on this line, though for some the number may be zero.

- Report patients who are MSAWs on Lines 14 and 15 and who work in agriculture—as defined by the Office of Management and Budget (OMB)-developed North American Industry Classification System (NAICS). This includes farming in all its branches, including codes 111 and 112 and all sub-codes therein, including sub-codes 1151 and 1152.
- MSAWs' status must be verified at least every 2 years by MSAW recipients.

Only health centers that receive section 330(g) (MSAW) funding complete Lines 14 and 15. For section 330(g) recipients, the sum of Lines 14 and 15 must equal Line 16.

- **Migratory Agricultural Workers (Line 14):** Report patients whose principal employment is in agriculture and who set up a temporary home to be employed as a migratory agricultural worker, as defined by section 330(g). Migratory agricultural workers are usually hired laborers who are paid piecework, hourly, or daily wages. Include patients who had such work as their principal employment within 24 months of their last visit during the calendar year. Also include their family members who used the health center, regardless of whether they move with the worker or set up a temporary home.
    - Agricultural workers who leave a community to work elsewhere are classified as migratory agricultural workers even when served in their home community.
    - Include aged and disabled former migratory agricultural workers, as defined in section 330(g)(1)(B), and their family members.
- **Seasonal Agricultural Workers (Line 15):** Report patients whose principal employment is in agriculture on a seasonal basis (e.g., picking fruit during the limited months of a picking season), but who DO NOT set up a temporary home for purposes of such employment. Seasonal agricultural workers are usually hired laborers who are paid piecework, hourly, or daily wages. Include patients who had such employment within 24 months of their last visit during the calendar year, as well as their family members who are patients of the health center.
    - Seasonal agricultural workers may be employed throughout the year for multiple crop seasons and as a result might work full time.

Total Homeless Population (Lines 17–23)

Total Homeless Population (Line 23): Report the total number of patients known to have been homeless at **any time** during the calendar year, even if their housing situation changed during the year. Patients are considered homeless for up to 12 months after they were last documented to experience homelessness, even if that was in the prior calendar year. All health centers must report on this line, though for some the number may be zero.

Report patients:

- Who lack housing
- Whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations
- Who live in transitional housing or permanent supportive housing

- Who experienced homelessness or were at risk of homelessness for up to 12 months after they were last documented to experience homelessness, including children and youth at risk of homelessness, homeless Veterans, and Veterans at risk of homelessness[9]

Only health centers receiving section 330(h) (HP) funding give separate totals for patients by housing location on Lines 17 through 22. The sum of Lines 17 through 22 must equal Line 23. Housing status is based on the housing arrangement (where the patient was housed the prior night) at the **first visit during the calendar year** when the patient is identified as experiencing homelessness.

- **Homeless Shelter (Line 17):** Report patients who are living in an organized shelter for individuals experiencing homelessness. Unlike permanent supportive housing, shelters generally provide meals and a place to sleep and are regarded as temporary, often with limitations on the number of days or hours of the day that the individual may be present.
- **Transitional (Line 18):** Transitional housing units are generally small units where people transition from a shelter and are given extended, but temporary, housing stays (generally between 6 months and 2 years) in a service-rich environment. Transitional housing provides a greater level of independence than shelters and may require the resident to pay some or all of the rent, take part in the maintenance of the facility, and/or cook their own meals.
    - Report only those patients who are transitioning from a homeless environment.
    - DO NOT include those who are transitioning from a carceral facility or those residing in or transitioning from an institutional treatment program, the military, schools, or other institutions.
- **Doubled Up (Line 19):** Report patients who are living with others. The arrangement is considered to be temporary and unstable, though a patient may live in a succession of such arrangements over a protracted period.
    - DO NOT include the individual who invites a patient experiencing homelessness to stay in their home for the night.
    - DO NOT include a co-tenant rental.
- **Street (Line 20):** Report in this category patients who are living outdoors, in a vehicle, in an encampment, in makeshift housing/shelter, or in other places generally not deemed safe or fit for human occupancy.
    - Report patients who spent the prior night in a carceral facility, in an institutional treatment program (e.g., mental health, substance use disorder [SUD]), or in a hospital based on where they intend to spend the night **after** their visit/release. If they DO NOT know, report their shelter arrangement as Street, Line 20.
- **Permanent Supportive Housing**[10] **(Line 21a):** Permanent supportive housing is in service-rich environments, without time limits and may be restricted to people with a disabling condition.
- **Other (Line 21):** Report patients who were housed when first seen during the year and were no longer homeless, but who were **still eligible for the program because they experienced homelessness during the previous 12 months**.
    - Under section 330(h), health centers may continue to provide services for up to 12 months after the last documentation of the patient experiencing homelessness. Include patients who the health center has previously served but are no longer in the homeless population.

[9] Health centers may use criteria as defined by the U.S. Department of Housing and Urban Development (HUD) to help in defining "children and youth at risk of homelessness, homeless Veterans, and Veterans at risk of homelessness."
[10] Health centers may use criteria as defined by HUD to help in defining permanent supportive housing.

  - Include patients who live in single-room-occupancy (SRO) hotels or motels and patients who live in other day-to-day paid housing or other housing programs that are intended for people experiencing homelessness.

- **Unknown (Line 22):** Report patients known to be experiencing homelessness whose housing arrangements are unknown.
- DO NOT report patients currently residing in a carceral facility or an institutional treatment program as homeless until they are released to the street with no housing arrangement.
- DO NOT report patients who are part of the foster system program and are placed with a family, group home, or in some other arrangement as homeless population.

Total School-Based Service Site Patients (Line 24)

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).

Other considerations:

- All patient characteristic details are to be collected and reported.
- Schools include preschool, kindergarten, and primary through secondary schools (exclude colleges and universities).
- Services target students at the school but may also be provided to siblings, parents, school staff, and patients residing in the immediate vicinity of the school.
- DO NOT include students who only receive screening services or mass treatment at a school, such as vaccinations or fluoride treatments.

Total Veterans (Line 25)

Report the total number of patients who served in the active military, naval, or air service, which includes full-time service in the Air Force, Army, Coast Guard, Marine Corps, Navy, Space Force, or as a commissioned officer of the PHS or National Oceanic and Atmospheric Administration. Also, include patients who served in the National Guard or Reserves on active-duty status.

Include a question about Veterans' status in the patient information/intake form at each service delivery site.

- Report only those who affirmatively indicate they previously served in these branches of the military or armed forces.
- DO NOT report patients who do not respond, regardless of other indicators.
- DO NOT report Veterans of other nations' militaries, even if they served in wars in which the United States was also involved.
- 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.
- DO NOT include family members or other Veterans Affairs beneficiaries who are not Veterans.

Total Residents of Public Housing (Line 26)

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).

- Report all patients seen at the health center service delivery site if it is located in or immediately accessible to local housing agency-developed, -owned, or -assisted low-income housing, including mixed-finance projects.
- This is the only field in the UDS Report that requires you to **provide a count of all patients based on the health center service delivery site's proximity to public housing**.
- DO NOT consider Section 8 housing units that receive no public housing agency support other than Section 8 housing vouchers as public housing.

Note: Include all patients served at service delivery site(s) located in or immediately accessible to public housing, even if they themselves are not residents of public housing.

FAQ FOR TABLE 4

1. **Do we determine a patient's income relative to the FPG based on the location of the health center or based on the residence of the patient?**

   Use the FPG based on the location of the health center. All states (except Alaska and Hawaii) and the U.S. territories use the same standard poverty guidelines. For patients being served in Alaska or Hawaii, use the FPG set for those locations.

2. **Homeless populations and MSAWs generally DO NOT have income verification. Can we report them as having income at 100% and below poverty?**

   No. Report them as having "Unknown" income if income was not verified at or within 12 months of the last calendar year visit, and implement steps to verify income at least yearly. Subject to your health center's financial policies and procedures, you may document their income in your system based on their verbal attestation of their income.

3. **We serve students at a school-based service site. They often DO NOT know what insurance they have, if any, and they have no information on their family's/household's income. Can we report them as having income at 100% and below poverty and Uninsured?**

   No. Obtain insurance information from the parents or guardians of students at the same time that you collect consent to treat, unless they are exclusively receiving minor consent services. Minor consent services are defined by state law and are generally limited to a very specific range of services, such as those related to contraception, sexually transmitted diseases, and mental health. Not all states provide for them. HRSA issued updated terms on health centers' compliance with applicable state or federal laws regarding parental consent. These updated terms will apply to all HRSA-funded health centers and Health Center Program look-alikes. Please review your Notice of Award or your Notice of Look-Alike Designation.

Note: Subject to the health center's policies and procedures, you may ask for this information and assure parents that you will not bill the insurance without their knowledge. If you DO NOT obtain the family's/household's income, report the child as having "Unknown" income. Collect and report the patient's health insurance information, even if it is not billed.

4. **If a patient is seen only for dental care, do we report the patient's dental insurance on Lines 7–12?**

   No. Table 4 reports only patients' medical coverage. All health centers must collect medical insurance information from all patients, even if they do not receive medical services.

5. **Our state is using Medicaid expansion provisions to help patients buy private insurance. Should we count them as Medicaid or Private?**

   If patients are Medicaid expansion patients, report them as Medicaid, Line 8a. You may need to look for specific plan numbers or other identifying characteristics in patients' insurance enrollment. If you cannot identify Medicaid expansion patients, report them as Private Insurance, Line 11.

6. **Do we classify patients in the insurance section as Uninsured if their medical insurance did not pay for the visit?**

   No. Always report based on the patient's primary medical insurance, even if the insurance did not pay or you cannot bill for the service. Some examples follow:

   - Report a patient with Medicare who was seen for a dental visit that was not paid for by Medicare as having Medicare for this table.
   - Report a patient with private insurance who had not reached their deductible as a Private Insurance patient.

7. **If we do not receive direct HP, MSAW, or RPH funding, do we need to report the total number of special medically underserved population patients served?**

   Yes. Even health centers that DO NOT receive grant funding for special medically underserved populations (330(g), (h), or (i)) must complete the following:

   - Line 16 (the total number of patients seen during the calendar year who were MSAWs and their family members), but not Lines 14 and 15,
   - Line 23 (total number of patients who were known to be in the homeless population at any time of the year and received services during the calendar year), but not Lines 17–22,
   - Line 24 (patients served at a school-based service site),
   - Line 25 (Veterans), and
   - Line 26 (total residents of public housing).

   The housing status details on Lines 17–22 are grayed out if you did not receive HP funding; only enter the total on Line 23.

   The MSAW details on Lines 14 and 15 are grayed out if you did not receive MSAW funding; only enter the total on Line 16.

8. **What timing decides a patient's homeless status and shelter arrangement?**

   For all health centers (regardless of HP funding status), include the total number of patients who experienced homelessness at any point during the calendar year and received services during the calendar year on Line 23.

   For recipients that receive HP funding, continue to count patients who are no longer experiencing homelessness due to becoming residents of permanent housing for 12 months after their last visit as homeless.

   For recipients that receive HP funding, report all patients experiencing homelessness by their housing arrangement as of their first visit during the calendar year on Lines 17–22.

9. Who should be reported as Residents of Public Housing on Line 26?

Report the total number of patients who were served at any health center service delivery site (as documented on Form 5B) **that you consider** to meet the statutory definition for RPH—located in or immediately accessible to public housing (as defined under section 330(i) of the PHS Act). Report the Residents of Public Housing line, regardless of whether the health center receives funding under section 330(i) (RPH) and regardless of whether patients lived in public housing. This is a site-based count, and the patient's residence in public housing is not to be considered.

10. We ask if a patient is a Veteran as part of the registration process, but we are concerned that not all Veterans respond. Any suggestions?

Yes. The way the question is asked makes a difference, and improving the wording can improve accuracy in the patients' response to Veteran status. For instance, health centers may have more success asking, *"Have you served in the United States military, armed forces, or uniformed services?"* rather than simply asking, *"Are you a Veteran?"* The broader phrasing captures those who may not identify as Veterans but have served. Examples include individuals from the U.S. Air Force, Army, Coast Guard, Marines, Navy, Space Force, National Guard, Reserves, or the U.S. PHS and National Oceanic & Atmospheric Association.

11. Can patients served by mobile units at schools be considered school-based service site patients?

Yes. Patients who receive a countable visit at an **approved in-scope mobile unit parked on the grounds of a school** are considered school-based patients. The school must be within the health center's service area.

TABLE 4: SELECTED PATIENT CHARACTERISTICS

Calendar Year: January 1, 2026, through December 31, 2026

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)	

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)		

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.)	

Line	Special Medically Underserved Populations	Number of Patients (A)
26	**Total Residents of Public Housing**[11] (All health centers report this line.)	

Table 4 Cross-Table Considerations:

- The total patients reported by insurance type must match on Table 4 (Lines 7–12) and the Patients by ZIP Code Table. For example, total Medicare patients on Table 4 (Line 9) must match the total of the Medicare Column D on the Patients by ZIP Code Table.
- Charges and collections by payer on Table 9D generally relates to insurance enrollment on Table 4. For example, dividing Medicaid revenue on Table 9D, Line 3, Column B, by Total Medicaid Patients on Table 4, Line 8, equals the average collection per Medicaid patient.
- If you submit Grant Reports, the total number of patients reported on a grant table(s) must be less than or equal to the corresponding number on the Universal Report for each cell.

[11] "Residents of public housing" refers to patients who are served at a health center located in or immediately accessible to a public housing site. Public housing includes public housing agency-developed, -owned, or -assisted low-income housing, including mixed-finance projects but excludes housing units with no public housing agency support other than Section 8 housing vouchers (Section 330(i) of the PHS Act).

Instructions for Table 5: Staffing and Utilization

Table 5 collects data on services provided to patients during the calendar year.

The text directly below contains changes to Table 5 from 2025 calendar year reporting to 2026 calendar year reporting:

Key changes have been made to Table 5, as outlined below:

- Enabling Services (Line 29) has been renamed Patient Support Services. Patient support service categories have also been reordered and renamed.
- Total Facility and Non-Clinical Support Personnel (Line 33) has been renamed Total Facility and Support Services Personnel.
- The Selected Service Detail Addendum (Lines 20a01–21h) is no longer reported.

This marks the conclusion of changes to Table 5 from 2025 calendar year reporting to 2026 calendar year reporting.

TABLE 5: STAFFING AND UTILIZATION

This table shows a profile of health center personnel by full-time equivalent (FTE) (Column A), the number of clinic (in-person) visits they render (Column B), the number of virtual visits they render (Column B2), and the number of unduplicated patients served in each service category (Column C).

Service categories that may reflect visits and patients include:

- Medical
- Dental
- Mental health
- Substance use disorder (SUD)
- Other professional
- Vision
- Patient support

Report patients once in each service category in which they received services. For example, a patient may be reported in both medical and dental patient categories. This often results in patients being counted in more than one service category.

DO NOT count a patient more than once in a service category. For example, regardless of number of medical visits or types of medical providers seen, the patient is only counted once as a medical patient. This is unlike the Patients by ZIP Code Table and Tables 3A, 3B, and 4, where patients are counted only once across these tables or sections within tables. See the Relationship Between Patient Counts on Patient Profile Tables for more information.

PERSONNEL FTES (COLUMN A)

Table 5 includes personnel FTE for all individuals who work in programs and activities that support the approved scope of project. Report all personnel in terms of **annualized** FTEs.

- Report FTEs of all personnel supporting health center operations defined by the scope of project in Column A whose work is based on time. Personnel may provide services on behalf of the health center under many different arrangements, including but not limited to salaried full-time, salaried part-time, hourly wages, National Health Service Corps (NHSC) assignment, under contract (paid based on hours worked or FTE), interns, residents, preceptors, or donated time (volunteers).
- DO NOT report FTEs for individuals who are paid by the health center on a fee-for-service basis in the FTE column, because there is no basis for determining their hours. Visits with providers paid through this arrangement are still reported in Column B or B2, and the patients who received those services are reported in Column C.

Personnel FTEs in Column A are reported only on the Universal Report table, not the Grant Report tables.

Identifying Employment Type and Calculating FTEs

The following describes the basis for determining someone's employment type for purposes of reporting on FTEs:

- One FTE (1.00) describes personnel who worked the equivalent of full time for one full year, according to employment agreements.
- Each health center defines the number of hours for "full-time" work and may define it differently for different positions. In some health centers, different positions have different definitions of full time. Positions should be calculated on the base number of hours. For example, if the employment contract states working 36 hours per week is full time (1.00 FTE), then an 18-hour-per-week personnel in this position would be considered 0.50 FTE.
- The FTE of personnel receiving full-time benefits for the full year would be considered full time = 1.00 FTE.
- Hourly personnel who work more than full time (i.e., overtime) will have a FTE greater than 1.00.
- For personnel who do not receive all the paid time off of full-time personnel (i.e., vacation, holidays, and sick benefits), the effective FTE is calculated by dividing worked hours by adjusted full-time hours (full-time hours minus paid time-off hours that full-time personnel receive).

Reporting FTEs on the Appropriate Line on Table 5

Allocate all personnel time by **function** among the major service categories listed. Except for physicians and dentists (although there is an exception to this, below, for corporate-level activities), personnel time can be allocated across multiple lines if personnel have more than one distinct position (e.g., a nurse serving as a medical provider and as a case manager). This determination is at the discretion of the health center.

DO NOT parse the parts of an encounter. For example, the nurse who handles a referral after a visit as a part of that visit would not be allocated out of nursing. The nurse who collects vitals on a patient and later gives instructions on wound care, for example, would not have a part of the time counted as health education—it is all a part of nursing.

The time spent by providers doing tasks in what could be considered non-direct-service clinical activities, such as charting, reviewing laboratory results, filling or renewing prescriptions, returning phone calls, arranging for referrals, participating in quality improvement (QI) activities, or supervising, is all considered part of their overall medical care services time and should NOT be separately reported in the central support category. However, if a chief medical officer or medical director or the like is engaged in administrative activities at the **corporate level** (e.g., attending board of directors or senior management meetings, advocating for the health center before the city council or Congress, writing grant applications, participating in labor negotiations, negotiating fees with insurance companies), time can be allocated to the central support services category. This does not, however, include non-

clinical activities in the medical area, such as supervising the clinical personnel, chairing or attending clinical meetings, developing clinical schedules, or writing clinical protocols.

Report an individual who is employed as a full-time provider for a full year as 1.00 FTE regardless of the number of direct patient care hours they provide. Providers who have released time to compensate for on-call hours, have weekly administrative sessions when they DO NOT see patients, or receive paid leave for continuing education or other reasons are still considered full-time per their employment contract. Similarly, DO NOT count providers who are not paid for overtime and work more than 40 hours per week as more than 1.00 FTE.

Other FTE Considerations:

- If a medical provider (such as a physician assistant/associate [PA]) **exclusively** provides another service (e.g., SUD or mental health treatment), does not provide medical care as part of their *position*, **and** has board certification or certification of added qualification in the specific service area, report them in the respective category of service they provide. Report costs in the corresponding category on Table 8A.
- Count the FTE for obligated loan-repayment recipients.
- Federally Qualified Health Center (FQHC) Medicare intermediary has different definitions for full-time providers; these are NOT to be used for UDS reporting.

Example FTE calculations are given in the FAQ for Table 5.

Personnel by Major Service Category

Personnel are distributed into categories that reflect the types of services they provide. Whenever possible, the UDS definitions of major service categories align with those used by Medicare. The following summarizes the personnel categories; a more detailed, though not exhaustive, list appears in Appendix A.

Medical Care Services (Lines 1–15)

Physicians, nurse practitioners (NPs), PAs, and certified nurse midwives (CNMs) who are a primary source of medical care, as allowed under their license, are included as medical providers. Supporting medical personnel include nurses, assistants, and technologists.

- **Physicians (Lines 1–7)**
  - Report physicians on Lines 1–7 consistent with their licensure. Physicians with dual boarding, such as internal medicine and pediatrics, should have their FTE and visits allocated to the respective lines.
  - Report licensed residents on the line for the specialty designation they are working toward, and credit them with their own visits. (Thus, count a family medicine resident as a family physician on Line 1.)
  - DO NOT report psychiatrists, ophthalmologists, pathologists, or radiologists here. They are separately reported on Lines 20a, 22a, 13, and 14, respectively.
  - DO NOT report naturopaths, acupuncturists, community and behavioral health aides/practitioners, or chiropractors on these lines. Report these providers on Line 22 (Other Professionals).
- **Nurse Practitioners (Line 9a)**
  - Report NPs, advanced practice registered nurses (APRNs), and advanced practice nurses.
  - DO NOT report psychiatric mental health NPs (included on Line 20b, Other Licensed Mental Health Providers) or CNMs (reported on Line 10) on this line.

- **Physician Assistants/Associates (Line 9b)**
  - Report PAs.
  - DO NOT include psychiatric mental health PAs here (included on Line 20b, Other Licensed Mental Health Providers).
- **Certified Nurse Midwives (Line 10)**
  - Report CNMs.
- **Nurses (Line 11)**
  - Report licensed registered nurses, licensed practical and vocational nurses, home health and visiting nurses, clinical nurse specialists, and public health nurses.
- **Other Medical Personnel (Line 12)**
  - Report medical assistants, nurse aides, and all other personnel, including unlicensed interns or residents, providing services in conjunction with a physician, NP, PA, CNM, or nurse.
  - DO NOT report non-medical personnel here.
    - DO NOT report personnel dedicated to QI or health information technology (health IT), including electronic health record (EHR) informatics, here. Report them on Line 30c, Information Technology.
    - DO NOT report patient health records or patient registration personnel here. Report them on Line 32, Patient Registration and Health Records Personnel.
- **Laboratory Personnel (Line 13)**
  - Report pathologists, medical technologists, laboratory technicians and assistants, and phlebotomists.
  - Some or all of nurses' time may be in this category according to the time assigned to this responsibility.
  - DO NOT report the time of a physician (except a pathologist) here.
- **X-ray Personnel (Line 14)**
  - Report radiologists, X-ray technologists, and X-ray technicians.
  - DO NOT include physician time (except radiologists) here, even if they were taking or reading X-rays or performing sonograms.

Dental Services (Lines 16–19)

- **Dentists (Line 16)**
  - Report general practitioners, oral surgeons, periodontists, and endodontists providing prevention, assessment, or treatment of a dental problem, including restoration.
- **Dental Hygienists (Line 17)**
  - Report licensed dental hygienists.
- **Dental Therapists (Line 17a)**
  - Several states and American Indian or Alaska Native communities license dental therapists.
  - Report personnel on this line only if they have a state license or tribal designation as such.
- **Other Dental Personnel (Line 18)**
  - Report dental assistants, advanced dental assistants, aides, and technicians.

Behavioral Health Services

Health centers that provide both mental health and substance use disorder (SUD) services may refer to these collectively as "behavioral health." However, for UDS reporting purposes, all visits, providers, and patients must be categorized as either mental health or SUD. Visits should be allocated based on the primary service delivered; only in limited circumstances where services cannot be reasonably distinguished, health centers are expected to apply reasonable methods to allocate visits, providers, and patients to the appropriate service category.

- Do:
  - Do classify each visit based on the primary service rendered during the visit (mental health vs. SUD), regardless of the provider's title.
  - Do reference use of chief complaint, diagnosis codes, procedure codes, or visit reason fields as the preferred basis for classification when Health IT/EHR systems cannot disaggregate visits.
  - Do use a reasonable and documented methodology (time spent, dominant service provided) when visits include both mental health and SUD services.
- DO NOT:
  - DO NOT use provider type (e.g., behavioral health provider) to drive classification; visits should be determined by service content.
  - DO NOT default all integrated behavioral health visits to mental health.
  - DO NOT classify visits solely based on the clinic or department name or staffing model.
  - DO NOT double-count the same visit across both categories.

Examples Specific to Behavioral Health Services:

- Classify depression screening and counseling visits under mental health services.
- If the primary visit diagnosis is SUD, then report the visit under SUD services.
- If the visit is co-occurring (e.g., both mental health and SUD services) but the patient's mental health is the primary visit focus, then report the visit under mental health services.

Mental Health Services (Lines 20a–20c)

Mental health services include psychiatric, psychological, psychosocial, or crisis intervention services.

- **Psychiatrists (Line 20a)**
- **Licensed Clinical Psychologists (Line 20a1)**
- **Licensed Clinical Social Workers (Line 20a2)**
  - Report licensed clinical social workers (LCSWs) and licensed independent clinical social workers (LICSWs). Report licensed master social workers (LMSWs) on Line 20b.
- **Other Licensed Mental Health Providers (Line 20b)**
  - Report other **licensed** mental health providers, including psychiatric social workers, board-certified psychiatric mental health NPs, psychiatric mental health registered nurses, family therapists, LMSWs, and other licensed master's degree–prepared providers.

Note: Use the "specify" field to detail the other licensed mental health personnel reported on this line. Use the drop-down option for common categories (described above) that are applicable.

- **Other Mental Health Personnel (Line 20c)**
  - Report unlicensed personnel and support personnel, including "certified" personnel, who provide counseling or treatment, or who support mental health providers.
  - Unlicensed interns or residents in any of the professions listed on Lines 20a through 20b are reported on Line 20c, unless they have a separate license under which they are practicing. Thus, a LCSW doing a psychology internship may be reported on Line 20a2 until they receive a license to practice as a psychologist.

Substance Use Disorder Services (Line 21)

- Report personnel who provide SUD services, including SUD social workers, psychiatric mental health registered nurses, psychiatric social workers, mental health nurses, clinical psychologists, clinical social workers, alcohol and other substance use counselors, family therapists, and other individuals providing SUD counseling and/or treatment services.
- SUD providers are credentialed according to the state's and health center's standards. Report medical providers treating patients with substance use diagnoses in the medical services category on Lines 1 through 10, NOT as SUD providers.

Note: If a medical provider (such as a PA) **exclusively** provides SUD treatment, does not provide any medical care as part of their *position*, **and** has board certification or certification of added qualification in this specific service area, report them and their activity on Line 21, Substance Use Disorder Services. Report costs in the corresponding category on Table 8A.

- DO NOT report physicians, NPs, PAs, CNMs, or Certified Registered Nurse Anesthetists who completed the one-time training on SUD treatment required under the Medication Access and Training Expansion Act and/or have a current Drug Enforcement Administration registration that includes Schedule III authority to provide medications for opioid use disorder (MOUD) here. Report MOUD providers on Lines 1–10 (if medical), Line 20a for psychiatrists, or Line 20b for psychiatric mental health NPs. Additional information about MOUD services is collected in Appendix C: Health Center Information Technology (Health IT) Capabilities and Other Data Elements Form.

Other Professional Health Services (Line 22)

Other professional personnel may provide services that support those of other providers.

- Report personnel who provide other professional health services. Some common professions are therapists, including occupational, speech, physical, massage, and respiratory therapists and speech pathologists; registered dietitians, including nutritionists and dietitians; podiatrists; chiropractors; traditional medicine, including naturopaths and acupuncturists; audiologists; and community and behavioral health aides/practitioners (CHA/Ps and BHA/Ps). A more complete list is included in Appendix A.
- These professionals are generally credentialed and privileged by the health center's governing board to act following their approved job descriptions.
- DO NOT report other professionals working in the Women, Infants, and Children (WIC) programs here. Report WIC nutritionists and other professionals working in WIC programs on Line 29a, Other Programs and Services Personnel.

Note: Use the "specify" field to detail the other professional personnel reported on this line. Use the drop-down option for common categories (described above) that are applicable.

Vision Services (Lines 22a–22d)

Report providers who perform eye exams for detection, care, treatment, and prevention of vision problems, including those that relate to chronic diseases such as diabetes, hypertension, thyroid disease, and arthritis, or for the prescription of corrective lenses.

- **Ophthalmologists (Line 22a)**
  - Report doctors of osteopathic medicine (DOs) and medical doctors (MDs) specializing in the provision of medical and surgical eye care.
- **Optometrists (Line 22b)**
  - Report doctors of optometry (ODs) who provide routine eye care services.
- **Other Vision Care Personnel (Line 22c)**
  - Report ophthalmologist and optometric assistants, aides, and technicians.

Pharmacy Services (Lines 23a–23d)

- Report personnel supporting pharmaceutical services.
- DO NOT report the time personnel spend helping patients apply for reduced-price medications from pharmaceutical companies through patient assistance programs (PAPs) here. Report them on Line 26a, Eligibility Assistance Services Personnel. If personnel work as a pharmacy assistant, for example, and also provide PAP enrollment assistance, allocate time spent in each category.
- DO NOT include time for individuals who work at a 340B contract pharmacy, since they are paid fee-for-service, and not based on time.
- DO NOT report personnel who manage pharmacy 340B contracts here. Report them on Line 30a as central support personnel.
- **Pharmacists (Line 23a)**
  - Report pharmacists supporting pharmaceutical services, such as dispensing medications prescribed by health care providers, providing pertinent medication information to health care teams and providers, and informing patients about proper usage of medications and side effects.
- **Clinical Pharmacists (Line 23b)**
  - Report licensed clinical pharmacists, including board-certified specialties (e.g., board-certified pharmacotherapy specialist, ambulatory care) on Line 23b. DO NOT allocate to other clinical or central support lines.
- **Pharmacy Technicians (Line 23c)**
  - Report fully licensed pharmacy technicians.
- **Other Pharmacy Personnel (Line 23d)**
  - Report pharmacist assistants and other supporting pharmaceutical services.

Patient Support Services (Lines 24–28b)

Report personnel who provide non-clinical support to facilitate health care access to improve health outcomes, including patient outreach, case management, referrals, health education, transportation, language assistance, and enrollment in health insurance.

Note: The UDS does not require credentials from a central credentialing body for personnel who provide patient support services.

- **Case Managers (Line 24)**
  - Report personnel who help patients manage their upstream drivers of health, including assessment of medical and social service needs; establishment of service plans; and maintenance of referral, tracking, and follow-up systems.
  - Include personnel who are trained as and called case managers, as well as individuals called care coordinators, referral coordinators, and other locally used titles.
  - Case managers may perform health education and eligibility assistance tasks during their case management work. DO NOT parse this time unless the personnel have dedicated time to other patient support service categories.
- **Health Education Specialists (Line 25)**
  - Report personnel who assess patient's health needs and design, deliver, and evaluate health education programs.
  - Report patient and community health educators with or without specific degrees.
  - DO NOT parse the time providers spent on health education during a visit for another service category (e.g., medical, dental).
- **Eligibility Assistance Services Personnel (Line 26a)**
  - Report personnel (e.g., patient navigators, certified assisters, eligibility workers) who help secure access to available health, social service, pharmacy, and other aid programs, including Medicaid, Medicare, WIC, Supplemental Security Income (SSI), food stamps through the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and patient assistance programs (PAPs).
- **Outreach Services Personnel (Line 26b)**
  - Report personnel conducting case finding, education, or other services to find individuals in need of health center services.
- **Transportation Services Personnel (Line 26c)**
  - Report personnel who provide transportation for patients (e.g., van drivers) or arrange for transportation (e.g., bus or taxi vouchers, long-distance transportation, ride share).
- **Language Assistance Services Personnel (Line 27b)**
  - Report personnel whose full time or dedicated time is devoted to translation and/or other language assistance services.
  - DO NOT include the part of the time a nurse, medical assistant, or other support personnel provided language assistance, translation, or bilingual services.

- **Community Health Workers (Line 28a)**
  - Report community, frontline public health workers who work in association with the local health care system. Personnel may be called by many different titles, including community health workers, community health advisors, lay health advocates, promotores de salud, community health representatives, peer health promoters, and peer health educators.
  - They may do some or all tasks of other patient support services. If some of their time is dedicated to these other tasks, allocate their time by function and report them on those lines.
  - DO NOT include personnel better classified under other service categories, such as Other Medical Personnel (Line 12) or Other Dental Personnel (Line 18).
- **Other Patient Support Service Personnel (Line 28b)**
  - Report all other personnel providing patient support services not described in any of the other service categories who provide in-scope services to support medical, dental, mental health, SUD, vision, or other professional health services. Complete the "specify" field to describe the personnel positions.
  - Include personnel performing peer support functions, such as doulas, SUD peer supporters, and recovery coaches.
  - DO NOT count services just because they do not fit into other lines as patient support services, especially Other Patient Support Services (Line 28b). Often, such services belong on Line 29a (Other Programs and Related Services Personnel) or are services that are not in-scope or separately reported on the UDS. If you decide to include a service that does not fit the strict descriptions for Patient Support Services (Lines 24–28a), you must check with the UDS Support Center and include a clear detailed explanation.

Other Programs and Related Services Personnel (Line 29a)

Some health centers run programs that include services that, while in-scope, are not directly a part of the listed medical, dental, mental health, substance use disorder, vision, or other professional health services.

- Report personnel for these programs, such as WIC programs; Head Start or Healthy Start programs; employment, vocational, AmeriCorps, or other job training programs; programs that provide basic needs, such as shelters/housing, food, and clothing; child care, frail elderly support programs such as Program of All-Inclusive Care for the Elderly (PACE), adult day health care (ADHC) programs, and youth programs; fitness or exercise programs; research programs; support group services; and public/retail pharmacies.

Note: Use the "specify" field to detail the types of other programs and personnel reported on this line. Use the drop-down option for common categories (described above) that are applicable.

Central Support Services (Lines 30a–32)

The central support services category for this report is more comprehensive than that used in some other program definitions and includes **all** such personnel working in a health center, whether an individual's salary was supported by HRSA's BPHC grant, or other funds included in the scope of project. Where proper, and when identifiable, report personnel included in a health center's federally approved budget indirect cost rate.

- **Management and Support Personnel (Line 30a)**
  - Report the management team, including the CEO, chief financial officer (CFO), chief information officer (CIO), chief medical officer (CMO), chief operations officer (COO), and human resources (HR) director, as well as other central support and office support personnel.
  - For CMOs, medical directors, or other personnel whose time is split between clinical and central support activities, report here only that part of their FTE corresponding to the corporate administration work. This DOES NOT include non-clinical activities in the medical area, such as supervising clinical personnel,

chairing or attending clinical meetings, developing clinical schedules, or writing clinical protocols. (See limits on central support time under Personnel FTEs.)

- **Fiscal and Billing Personnel (Line 30b)**
  - Report personnel doing accounting and billing tasks in support of health center operations for in-scope services.
  - DO NOT include the CFO here. Report the CFO on Line 30a, Management and Support Personnel.
- **Information Technology Personnel (Line 30c)**
  - Report information systems technical personnel who maintain and use the computing systems that support work within the scope of project.
  - Report personnel managing the hardware and software of a health IT system, including electronic health record (EHR) systems.
  - Report IT personnel who perform data entry and provide training and technical assistance as part of the personnel and service categories for which they do this work.
  - Report personnel who design and oversee quality improvement (QI) systems. They may have clinical, IT, or research backgrounds, and may include QI nurses, data specialists, statisticians, and designers of health IT.
  - Report personnel who support health IT to the extent that they are working with the QI system, including personnel designing medical forms and conducting analysis of health IT data on Line 30c.
  - Report personnel who document services in the health IT in their proper service category, not here.
  - DO NOT include on this line the time of providers, such as physicians or dentists, who are also involved in the QI process. Their time is to stay on the service category lines.
- **Facility Personnel (Line 31)**
  - Report personnel with facility support and maintenance responsibilities, including custodians, housekeeping personnel, groundskeepers, security personnel, and other maintenance personnel. If facility work is contracted (e.g., janitorial services), DO NOT include an FTE; but report the contracted costs on Line 14, Facility Costs, on Table 8A.
- **Patient Registration and Health Records Personnel (Line 32)**
  - Report intake personnel, front desk personnel, and patient health records personnel.

VISITS (COLUMNS B AND B2)

Report only clinic (in-person) and virtual visits that meet the countable visit definitions, as described in the Instructions for Tables that Report Visits, Patients, and Providers section of the UDS Manual.

- Report Clinic Visits (Column B) and Virtual Visits (Column B2). These are mutually exclusive, and total visits are calculated by adding Columns B and B2.
- Report visits on the same line as the provider who conducted the visit. All or most visits reported in Column B will be provided by personnel identified in Column A.
- Include visits bought from contracted providers on a fee-for-service basis, even though the FTE of the provider is not reported in Column A.
- DO NOT report encounters that are screenings, tests, or vaccinations as visits. Only report encounters that meet the full definition as a visit.

- The total number of visits reported on a Grant Report must be less than or equal to the corresponding number on the Universal Report for each cell.

Note: A visit does not need to be billable to be counted on the UDS Report. Countable visits can include services that have no charge or that are funded by grants, as long as they meet the countable visit definition.

Clinic Visits (Column B)

- Report any documented **in-person** encounter with a provider that fully meets the countable visit definition as Clinic Visits, Column B.

Virtual Visits (Column B2)

- Report any documented **virtual (telehealth)** encounter with a provider that fully meets the countable visit definition as Virtual Visits, Column B2.
- Payer, state, and federal telehealth definitions, regulations, and billing requirements about the acceptable modes of care delivery, types of providers, informed consent, and location of the patient and/or provider are NOT applicable in determining virtual patient visits for UDS reporting.

Virtual Visit Considerations

- Virtual visit reporting should be consistent with the health center's scope of project.
- Virtual visits must meet the countable visit definition.
- All reporting requirements for multiple visits in the same service category on the same day apply, **except** that two different providers based out of two different in-scope service delivery sites may be reported as two visits.
- Report virtual visits where:
  - The health center provider delivered care to a patient who was elsewhere (i.e., not physically at the health center).
  - The health center patient received services through telehealth by a non–health center provider paid for by the health center or by a volunteer provider who was at the health center.
  - The provider was not physically present at the health center when providing care to the patient, who was in a separate location. The provider must have had remote access to the patient's health record at the time of the visit to review it and record their activities.
  - Interactive, synchronous audio or audio-video telecommunication systems that permit real-time communication between the provider and the patient were used.
  - Services are coded and charged as being delivered by telehealth, even if a third-party payer does not recognize or pay for such services.

Note: Use codes that will result in correct identification of virtual visits. These include telehealth-specific codes **with** the CPT or Healthcare Common Procedure Coding System (HCPCS) codes such as 98008-98015, 98689, 99422, 99423, G0071, G0406-G0408, G0425-G0427, G2025, modifier "95," modifier "93" (audio-only medical services), or Place of Service code "02" to find virtual visits.

- DO NOT report as a virtual visit:
  - Situations in which the health center does not pay for virtual services provided by a non–health center provider (referral).

- Other modes of telehealth services (e.g., store and forward, remote patient monitoring, mobile health) or provider-to-provider consultations.
- A separate clinic (in-person) visit at the site where the patient is located (i.e., originating clinic).
- A follow-up call for a health status check following an earlier appointment.

Visits Purchased from Non-Personnel Providers on a Fee-For-Service Basis

- Report these visits in Column B (clinic) or B2 (virtual) even though no corresponding FTEs are included in Column A. To count, the visit must meet **all** of the following criteria:
  - The service was provided to a health center patient by a provider who is not salaried, a volunteer, or contracted on the basis of time worked, but meets the health center's credentialing policies.
  - The service was paid for in full by the health center.
  - The service otherwise met the definition of a visit.
- DO NOT include:
  - Unpaid referrals.
  - Referrals where a third party (e.g., the patient's insurance company) will make the payment directly to the external provider.
  - Referrals where only nominal amounts, such as facility fees, are paid for by the health center.

Visit Considerations by Personnel Line

Physicians, NPs, PAs, or CNMs (Lines 1–10)

- Report visits provided by licensed residents, interns, and fellows.
- DO NOT credit anyone other than a licensed medical provider with medical visits, even if these individuals are working under the supervision of a licensed medical provider.
  - Exception: Report the visits of a supervising medical provider's student (i.e., the physician is overseeing students enrolled in a graduate education program leading to a license as a physician) as long as the supervising physician (preceptor):
    - Has no other responsibilities, including the supervision of other personnel, at the time services are given by the students
    - Has primary responsibility for the patients
    - Reviews the care given by the students during or directly after each visit
    - Documents the extent of their participation in the review and direction of the services given to each patient

Nurses (Line 11)

- Services may be provided under standing orders of a medical provider, under specific instructions from an earlier visit, or under the general supervision of a physician, NP, PA, or CNM who has no direct contact with the patient during the visit. These services must meet the requirement of exercising independent professional judgment.
- Report nurse visits that meet all visit criteria. See instructions for Countable Visits. Note that most patient services provided by a nurse DO NOT meet the full visit criteria.

- Report triage services provided by nurses and visiting nurse services when a nurse sees patients independently, such as in the patients' homes, to evaluate their condition(s).
- Report visits charged and coded as CPT 99211 only when all parts of UDS countable visit requirements were met.
- DO NOT report a follow-up service or completion of services from another visit (e.g., nurse calls to check up on how a patient is doing after a visit, nurse checks wound or removes sutures, nurse gives vaccines), even if it occurs at a later date.
- DO NOT report encounters with a nurse where the primary purpose is to conduct a lab test, give an injection, or dispense or administer a medication, regardless of the level of observation needed, as a visit.
- Most states prohibit a licensed vocational nurse or licensed practical nurse from exercising independent professional judgment; DO NOT count visits for them.

Dentists, dental hygienists, and dental therapists (Lines 16, 17, and 17a)

- Report only one visit per patient per day, regardless of the number of dental providers who provide services (e.g., dentist and dental hygienist both see the patient) or the volume of service (i.e., number of procedures) provided.
- DO NOT report the application of dental varnishes, fluoride treatments, or dental screenings, absent other comprehensive dental services, as a visit.
- DO NOT report as a dental visit medical providers who examine a patient's dentition or give fluoride treatments.
- DO NOT report as a dental visit a phone call between the patient and provider for a follow-up on a completed procedure or service.
- DO NOT credit anyone other than a licensed dental provider with dental visits, even if these individuals are working under the supervision of a licensed dental provider.
    - Exception: Report the visits of a supervising dentist's student (i.e., the dentist is overseeing dental students enrolled in a graduate education program leading to a license as a dentist) as long as the supervising dentist (preceptor):
        - Has no other responsibilities, including the supervision of other personnel, at the time services are given by the students.
        - Has primary responsibility for the patients.
        - Reviews the care given by the students during or directly after each visit.
        - Documents the extent of their participation in the review and direction of the services given to each patient.

Other mental health (Line 20c)

- Report visits with unlicensed mental health personnel regardless of if or how they are billed. DO NOT report their visits elsewhere.

Substance use disorder (Line 21)

- Report individual and group SUD treatment or counseling visits provided by substance use specialists that are outside of a medical or mental health visit.

- DO NOT report visits only for dispensing medications (i.e., narcotic agonists, antagonists, or other medications), regardless of the level of oversight that occurs during this activity.

Other professional (Line 22)

- Report visits by other professional health service providers included in Appendix A.
- If you include a visit in this category, you must check with the UDS Support Center and include a detailed explanation in the "specify" box.

Vision services (Lines 22a–22d)

- DO NOT report the services of students or anyone other than a licensed vision service provider as vision services visits.
- DO NOT report retinography (imaging of the retina), whether performed by a licensed vision service provider or anyone else, as a visit unless accompanied by a comprehensive vision exam.
- DO NOT report fittings (glasses or contact lenses) as a visit, regardless of who performs the fitting.

Case managers (Line 24)

- Case management visits must be documented in the patient's health record.
- When a case manager serves an entire family (e.g., helping with housing or Medicaid eligibility), report only one visit, generally for an adult member of the family, regardless of documentation in other charts.
- Case management is rarely the only type of service provided to a patient during the year.
- DO NOT count contacts made with third parties.

Health education (Line 25)

- Report only services provided one-on-one with the patient.
- Health education is provided to support the delivery of other health care services and is rarely the only type of service provided to a patient during the year.
- DO NOT report group or community education classes or visits.

DO NOT Report Visits or Patients for Services Provided by the Following:

- Other Medical Personnel (Line 12)
- Laboratory Personnel (Line 13)
- X-ray Personnel (Line 14)
- Other Dental Personnel (Line 18)
- Other Vision Care Personnel (Line 22c)
- Pharmacists (Line 23a)
- Clinical Pharmacists (Line 23b)
- Pharmacy Technicians (Line 23c)
- Other Pharmacy Personnel (Line 23d)
- Pharmacy Personnel (Line 23)
- Eligibility Assistance Services Personnel (Line 26a)
- Outreach Services Personnel (Line 26b)
- Transportation Services Personnel (Line 26c)
- Language Assistance Services Personnel (Line 27b)
- Community Health Workers (Line 28a)
- Other Patient Support Services Personnel (Line 28b)
- Other Programs and Services (Line 29a)
- Management and Support Personnel (Line 30a)
- Fiscal and Billing Personnel (Line 30b)
- Information Technology Personnel (Line 30c)
- Facility Personnel (Line 31)
- Patient Registration and Health Records Personnel (Line 32)

Columns B and B2 are grayed out on the lines listed above. Additionally, some encounters cannot be reported as countable visits regardless of who provides them. Please review the Services and Individuals NOT Reported on the UDS Report section for specifics.

PATIENTS (COLUMN C)

A patient is an individual who has at least one countable visit during the calendar year. For further details, see the Instructions for Tables That Report Visits, Patients, and Providers section.

- Report an unduplicated patient count in Column C for each of the seven categories of services shown below for which patients had visits reported in Columns B or B2 during the calendar year.
  - Medical services (Line 15)
  - Dental services (Line 19)
  - Mental health services (Line 20)
  - Substance use disorder services (Line 21)
  - Vision services (Line 22d)
  - Other professional services (Line 22)
  - Patient support services (Line 29)
- Report an individual only once as a patient in each service category (e.g., medical, dental) for which they received services, regardless of the number of visits they had or the different providers they saw during the year.
- Because patients must have at least one countable visit, the number of patients cannot exceed the number of visits.
- Patients reported on Table 5 must be included on the demographics tables: Patients by ZIP Code Table and Tables 3A, 3B, and 4.

- DO NOT report individuals who only receive services for which no visits are generated (e.g., laboratory, imaging, pharmacy, transportation, and outreach).
- The total number of patients reported on a Grant Report must be less than or equal to the corresponding number on the Universal Report for each cell.

Note: Column C is grayed out on the detail lines within service categories.

FAQ FOR TABLE 5

1. **How do we determine FTE?**

   Use employment contracts to determine FTE.

   For personnel with full benefits (i.e., vacation, holiday, sick benefits), divide hours paid by what the health center considers to be the base hours for full-time. For example, a physician who, per their employment contract, must work only four 9-hour sessions (36 hours) per week is considered full time and equals 1.00 FTE.

   For personnel with no or reduced benefits, divide hours paid by base hours minus unpaid benefit hours. For example, if the health center gives 10 days for holidays, 12 sick days, 5 continuing medical education (CME) days, and 3 weeks of vacation, that's a total of 336 hours of paid time off, assuming an 8-hour workday. Subtract that from the base calculation. If 2,080 hours is full time for the health center, subtracting 336 hours of paid time off = 1,744 hours. The 1,744 hours becomes the base hours calculation for personnel with no benefits. If personnel are paid for 1,040 hours, divide 1,040 by 1,744 to get 0.59 FTE (reported out to two decimal places).

2. **Our physicians work 35-hour weeks. Do we report as 0.875 (35 divided by 40) FTE?**

   No. Count them as 1.00 FTE. HRSA's BPHC does not require 40-hour workweeks. Use whatever workweek time is considered full time at your organization. For example, some organizations use 2,080 hours, others use 1,820, and others may have other standards for determining what is full time.

3. **Do we calculate FTE for personnel with no or reduced benefits the same way we do for personnel receiving full benefits?**

   If personnel receive no or reduced benefits, calculate FTE based on paid hours. Divide paid hours by base hours minus unpaid benefit hours. For example, if full-time personnel with full benefits are paid for 2,080 hours, in which 80 hours are for holidays and 120 hours are for vacation, then for personnel with no benefits subtract the unpaid benefit hours from full-time hours (2,080 – 80 – 120) to get 1,880 hours. To calculate FTE for the personnel with no benefits, divide their paid hours by the 1,880 base hour calculation.

4. **How do I report the FTEs for a provider who regularly sees patients 75% of the time and covers after-hours call for the remaining 25% of their salary?**

   Report personnel who are hired as full-time providers as 1.00 FTE regardless of the number of direct patient care hours they provide. Count as 1.00 FTE providers hired as full-time who have released time to compensate for on-call hours, who have released time to compensate for hours spent on clinical committees, or who receive leave for continuing education or other activities.

   For example, DO NOT adjust for the time a physician spends while not in contact with the patient, such as charting, reviewing laboratory results, filling prescriptions, returning phone calls, or arranging for referrals. These tasks are considered part of their time as a physician. The exception to this rule is when a medical director or CMO is engaged in administrative activities at the corporate level, in which case time is allocated

to the central support category. This does not, however, include non-clinical activities in the medical area, such as chairing or attending meetings, supervising personnel, writing clinical protocols, designing formularies, setting hours, or approving specialty referrals.

5. **Our nurses perform services that cross service categories. Do we allocate the FTE and visit activity by category?**

   That depends on if their time is distinctly allocated by work among the major service categories. If, for example, a full-time nurse provides direct medical services and provides some patient education while seeing the patient for medical care, they would be counted as 1.00 FTE on Line 11 (Nurses). If that nurse provided case management services during 10 dedicated hours per week and provided medical care services for the other 30 hours per week, the time would be allocated as 0.25 FTE case manager (Line 24) and 0.75 FTE nurse (Line 11). Another example includes a nurse who dedicates 20 hours to medical care and 20 hours to providing health education each week would split their 1.00 FTE, with 0.50 FTE as a medical nurse and 0.50 FTE as a health educator.

6. **If I report case management services on Table 5, do I have to report costs for case management services on Table 8A?**

   If a health center reports case management activity on Table 5, Line 24, then costs for case management services should be reported on Table 8A, Line 11, unless the services were provided by volunteers. Similarly, if case management costs are reported on Table 8A, case management visits and case managers should be reported on Table 5, unless the service was contracted with no personnel time specifically identified.

7. **How are contracted personnel and their activities reported on Table 5?**

   If the contracted personnel are paid based on time worked (such as one day per week), report the FTE on Table 5, Column A, and report the visits and patients receiving services from this provider. (See Appendix B for a more complete discussion of calculating the FTE of these providers.) If the contracted personnel are paid on a fee-for-service basis, DO NOT report FTE on Table 5, Column A, but report the visits and patients. This may need more explanation in your UDS Report to clarify why visits and patients are reported, but no FTE.

8. **How should activity be reported on Table 5 for providers who provide both mental health and SUD services?**

   Some health centers have integrated the positions of mental health provider and SUD provider into a single position. In this instance, all visits, providers, and patients must be parsed into mental health or SUD categories, unless these services cannot be reasonably distinguished. Carefully record the time and activities of these dual-role providers. In this case, identify each visit as either a mental health visit or an SUD visit so the patients and visits can be correctly classified. In addition, keep track of providers' time so that FTEs on Table 5 (and associated costs on Table 8A) can be correctly allocated and recorded to the proper line. If these services cannot be reasonably distinguished, health centers are expected to apply reasonable methods to allocate visits, patients, and providers. Report associated costs on Table 8A on the corresponding lines.

9. **If a psychiatric mental health NP provides primary medical services to the same patient during a visit, in addition to mental health and SUD services, how should we count this?**

   Report the visit under mental health, Table 5, Line 20b, since psychiatric mental health NPs are classified as Other Licensed Mental Health Providers. DO NOT count the visits as one of each type. Be sure the corresponding costs on Table 8A are reported as mental health.

10. Do I count the time of volunteer providers?

Yes. Count the time of volunteers like that of any other personnel. Note, however, that some may work shorter days because they DO NOT receive a salary, paid vacations, or holidays. This would make them less than full-time (in other words, less than 1.0 FTE).

11. We contract with many licensed physicians to read our test results: an ophthalmologist reads the retinal photos that our medical assistant takes, a radiologist over-reads the X-rays that our X-ray tech takes, the outside laboratory's pathologist provides the test results from their machines, and a consulting cardiologist confirms findings of our electrocardiograms (EKGs). Should we report them as personnel, and do we report what they do as visits?

No. Tests are **NOT** counted as visits. DO NOT report test analysis and reporting activities as visits. DO NOT report the time (FTE) of any individual who is working on a contract basis when the payment is not for their time worked but, rather, for the activity that they do. Report the costs for tests on Table 8A.

Under some circumstances, the EHBs may identify a system edit (costs with no personnel) that you will need to explain.

12. Where do we report community health workers who we employ?

Report personnel with responsibility as community health workers on Line 28a, as described in the Patient Support Services section. If, however, you are using this term to describe someone who is doing the tasks normally associated with a medical assistant, an outreach worker, or another job title, count them in the corresponding category.

13. Where do we report medical providers whose only activity at a visit is providing MOUD?

MOUD provided by a medical provider is to be counted as medical. Report this activity on the line of the credentialed personnel providing this treatment (physicians are counted in medical [Lines 1–8], even if they only provide SUD services at the visit). DO NOT count them on the SUD line of Table 5.

If a medical provider (such as a PA) **exclusively** provides SUD treatment and does not provide any medical care as part of their *position* **and** has board certification or certification of added qualification in this specific service area, report them and their activity on Line 21, Substance Use Disorder Services. Report costs in the corresponding category on Table 8A.

14. How do I count participants in a group session?

Only count participants in group treatment sessions for SUD or mental health. The visit must be recorded in each participant's health record.

Each patient charted in a group session must be billed and the service must be paid in line with health center policy by either the patient, insurance, or another contract maintained by the health center. If some patients or visits are billed and others are not, count only those that are billed. If other people are included in a mental health or SUD session but are not independently billed or charted, DO NOT count them as having a visit.

DO NOT count a group encounter with a patient that is not recorded in a patient health record.

DO NOT report any group medical visits or group health education visits. Although in some instances they may be billable, the UDS specifically does not count these as visits.

15. Are virtual visits only allowed after a clinic (in-person) visit at the health center?

No, there is no requirement for a first visit to be in-person. If the first or only visit is a countable virtual visit, the health center must still register the patient and collect and report all relevant demographic, service, clinical, and financial data on the UDS tables.

16. Should the sum of patients on Table 5 equal the total number of patients reported on Table 3A?

No. On Table 5, report patients for each type of service received. For example, count a patient who receives both medical and dental services once as a medical patient on Line 15 and once as a dental patient on Line 19. The sum of Table 5 would equal the total number of patients reported on Table 3A only if one type of service is reported on Table 5.

TABLE 5: STAFFING AND UTILIZATION

Calendar Year: January 1, 2026, through December 31, 2026

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–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___)				

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	Pharmacy 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)				

Table 5 Cross-Table Considerations:

- Total patients on Table 5, Column C, is typically greater than the total number of patients on Table 3A (unless only one type of service is offered at the health center).
- The personnel on Table 5 are routinely compared to the costs on Table 8A. See the crosswalk of comparable fields in Appendix B.
- Billable visits reported on Table 5 should relate to patient charges reported on Table 9D.
- The total number of patients and visits reported on a Grant Report must be less than or equal to the corresponding number on the Universal Report for each cell.

Instructions for Table 6A: Selected Diagnoses and Services Rendered

This table collects data on selected diagnoses and selected services rendered to health center patients. The primary data sources for this table are your billing system, laboratory reports, and/or other information captured in your health IT systems or EHRs. The selected diagnoses and services represent those that are prevalent among Health Center Program patients, have been regarded as sentinel indicators of access to primary care, and/or are of special interest to HRSA.

The text directly below contains changes to Table 6A from 2025 calendar year reporting to 2026 calendar year reporting:

Several key changes have been made to Table 6A, as outlined below:

- Some diagnosis and service codes have been updated. All code changes are shown in this table and detailed in the "Table 6A Code Changes" file available on the UDS Clinical Care resources webpage.
- Eleven selected diagnoses and services lines have been removed: respiratory conditions related to COVID-19 (Line 6a), abnormal breast cancer findings, female (Line 7), abnormal cervical findings (Line 8), contact dermatitis and other eczema (Line 12), novel coronavirus (SARS-CoV-2) diagnostic test (Line 21c), novel coronavirus (SARS-CoV-2) antibody test (Line 21d), mammogram (Line 22), Pap test (Line 23), sealants (Line 30), oral surgery (extractions and other surgical procedures) (Line 33), rehabilitative services (Endo, Perio, Prostho, Ortho) (Line 34).
- Eleven new lines have been added: diabetes mellitus type 1 (Line 9a), intellectual and developmental disabilities (IDD) (Line 20g), autism spectrum disorder (ASD) screening (Line 26g), case management (Line 35), eligibility assistance (Line 36), transportation (Line 37), language assistance services (Line 38), upstream drivers of health screening (Line 39), food insecurity (Line 40), housing instability (Line 41), financial insecurity (Line 42).
- Health supervision of infant or child (ages 0 through 11) (Line 26) has been renamed to well child visit (ages 0 through 11).
- 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.

This marks the conclusion of changes to Table 6A from 2025 calendar year reporting to 2026 calendar year reporting.

SELECTED DIAGNOSES (LINES 1–20G)

Lines 1 through 20g present the name and applicable ICD-10-CM and value set codes for the diagnosis or diagnostic range/group. Wherever possible, diagnoses have been grouped into code ranges.

- Report all countable visits (both clinic [in-person] and virtual) and patients where the provider-rendered diagnostic codes are included in the range/group of ICD-10-CM and value set codes shown in the given line.
- Report only diagnoses that were addressed in documented, countable visits with licensed or credentialed medical, dental, mental health, substance use disorder, or vision providers.
- Report all diagnoses **rendered** at a specific countable visit. However, DO NOT count active diagnoses on problem lists or laboratory test results present at the time of the visit but not addressed during the visit.
- Use age at time of visit for diagnoses with specified age ranges.

- DO NOT report a diagnosis made by another non-clinical professional or patient support service provider.

Selected Diagnoses Visits and Patients (Columns A and B)

Number of Visits by Diagnosis Regardless of Primacy (Column A)

- Report on Lines 1–20g the total number of visits (clinic [in-person] and virtual) during the calendar year for which one or more of the listed diagnoses is made or treated and documented in the health IT/EHR or visit/billing record.
- Include each diagnosis made or treated at a visit, regardless of the number of diagnoses listed for the visit. For example, count a patient visit with a diagnosis of hypertension and a diagnosis of diabetes once on Line 9 (and Line 9a if it is type I) for diabetes and once on Line 11 for hypertension.

Number of Patients with Diagnosis (Column B)

- Report each patient who had one or more visits (clinic [in-person] and/or virtual) during the calendar year that were reported in the corresponding cell in Column A.
- Report a patient **only once** on any given line, regardless of the number of visits made for that specific diagnosis or family of diagnoses. For example, if a patient received treatment at a single visit or on multiple visits for both anxiety disorder and obsessive-compulsive disorder, they will be counted once on Line 20b, anxiety disorders, because both disorders are part of the same family of diagnoses.

SELECTED TESTS/SCREENINGS (LINES 21–26G AND LINES 35–42)

Lines 21 through 26g and Lines 35–42 present the name and applicable ICD-10-CM diagnostic, HCPCS, CPT procedure, SNOMED CT codes, and/or value sets for selected tests, procedures, screenings, preventive services, patient support services, and upstream drivers of health services. For each line, report visits that are associated with a qualifying code from any of these code systems. For example, count only one visit even if there is a qualifying CPT code *and* a qualifying ICD-10-CM code.

- Report only those services provided to patients who had one or more countable visits during the year.
- Only report tests, screenings, or procedures (e.g., X-rays, tomography) that are:
  - Done by the health center; or
  - Not done by the health center, but paid for by the health center; or
  - Not done by the health center or paid for by the health center but ordered by the health center, and the results of which are returned to the health center provider to evaluate and follow up with the patient based on the results.
- During a visit with the provider, selected screenings or tests may be ordered. Report only completed services (NOT orders) in this section even if they were done at a later date.
- Use age at time of visit for diagnoses and tests with specified age ranges.

Specific test, screening, and procedure lines considerations:

- **Pre-Exposure Prophylaxis (PrEP)-associated prescribing and management (Line 21e):** Use code Z29.81 for PrEP prescribed to patients for the purposes of preventing HIV. Report only patients with an active prescription for PrEP based on a patient's risk for HIV exposure. Count PrEP only if the following medications are prescribed: emtricitabine/tenofovir disoproxil fumarate (FTC/TDF), emtricitabine/tenofovir alafenamide (FTC/TAF), cabotegravir, or lenacapavir for the purposes of preventing HIV.

- **Medications for opioid use disorder (MOUD) (Line 26c3):** Count only medications prescribed, administered, or paid for by the health center to patients that are specifically approved by the U.S. Food and Drug Administration (FDA) for opioid use disorder (OUD) treatment. These medications are limited to buprenorphine, methadone, and naltrexone **only**.

Note: ICD-10-CM codes for some services (such as childhood lead test screening or smoke and tobacco use cessation counseling) are listed to ensure capture of tests that are done by the health center but may be coded with a different CPT code for state reimbursement. In some instances, payers (especially governmental payers) and laboratories ask health centers to use different codes for services. In these instances, health centers should internally map these codes to the specified list for reporting purposes.

Selected Tests/Screenings Visits and Patients (Columns A and B)

Number of Visits (Column A)

- Report the total number of visits (clinic [in-person] and/or virtual) during which one or more of the listed diagnostic tests, screenings, preventive services, patient support services, and/or upstream drivers of health services were provided during the year. Services may have been provided at the time of a visit, before a visit, or after a visit.
- Codes for these services may be diagnostic (ICD-10-CM), procedure (CPT or HCPCS), SNOMED CT, or value sets.
- During a single visit, more than one test, screening, preventive service, patient support service, or upstream drivers of health service may be provided. Report each on the applicable line. If they are on the same line, report only one visit.

Number of Patients (Column B)

- Report patients who had one or more visits (clinic [in-person] and/or virtual) during the calendar year for which one or more of the selected diagnostic tests, screenings, preventive services, patient support services, and/or upstream drivers of health services listed on Lines 21–26g or Lines 35–42 were provided.
- Report patients who received more than one type of service during a single visit on each applicable line. For example, if a patient had an HIV test and contraceptive management during the same visit, this patient would be counted on both Lines 21 and 25.
- Report a patient **only once** per service, regardless of the number of times a patient receives a given service. For example, an infant who has an immunization at each of several well-child visits in the year has each visit reported in Column A but is counted only once in Column B.

Note: Include follow-up services related to a countable visit. For example, if a provider asks that a patient return in 30 days for a flu shot, when that patient presents, the shot is counted. DO NOT report a service for an individual who is NOT a health center patient who comes in just for a flu shot during a health center–run flu clinic.

DENTAL SERVICES (LINES 27–32)

Lines 27 through 32 present the name and applicable American Dental Association (ADA) procedure and CPT codes for selected dental services. Except for fluoride treatment, which may also be provided by a medical provider, these services may be performed only by a dental provider (who is reported on Lines 16–17a on Table 5) or by an in-scope dental contractor paid by the health center. Wherever appropriate, services have been grouped into code ranges. The use of a "primary code" is not required; report all services that meet the criteria for Lines 27–32.

Dental Services Visits and Patients (Columns A and B)

Number of Visits (Column A)

- Report the total number of visits (clinic [in-person] and/or virtual) for which one or more of the listed diagnostic tests, screenings, and/or dental services were provided during the year. Services may be at the time of a visit, before a visit, or after a visit.
- During one visit, more than one service may be provided. Report each on their separate, applicable line. If they are on the same line, report only one visit. For example, if a patient had more than one tooth filled during a visit, report only one visit for restorative services (Line 32), NOT one visit per tooth.

Number of Patients (Column B)

- Report patients who had at least one visit with a dental professional during the calendar year for each of the selected dental services listed.
- Report a patient who had multiple types of services on each line. For example, a patient who had two teeth repaired and fluoride applied during a single visit is reported once on Line 31 and once on Line 32.
- DO NOT report services provided by personnel other than licensed dentists, dental hygienists, dental therapists, or personnel working under their direct supervision, unless the service is fluoride treatment provided at a medical visit.
- DO NOT report fluoride treatments or varnishes that are applied outside of a comprehensive treatment plan, including when provided as part of a community service at schools, on this table or as a visit on Table 5.

PATIENT SUPPORT SERVICES AND UPSTREAM DRIVERS OF HEALTH (LINES 35–42)

Lines 35 through 38 present the name and applicable codes or value set object identifier (OID) for selected patient support services. Only visits and patients that include the direct provision of the indicated patient support services (not referral or education alone) are to be counted.

Lines 39 through 42 present the name and applicable codes or value set OID for selected upstream drivers of health services. Upstream drivers of health screening (Line 39) includes use of a standardized screener to screen for upstream drivers of health. Lines 40 through 42 includes the provision of services to address food insecurity, housing instability, and financial insecurity, respectively.

SERVICES PROVIDED BY MULTIPLE ENTITIES

Be particularly careful when multiple entities are involved with a service. Use the following rules and general examples to guide reporting:

- Report the service if a health center provider orders and performs the service. For example, count a rapid HbA1c test ordered by a health center provider and done in the health center lab.
- If the health center provider orders a test (e.g., HIV test) and the sample is collected at the health center and then sent to a reference lab for processing, report the test regardless of whether the test is paid for by the patient, the patient's insurance company,[12] a government entity, or the health center.
- Report a test when the health center provider asks a patient to get that test from a third party and the health center provider receives and reviews the test results with or for the patient, regardless of who pays for the

[12] Billing rules require that the charge for a lab test ordered by a provider be sent directly to a third party (including Medicaid and Medicare) and not to the provider or the health center.

service. For example, report HIV tests done by a third-party provider that a health center contracts with and for which the health center reviews the result with the patient.

- DO NOT report vaccinations done by a health department when patients are referred to a city or county health department and the health center does not pay for the service, including referrals where a third party (e.g., the patient's insurance company) will make the payment.
- DO NOT report a test or service that a provider asks the patient to get from a third-party provider (e.g., an HIV test referred to a Ryan White program) that **does not bill the health center**, including referrals where a third party (e.g., the patient's insurance company) will make the payment if the test or service results are reviewed and acted on by the third-party provider. For example, DO NOT count an HIV test done by the county health department for which the county will follow up with the patient directly and the health center did not pay for the service. (These are generally noted in Column III: Formal Written Referral Arrangement [Health center DOES NOT pay] of Form 5A: Services Provided).

FAQ FOR TABLE 6A

1. **If a case manager or health educator serves a patient who, for example, has diabetes, we often report that diagnostic code for the visit. Should we report this on Table 6A?**

   No. Report on Table 6A only visits with medical, dental, mental health, substance use disorder, and vision providers.

2. **The instructions for this table call for diagnoses and services at visits. If we provide the service but it is not counted as a visit (such as an immunization given at a health fair), should it be reported on this table?**

   Report the indicated diagnosis if it is documented as part of a countable visit. Report services and procedures when documented in the patient health record and provided at any point during the year to a health center patient (i.e., had at least one countable visit during the calendar year).

   Report the visit on this table if a follow-up service is provided to a health center patient because of a prescription or plan from an earlier countable visit, such as if a provider asks a patient to come back in 2 months for PrEP management.

   DO NOT report services given to individuals who are not health center patients (did not have a visit during the calendar year), regardless of who provided the service or the level of documentation that is done, such as an HIV test or flu shot given at a health fair to non–health center patients.

3. **What do we do if some diagnostic and/or procedure codes in our system are different from the codes listed?**

   Information for Table 6A may not be available using the codes shown because of idiosyncrasies in state or clinic billing systems. Generally, these involve situations where (a) the state uses unique billing codes other than the CPT code for state billing purposes (e.g., Early and Periodic Screening, Diagnosis, and Treatment [EPSDT]) or (b) internal or state confidentiality rules mask certain diagnostic data. The following table gives examples of problems and solutions:

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

4. The instructions specifically say that the source of information for Table 6A is "billing systems or health ITs/EHRs." There are some services for which we DO NOT bill and/or for which there are no visits in our system. What do we do?

Although health centers are only required to report data derived from billing systems or health ITs/EHRs, the reported data may understate services in the circumstances described below. In today's health ITs/EHRs, diagnoses and/or services should be captured in one of the templates available. To more accurately show the level of service, use other codes in the system to enable the tracking.

DO NOT report referrals for which you DO NOT pay or evaluate results and give feedback to the patient (e.g., sending patients to the county health department for flu shots).

Line	Problem	Potential Solution
21	HIV test samples are collected by us but processed and paid for by the state and DO NOT show on the visit form or in the billing system.	• Preferred: Use the correct code, but report a zero charge. • Alternative: Use documented completed lab results returned to the health center.
Multiple	Tests (e.g., HIV tests) are ordered and samples collected by us. We send samples to a reference lab for processing, but the lab bills Medicaid or Medicare directly.	• Preferred: Use the correct code, but report a zero charge. • Alternative: Use documented completed lab results returned to the health center.
24	Flu shots and other vaccinations are NOT counted because the vaccines are obtained at no cost to the health center.	• Preferred: Use the correct code, but report a zero charge.
25	Contraceptive management is funded under Title X or a state voluntary family planning program and does not have a Z30- diagnosis attached to it.	• Preferred: Add a "dummy code" you can map to the Z30- code. • Alternative: Code with both the Z30- and the state-mandated code, but suppress printing of the Z30- code. Take care not to count the same visit twice.

5. Do we need to report all diagnoses and services rendered during a visit?

Health centers must document all diagnoses and services provided during all UDS countable visits. However, there are some diagnoses and services that are not reported on Table 6A. It is important that you appropriately document the breadth of comprehensive services delivered during each visit.

6. What happens if the CPT, HCPCS, ICD-10-CM, SNOMED CT, or OID codes change again?

The codes are reviewed and updated each year by the UDS Support Center personnel. If you think a CPT, ICD-10-CM, HCPCS, ADA, SNOMED CT, or OID value set code for a measure is not shown in the list or has changed, contact the UDS Support Center at **1-866-UDS HELP**, udshelp330@bphcdata.net, or the BPHC Contact Form. Personnel will review the code(s) with HRSA's BPHC and advise you on how to report for the calendar year. HRSA's BPHC-approved changes to codes will also be incorporated in the manual for future reporting.

7. Are there ICD-10-CM codes for PrEP prescribing and management?

Health centers must limit the reporting of Line 21e to patients **prescribed PrEP based on a patient's risk for HIV exposure** AND limited to FTC/TDF, FTC/TAF, cabotegravir, or lenacapavir for the purposes of **preventing** HIV. ICD-10-CM code Z29.81 should be used to identify PrEP prescribing and management for health center patients. Health centers can cross-check and compare their counts with America's HIV Epidemic Analysis Dashboard, which gives state- and territory-level counts of individuals prescribed PrEP.

8. We DO NOT perform some services and tests and refer these out. Can we count these?

Possibly. If you paid another provider to provide the requested service, or if the results are returned to the health center provider to **evaluate and give results** back to the patient, you may report these services. The following examples illustrate these rules:

- Report a blood draw done by the health center and sent to an outside lab who then bills Medicaid and sends the results back to the health center.
- DO NOT report the referral of a patient to the local hospital or county health department for an HIV test where the local hospital or county health department providers do the test and give results directly to the patient.

9. Can we count patients on multiple lines if they had more than one type of service at a visit?

Yes. If patients receive multiple services at one visit and the services are shown on this table, you should report the patient and visit once on each applicable line. The following examples illustrate these rules:

- Report a patient with hypertension who also receives an HIV test on Line 11 (hypertension) and on Line 21 (HIV test).
- If both an HIV test and case management were provided during a visit, then report a visit on both Line 21 (HIV test) and Line 35 (case management).
- If a patient receives multiple immunizations at one visit, report only one visit on Line 24.
- Report a patient who comes in for an annual physical and a flu shot on Line 24a (flu shot) but not on a diagnostic line (since annual physical is not collected on this table).

10. Should mental health and SUD services be reported on Table 6A if they are provided by a medical provider?

Yes. Table 6A reports clinical activity regardless of provider type. Any mental health or SUD services provided by a provider during a medical visit—including Screening, Brief Intervention, and Referral to Treatment (SBIRT), counseling, and treatment—must be reported on the corresponding mental health and SUD services lines of Table 6A.

11. Can we count patients as having received alcohol- or substance use–related SBIRT when only some parts are complete?

To count the patient as having received SBIRT (Line 26b), the patient must have received screening **and** brief intervention **OR** screening, brief intervention, **and** referral to treatment.

12. Is it expected that we include all patients of any age for Line 26e, Childhood development screenings and evaluations, if the listed ICD-10 or CPT-4 codes apply?

No. Limit to patients ages 0 through 5 who had childhood development screenings and evaluations using the listed ICD-10 or CPT-4 codes.

13. Is it expected that all patients of a certain age be routinely screened for ADRD?

No. Alzheimer's disease and related dementias (ADRD) screening is only indicated in cases where the provider has determined screening of a patient's cognitive decline is appropriate based on symptoms.

14. What are the acceptable screeners for ADRD screening?

The cognitive screeners included in the value set listed on Line 26f are acceptable for use, including Brief Interview for Mental Status (BIMS) Minimum Data Set version 3 (MDSv3), Saint Louis University Mental Status Examination (SLUMS), Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE), the Eight-item Informant Interview to Differentiate Aging and Dementia (AD8®), the Mini Mental State Examination (MMSE), the Montreal Cognitive Assessment (MoCA), Blessed Orientation-Memory-Concentration (BOMC), and Mini-Cog©. Health centers may also use other standardized screeners for ADRD if they are equivalent to the intended service and documented as such.

15. Are there limits on what we should include on Line 26c3 for MOUD? Do the medications need to be administered at the health center?

Count only medications provided to patients that are specifically approved by the FDA for OUD treatment. These medications are limited to buprenorphine, methadone, and naltrexone **only**.

While the value set provided for Line 26c3 serves as a primary guide for identifying relevant codes and products, it is not exhaustive. Report all patients who received these medications for OUD treatment, regardless of the specific dosage or formulation. As with other lines on this table, report only when MOUD was:

- Prescribed or administered by an eligible health center provider. MOUD prescribed for at-home use or administered by a health center provider is permitted.
- Not provided by the health center but administered by an eligible provider and paid for by the health center.

16. Do the reporting requirements for screenings and tests on Table 6A only accept the specific codes listed in the manual, or can we report equivalent, standardized screeners and tests?

Report services based on the codes provided. If a health center performs a service using an alternative code that has been mapped internally as a *direct* clinical equivalent to a listed code, those services should also be reported. The reported service must meet the clinical intent and definition of the specific line.

17. Should we include a patient support service that was provided if it aligns with the requested information, but the SNOMED CT is not listed?

Report services provided by the health center only if they are equivalent to the requested service. Refer to Sources of Codes to verify. If you think a CPT, ICD, HCPCS, ADA, SNOMED CT, or OID value set code for a measure is not shown in the list or has changed, contact the UDS Support Center at **1-866-UDS HELP**, udshelp330@bphcdata.net, or the BPHC Contact Form.

TABLE 6A: SELECTED DIAGNOSES AND SERVICES RENDERED

Calendar Year: January 1, 2026, through December 31, 2026

SELECTED DIAGNOSES

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-		
	Selected Other Medical Conditions			
9	Diabetes mellitus	**ICD-10:** E08- through E13-, O24- (exclude O24.4-) **OID:** 2.16.840.1.113762.1.4.1219.33		
9a	Diabetes mellitus type 1	**ICD-10:** E10-		
10	Heart disease (selected)	**ICD-10:** I01-, I02- (exclude I02.9), I20- through I25-, I27-, I28-, I30- through I52-, Q24-		
11	Hypertension	**ICD-10:** I10- through I16-		
13	Dehydration	**ICD-10:** E86-		
14	Exposure to heat or cold	**ICD-10:** T33-, T34-, T67-, T68-, T69-, W92-, W93-, X30-, X31-, X32-, Z57.6		
14a	Overweight and obesity	**ICD-10:** E66-, Z68- (exclude Z68.0 through Z68.24, Z68.5 through Z68.52)		

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 Childhood Conditions (limited to ages 0 through 17)			
15	Otitis media and Eustachian tube disorders	**ICD-10:** H65- through H69-		
16	Selected perinatal/neonatal medical conditions	**ICD-10:** A33, P19-, P22- through P29- (exclude P29.3-), P35- through P96- (exclude P54-, P91.6-, P92-, P96.81), Q86-		
17	Lack of expected normal physiological development (such as delayed milestone, failure to gain weight, failure to thrive); nutritional deficiencies in children only. Does not include sexual or mental development.	**ICD-10:** E40- through E46-, E50- through E63-, P92-, R62- (exclude R62.7), R63.3- (exclude R63.39)		
	Selected Mental Health Conditions, Substance Use Disorders, and Exploitations			
18	Alcohol-related disorders	**ICD-10:** F10-, G62.1, I42.6, K70-, O99.31-		
19	Other substance-related disorders (excluding tobacco use disorders)	**ICD-10:** F11- through F19- (exclude F17-), G62.0, O99.32-		
19a	Tobacco use disorder	**ICD-10:** F17-, O99.33-, Z72.0		
20a	Depression and other mood disorders	**ICD-10:** F30- through F39-		
20b	Anxiety disorders, including post-traumatic stress disorder (PTSD)	**ICD-10:** F06.4, F40- through F42-, F43.0, F43.1-, F43.8-, F93.0		
20c	Attention deficit and disruptive behavior disorders	**ICD-10:** F90- through F91-		
20d	Other mental disorders, excluding substance or alcohol dependence	**ICD-10:** F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0- and F43.1-), F50- through F99- (exclude F55-, F84.2, F90-, F91-, F93.0, F98-), O99.34-, R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0		
20e	Human trafficking	**ICD-10:** T74.5- through T74.6-, T76.5- through T76.6-, Z04.81, Z04.82, Z62.813, Z91.42		
20f	Intimate partner violence	**ICD-10:** T74.11-, T74.21-, T74.31-, Z69.11		
20g	Intellectual and developmental disabilities	**ICD-10:** F70- through F89-, G80 through G80.9		

SELECTED SERVICES RENDERED

Line	Service Category	Applicable ICD-10-CM, CPT-4/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		
24a	Seasonal flu vaccine	**CPT-4:** 90653, 90656, 90657, 90658, 90660, 90661, 90662, 90672, 90673, 90674, 90682, 90685, 90686, 90687, 90688, 90694, 90724, 90756		
24b	Coronavirus (SARS-CoV-2) vaccine	**CPT-4:** 91300 through 91323		
25	Contraceptive management	**ICD-10:** Z30-		
26	Well child visit (ages 0 through 11)	**ICD-10:** Z00.1-, Z76.1. Z76.2 **CPT-4:** 99381 through 99383, 99391 through 99393		
26a	Childhood lead test screening (9 to 72 months)	**ICD-10:** Z13.88 **CPT-4:** 83655		
26b	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	**CPT-4:** 99408, 99409 **HCPCS:** G0396, G0397, G0443, G2011, H0050		
26c	Smoke and tobacco use cessation counseling	**ICD-10:** Z71.6 **CPT-4:** 99406, 99407 **HCPCS:** G9906		
26c2	Tobacco use cessation pharmacotherapies	**OID:** 2.16.840.1.113883.3.526.3.1190		
26c3	Medications for opioid use disorder (MOUD)	**OID:** 2.16.840.1.113762.1.4.1046.269		
26d	Comprehensive and intermediate eye exams	**CPT-4:** 92002, 92004, 92012, 92014		

Line	Service Category	Applicable ICD-10-CM, CPT-4/PLA, or HCPCS, SNOMED CT, or OID Code	Number of Visits (A)	Number of Patients (B)
26e	Childhood development screenings and evaluations (ages 0 through 5)	**ICD-10:** Z13.4- **CPT-4:** 96110, 96112, 96113, 96127		
26f	Alzheimer's disease and related dementias (ADRD) screening	**CPT-4:** 99483 **OID:** 2.16.840.1.113883.3.526.3.1006		
26g	Autism spectrum disorder (ASD) screening	**ICD-10:** Z13.41		

Line	Service Category	Applicable ADA Code	Number of Visits (A)	Number of Patients (B)
	Selected Dental Services			
27	Emergency services	**CDT:** D0140, D9110		
28	Oral exams	**CDT:** D0120, D0145, D0150, D0160, D0170, D0171, D0180		
29	Prophylaxis—adult or child	**CDT:** D1110, D1120		
31	Fluoride treatment—adult or child	**CDT:** D1206, D1208 **CPT-4:** 99188		
32	Restorative services	**CDT:** D21xx through D29xx		

Line	Service Category	Applicable ICD-10-CM, CPT-4/PLA, HCPCS, SNOMED CT, or OID Code	Number of Visits (A)	Number of Patients (B)
	Selected Patient Support Services			
35	Case management	**CPT-4:** 99366, 99487, 99424, 99426, 99484, 99490, 99491, 99492, 99493, 99437, 99439, 99495, 99496 **HCPCS:** G0019, G0022, G0323, G0556, G0557, G0558, G2214, T1016, T1017		
36	Eligibility assistance	**SNOMED:** 661901000124106, 662501000124105, 671291000124100, 661871000124106, 662401000124109, 662111000124100, 662731000124107, 662091000124109, 662551000124109, 662231000124100, 662671000124100, 472321000124103, 472301000124108, 661781000124104, 662431000124101, 581041000124102, 662211000124106, 662571000124104		
37	Transportation	**ICD-10:** Z59.82 **OID:** 2.16.840.1.113762.1.4.1247.106		
38	Language assistance services	**OID:** 2.16.840.1.113762.1.4.1247.267		

Line	Service Category	Applicable ICD-10-CM, CPT-4/PLA, HCPCS, SNOMED CT, or OID Code	Number of Visits (A)	Number of Patients (B)
	Selected Upstream Drivers of Health Services			
39	Upstream drivers of health screening	**OID:** 2.16.840.1.113762.1.4.1247.126		
40	Food insecurity	**OID:** 2.16.840.1.113762.1.4.1247.15, 2.16.840.1.113762.1.4.1247.9, 2.16.840.1.113762.1.4.1247.6		
41	Housing instability	**OID**: 2.16.840.1.113762.1.4.1247.19, 2.16.840.1.113762.1.4.1247.43		
42	Financial insecurity	**OID:** 2.16.840.1.113762.1.4.1247.109		

SOURCES OF CODES

Code System	Primary Source	Secondary Source
ICD-10-CM	National Center for Health Statistics (NCHS)	ICD10Data.com
CPT	American Medical Association (AMA)	CMS
Code on Dental Procedures and Nomenclature (CDT)	American Dental Association (ADA)	
CVX	Centers for Disease Control and Prevention (CDC) Vaccine Administered Code Set (CVX)	
HCPCS	CMS	HCPCSData.com
SNOMED CT	National Library of Medicine SNOMED CT	SNOMED CT Concept Lookup
Value Sets	National Library of Medicine Value Set Authority Center	

Note: "X" in a code denotes any number, including the absence of a number in that place. **Dashes (-) in a code** indicate that more characters are needed. ICD-10-CM codes all have at least four digits. These codes are not intended to show whether or not a code is billable. Instead, they identify ranges of codes in the series that should be considered.

Table 6A Cross-Table Considerations:

- The count of patients by diagnosis reported on Table 6A will not be the same count as on Tables 6B and 7, due to differences in criteria that must be met for inclusion on Tables 6B or 7.
- If you submit Grant Reports, the total number of patients and visits reported on a Grant Report must be less than or equal to the corresponding number on the Universal Report for each cell.

Instructions for Tables 6B and 7

Tables 6B and 7 collect data on selected quality of care and clinical health outcome measures. First adopted in 2008, these measures are routinely updated and will continue to evolve in line with the Agency for Healthcare Research and Quality (AHRQ) National Quality Strategy, CMS electronic clinical quality measures (eCQMs), and other national quality initiatives.

The clinical quality measures (CQMs) described in this manual must be reported by all health centers using specifications described below. The majority of the UDS CQMs are aligned with CMS 2026 Performance Period Eligible Professional/Eligible Clinician eCQMs. However, not all UDS CQMs have an associated eCQM. For measures with an eCQM, use the electronic specifications for the CQM number and version referenced in the UDS Manual for 2026 measurement period. Although there are other year and version updates available from CMS, they are **NOT to be used**. For measures without an eCQM specification, use collection methods consistent with the specified UDS reporting instructions.

Note: The phrase "measurement period" used in this section is intended to represent calendar year 2026 unless another timeframe is specifically noted.

Guidance for UDS CQM reporting: Evaluate and include patients seen during the calendar year for a countable UDS visit on Table 5 **AND** who meet initial population[13] requirements **AND** who had a visit that meets the qualifying encounter definitions in the CQM specification.

Measure specifications can be found at the CMS Electronic Clinical Quality Improvement (eCQI) Resource Center. Further clarification or interpretation of CMS eCQMs may be given by the eCQM Flows and the measure steward (listed in Appendix E). HRSA's BPHC defers to the measure steward organization for all guidance, including the development and upkeep of CQM requirements and logic. If a health center's health IT/EHR can access and apply Value Set Authority Center (VSAC)[14] resources, it is required that you use the official VSAC vocabulary value sets for CQM reporting. Health centers are advised to evaluate their workflows and partner with their health IT/EHR vendors to ensure required data are collected accurately for measure computation.

COLUMN LOGIC INSTRUCTIONS

Number of Patients in the Denominator (Column A [A, 2A, or 3A])

- Report the total number of patients who fit the detailed criteria described for the specified measure.
- Report all health center patients meeting the denominator criteria, including patients seen at all sites (e.g., urgent care, prenatal), at all in-scope programs (e.g., special medically underserved populations), and by all providers.
- Remove patients who meet exclusion criteria from the denominator.
- Remove patients who meet exception criteria and do not meet numerator criteria from the denominator.
- A patient may only be counted once per CQM per measurement period, regardless of whether they had multiple interactions with the health center during the year.
    - The one exception is if a patient receives prenatal care for two different pregnancies in the same year.

[13] The target group for a specific performance measure, involving patients or events who share a common set of specified characteristics, for which patients will be drawn from for evaluation.
[14] Requires free user account and login.

Because the denominator for each measure is defined in whole or in part in terms of age (or age and sex), comparisons to the numbers on Tables 3A, 6B, and 7 will be made when evaluating your submission. The numbers in Column A of Tables 6B and 7 will NOT be equal to those that might be calculated on Table 3A for the following reasons:

(1) Table 3A measures age as of December 31 of the calendar year. Tables 6B and 7 measure stewards may define other periods to measure age.

(2) Most of the measures have exclusion and exception criteria that exclude some patients from the assessment.

Although comparisons may be made between the numbers on Table 6A and Tables 6B and 7, the numbers in Column A of Tables 6B and 7 will NOT be equal to those reported in Column B of Table 6A for the following reasons:

(1) All patients, regardless of age, seen for all reportable services and diagnoses, are included on Table 6A, but Tables 6B and 7 relate only to patients of specific age ranges.

(2) Table 6A asks about selected diagnoses and services during the calendar year, but in Tables 6B and 7 measures may require patients to be considered based on active diagnoses or a look-back period of completed services.

(3) Codes used for metrics across the two tables may differ.

Typically, not all prenatal care patients will deliver during the calendar year. Delivery outcomes on Table 7 are compared to total prenatal care patients on Table 6B.

Number of Records Reviewed (Column B [B, 2B, or 3B])

- Report in Column B the total number of health center patients from the denominator (Column A) for whom data have been reviewed.
- The number in Column B (records reviewed) must be no less than 80% of the number in Column A. The number will essentially become the denominator used to calculate the performance rate for the measure.
- Column B must be:
  - All patients who fit the denominator criteria (the same number reported in Column A), or
  - A number equal to or greater than 80% of all patients who meet the denominator criteria (no less than 80% of the number reported in Column A). In order to use this option:
    - The reduced total (in Column B) may not be the result of excluding patients based on a variable related to the measure. For example, if patients from a pediatric service delivery site are missing from the health IT/EHR, this method cannot be used for the Childhood Immunization Status eCQM.
    - Patients must be drawn from all service delivery sites and grant funds.
    - Data source must cover the measurement period (e.g., 5 years for Pap tests, 2 years for immunizations) and include information to assess meeting the CQM numerator criteria and to evaluate exclusions and exceptions.
- Although review of a reduced number of records is allowed, a full EHR or health IT system reporting is preferred. In either case, always report the total patients who fit the detailed denominator criteria in Column A. DO NOT reduce the denominator in Column A, even if using a reduced number in Column B.
- Records from prior providers, including look-back information, may be added to the health center's health IT/EHR system according to internal policies and used in measure reporting.

Guidance: If you DO NOT have an EHR or health IT system in place or cannot report results for a minimum of 80% of all patients eligible for the CQM from all service delivery sites, please contact the UDS Support Center to discuss reporting options.

Number of Charts/Records Meeting the Numerator Criteria (Column C [C or 2C] or 3F)

- Report the total number of records (included in the count for Column B) that meet the numerator criteria for the specified CQM. The number in Column C or F (records in the numerator) can never exceed the number in Column B (patient health records reviewed).
- Remove patients who meet exception criteria from the numerator and denominator if numerator criteria are not met.

Note: The percentage of patient health records meeting the numerator criteria can be calculated by dividing Column C or 3F by Column B.

And vs. Or

If conditions are linked with *"*and," every condition must be satisfied to meet the numerator criteria. If linked with *"*or," asses them in order, and if none apply, the numerator criteria are not met.

DETAILED INSTRUCTIONS FOR CLINICAL QUALITY MEASURES

Report each CQM for patients who had a countable visit and an eligible encounter per CQM specifications using the criteria outlined below. Each measure has been organized in the same way to help with data collection and reporting.

- **Measure Description:** The published narrative summary and intent of the measure, as provided in the CQM specification.
- **Denominator:** Patients who fit the detailed criteria described in the specific measure are to be included and evaluated.
- **Qualifying Encounter:** An encounter that meets the specific criteria defined in a measure's specification and establishes the patient's eligibility for inclusion in the denominator.
- **Numerator:** Records (from the denominator) that meet the criteria for the specified measure.
- **Denominator Exclusions:** Patients not to be considered for the measure and who are removed from the denominator before determining if numerator criteria are met.
- **Denominator Exceptions:** Patients who meet denominator criteria, do not meet numerator criteria, and meet any of the exceptions listed for the measure and, therefore, are removed from the denominator and numerator.
- **Specification Guidance:** CMS measure guidance that helps with understanding and implementing eCQMs.
- **UDS Reporting Considerations:** Additional HRSA's BPHC requirements and guidance that apply to the specific CQM and may differ from or expand upon CQM specifications.

Guidance for each CQM:

Determine whether an individual is included in the measure denominator.

1. First, determine whether the individual is a patient who had at least one UDS Countable Visit during the calendar year, as reported on Table 5. If yes, proceed to step 2.
2. Next, verify whether each patient with a UDS countable visit meets the CQMs initial population criteria (e.g., age) and review for any applicable exclusions. These criteria vary by measure and are defined by the measure steward as outlined in the specification.
3. Third, determine whether the patient had a qualifying encounter, as defined in the CQM specifications. These criteria vary by measure.

Patients included in the denominator (if steps 1–3 are met) are then evaluated for inclusion in the numerator, based on the criteria outlined in the specified measure. If the numerator criteria are not met, patients are evaluated for applicable exceptions.

Instructions for Table 6B: Quality of Care Measures

Table 6B reports on "process measures"[15]—services known to correlate with improved long-term health.

The text directly below contains changes to Table 6B from 2025 calendar year reporting to 2026 calendar year reporting:

Several key changes have been made to Table 6B, as outlined below:

- The specifications for the reported CQMs have been revised to align with the CMS eCQMs. The CQMs are aligned with the most current eCQMs for Eligible Professionals for the 2026 version number referenced in the UDS Manual for the measurement period. (Later version updates may be available, but they should not be used for the 2026 reporting.)
- The childhood immunization status measure reporting is voluntary for 2026.
- The breast cancer screening measure denominator age range changed from 52–74 years of age to 42–74 years of age.
- The HIV screening measure denominator has been updated to include patients 15–65 years of age at the start of the measurement period without an HIV diagnosis before the start of the measurement period.
- The depression screening measure numerator has been revised to indicate that if there is a positive depression screen, a follow-up plan is documented on the date of or up to 2 days after the date of the qualifying encounter, or an active depression medication overlaps the date of the qualifying encounter.
- 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.
- A new measure has been added for patients age 65 years of age and older who were screened for future fall risk.

This marks the conclusion of changes to Table 6B from 2025 calendar year reporting to 2026 calendar year reporting.

[15] With the exception that the Depression Remission measure is an outcome measure.

TABLE 6B: QUALITY OF CARE MEASURES

This table specifically includes the following CQMs:

Screening and Preventive Care	Maternal Care and Children's Health	Disease Management
• Cervical Cancer Screening • Breast Cancer Screening • Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan • Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention • Colorectal Cancer Screening • HIV Screening • Preventive Care and Screening: Screening for Depression and Follow-Up Plan • Falls: Screening for Future Fall Risk	• Early Entry into Prenatal Care • Childhood Immunization Status • Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents • Sealant Receipt on Permanent First Molars	• Statin Therapy for the Prevention and Treatment of Cardiovascular Disease • Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet • HIV Linkage to Care • Depression Remission at Twelve Months • Initiation and Engagement of SUD Treatment

SECTIONS A AND B: DEMOGRAPHIC CHARACTERISTICS OF PRENATAL CARE PATIENTS

These sections include information about patients in a prenatal care program.

- **Section A:** Report by age all women who received prenatal care, including cross-year prenatal care and delivery situations, whether provided directly by the health center or through a health center–arranged referral. A referral network is established with a provider or entity through a formal contractual agreement (as recorded on Form 5A, Column II) or a formal written referral arrangement (as recorded on Form 5A, Column III).
- **Section B:** Report each patient's trimester when she entered prenatal care, regardless of whether prenatal care or delivery services were provided directly or elsewhere through a formal referral arrangement.

DO NOT include:

- Women who had a positive pregnancy test but did not start prenatal care with the health center or its referral network.[16]
- Women who received all prenatal care and delivery without involvement from a health center provider or outside of the health center's referral network.
- Pregnant women who received non-pregnancy-related services at the health center but obtained all prenatal care and delivery elsewhere outside the referral network.

[16] External organizations or providers to which the health center formally refers patients for services not provided onsite.

Prenatal Care by Referral Only (check box)

All health centers must provide prenatal care to patients, either directly or by referral.

- Check the "Prenatal Care by Referral Only" box if all prenatal care is provided exclusively through direct formal written referral to another provider (such as a memorandum of understanding or memorandum of agreement), as described on Form 5A, Columns II and III.
- DO NOT check this box if your health center providers deliver some or all prenatal care to pregnant women.

Section A: Age of Prenatal Care Patients (Lines 1–6)

- Report the total number of patients by age group who received prenatal care during the calendar year from the health center or from a provider in your referral network, regardless of when that care was started.
- Include patients who:
  - Receive all prenatal care from the health center,
  - Were referred by the health center for all prenatal care,
  - Started prenatal care with another provider and later transferred to the health center,
  - Started prenatal care at the health center and later transferred to another provider, even if the provider is outside the referral network,
  - Received all prenatal care from a health center provider but were delivered by another provider,
  - Began or were referred for prenatal care in the previous (2025) or current calendar year (2026) and were known to have delivered in the current year (2026), even if the delivery is the only service in the current year, or
  - Began or were referred for prenatal care in the current year (2026), but will not deliver until next year (2027).
- Use the patient's age on December 31 of the calendar year to assign the age group.

Note: Typically, about half of all reported prenatal patients will also appear in either the prior year or the following year's UDS Report.

Section B: Early Entry into Prenatal Care (Lines 7–9), No eCQM

Measure Description

Percentage of prenatal care patients who entered prenatal care during their first trimester.

Calculate as follows:

Denominator: Line 7 + Line 8 + Line 9, Columns A + B

- Patients seen for prenatal care during the year

Numerator: Line 7, Columns A + B

- Patients who began prenatal care at the health center or with a referral provider (Column A), or who began care with another prenatal provider (Column B), during their first trimester

Exclusions/Exceptions

- Denominator Exclusions
  - Not applicable
- Denominator Exceptions
  - Not applicable

Specification Guidance

- Not applicable

UDS Reporting Considerations

- Report on Lines 7–9 all patients who received prenatal care—directly or by referral—including, but not limited to, the delivery of a baby during the calendar year.
  - **First Trimester (Line 7):** Report patients whose first prenatal visit occurred through the end of the 13th week after the first day of their last menstrual period (LMP), or when they were clinically identified to be in their first trimester based on documented estimated date of delivery (EDD).
  - **Second Trimester (Line 8):** Report patients whose first prenatal care visit occurred between the start of the 14th week and the end of the 27th week after the first day of their LMP, or when they were clinically identified to be in their second trimester based on documented EDD.
  - **Third Trimester (Line 9):** Report patients whose first prenatal care visit occurred at 28 weeks or more after the first day of their LMP, or when they were clinically identified to be in their third trimester based on documented EDD.
- Report trimester of entry, as described above, in either Column A, Patients Having First Visit with Health Center, or Column B, Patients Having First Visit with Another Provider, using this guidance:
  - **Column A:** Report patients who began prenatal care through the health center or a provider through the health center's formal referral network.
  - **Column B:** Report patients who began prenatal care independently with another provider and then transferred to the health center or to a provider through the health center's formal referral network.

Note: It is unusual for the number in Column B, Patients Having First Visit with Another Provider, to be very large or larger than that in Column A, Patients Having First Visit with Health Center. The sum of the numbers in the six cells of Lines 7 through 9 is the total number of patients who received some or all of their prenatal care from the health center during the calendar year and is equal to the number reported on Line 6.

Apply the following rules when reporting prenatal care patients:

- Count the start of prenatal care only when the patient receives a **comprehensive prenatal exam** from the health center or with the referred network provider.
- DO NOT count visits that include pregnancy and other lab tests, dispensing vitamins, taking a health history, and/or obtaining a nutritional or psychosocial assessment only as the start of prenatal care.
- Patient self-report of trimester of entry is acceptable.
- If a patient receives prenatal care for two different pregnancies in the same year, report them twice.

SECTIONS C THROUGH N: OTHER QUALITY OF CARE MEASURES

- For each of the measures, report patients who had a UDS countable visit during the year (reported at least once on Table 5) who had a qualifying encounter as defined in the measure specifications.
- Calculate age using the dates required for each CQM.
- DO NOT exclude patients seen only for urgent care, a single acute visit, or specialty care or those who later left the practice. If they had a countable visit and met the qualifying encounter criteria, they must be included.
- For measures requiring screenings, tests, or procedures, the results must be available in the patient health record.

Note: In this section, the term "measurement period" is the timeframe specified by the measure steward. For measures not electronically specified, the measurement period is calendar year 2026.

Childhood Immunization Status (Line 10), CMS117v14

Measure Description

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.

Calculate as follows:

Denominator: Columns A and B

- Children who turn 2 years of age during the measurement period and who had a qualifying encounter during the measurement period, as specified in the measure criteria
  - Include only patients who turn 2 years of age during the measurement period, reflective of children with birthdate on or after January 1, 2024, and birthdate on or before December 31, 2024.

Numerator: Column C

- **Diphtheria, tetanus, and pertussis (DTaP) vaccination**

  Children with any of the following on or before the child's second birthday meet the criteria:
  - At least four DTaP vaccinations, with different dates of service. DO NOT count a vaccination administered prior to 42 days after birth.
  - Anaphylaxis due to the diphtheria, tetanus, or pertussis vaccine.
  - Encephalitis due to the diphtheria, tetanus, or pertussis vaccine.
- **Poliovirus vaccination (IPV)**

  Children with either of the following on or before the child's second birthday meet the criteria:
  - At least three IPV vaccinations, with different dates of service. DO NOT count a vaccination administered prior to 42 days after birth.
  - Anaphylaxis due to the IPV vaccine.

- **Measles, mumps, and rubella vaccination (MMR)**

  Children with any of the following meet the criteria:

  - At least one MMR vaccination on or between the child's first and second birthdays.
  - Anaphylaxis due to the MMR vaccine on or before the child's second birthday.
  - All of the following anytime on or before the child's second birthday (on the same or different date of service): history of measles, mumps, or rubella.

- **Haemophilus influenzae type B vaccination (HiB)**

  Children with either of the following meet the criteria on or before the child's second birthday:

  - At least three HiB vaccinations, with different dates of service. DO NOT count a vaccination administered prior to 42 days after birth.
  - Anaphylaxis due to the HiB vaccine.

- **Hepatitis B (HepB)**

  Children with any of the following on or before the child's second birthday meet the criteria:

  - At least three hepatitis B vaccinations, with different dates of service.
  - One of the three vaccinations can be a newborn hepatitis B vaccination during the eight-day period that begins on the date of birth and ends seven days after the date of birth. For example, if the patient's date of birth is December 1, the newborn hepatitis B vaccination must be on or between December 1 and December 8.
  - Anaphylaxis due to the hepatitis B vaccine.
  - History of hepatitis B illness.

- **Varicella vaccination (VZV)**

  Children with any of the following meet the criteria:

  - At least one VZV vaccination, with a date of service on or between the child's first and second birthdays.
  - Anaphylaxis due to the VZV vaccine on or before the child's second birthday.
  - History of varicella (e.g., chicken pox) illness on or before the child's second birthday.

- **Pneumococcal conjugate (PCV)**

  Children with either of the following on or before the child's second birthday meet the criteria:

  - At least four pneumococcal conjugate vaccinations, with different dates of service on or before the child's second birthday. DO NOT count a vaccination administered prior to 42 days after birth.
  - Anaphylaxis due to the pneumococcal vaccine on or before the child's second birthday.

- **Hepatitis A (HepA)**

  Children with any of the following meet the criteria:

  - At least one hepatitis A vaccination, with a date of service on or between the child's first and second birthdays.
  - Anaphylaxis due to the hepatitis A vaccine on or before the child's second birthday.
  - History of hepatitis A illness on or before the child's second birthday.

- **Rotavirus (RV)**

  Children with any of the following meet the criteria:

  - At least two doses of the two-dose rotavirus vaccine on different dates of service on or before the child's second birthday. DO NOT count a vaccination administered prior to 42 days after birth.
  - At least three doses of the three-dose rotavirus vaccine on different dates of service on or before the child's second birthday. DO NOT count a vaccination administered prior to 42 days after birth.
  - At least one dose of the two-dose rotavirus vaccine and at least two doses of the three-dose rotavirus vaccine, all on different dates of service, on or before the child's second birthday. DO NOT count a vaccination administered prior to 42 days after birth.
  - Anaphylaxis due to the rotavirus vaccine on or before the child's second birthday.

- **Influenza (Flu)**

  Children with either of the following on or before their second birthday meet the criteria:

  - At least two influenza vaccinations, with different dates of service on or before the child's second birthday. DO NOT count a vaccination administered prior to 6 months (180 days) after birth.
    - One of the two vaccinations can be a live attenuated influenza vaccine (LAIV) vaccination (the nasal spray flu vaccine) administered on the child's second birthday. DO NOT count a LAIV vaccination administered before the child's second birthday.
  - Anaphylaxis due to the influenza vaccine.

Exclusions/Exceptions

- Denominator Exclusions
  - Children who were in hospice care for any part of the measurement period
  - Children with any of the following on or before the child's second birthday:
    - Severe combined immunodeficiency
    - Immunodeficiency
    - Human immunodeficiency virus (HIV)
    - Lymphoreticular cancer, multiple myeloma, or leukemia
    - Intussusception
- Denominator Exceptions
  - Not applicable

Specification Guidance

- The measure allows a grace period by measuring numerator criteria with these recommendations between birth and age 2.

UDS Reporting Considerations

- For the 2026 performance year, health centers will have the option to voluntarily report on this measure.
- The patient must have at least one UDS countable visit on Table 5 during the measurement period to be included.

- Include all children who turn 2 years of age during the measurement period, regardless of when their visit(s) occurred during the year.
- Include children in the denominator seen for any medical visit (well-child[17] or acute).
- Include children in the denominator with no vaccination records or those first seen too late to complete all vaccines before age 2.
- Include children with vaccine contraindications; if allowed by the specification, count them as compliant for that specific vaccine.
- To meet the numerator, a patient's health record must document each vaccine and its administration date.
- Immunization registries may be used to supplement records if results are added to the health IT/EHR and correctly coded before the end of the measurement period.
- DO NOT include or count:
  - In the denominator, children who only received a vaccination and no other services at the health center.
  - In the numerator, patient health records stating only "up to date" without full immunization dates and vaccine names.
  - In the numerator, verbal reports of vaccination without documentation.
  - In the numerator, good-faith efforts that did not result in completed vaccinations (e.g., parental no-shows, vaccine refusal, loss to follow-up).

Cervical Cancer Screening (Line 11), CMS124v14

Measure Description

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

- Women age 21*–64 who had cervical cytology performed within the last 3 years
- Women age 30–64 who had human papillomavirus (HPV) testing performed within the last 5 years

* To report on women who received cervical cancer screening on or after 21 years of age, the denominator will include patients who are 24 years of age as of December 31. See Specification Guidance for further detail. Calculate as follows:

Denominator: Columns A and B

- Women 24 through 64 years of age by the end of the measurement period with a qualifying encounter during the measurement period, as specified in the measure criteria
  - Include women with birthdate on or after January 1, 1962, and birthdate on or before December 31, 2002.

[17] Health centers should add to their denominator those patients whose only visits were well-child visits (99381, 99382, 99391, 99392) if their automated system does not include them. In addition, if your state uses different codes for EPSDT visits, those codes should be added.

Numerator: Column C

- Women with one or more screenings for cervical cancer. Appropriate screenings are defined by any one of the following criteria:
  - Cervical cytology performed during the measurement period or the 2 years prior to the measurement period for women 24–64 years of age by the end of the measurement period.
  - Cervical HPV testing performed during the measurement period or the 4 years prior to the measurement period for women who are 30 years or older at the time of the test.

Exclusions/Exceptions

- Denominator Exclusions
  - Patients who were in hospice care for any part of the measurement period
  - Women who had a hysterectomy with no residual cervix or a congenital absence of cervix
  - Patients who received palliative care for any part of the measurement period
- Denominator Exceptions
  - Not applicable

Specification Guidance

- To make sure the measure is looking for a cervical cytology test only after a woman turns 21 years of age, the youngest age in the initial population is 23, although these patients must be 24 by the end of the measurement period.
- The measure may include screenings done outside the age range of patients referenced in the initial population.
- Screenings that occur before the measurement period are valid to meet measure criteria.
- Evidence of high-risk human papillomavirus (hrHPV) testing within the last 5 years also captures patients who had cotesting; therefore, other methods to identify cotesting are not necessary.

UDS Reporting Considerations

- The patient must have at least one UDS countable visit on Table 5 during the measurement period to be included.
- Include documentation of any cervical cytology and HPV tests performed outside of the health center, including:
  - Test date,
  - Performing provider or agency, and
  - test result or a copy of the report.
- Patient-collected (self-swab) HPV tests may be included **only if** the specimen is processed by a Clinical Laboratory Improvement Amendments (CLIA)-certified laboratory and the official test result is documented in the patient health record.
- DO NOT count in the numerator patient health records where the patient refused testing.

Breast Cancer Screening (Line 11a), CMS125v14

Measure Description

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

* To report on women who received breast cancer screening on or after 40 years of age, the denominator will include patients who are at least 42 years of age on or after December 31. See Specification Guidance for further detail.

Calculate as follows:

Denominator: Columns A and B

- Women 42 through 74 years of age by the end of the measurement period with a qualifying encounter during the measurement period, as specified in the measure criteria
    - Include women with birthdate on or after January 1, 1952, and birthdate on or before December 31, 1984.

Numerator: Column C

- Women with one or more mammograms any time on or between October 1 two years prior to the measurement period and the end of the measurement period

Exclusions/Exceptions

- Denominator Exclusions
    - Patients who were in hospice care for any part of the measurement period
    - Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy on or before the end of the measurement period
    - Patients aged 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria: advanced illness diagnosis during the measurement period or the year prior; or taking dementia medications during the measurement period or the year prior
    - Patients aged 66 and older by the end of the measurement period who were living long-term in a nursing home any time on or before the end of the measurement period
    - Patients who received palliative care for any part of the measurement period
- Denominator Exceptions
    - Not applicable

Specification Guidance

- The measure evaluates primary screening. DO NOT count biopsies, breast ultrasounds, or magnetic resonance imaging (MRI), because they are not appropriate methods for primary breast cancer screening.
- The measure only evaluates whether tests were done after a woman turned 40 years of age. The youngest age in the initial population is 42.
- The measure may include screenings done outside the age range of patients referenced in the initial population. Screenings that occur before the measurement period are valid to meet measure criteria.

UDS Reporting Considerations

- The patient must have at least one UDS countable visit on Table 5 during the measurement period to be included.
- If a mammogram was done outside of the health center, include documentation in the patient health record at the health center with the date the test was done, who did it, and the result of the finding provided by the agency that conducted the diagnostic study or a copy of the results.
- Include only patients who are biological females.
- DO NOT count as compliant for the CQM those charts that note the refusal of the patient to receive the screening or test.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Line 12), CMS155v14

Measure Description

Percentage of patients 3–17 years of age who had an outpatient visit with a **primary care physician (PCP) or obstetrician/gynecologist (OB/GYN)** and who had evidence of height, weight, and body mass index (BMI) percentile documentation **and** who had documentation of counseling for nutrition **and** who had documentation of counseling for physical activity during the measurement period

Calculate as follows:

Denominator: Columns A and B

- Patients 3 through 17 years of age by the end of the measurement period with a qualifying encounter during the measurement period, as specified in the measure criteria
    - Include children and adolescents with birthdate on or after January 1, 2009, and birthdate on or before December 31, 2023.

Numerator: Column C

- Children and adolescents who have had:
    - their height, weight, and BMI percentile recorded during the measurement period ***and***
    - counseling for nutrition during the measurement period ***and***
    - counseling for physical activity during the measurement period.

Exclusions/Exceptions

- Denominator Exclusions
    - Patients who were in hospice care for any part of the measurement period
    - Women who have a diagnosis of pregnancy during the measurement period
- Denominator Exceptions
    - Not applicable

Specification Guidance

- Because BMI norms for youth vary with age and sex, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

UDS Reporting Considerations

- The patient must have a countable visit reported on Table 5 of the UDS Report in the measurement period to be included in this measure.
- Include qualifying encounters performed by any provider, as included in the specification criteria. Note that this is different from the eCQM description, which states that the visit must be performed by a PCP or an OB/GYN. For example, include patients who had a medical visit with an NP or PA.
- The UDS numerator differs from the eCQM in that the eCQM requires the numerator elements to be reported separately against two age strata (age 3–11, age 12–17). For UDS purposes, the patients must have had all three parts completed to meet the numerator criteria using one age strata (age 3–17).
- DO NOT count as meeting the numerator criteria charts that show only that a well-child visit was scheduled, provided, or billed. The electronic or paper well-child visit template/form must document each of the elements noted above.
- Patient-reported height and weight are allowed to be used in this measure, as long as the information is recorded in the EHR and is accurate enough for use in clinical care. Determining the acceptability, reliability, and validity of patient-reported information is left to the discretion of the provider.

Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (Line 13), CMS69v14

Measure Description

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

Note: Normal parameters: For age 18 years and older, BMI greater than or equal to 18.5 kg/m^2 and less than 25 kg/m^2

Calculate as follows:

Denominator: Columns A and B

- Patients 18 years of age or older on the date of the visit with at least one qualifying encounter during the measurement period, as specified in the measure criteria
    - Include patients with birthdate on or before January 1, 2008, who were 18 years of age or older on the date of their last visit.

Note: Patients who **only** had virtual visits during the year are NOT to be included in the denominator, according to the measure criteria.

Numerator: Column C

- Patients with a documented BMI during the most recent visit or during the measurement period, **and** BMI is within normal parameters, **and**
- Patients with a documented BMI during the most recent visit or during the measurement period, **and** when the BMI is outside of normal parameters, a follow-up plan is documented at the visit where the BMI was outside of normal parameters or during the measurement period

Exclusions/Exceptions

- Denominator Exclusions
  - Women who are pregnant at any time during the measurement period
  - Patients receiving palliative or hospice care at any time during the measurement period
- Denominator Exceptions
  - Patients who refuse measurement of height and/or weight
  - Patients with a documented medical reason for not documenting BMI or for not documenting a follow-up plan for a BMI outside normal parameters (see Specification Guidance)

Specification Guidance

- An eligible provider or their personnel must measure both height and weight. Both height and weight must be measured during the measurement period.
- BMI may be documented in the patient health record at the health center or in outside patient health records obtained by the health center.
- If the documented BMI is outside of normal parameters, then a follow-up plan is to be documented during the visit **or** during the measurement period.
- If more than one BMI is reported during the measurement period, and any of the documented BMI assessments is outside of normal parameters, documentation of an appropriate follow-up plan is to be used to determine whether performance has been met.
- Documented medical reasons for denominator exceptions include, but are not limited to:
  - Elderly patients (65 years or older) for whom weight reduction or gain would complicate other underlying health conditions, such as the following examples:
    - Illness or physical disability
    - Mental illness, dementia, confusion
    - Nutritional deficiency, such as vitamin or mineral deficiency
  - Patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- If a patient meets exception criteria for the denominator (i.e., the patient refuses height or weight measurement or has a documented medical reason for not documenting BMI or a follow-up plan), an eligible clinician must document those criteria on the same day as the qualifying encounter.
- DO NOT use self-reported height and weight values.

UDS Reporting Considerations

- The patient must have at least one UDS countable visit on Table 5 during the measurement period to be included.
- Documentation in the patient health record must show the actual BMI, or the template normally viewed by a provider must display BMI.
- A follow-up plan may include, but is not limited to documentation of education, referral (such as a registered dietitian nutritionist [RDN], occupational therapist, physical therapist, PCP, exercise physiologist, mental health professional, or surgeon) for lifestyle/behavioral therapy, pharmacological interventions, dietary supplements, exercise counseling, and/or nutrition counseling.
- If the **only** visits during the year are telehealth and/or telephone visits, exclude the patient from the denominator.
- DO NOT count as meeting the numerator criteria charts or templates that display only height and weight but not the calculated BMI. The fact that a health IT/EHR system can calculate BMI does not replace the presence of the BMI itself.

Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Line 14a), CMS138v14

Measure Description

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 6 months prior to the measurement period if identified as a tobacco user

Calculate as follows:

Denominator: Columns A and B

- Patients aged 12 years and older at the start of the measurement period seen for at least two qualifying encounters in the measurement period or at least one preventive care qualifying encounter during the measurement period, as specified in the measure criteria
    - Include patients with birthdate on or before January 1, 2014.

Numerator: Column C

- Patients who were screened for tobacco use at least once during the measurement period and NOT identified as a tobacco user, **and**
- Patients who were screened for tobacco use at least once during the measurement period **and**, if identified as a tobacco user, received tobacco cessation intervention during the measurement period or during the 6 months prior to the measurement period

Exclusions/Exceptions

- Denominator Exclusions
    - Patients who were in hospice care for any part of the measurement period
- Denominator Exceptions
    - Not applicable

Specification Guidance

- If patients use any type of tobacco (i.e., smokes or uses smokeless tobacco), tobacco cessation intervention (counseling and/or pharmacotherapy) is expected. The measure uses the U.S. Food and Drug Administration definition of tobacco, which includes e-cigarettes, hookah pens, and other electronic nicotine delivery systems. Therefore, the measure does consider the use of e-cigarettes and other electronic nicotine delivery systems to be tobacco use.
- A patient needs one preventive visit to be considered for the denominator. Preventive visits are defined by the value sets listed under *Preventive Visit During Measurement Period* in the measure specifications. If a patient has not had a preventive visit, they need two other qualifying visits to be considered for the denominator. Other qualifying visits are defined by the value sets listed under *Qualifying Visit During Measurement Period* in the measure specifications.
- To promote a team-based approach to patient care, the tobacco cessation intervention can be done by another health care provider; therefore, the tobacco use screening and tobacco cessation intervention DO NOT need to be done by the same provider.
- If a patient has multiple tobacco use screenings during the measurement period, use the most recent screening that has a documented status of tobacco user or non-user.
- If tobacco use status of a patient is unknown, the patient does NOT meet the screening part required to be counted in the numerator and has not met the numerator criteria. "Unknown" includes patients who were not screened and patients with indefinite answers.

UDS Reporting Considerations

- The patient must have at least one UDS countable visit on Table 5 during the measurement period to be included.
- Report in the numerator records that show that the patient had been asked about their use of all forms of tobacco during the measurement period.
- If the cessation intervention is pharmacotherapy, then the prescription must be active (one that has not expired) or ordered during the measurement period.
- Include patients who receive tobacco cessation intervention by any provider, including those who:
  - Received tobacco use cessation counseling services, **or**
  - Received an order for (a prescription or a recommendation to buy an over-the-counter product) a tobacco use cessation medication, **or**
  - Are on (using) a tobacco use cessation agent.
- eCQM specifications define separate patient populations for this assessment (patients screened for tobacco use, patients screened and identified as tobacco users who received cessation intervention). For UDS reporting, patient populations are combined and evaluated as a single denominator.
- DO NOT count providing written self-help materials only as meeting the numerator criteria.

Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Line 17a), CMS347v9

Measure Description

Percentage of the following patients—all considered at high risk of cardiovascular events—who were prescribed or were on statin therapy during the measurement period:

- All patients who were previously diagnosed with or currently have a diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD) or have ever had an ASCVD procedure, **or**
- Patients 20 through 75 years of age who have ever had a low-density lipoprotein cholesterol (LDL-C) laboratory result level greater than or equal to 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia, **or**
- Patients 40 through 75 years of age with a diagnosis of diabetes, **or**
- Patients 40 through 75 years of age with a 10-year ASCVD risk score greater than or equal to 20 percent

Calculate as follows:

Denominator: Columns A and B

To prevent patients from being counted more than once in the denominator, identify patients meeting the criteria listed in the first bullet below. If a patient is identified, they meet the risk requirement and are included in the denominator. If the patient is **not** identified from the first criteria, move to the next. Continue through the four categories of risk criteria to identify individual patients at high risk of cardiovascular events.

- **Population 1: Clinical ASCVD risk:** All patients who were previously diagnosed with or currently have a diagnosis of ASCVD, including an ASCVD procedure before the end of the measurement period. If NOT, screen for Population 2.
- **Population 2: LDL-C level or familial hypercholesterolemia risk:** Patients who were 20 through 75 years of age at the start of the measurement period who:
  - Ever had a laboratory result of LDL-C greater than or equal to 190 mg/dL **or**
  - Were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia, and
  - If NOT, screen for Population 3.
- **Population 3: Diabetes risk:** Patients 40 through 75 years of age at the start of the measurement period with type 1 or type 2 diabetes. If NOT, screen for Population 4.
- **Population 4: ASCVD score risk:** Patients aged 40 through 75 at the start of the measurement period with a 10-year ASCVD risk score greater than or equal to 20% during the measurement period
- With a qualifying encounter during the measurement period, as specified in the measure criteria
- Include patients:
  - Of any age for the clinical ASCVD determination;
  - With birthdate on or before January 1, 2006, for LDL-C or familial hypercholesterolemia determination;
  - With birthdate on or after January 2, 1950, and birthdate on or before January 1, 1986, for diabetes determination; and

- With birthdate on or after January 2, 1950, and birthdate on or before January 1, 1986, for high 10-year ASCVD risk score.

Numerator: Column C

- Patients who are actively using or who received an order (prescription) for statin therapy at any time during the measurement period

Exclusions/Exceptions

- Denominator Exclusions
  - Women who are breastfeeding at any time during the measurement period
  - Patients who have a diagnosis of rhabdomyolysis at any time during the measurement period
- Denominator Exceptions
  - Patients with statin-associated muscle symptoms or an allergy to statin medication
  - Patients who are receiving palliative or hospice care
  - Patients with active liver disease or hepatic disease or insufficiency
  - Patients with end-stage renal disease (ESRD)
  - Patients with documentation of a medical reason for not being prescribed statin therapy

Specification Guidance

- Current statin therapy (including statin medication samples provided to patients) must be documented in the patient's current medication list or ordered during the measurement period.
- Any documentation of a 10-year ASCVD risk score ≥ 20 will qualify the patient for the denominator population, even if the risk score changes later in the measurement period.
- Make sure patients are not counted in the denominator more than once. Once a patient meets one set of denominator criteria (check from first listed in Measure Description to last), they are included and further risk checks are not needed.
- Intensity of statin therapy or lifestyle modification coaching is **NOT** being assessed for this measure; only prescription or use of any statin therapy is being assessed.
- DO NOT count *other* cholesterol-lowering medications as meeting the numerator criteria; only statin therapy meets the numerator criteria.
- Patient adherence to statin therapy is not calculated in this measure.

UDS Reporting Considerations

- The patient must have at least one UDS countable visit on Table 5 during the measurement period to be included.
- If the **only** visits during the year are telephone visits, exclude the patient from the denominator.
- ASCVD risk assessments to identify Population 4 are strongly encouraged.

- If you conducted ASCVD risk assessments and no patients are identified for Population 4, and if you implemented the measure as specified, it could mean that either no patients meet the criteria for Population 4 or that all patients were identified through the preceding initial Populations 1–3. Review the guidance for each initial population to verify that implementation matches specifications.
- If you did not conduct ASCVD risk assessments, DO NOT report any cases as eligible for the measure's fourth population. In this situation, zero patients will be eligible for Population 4, but still report the measure using measure steward guidance for the preceding initial populations.

Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet (Line 18), CMS164v7

Measure Description

Percentage of patients 18 years of age and older who were diagnosed with acute myocardial infarction (AMI), or who had a coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCIs) in the 12 months prior to the measurement period **or** who had an **active** diagnosis of IVD during the measurement period, and who had documented use of aspirin or another antiplatelet during the measurement period

Calculate as follows:

Denominator: Columns A and B

- Patients 18 years of age and older with a qualifying encounter during the measurement period who had an AMI, CABG, or PCI during the 12 months prior to the measurement period **or** who had a diagnosis of IVD overlapping the measurement period, as specified in the measure criteria
  - Include patients with birthdate on or before January 1, 2008.

Numerator: Column C

- Patients who had an active medication of aspirin or another antiplatelet during the measurement period

Exclusions/Exceptions

- Denominator Exclusions
  - Patients who had documentation of use of anticoagulant medications overlapping the measurement period
  - Patients who were in hospice care during the measurement period
- Denominator Exceptions
  - Not applicable

Specification Guidance

- Include in the numerator patients who received a prescription for, were given, or were using aspirin or another antiplatelet medication.

UDS Reporting Considerations

- The patient must have at least one UDS countable visit on Table 5 during the measurement period to be included.
- The electronic specifications for this measure have not been updated. Follow the CMS164v7 specifications for UDS reporting.

Colorectal Cancer Screening (Line 19), CMS130v14

Measure Description

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

*Use 46 on or after December 31 as the initial age to include in assessment.

Calculate as follows:

Denominator: Columns A and B

- Patients 46 through 75 years of age by the end of the measurement period with a qualifying encounter during the measurement period, as specified in the measure criteria
    - Include patients with birthdate on or after January 1, 1951, and birthdate on or before December 31, 1980.

Numerator: Column C

- Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any **one** of the following criteria:
    - Fecal occult blood test (FOBT) during the measurement period
    - Stool deoxyribonucleic acid (DNA) (sDNA) with fecal immunochemical test (FIT)- during the measurement period or the 2 years prior to the measurement period
    - Flexible sigmoidoscopy during the measurement period or the 4 years prior to the measurement period
    - Computerized tomography (CT) colonography during the measurement period or the 4 years prior to the measurement period
    - Colonoscopy during the measurement period or the 9 years prior to the measurement period

Exclusions/Exceptions

- Denominator Exclusions
    - Patients who were in hospice care for any part of the measurement period
    - Patients with a diagnosis or past history of total colectomy or colorectal cancer
    - Patients aged 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria: advanced illness diagnosis during the measurement period or the year prior; or taking dementia medications during the measurement period or the year prior
    - Patients aged 66 and older by the end of the measurement period who were living long-term in a nursing home any time on or before the end of the measurement period
    - Patients receiving palliative care for any part of the measurement period
- Denominator Exceptions
    - Not applicable

Specification Guidance

- DO NOT count digital rectal exam (DRE) or FOBTs done in an office setting or done on a sample collected via DRE.

- The measure may include screenings done outside the defined age range of patients referenced in the initial populations. Screenings that occur before the measurement period are valid to meet the measure criteria.

UDS Reporting Considerations

- The patient must have at least one UDS countable visit on Table 5 during the measurement period to be included.
- There are two FOBT options for this measure: the guaiac fecal occult blood test (gFOBT) and the immunochemical-based fecal occult blood test (iFOBT).
- Lab tests (FOBT and sDNA with FIT) done elsewhere must be confirmed by documentation in the patient's health record with either a copy of the test results or correspondence between the clinic personnel and the performing lab/provider showing the results.
- Check manufacturer recommendations for specimen collection guidelines and best practices.
- FOBT and sDNA with FIT test kits can be mailed to patients, but receipt, processing, and documentation of the test sample is required.
- DO NOT use self-reported test results.

HIV Linkage to Care (Line 20), No eCQM

Measure Description

Percentage of patients newly diagnosed with HIV who were seen for follow-up treatment within 30 days of diagnosis[18]

Calculate as follows:

Denominator: Columns A and B

- Patients newly diagnosed with HIV by the health center between December 1 of the prior year through November 30 of the current measurement period and who had at least one qualifying encounter during the measurement period, as specified in the measure criteria
    - Include patients who were diagnosed with HIV for the first time ever[19] by the health center between December 1, 2025, and November 30, 2026,[20] and had at least one visit during the measurement period.

Numerator: Column C

- Newly diagnosed HIV patients that received treatment within 30 days of diagnosis. Include patients who were newly diagnosed by your health center providers **and**:
    - had a documented visit with your health center provider who initiates treatment for HIV, **or**
    - had a documented visit with a referral resource who initiates treatment for HIV.

[18] Note that this measure does not conform to the calendar year reporting requirement.
[19] "Patients newly diagnosed with HIV" is defined as patients without a previous HIV diagnosis who received a reactive initial HIV test confirmed by a positive supplemental antibody immunoassay HIV test.
[20] Because the measure allows up to 30 days to complete the follow-up, look back 30 days to find the entire denominator of patients who should have had a follow-up during the measurement period.

Exclusions/Exceptions

- Denominator Exclusions
  - Not applicable
- Denominator Exceptions
  - Not applicable

Specification Guidance

- Not applicable

UDS Reporting Considerations

- The patient must have at least one UDS countable visit on Table 5 during the measurement period to be included.
- Only include in the denominator patients newly diagnosed with HIV in 2026 by a health center provider. For most health centers, the number will typically be below five.
- **Treatment**—NOT merely a referral, education, or retesting—**must begin** within 30 days of the HIV diagnosis. Include patients in the numerator only if HIV care was initiated within this 30-day window. For patients treated by referral (e.g., to a Ryan White provider), treatment must begin within 30 days, and documentation from the referral provider confirming treatment and visit date is required.
- Patient identification may span multiple years and include prior-year patients.
- Reactive initial HIV tests and self-reported HIV positivity require a confirmatory supplemental test.
- DO NOT include patients who:
  - Were diagnosed elsewhere, even with documentation.
  - Had a reactive screening test without a positive supplemental test.
  - Had a reactive screening test given at the health center but were sent elsewhere for definitive testing and treatment.

Note: Although ICD-10 Z21 is appropriate for coding symptomatic or asymptomatic HIV, there are no standardized codes to identify **newly** diagnosed HIV patients. Health centers are encouraged to identify and track new diagnoses through their health IT/EHR or a separate system. Examples of processes that could help include recording the new diagnosis during the visit and using a "dummy code," monitoring patient problem lists, reviewing audit trail logs, or creating a rules-based alert based on the first time a diagnosis code is documented.

HIV Screening (Line 20a), CMS349v8

Measure Description

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

This is calculated as follows:

Denominator: Columns A and B

- Patients aged 15 through 65 years of age at the start of the measurement period without an HIV diagnosis prior to the start of the measurement period AND who had at least one outpatient qualifying encounter during the measurement period, as specified in the measure criteria
    - Include patients with birthdate on or after January 2, 1960, and birthdate on or before January 1, 2011.

Numerator: Column C

- Patients with documentation of an HIV test performed on or after their 15th birthday and before their 66th birthday

Exclusions/Exceptions

- Denominator Exclusions
    - Patients diagnosed with HIV prior to the start of the measurement period
- Denominator Exceptions
    - Patients who died on or before the end of the measurement period

Specification Guidance

- This measure evaluates the proportion of patients aged 15–65 at the start of the measurement period who have documentation of having received an HIV test at least once on or after their 15th birthday and before their 66th birthday.
- The health center must have documentation of the administration of the laboratory or point of care (POC) test present in the patient's health record.
- HIV tests done elsewhere must be documented in the patient's health record: either a copy of the test results or correspondence between the clinic personnel and the performing laboratory or provider showing the results.
- Patient attestation or self-report to meet the measure requirements is NOT allowed.

UDS Reporting Considerations

- The patient must have at least one UDS countable visit on Table 5 during the measurement period to be included.
- If the **only** visits during the year are telephone visits, exclude the patient from the denominator.

Preventive Care and Screening: Screening for Depression and Follow-Up Plan (Line 21), CMS2v15

Measure Description

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 visit 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 visit

This is calculated as follows:

Denominator: Columns A and B

- Patients aged 12 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
    - Include patients with birthdate on or before January 1, 2014.

Numerator: Column C

- Patients who were screened for depression on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized tool, and screened negative for depression
- Patients who were screened for depression on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized tool, and if screened positive for depression, a follow-up plan is documented on the date of or up to 2 days after the date of the qualifying encounter or an active depression medication overlaps the date of the qualifying encounter.

Note: Include in the numerator patients with a negative screening and those with a positive screening who had a follow-up plan documented.

Exclusions/Exceptions

- Denominator Exclusions
    - Patients who have ever been diagnosed with bipolar disorder at any time prior to the qualifying encounter
- Denominator Exceptions
    - Patients who refuse to participate in or complete the depression screening
    - Medical reason(s), including:
        - Patients who are in urgent or emergent situations[21] where time is of the essence and to delay treatment would jeopardize the patient's health status
        - Patients with documentation of medical reasons for not screening the patient for depression (e.g., cognitive, functional, or motivational limitations) that may impact the accuracy of results

Specification Guidance

- The depression screening must be completed on the date of the visit or up to 14 days before the date of the visit using an age-appropriate standardized depression screening tool and must be reviewed and addressed in the office of the provider on the date of the visit.

[21] Do not exclude patients seen for routine care in urgent care centers or emergency rooms you operate.

- Numerator should be evaluated and reported based on the screening outcome.
- If the screening result is positive: a follow-up plan must be documented on the date of the visit or up to 2 days after the visit, or an active depression medication overlaps the date. A follow-up plan could be further evaluation, referral, treatment, pharmacological intervention (prescribed or active depression medication), exercise regimens, education counseling, coping support, completion of a mental health crisis plan, or other interventions.
- Standardized depression screening tools[22] are normalized and validated for the age-appropriate patient population in which they are used, must be documented in the patient health record, and must be used to meet the numerator criteria.
    - The measure is not prescriptive in the specific screening tool being used. Examples of depression screening tools for adolescents, adults, and perinatal patients are included in the FAQ for Table 6B.
    - Document the screening tool used in the patient health record. Each standardized screening tool gives guidance on whether a particular score is considered positive for depression.
    - While there are many validated depression screening tools, they are not necessarily diagnostic tools. Patients with elevated depression screening scores should be followed by a clinician to evaluate whether a depression diagnosis is appropriate, but a medication and/or referral are not always indicated for a positive score. In these cases, a follow-up plan is appropriate.
- Use the most recent screening results.
- Follow-up for a positive depression screening must include one or more of the following:
    - Additional interventions designed to treat depression, such as behavioral health evaluation, psychotherapy, or additional treatment.
    - Referral to a provider for further evaluation for depression.
    - Pharmacological interventions, when appropriate.

UDS Reporting Considerations

- The patient must have at least one UDS countable visit on Table 5 during the measurement period to be included.
- A Patient Health Questionnaire (PHQ-9)[23] performed in follow up to a PHQ-2 is still a **screening**. DO NOT count the PHQ-9 screening alone as meeting the numerator criteria for a follow-up plan to a positive depression screening.
- Screening may occur outside of a countable visit.
- Count eligible patients once in the denominator, regardless of how many times they were screened.
- Documentation of a follow-up plan "on the date of the visit" can refer to any countable visit, NOT only a medical visit.
- A suicide risk assessment DOES NOT qualify for the numerator as a follow-up plan.
- DO NOT count patients who are re-screened as meeting the numerator criteria for a follow-up plan to a positive screen.

[22] Refer to the publisher and the health center clinical team to interpret the results of screening tools.
[23] A PHQ is a screening instrument used by providers to monitor the severity of depression and response to treatment.

Depression Remission at Twelve Months (Line 21a), CMS159v14

Measure Description

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

This is calculated as follows:

Denominator: Columns A and B

- Patients aged 12 years and older at the start of the measurement period with a diagnosis of major depression or dysthymia and an initial PHQ-9 or PHQ-9 modified for teens (PHQ-9M) score greater than 9 during the index event between November 1, 2024, through October 31, 2025,[24] and at least one qualifying encounter during the measurement period, as specified in the measure criteria
    - Include patients with birthdate on or before November 1, 2012, who were 12 years of age or older on the date of the index event.

Note: Patients may be screened using PHQ-9 and PHQ-9M on the same date or up to 7 days prior to the visit (index event).

Numerator: Column C

- Patients who achieved remission at 12 months, as demonstrated by the most recent 12-month (+/- 60 days) PHQ-9 or PHQ-9M score of less than 5

Note: If a patient had multiple PHQ-9 or PHQ-9M scores within the 12-month (+/- 60 days) window, the *most recent* score must be used to assess the patient for the numerator.

Exclusions/Exceptions

- Denominator Exclusions
    - Patients with a diagnosis of bipolar disorder, personality disorder emotionally labile, schizophrenia, psychotic disorder, or pervasive developmental disorder (e.g., autism spectrum disorder)
    - Patients:
        - Who died
        - Who received hospice or palliative care services
- Denominator Exceptions
    - Not applicable

Specification Guidance

- Not applicable

[24] This CQM uses a unique measurement period to account for the full time period available to meet the numerator criteria.

UDS Reporting Considerations

- The patient must have at least one UDS countable visit on Table 5 during the measurement period to be included.
- Although PHQ-9 is not the only screening tool approved for the **Screening for Depression and Follow-Up Plan** measure, performance for the **Depression Remission at Twelve Months** must be evaluated using a PHQ-9 or PHQ-9M screening tool.
- The PHQ-9M may have been mislabeled as PHQ modified for adolescents (PHQ-A) in the health IT/EHR. This mislabeling often occurs within the EHR form or flowsheet name, where the PHQ-9M is incorrectly labeled as PHQ-A. The PHQ-A is an 80+ item questionnaire and is not equivalent to the 9-question PHQ-9M. Update the health IT/EHR with and use the PHQ-9M version approved by the PHQ-9 developers for screening adolescents.
- The index event is the date the patient had an initial PHQ-9 or PHQ-9M (modified for teens) score greater than 9 and a diagnosis of major depression or dysthymia during the period between November 1, 2024, through October 31, 2025.
- Count eligible patients once in the denominator, regardless of how many times they were screened.
- The PHQ-9 or PHQ-9M may be completed virtually or over the phone on the same date or up to 7 days before the visit (index event).
- Medical assistants, nurses, and other support personnel may perform the PHQ-9 or PHQ-9M.
- If a patient initially (at index event) screens positive for major depression or dysthymia and refuses the 12-month follow-up screening, count the patient in the denominator but not in the numerator, as they do not meet numerator criteria.

Note: The depression screening for the *Preventive Care and Screening: Screening for Depression and Follow-Up Plan* measure may be completed up to 14 days before the date of the visit, while the depression screening for the *Depression Remission at Twelve Months* measure may be completed up to 7 days before the date of the visit (index event). Given this, a patient who receives a screening **more than 7 days before the index event** (November 1, 2024, through October 31, 2025) will not be counted in the denominator or numerator for the Depression Remission at Twelve Months measure.

Sealant Receipt on Permanent First Molars (Lines 22a and 22b), SFM-CH-A

Measure Description

Percentage of children 10 years of age who have ever received sealants on permanent first molar teeth (two rates are reported):

a. Percentage of children who have ever received at least one sealant on a permanent first molar tooth

b. Percentage of children who have received sealants on all four molar teeth

Calculate as follows:

Denominator: Columns A and B

- **Denominator 1 and 2 (Lines 22a and 22b):** Children who turn 10 years of age during the measurement period and had at least one qualifying encounter during the measurement period, as specified in the measure criteria

- Include only patients who turn 10 years of age during the measurement period, reflective of children with birthdate on or after January 1, 2016, and birthdate on or before December 31, 2016.

Note: The denominator for Lines 22a and 22b must be the same.

Numerator: Column C

- **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

Exclusions/Exceptions

- 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
  - Not applicable

Specification Guidance

- A record with a missing or invalid tooth number code may NOT be counted in the numerator.
- Services provided on the 10th birthday are NOT included in the numerator.
- Sealants that are received prior to the 48 months before the 10th birthday are NOT included in the numerator.

UDS Reporting Considerations

- The patient must have at least one UDS countable visit on Table 5 during the measurement period to be included.
- This measure is not risk-based. Eligibility for the denominator is determined by age and dental visit criteria. Documentation of a sealant placed on at least one permanent first molar, which may be captured through tooth-level procedure codes or clinical documentation, is required to meet the numerator criteria.

Initiation and Engagement of Substance Use Disorder Treatment (Lines 23a and 23b), CMS137v14

Measure Description

Percentage of patients 13 years of age and older with a new substance use disorder (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

Calculate as follows:

Denominator: Columns A and B

- **Denominator 1 and 2 (Lines 23a and 23b):** Patients 13 years of age and older as of the start of the measurement period who were diagnosed with a new SUD episode during a visit between January 1 and November 14 of the measurement period
    - Include patients with birthdate on or before January 1, 2013.

Note: The denominator for Lines 23a and 23b must be the same.

Numerator: Column C

- **Numerator 1 (Line 23a):** Patients with initiation of treatment that includes either an intervention or medication for the treatment of SUD within 14 days of the new SUD episode
- **Numerator 2 (Line 23b):** Patients with engagement in ongoing SUD treatment within 34 days of initiation, which includes:
    - A long-acting SUD medication on the day after the initiation of treatment through 34 days after the initiation of treatment
    - One of the following options on the day after the initiation of treatment through 34 days after the initiation of treatment: a) two engagement visits, b) two engagement medication treatment events, c) one engagement visit and one engagement medication treatment event

Note: If a patient does not initiate treatment within 14 days of the new SUD episode, they are not included in the initiation numerator (Line 23a) or the engagement numerator (Line 23b). The numerator of Line 23b is a subset of the numerator of Line 23a.

Exclusions/Exceptions

- Denominator Exclusions
    - Patients who are in hospice care for any part of the measurement period
- Denominator Exceptions
    - Not applicable

Specification Guidance

- Not applicable

UDS Reporting Considerations

- The patient must have at least one UDS countable visit on Table 5 during the measurement period to be included.
- The new SUD episode is the first encounter during the Intake Period with a diagnosis of SUD with no encounter or medication treatment for a diagnosis of SUD in the 60 days prior. Patients with an active SUD diagnosis are not considered for the measure.
- The Intake Period: January 1–November 14 of the calendar year. The Intake Period is used to capture new SUD episodes. The November 14 cutoff date makes sure that initiation and engagement can occur before the measurement period ends.
- The initiation of treatment is the first SUD treatment within 14 days of a new SUD episode. The engagement of treatment is the ongoing treatment during the 34 days after initiation of treatment.

- **Engagement visits** are psychosocial visits with non-medication intervention, and **engagement medication treatment events** are initiation with long- or short-acting SUD medications.
- Treatment includes inpatient SUD admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations, and medications for the treatment of SUD. Medications that would satisfy the numerator include ordered or administered long-acting or short-acting medications included in the value sets. However, the specific combination of medication types that meets the requirement differs depending on the numerator.
- Substances included within the SUD diagnosis value set are cocaine, alcohol, opioids, psychoactive substances, amfetamine, amfetamine derivative, psychostimulants, hypnotics, and methylenedioxymethamphetamine.
- Patient refusal is NOT an exception or exclusion criteria for the measure.

Falls: Screening for Future Fall Risk (Line 24), CMS139v14

Measure Description

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

Calculate as follows:

Denominator: Columns A and B

- 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
  - Include patients with birthdate on or before January 1, 1961.

Numerator: Column C

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

Exclusions/Exceptions

- Denominator Exclusions
  - Patients receiving hospice care at any time during the measurement period
- Denominator Exceptions
  - Not applicable

Specification Guidance

- Not applicable

UDS Reporting Considerations

- The patient must have at least one UDS countable visit on Table 5 during the measurement period to be included.
- **Fall** is a sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than because of sudden onset of paralysis, epileptic seizure, or overwhelming external force.
- **Screening for future fall risk** is an assessment of whether a patient has experienced a fall or problems with gait or balance.

- A specific screening tool is not required for this measure; however, potential screening tools include the Morse Fall Scale and the Timed Up-and-Go (TUG) test, and Get-Up-and-Go test.
    - Use of CDC's Stopping Elderly Accidents, Deaths, and Injuries (STEADI) tools may facilitate standardized documentation; however, use of STEADI itself is not required for UDS reporting.

FAQ FOR TABLE 6B

1. On which line do we count patients who began prenatal care during the first trimester?

Report the patient on Line 7, and in Column A or B depending on if they began their care with the health center or with a non–health center provider. For example:

- If the patient began prenatal care during the first trimester at a health center's service delivery site or with a provider to which the health center referred the patient, report the patient on Line 7 in Column A.
- If the patient received prenatal care from another provider during the first trimester before coming to the health center's service delivery site, report the patient on Line 7 in Column B, regardless of when the patient begins care with the health center or through direct referral from the health center to another provider.

2. What timeframe is used to determine each of the trimesters of entry into prenatal care?

The trimesters of entry into prenatal care are as follows:

- First trimester: 0 weeks–13 and 6/7 weeks (months 1–3)
- Second trimester: 14 and 0/7 weeks–27 and 6/7 weeks (months 4–6)
- Third trimester: 28 and 0/7 weeks–40 and 6/7 weeks (months 7–9)

3. If a prenatal care patient from the prior year delivered during 2026, would we include the patient as a prenatal care patient in the 2026 UDS Report?

Yes. The prenatal care patient would be included in the 2026 UDS Report as a prenatal care patient on Table 6B, and birth outcomes will be reported on Table 7, even if they had no other visit in the calendar year.

4. A child came in only once during the year for an injury and never returned for well-child care. Do we have to consider the child's patient health record to not have met the numerator criteria since we only treated for the injury?

Yes. After a patient enters a health center's system of care, the health center is expected to provide all needed preventive health care and/or document that the patient has received it. If the visit they had is coded with a qualifying encounter for inclusion in the denominator of the CQM, report the patient in the denominator but NOT the numerator, since the record did not meet the numerator criteria.

5. If we inform parents of the importance of immunizations, but they refuse to have their child immunized, may we count the patient health record as having met the numerator criteria if the refusal is documented?

No. A child is fully immunized only if there is documentation that the child received the vaccine or there is contraindication for the vaccine, evidence of the antigen, or history of illness. Refusal does NOT meet the exclusion criteria.

6. **Do parents need to bring to the health center documentation of childhood immunizations received outside the health center?**

   When possible, health centers are encouraged to access childhood immunizations provided outside the health center through health information exchange, through read-only EHR access to immunization information systems, or through other health information exchange-facilitated means. If health information exchange access to this information is not available, parents are encouraged to provide documentation of immunizations that their children received elsewhere. Documentation of childhood immunizations may also be obtained by contacting providers of immunizations directly to obtain documentation by fax or email, by asking health center patients to mail a copy of their immunization history, through receipt of payment for the vaccine from the pharmacy, by finding the child in a state or county immunization registry, or through other appropriate means.

7. **Some of the immunization details are different from those used by the CDC in the Clinic Assessment Software Application (CASA) or Comprehensive-CASA (coCASA) reviews of our clinic. May we use these CDC standards to report on the UDS?**

   No. HRSA's BPHC uses the CMS eCQM standards to evaluate provision of vaccines to children. Using a different set of standards will distort the data. A health center **may** use a different set of standards for its own internal QI/quality assurance program, but these may not be substituted for the UDS reporting requirements.

8. **Does the cervical cancer screening review for women start at age 21?**

   No. For this measure, consider only women who were age 24 through age 64 by the end of the measurement period. Because the measure asks about Pap tests **administered within the last 3 years** (2026, 2025, or 2024), a 24-year-old woman assessed under this measure may have been 21 in 2024. If the patient received a Pap test in that year, the patient would be considered to have met the numerator criteria. The youngest age in the initial population is 23, although these patients must be 24 by the end of the measurement period to be counted in the measure.

9. **What is the difference between self-swab and self-reporting for the cervical cancer screening measure?**

   Current value sets for the measure do not specify collection method or location (e.g., in office vs. home) and are primarily oriented to test type and laboratory processing type. For the cervical cancer screening measure, self-reported screening does NOT meet the numerator criteria. Patient statements such as reporting that a Pap test or HPV test was completed elsewhere cannot be used unless there is clinical documentation or laboratory evidence in the patient health record. In contrast, a self-collected HPV test (self-swab) may be counted only if the test is FDA approved, processed by a clinical laboratory, and clearly documented in the patient health record, including the test type, date performed, and results. In addition to the HPV test being documented in the EHR, it must be approved for entry by the provider using any of the codes found in the corresponding "HPV Test" value set, have a non-null result, and be performed within the required timeframe. When these requirements are met, a self-swab is considered equivalent to a clinician-collected screening. Further inquiry about this topic can be made on the ONC Project Tracking System.

10. **What if a patient we treat for hypertension and diabetes goes to an OB/GYN in the community for reproductive health care? Do we still have to consider the patient in the denominator for the cervical cancer screening measure? What if we DO NOT offer Pap tests?**

    After the patient has been seen in your clinic for care, you must make sure that they have the appropriate cervical cancer screening. This can be done by providing the Pap test or documenting the results of a test that another provider did. Health centers are encouraged to coordinate care and document Pap test results by contacting providers. The health center may obtain a copy of the patient's test result to include in their patient health record to inform their future care. Consider the patient as part of the denominator for the cervical cancer screening measure if they had a **qualifying encounter**, as specified in the measure criteria, in the

measurement period. If no evidence of a timely cervical cancer screening is included in their patient health record, consider this as NOT having met the numerator criteria.

11. Does "counseling for nutrition and . . . physical activity" include specific content that must be provided? Does it need to be provided if the child is within the normal range?

No, the counseling has no specific required content, although it does have specific CPT coding requirements. It is tailored by the provider given the patient's BMI percentile and other clinical and upstream drivers of health data.

Yes, the counseling must be provided to all children and adolescents. Counseling is aimed at promoting routine physical activity and healthy eating for **all** children and adolescents. For younger children, counseling will be provided to the parent or caregiver.

12. For adult patients, our protocol calls for weight to be measured at every visit but height to be measured "at least once every 2 years." Is this acceptable?

No. BMI is calculated using height and weight reported during the measurement period. Height and weight may be obtained from separate visits, as long as both are measured during the most recent visit or during the measurement period.

13. The tobacco screening measure says that there must be intervention for tobacco users. What specific interventions must be used?

A broad range of counseling and pharmacotherapy is available for tobacco use. Which intervention to use is at the discretion of each provider.

14. Do quit lines meet the numerator criteria for tobacco cessation?

Yes. Tobacco cessation services provided by quit lines do meet the numerator criteria for the tobacco screening and cessation intervention measure if the intervention is documented in the patient's health record.

15. Do DNA colorectal cancer screening tests meet the numerator criteria for the colorectal cancer screening measure?

Yes. sDNA with FIT colorectal cancer screening tests (such as Cologuard) meet the numerator criteria for the colorectal cancer screening measure when done during the measurement period or in the 2 years prior.

16. Can blood tests count towards the colorectal screening measure?

This measure is based on guidelines from the U.S. Preventive Services Task Force (USPSTF), which does not recognize the colorectal cancer blood test as an acceptable option for meeting the measure's criteria. To meet the numerator requirements, applicable screenings include Fecal Occult Blood Test, Stool DNA with Fecal Immunochemical Test (FIT), Flexible Sigmoidoscopy, CT Colonography, or a colonoscopy. Clinically equivalent services may be mapped to the codes used in a measure's value sets to satisfy a value set requirement. If mapping is conducted, you should maintain documentation in case of a CMS audit.

17. If a patient who is newly diagnosed with HIV dies before they receive treatment, do we count them in the HIV linkage to care measure?

Yes. Include the patient in the denominator, assuming they met the diagnosis criteria. If they died before receiving the first visit for initiation of treatment, DO NOT count them in the numerator.

18. What standardized depression screenings comply with the Screening for Depression and Follow-Up Plan measure?

Use a standardized depression screening tool, which is a normalized and validated tool developed for the patient population in which it is to be used. Examples of depression screening tools include, **but are not limited to, those listed in the following chart**:

Adolescent Screening Tools (12–17 years)	Adult Screening Tools (18 years and older)	Perinatal Screening Tools
• Beck Depression Inventory-Primary Care Version (BDI-PC) • Center for Epidemiologic Studies Depression Scale (CES-D) • Kutcher Adolescent Depression Scale (KADS) • Mood Feeling Questionnaire (MFQ) • Patient Health Questionnaire (PHQ-9) • Patient Health Questionnaire for Adolescents (PHQ-A) • Patient Health Questionnaire Modified for Teens (PHQ-9M) • Pediatric Symptom Checklist (PSC-17) • Primary Care Evaluation of Mental Disorders (PRIME MD)-PHQ-2	• Beck Depression Inventory (BDI or BDI-II) • CES-D • Computerized Adaptive Diagnostic Screener (CAD-MDD) • Computerized Adaptive Testing Depression Inventory (CAT-DI) • Cornell Scale for Depression in Dementia (CSDD) • Depression Scale (DEPS) • Duke Anxiety-Depression Scale (DADS) • Geriatric Depression Scale (GDS) • Hamilton Rating Scale for Depression (HAM-D) • Patient Reported Outcomes Measurement Information System (PROMIS) Depression – Short Form • PHQ-9 • PRIME MD-PHQ-2 • PROMIS Depression – Computer Adaptive Test (CAT) • Quick Inventory of Depressive Symptomatology Self-Report (QID-SR)	• BDI • BDI-II • CES-D • Edinburgh Postnatal Depression Scale • PHQ-9 • Postpartum Depression Screening Scale • Zung Self-Rating Depression Scale

19. For the Depression Remission Measure, which score should be used if the patient has multiple PHQ-9 or PHQ-9M scores within the 12-month window? What if the most recent score is > 5?

If a patient has multiple PHQ-9 or PHQ-9M score within the 12-month (+/- 60 days) window, the most recent score should be used to assess the patient for numerator inclusion, regardless of the score value. For example, a patient first had a PHQ-9 score of 4 within the window, but then 2 weeks later (and still within the window)

had a PHQ-9 score of 6. The most recent score of 6 would be used to assess the patient for numerator inclusion, and in this case the patient would NOT meet be counted in the numerator.

20. The UDS manual defines a new SUD episode as " . . . the first encounter during the Intake Period with a diagnosis of SUD with no encounter or medication treatment for a diagnosis of SUD in the 60 days prior." What type of "encounter" is this speaking to?

Qualifying encounters may take place in various settings, given that a SUD diagnosis is included, including:

- Office visits
- Emergency department evaluation and management visits
- Detoxification visits
- Initial hospital inpatient visits
- Hospital inpatient discharge services, including same-day discharge
- Telephone or virtual visits
- Psychotherapy, mental health, or substance use disorder counseling

Additional information about qualifying encounters can be found on the eCQI Resource Center and Value Set Authority Center websites.

21. Is referring for care an acceptable method of "initiating" treatment for numerator 1 (Line 23a) or "continued engagement" for numerator 2 (Line 23b) for the Initiation and Engagement of SUD Treatment Measure?

Services may be provided via referral to an outside provider; however, for both numerators, a referral alone without documentation of the actual service provided does NOT meet the requirement for numerator inclusion. Documentation must include treatment provided, provider details, and date of service in the patient health record.

22. How does the UDS reporting requirement for the initiation and engagement of SUD measure relate to Certified Community Behavioral Health Clinics (CCBHCs)?

The UDS CQMs are required for all health centers. CCBHCs may contract with one or more health centers to support quality reporting, including CQMs. CCBHCs must adhere to specific quality reporting standards, including the UDS framework for collecting and reporting on the initiation and engagement of SUD measure and related data.

23. What substances are included in the Initiation and Engagement of SUD Treatment (Lines 23a and 23b) measure?

This measure includes all substance use disorders, including alcohol use disorder and other substance use disorders (e.g., opioids and non-opioid substances), as identified through qualifying SUD diagnosis codes included in the value set.

24. What counts as a new SUD episode for the SUD measure?

A new SUD episode occurs when a patient has a qualifying encounter with an SUD diagnosis during the intake period and no SUD-related diagnosis or treatment in the 60 days before that encounter. This lookback period helps ensure the episode represents a new opportunity to start treatment.

25. Should patients with a history of SUD be excluded from the SUD measure?

A prior history of SUD does not exclude a patient from the denominator. Include patients with a new SUD episode as long as they did not receive SUD-related services or treatment in the 60 days before the first encounter for a new SUD episode.

26. What is the difference between initiation and engagement of treatment for the SUD measure?

Initiation is when the patient receives a qualifying SUD intervention or medication treatment service within 14 days of the new SUD episode. This may include a psychosocial visit or an order of short-acting or long-acting SUD medication.

Engagement is when the patient receives additional qualifying SUD treatment services within 34 days after initiation, demonstrating continued participation in treatment. This may include a long-acting SUD medication or two further qualifying events: two engagement visits (e.g., counseling, psychotherapy), two engagement medication events (short-acting prescriptions or refills), or one engagement visit and one engagement medication event (combined).

27. What standardized fall risk screenings comply with the Screening for Future Fall Risk measure?

Health centers are encouraged to implement evidence-based approaches to identify and address fall risk, particularly among patients aged 65 years and older. While a specific screening tool is not required for this measure, potential screening tools include the Morse Fall Scale, Timed Up-and-Go test (TUG), and the Get-Up-and-Go test. The Centers for Disease Control and Prevention (CDC) has developed the initiative, which provides standardized clinical tools and workflows to support fall risk screening, assessment, and intervention in primary care settings. The CDC STEADI initiative also includes a structured clinical algorithm that guides providers through:

- Screening patients for fall risk (e.g., key screening questions, functional assessments)
- Conducting multifactorial risk assessments (e.g., gait, strength, medication review, vision)

Health centers may access these resources here.

28. How should we collect data for measures that require a look-back period?

Many of the UDS CQMs (e.g., cervical cancer screening, colorectal cancer screening, childhood immunizations, others) require a look-back period (reference to historical data before the measurement period). It is important to note this information in patient health records. It is recommended that you obtain records for new patients from their former providers to document their prior treatment, including data for look-back periods. Patient health records obtained from other providers may be recorded in the health center's health IT/EHR consistent with internal patient health record policies, at which point they could be used in the performance review. Additionally, if you change EHRs, make sure that the prior data are transferred to the new system.

29. Can we use the Healthcare Effectiveness Data and Information Set (HEDIS) directly to report on the CQMs?

No. For UDS reporting, you must report on the CQMs defined by UDS and outlined in this manual.

30. Can brand-name prescriptions meet the numerator criteria for measures that include a pharmaceutical component?

Yes. Since only scientific or generic names are stored in the RxNORM value sets, the health center and vendor need to map the generic and brand names when a new equivalent or brand name is discovered missing from RxNORM.

31. What does "diagnosis that overlaps the measurement period" mean, as stated for some of the measures?

The overlap statement means that if patients had the diagnosis at any point during the measurement period, they are to be included in the denominator and assessed for meeting the numerator criteria.

32. If we can see that the patient has received a needed service (such as a mammogram or colonoscopy), such as through our health information exchange or read-only EHR access, can we count that toward CQM compliance?

Yes. If a needed service is viewable and accessible in the patient health record directly, or through health information exchange or read-only EHR access, it may count toward CQM compliance as long as it meets the specified numerator criteria.

33. What do we need to do in the reporting of specific CQMs that we have identified to have a denominator exclusion?

Patients who have been identified to have met a denominator exclusion during the numerator criteria check need to be removed from both the numerator and denominator (and should no longer be considered for the measure).

34. We would like to recommend changes to specific eCQM requirements being collected in the UDS. Can HRSA make the changes based on our feedback?

Please contact the measure steward through the ASTP/ONC Issue Tracking System to submit recommendations to existing eCQM logic. Appendix G includes the list of measure stewards.

TABLE 6B: QUALITY OF CARE MEASURES

Calendar Year: January 1, 2026, through December 31, 2026

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

Section A—Age Categories for Prenatal Care Patients: Demographic Characteristics of Prenatal Care Patients

Line	Age	Number of Patients (A)
1	Less than 15 years	
2	Ages 15–19	
3	Ages 20–24	
4	Ages 25–44	
5	Ages 45 and over	
6	**Total Patients (Sum of Lines 1–5)**	

Section B—Early Entry into Prenatal Care

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		

Section C—Childhood Immunization Status

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			

Section D—Cervical and Breast Cancer Screening

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 Screening**	**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			

Section E—Weight Assessment and Counseling for Nutrition and Physical Activity of Children/Adolescents

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			

Section F—Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Line	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Total Patients Aged 18 and Older (A)	Number of Records Reviewed (B)	Number of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate (C)
13	MEASURE: Percentage of patients 18 years of age and older with (1) BMI documented and (2) follow-up plan documented if BMI is outside normal parameters			

Section G—Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Line	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Total Patients Aged 12 and Older (A)	Number of Records Reviewed (B)	Number of Patients Assessed for Tobacco Use *and* Provided Intervention if a Tobacco User (C)
14a	MEASURE: Percentage of patients aged 12 years of age and older who (1) were screened for tobacco use one or more times during the measurement period, **and** (2) if identified to be a tobacco user received cessation counseling intervention			

Section H—Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Line	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Total Patients at High Risk of Cardiovascular Events (A)	Number of Records Reviewed (B)	Number of Patients Prescribed or On Statin Therapy (C)
17a	MEASURE: Percentage of patients at high risk of cardiovascular events who were prescribed or were on statin therapy			

Section I—Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet

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

Section J—Colorectal Cancer Screening

Line	Colorectal Cancer Screening	Total Patients Aged 46 through 75 (A)	Number of Records Reviewed (B)	Number of Patients with Appropriate Screening for Colorectal Cancer (C)
19	MEASURE: Percentage of patients 46 through 75 years of age who had appropriate screening for colorectal cancer			

Section K—HIV Measures

Line	HIV Linkage to Care	Total Patients First Diagnosed with HIV (A)	Number of Records Reviewed (B)	Number of Patients Seen Within 30 Days of First Diagnosis of HIV (C)
20	MEASURE: Percentage of patients whose first-ever HIV diagnosis was made by health center personnel between December 1 of the prior year and November 30 of the measurement period and who were seen for follow-up treatment within 30 days of that first-ever diagnosis			
Line	**HIV Screening**	**Total Patients Aged 15 through 65 (A)**	**Number of Records Reviewed (B)**	**Number of Patients Tested for HIV (C)**
20a	MEASURE: Percentage of patients 15 through 65 years of age who were tested for HIV when within age range			

Section L—Depression Measures

Line	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Total Patients Aged 12 and Older (A)	Number of Records Reviewed (B)	Number of Patients Screened for Depression and Follow-Up Plan Documented as Appropriate (C)
21	MEASURE: Percentage of patients 12 years of age and older who were (1) screened for depression with a standardized tool *and,* if screening was positive, (2) had a follow-up plan documented or active depression medication			
Line	**Depression Remission at Twelve Months**	**Total Patients Aged 12 and Older with Major Depression or Dysthymia (A)**	**Number of Records Reviewed (B)**	**Number of Patients who Reached Remission (C)**
21a	MEASURE: Percentage of patients 12 years of age and older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event			

Section M—Sealant Receipt on Permanent First Molars

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**			

Section N—Substance Use Disorder (SUD) Measures

Line	Initiation and Engagement of Substance Use Disorder (SUD) Treatment	Total Patients Aged 13 and Older Diagnosed with a New SUD Episode (A)	Number of Records Reviewed (B)	Number of Patients who Received SUD Treatment (C)
23a	MEASURE: Percentage of patients with a new SUD episode who **initiated treatment**, including either an intervention or medication for the treatment of SUD, within 14 days of the new SUD episode			
23b	MEASURE: Percentage of patients with a new SUD episode 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			

Section O—Screening for Future Falls Risk

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			

Table 6B Cross-Table Considerations:

- Patients with countable visits on Table 5 are generally eligible for inclusion in CQMs reported on Table 6B if they also have a visit that meets the qualifying encounter definition in the CQM criteria.
- The relationship between the denominators on Table 6B should be verified as reasonable when compared to the total number of patients by age on Table 3A and the percentage of patients by service category on Table 5.
- The count of patients by diagnosis reported on Table 6A will NOT be the same count as on Table 6B, due to differences in criteria that must be met for inclusion on Table 6B.

Instructions for Table 7: Health Outcomes

The health outcome measures reported on Table 7 document measurable outcomes of clinical intervention as a surrogate for good long-term health outcomes.

The text directly below contains changes to Table 7 from 2025 calendar year reporting to 2026 calendar year reporting:

Several key changes have been made to Table 7, as outlined below:

- The CQMs specifications reported have been revised to align with the CMS eCQMs. The clinical quality of care measures are aligned with the most current eCQMs for Eligible Professionals for the 2026 version number referenced in the UDS Manual for the measurement period. (Later version updates are available, but they should not be used for the 2026 reporting.)

This marks the conclusion of changes to Table 7 from 2025 calendar year reporting to 2026 calendar year reporting.

TABLE 7: HEALTH OUTCOMES MEASURES

This table specifically includes the following CQMs:

Maternal Care and Children's Health	Disease Management
• Low Birth Weight	• Controlling High Blood Pressure • Diabetes: Glycemic Status Assessment Greater Than 9%

RACE AND ETHNICITY REPORTING

Table 7 reports data by race and Hispanic, Latino/a, or Spanish ethnicity.

- Race and Hispanic, Latino/a, or Spanish ethnicity are self-reported by patients and should be collected as part of a standard registration process.
- Care must be taken by health centers that have separate reporting systems for patient registration and clinical data to make sure race and ethnicity data across the systems are aligned.
- Because Table 7 measures are defined by race and ethnicity, comparisons between the numbers on Tables 3B and 7 will be made when evaluating your submission. See the crosswalk of comparable fields in Appendix B.

Note: The reporting of patients' race and ethnicity on the UDS may differ from the race and ethnicity levels needed for other eCQM reporting programs.

Note: The "Subtotal Hispanic, Latino/a, or Spanish Origin" and "Subtotal Not Hispanic, Latino/a, or Spanish Origin" lines are grayed out on all three sections of Table 7. They are given as a system-generated subtotal in the EHBs.

SECTION A: DELIVERIES AND BIRTH WEIGHT

HIV-POSITIVE PREGNANT WOMEN, TOP LINE (LINE 0)

Report the total number of HIV-positive pregnant women served by the health center during the calendar year on Line 0, regardless of whether the health center provides prenatal care or HIV treatment for these patients.

DELIVERIES PERFORMED BY HEALTH CENTER PROVIDER (LINE 2)

Report the total number of deliveries performed by health center providers.

Include **all** deliveries, regardless of outcome or whether the patient received prenatal care at the health center during the calendar year. Include these situations:

- Deliveries of another doctor's patients when the health center provider is on call at the time of delivery.
- Emergency room deliveries performed while the health center provider is on call.
- Deliveries of non–health center patients required to maintain hospital privileges.

DO NOT include deliveries for which a provider bills independently and keeps the payment (e.g., moonlighting).

DELIVERIES AND BIRTH WEIGHT DATA BY RACE AND HISPANIC, LATINO/A, OR SPANISH ETHNICITY (COLUMNS 1A–1D)

- **Prenatal Care Patients Who Delivered (Column 1A):** Report **all** health center prenatal care patients who delivered during the calendar year, whether they received direct prenatal care at the health center or were referred elsewhere, including delivery-only referrals. These patients must also be included in the prenatal care counts on Table 6B.
- **Live Births (Columns 1B–1D):** Report **all** babies born during the calendar year to the prenatal care patients who delivered (Column 1A), regardless of whether the delivery was performed by a health center provider or an external provider.
- Report patients (Column 1A) and babies (Columns 1B, 1C, and 1D) separately by race and ethnicity. Use maternal race and ethnicity from the patient registration form. Use infant race and ethnicity from infant registration form, birth certificate, or parental report. Mother and baby may have different race and ethnicity. Use the race and ethnicity categories and subcategories defined in Table 3B.

Prenatal Care Patients Who Delivered (Column 1A)

Report all health center prenatal care patients who delivered during the calendar year, including those whose care or delivery was provided partly or entirely by a referral provider.

- Count each patient once, even if the delivery involved multiple births (e.g., twins or triplets), or resulted in a stillbirth. Include all documented deliveries, regardless of the outcome.

DO NOT include:

- Patients for whom there is no documentation that a delivery occurred.
- Patients who lack explicit delivery documentation.
- Miscarriages.

Note: The percentage of prenatal care patients who delivered can be calculated by dividing Table 7, Line i, Column 1A by Table 6B, Line 6, Column A. Use the cross-table guidance in Appendix B on the relationship between prenatal care on Table 6B and deliveries on Table 7 to help with this reporting.

Birth Weight of Infants Born to Prenatal Care Patients Who Delivered During the Year (Columns 1B–1D)

Low Birth Weight (Columns 1B and 1C), no eCQM

Measure Description

Percentage of babies of health center prenatal care patients born whose birth weight was below normal (less than 2,500 grams)

Note: The reporting of this measure captures all birth weight categories.

Calculate as follows:

Denominator: Columns 1B + 1C + 1D

- Babies born during the measurement period to prenatal care patients

Numerator: Columns 1B + 1C

- Babies born with a birth weight below normal (under 2,500 grams)

Exclusions/Exceptions

- Denominator Exclusions
  - Stillbirths or miscarriages
- Denominator Exceptions
  - Not applicable

Specification Guidance

- Not applicable

UDS Reporting Considerations

- Report the total number of **live** births during the calendar year for patients who received prenatal care from the health center or a referral provider during the calendar year, according to the appropriate birth weight group (in grams):
  - **Very Low Birth Weight (LBW) (Column 1B):** Weight at birth was less than 1,500 grams.
  - **LBW (Column 1C):** Weight at birth was 1,500 grams through 2,499 grams.
  - **Normal Birth Weight (Column 1D):** Weight at birth was equal to or greater than 2,500 grams.

Note: Be careful not to confuse pounds and ounces for grams when reporting these numbers. Include birth weight for neonatal demises (death of a live-born baby within the first 28 days of life).

- If the delivery is of multiple babies (e.g., twins or triplets), report the birth weight of each baby separately.
- Report delivery data for all prenatal care patients, whether the health center performed the delivery, referred it to another provider, or the patient sought care elsewhere. **Tracking and follow-up on all prenatal care patients are required.**

- In rare instances, there may be no birth outcomes recorded although there may be evidence (i.e., records show delivery occurred) that the patient delivered. Report the patient as having delivered (Column 1A) with no birth outcomes (Columns 1B–1D).
- The number of deliveries reported in Column 1A will normally be different than the total number of babies reported in Columns 1B–1D because of multiple births and stillbirths.
- Although data are given for each race and ethnicity category, the measure looks only at the totals.[25]

Note: This is a "negative" measure: The *higher* the proportion of infants born below normal birth weight, the *worse* the performance on the measure.

SECTIONS B AND C: OTHER HEALTH OUTCOME MEASURES

- For Sections B and C, report patients who had both a UDS countable visit during the year (reported at least once on Table 5) **AND** a qualifying encounter as specified in the measure specifications.
- Calculate age using the dates required for each CQM.
- DO NOT exclude patients seen only for urgent care, a single acute visit, or specialty care or those who later left the practice. If they had a countable visit and met the qualifying encounter criteria, they must be included.
- For measures requiring screenings, tests, or procedures, the results must be available in the patient health record.

Note: In this section, the term "measurement period" is the timeframe specified by the measure steward.

Controlling High Blood Pressure (Columns 2A–2C), CMS165v14

Measure Description

Percentage of patients 18–85 years of age who had a 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 (BP) was adequately controlled (less than 140/90 mmHg) during the measurement period

Calculate as follows:

Denominator: Columns 2A and 2B

- Patients 18 through 85 years of age by the end of the measurement period who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first 6 months of the measurement period, with a qualifying encounter during the measurement period, as specified in the measure criteria
  - Include patients with birthdate on or after January 1, 1941, and birthdate on or before December 31, 2008.

Numerator: Column 2C

- Patients whose most recent blood pressure is adequately controlled (systolic blood pressure less than 140 mmHg and diastolic blood pressure less than 90 mmHg) during the measurement period

[25] However, during the review of the UDS Report, the health center may be questioned about unusually high or low proportion of low-birth-weight babies for individual race or ethnicity categories.

Exclusions/Exceptions

- Denominator Exclusions
  - Patients who were in hospice care for any part of the measurement period
  - Patients with evidence of ESRD, dialysis, or renal transplant before or during the measurement period
  - Women with a diagnosis of pregnancy during the measurement period
  - Patients aged 66–80 by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria: advanced illness diagnosis during the measurement period or the year prior; or taking dementia medications during the measurement period or the year prior
  - Patients 81 and older by the end of the measurement period with an indication of frailty for any part of the measurement period
  - Patients aged 66 or older by the end of the measurement period who were living long-term in a nursing home any time on or before the end of the measurement period
  - Patients who received palliative care for any part of the measurement period
- Denominator Exceptions
  - Not applicable

Specification Guidance

- Only blood pressure readings done by a provider or an automated blood pressure monitor or device are acceptable for the numerator criteria with this measure.
- Blood pressure readings are acceptable if:
  - taken in person by a clinician,
  - measured remotely by an electronic monitoring device capable of transmitting the blood pressure data to the clinician, or
  - taken by an **automated** blood pressure monitor or device and conveyed by the patient to the clinician. This is not considered patient self-reporting.
- It is the clinician's responsibility and discretion to confirm the remote monitoring device used to obtain the blood pressure is considered acceptable and reliable and whether the blood pressure reading is considered accurate before documenting it in the patient's health record.
- If there are multiple blood pressure readings on the last day the patient was seen, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading.
- If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled." Report them in Columns 2A and 2B, but NOT in Column 2C.
- Blood pressure ranges and thresholds do not meet criteria for this measure. A distinct numeric result for both the systolic and diastolic BP reading is needed for numerator CQM compliance.
- DO NOT include blood pressure readings taken during an acute inpatient stay or emergency department visit.

UDS Reporting Considerations

- The patient must have at least one UDS countable visit on Table 5 during the measurement period to be included.

- Include patients who have an active diagnosis of essential hypertension, even if their qualifying encounter, as specified by the measure steward, during the year was unrelated to the diagnosis.
- Include blood pressure readings taken and documented in the patient's health record at any visit type by the health center as long as the result used for this measure is from the most recent calendar year visit.
- Although data are collected for each race and ethnicity category, the measure looks only at the totals.

Diabetes: Glycemic Status Assessment Greater Than 9% (Columns 3A–3F), CMS122v14

Measure Description

Percentage of patients 18–75 years of age with diabetes who had a glycemic status assessment (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) greater than 9.0 percent during the measurement period

Calculate as follows:

Denominator: Columns 3A and 3B

- Patients 18 through 75 years of age by the end of the measurement period with diabetes and with a qualifying encounter during the measurement period, as specified in the measure criteria
  - Include patients with birthdate on or after January 1, 1951, and birthdate on or before December 31, 2008.

Numerator: Column 3F

- Patients whose most recent glycemic status assessment (HbA1c or GMI) performed during the measurement period was greater than 9.0%, or was missing, or was not performed during the measurement period

Exclusions/Exceptions

- Denominator Exclusions
  - Patients who were in hospice care for any part of the measurement period
  - Patients aged 66 or older by the end of the measurement period who were living long-term in a nursing home any time on or before the end of the measurement period
  - Patients aged 66 or older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria: advanced illness diagnosis during the measurement period or the year prior; or taking dementia medications during the measurement period or the year prior
  - Patients who received palliative care for any part of the measurement period
- Denominator Exceptions
  - Not applicable

Specification Guidance

- If the glycemic status assessment (HbA1c or GMI) is in the patient health record, the test can be used to determine the numerator criteria.
- Glycemic status assessment (HbA1c or GMI) must be reported as a percentage.
- If multiple glycemic status assessments were recorded for a single date, use the lowest result.

UDS Reporting Considerations

- The patient must have at least one UDS countable visit on Table 5 during the measurement period to be included.
- Report patients who have an active diagnosis of diabetes even if their qualifying encounter during the year was unrelated to the diagnosis.
- Use codes as outlined in the measure specifications to determine if diagnosis of secondary diabetes due to another condition is to be included.
- Include patients in the numerator whose most recent HbA1c or GMI level is greater than 9.0%, for whom the most recent HbA1c or GMI result is missing, or for whom no HbA1c or GMI tests were done or documented during the measurement period. Patient self-report is NOT accepted.
- Even if the treatment of the patient's diabetes has been referred to a non–health center provider, the health center is expected to have the current lab test results in its records.
- Although data are given for each race and ethnicity category, the measure looks only at the totals.

Note: This is a "negative" measure: The *lower* the number of adult patients with diabetes with poor diabetes control, the better the performance on the measure.

FAQ FOR TABLE 7

1. **When would we use Line h, "Unreported/Chose not to disclose" race and ethnicity?**

   Use Line h only in those instances where patients DO NOT provide their race **and** DO NOT state whether they are of Hispanic, Latino/a, or Spanish origin. Report patients who provide a race but DO NOT affirmatively answer a question about Hispanic, Latino/a, or Spanish ethnicity as Not Hispanic, Latino/a, or Spanish origin on the appropriate race line (Lines 2a–2g). Report patients who indicate they are Hispanic, Latino/a, or Spanish origin but DO NOT provide a race on Line 1g.

2. **Data are requested by race and Hispanic, Latino/a, or Spanish ethnicity. How are these to be coded?**

   Report race and Hispanic, Latino/a, or Spanish ethnicity on this table in the same manner used to report on Table 3B. Refer to instructions for Table 3B for further information describing race and ethnicity categories, including subcategories. Make sure the same information is recorded in both the patient health record and the registration form to avoid errors.

3. **Do patients with diabetes need to bring to the health center documentation of HbA1c tests or GMI calculations received from outside the health center?**

   The health center must have HbA1c test or GMI calculation results in patient health records. If the health center does not do the test or calculation, they should contact the provider who did the tests. The documentation can be brought in by the patient but can also be obtained electronically by fax or through other appropriate means.

4. **In Section A, Deliveries and Birth Weight, should the race and ethnicity of the baby be the same as that of the mother?**

   Not necessarily. The baby's race and ethnicity may differ from the race and ethnicity of the mother. Report the race and ethnicity of the mother (Column 1A) separately from that of the baby (Column 1B, 1C, or 1D).

5. How do we determine "active diagnosis" that is needed for some measures?

Active diagnosis is a condition documented in the patient health record that is currently present and relevant to the patient's care. An active diagnosis is generally identified on the active problem list or recorded as an encounter diagnosis with an active status. Specifications will indicate when a measure requires an active diagnosis.

6. Can we use our community health management system to report on the CQMs?

Possibly. Health centers that have Assistant Secretary for Technology Policy (ASTP)/Office of the National Coordinator for Health Information Technology (ONC)-certified health IT systems, including community health management systems, may use them to collect, calculate, run, and report measure results, but only if such health IT systems apply measure definitions and use standardized logic and value sets, as detailed in the specification criteria for that version of the measure.

TABLE 7: HEALTH OUTCOMES

Calendar Year: January 1, 2026, through December 31, 2026

Section A: Deliveries and Birth Weight

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

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				
1b2p	Other Pacific Islander				
1b3p	Guamanian or Chamorro				

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)
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				
	Cuban				
1a1c	Asian Indian				
1a2c	Chinese				
1a3c	Filipino				
1a4c	Japanese				
1a5c	Korean				
1a6c	Vietnamese				
1a7c	Other Asian				
1b1c	Native Hawaiian				
1b2c	Other Pacific Islander				
1b3c	Guamanian or Chamorro				
1b4c	Samoan				
1cc	Black or African American				
1dc	American Indian/Alaska Native				
1ec	White				
1fc	More than One Race				
1gc	Unreported/Chose Not to Disclose Race				
	Subtotal Cuban				
	Another Hispanic, Latino/a, or Spanish Origin				
1a1a	Asian Indian				
1a2a	Chinese				
1a3a	Filipino				
1a4a	Japanese				
1a5a	Korean				
1a6a	Vietnamese				
1a7a	Other Asian				
1b1a	Native Hawaiian				
1b2a	Other Pacific Islander				

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)
1b3a	Guamanian or Chamorro				
1b4a	Samoan				
1ca	Black or African American				
1da	American Indian/Alaska Native				
1ea	White				
1fa	More than One Race				
1ga	Unreported/Chose Not to Disclose Race				
	Subtotal Another Hispanic, Latino/a, or Spanish Origin				
	Hispanic, Latino/a, or Spanish Origin Combined				
1a1o	Asian Indian				
1a2o	Chinese				
1a3o	Filipino				
1a4o	Japanese				
1a5o	Korean				
1a6o	Vietnamese				
1a7o	Other Asian				
1b1o	Native Hawaiian				
1b2o	Other Pacific Islander				
1b3o	Guamanian or Chamorro				
1b4o	Samoan				
1co	Black or African American				
1do	American Indian/Alaska Native				
1eo	White				
1fo	More than One Race				
1go	Unreported/Chose Not to Disclose Race				
	Subtotal Hispanic, Latino/a, or Spanish Origin, Combined				
	Total Hispanic, Latino/a, or Spanish Origin				
	Not Hispanic, Latino/a, or Spanish Origin				
2a1	Asian Indian				
2a2	Chinese				
2a3	Filipino				
2a4	Japanese				
2a5	Korean				
2a6	Vietnamese				
2a7	Other Asian				

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)
2b1	Native Hawaiian				
2b2	Other Pacific Islander				
2b3	Guamanian or Chamorro				
2b4	Samoan				
2c	Black or African American				
2d	American Indian/Alaska Native				
2e	White				
2f	More than One Race				
2g	Unreported/Chose Not to Disclose Race				
	Total Not Hispanic, Latino/a, or Spanish Origin				
	Unreported/Chose Not to Disclose Race and Ethnicity				
h	Unreported/Chose Not to Disclose Race and Ethnicity				
i	**Total**				

Section B: Controlling High Blood Pressure

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			

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)
1ep	White			
1fp	More than One Race			
1gp	Unreported/Chose Not to Disclose Race			
	Subtotal Puerto Rican			
	Cuban			
1a1c	Asian Indian			
1a2c	Chinese			
1a3c	Filipino			
1a4c	Japanese			
1a5c	Korean			
1a6c	Vietnamese			
1a7c	Other Asian			
1b1c	Native Hawaiian			
1b2c	Other Pacific Islander			
1b3c	Guamanian or Chamorro			
1b4c	Samoan			
1cc	Black or African American			
1dc	American Indian/Alaska Native			
1ec	White			
1fc	More than One Race			
1gc	Unreported/Chose Not to Disclose Race			
	Subtotal Cuban			
	Another Hispanic, Latino/a, or Spanish Origin			
1a1a	Asian Indian			
1a2a	Chinese			
1a3a	Filipino			
1a4a	Japanese			
1a5a	Korean			
1a6a	Vietnamese			
1a7a	Other Asian			
1b1a	Native Hawaiian			
1b2a	Other Pacific Islander			
1b3a	Guamanian or Chamorro			
1b4a	Samoan			
1ca	Black or African American			

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)
1da	American Indian/Alaska Native			
1ea	White			
1fa	More than One Race			
1ga	Unreported/Chose Not to Disclose Race			
	Subtotal Another Hispanic, Latino/a, or Spanish Origin			
	Hispanic, Latino/a, or Spanish Origin, Combined			
1a1o	Asian Indian			
1a2o	Chinese			
1a3o	Filipino			
1a4o	Japanese			
1a5o	Korean			
1a6o	Vietnamese			
1a7o	Other Asian			
1b1o	Native Hawaiian			
1b2o	Other Pacific Islander			
1b3o	Guamanian or Chamorro			
1b4o	Samoan			
1co	Black or African American			
1do	American Indian/Alaska Native			
1eo	White			
1fo	More than One Race			
1go	Unreported/Chose Not to Disclose Race			
	Subtotal Hispanic, Latino/a, or Spanish Origin, Combined			
	Total Hispanic, Latino/a, or Spanish Origin			
	Not Hispanic, Latino/a, or Spanish Origin			
2a1	Asian Indian			
2a2	Chinese			
2a3	Filipino			
2a4	Japanese			
2a5	Korean			
2a6	Vietnamese			

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)
2a7	Other Asian			
2b1	Native Hawaiian			
2b2	Other Pacific Islander			
2b3	Guamanian or Chamorro			
2b4	Samoan			
2c	Black or African American			
2d	American Indian/Alaska Native			
2e	White			
2f	More than One Race			
2g	Unreported/Chose Not to Disclose Race			
	Total Not Hispanic, Latino/a, or Spanish Origin			
	Unreported/Chose Not to Disclose Race and Ethnicity			
h	Unreported/Chose Not to Disclose Race and Ethnicity			
i	**Total**			

Section C: Diabetes: Glycemic Status Assessment Greater Than 9%

Line	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3A)	Number of Records Reviewed (3B)	Patients with Glycemic Status Assessment >9%, Missing, or No Test During Year (3F)
	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			

Line	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3A)	Number of Records Reviewed (3B)	Patients with Glycemic Status Assessment >9%, Missing, or No Test During Year (3F)
1dp	American Indian/Alaska Native			
1ep	White			
1fp	More than One Race			
1gp	Unreported/Chose Not to Disclose Race			
	Subtotal Puerto Rican			
	Cuban			
1a1c	Asian Indian			
1a2c	Chinese			
1a3c	Filipino			
1a4c	Japanese			
1a5c	Korean			
1a6c	Vietnamese			
1a7c	Other Asian			
1b1c	Native Hawaiian			
1b2c	Other Pacific Islander			
1b3c	Guamanian or Chamorro			
1b4c	Samoan			
1cc	Black or African American			
1dc	American Indian/Alaska Native			
1ec	White			
1fc	More than One Race			
1gc	Unreported/Chose Not to Disclose Race			
	Subtotal Cuban			
	Another Hispanic, Latino/a, or Spanish Origin			
1a1a	Asian Indian			
1a2a	Chinese			
1a3a	Filipino			
1a4a	Japanese			
1a5a	Korean			
1a6a	Vietnamese			
1a7a	Other Asian			
1b1a	Native Hawaiian			
1b2a	Other Pacific Islander			
1b3a	Guamanian or Chamorro			

Line	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3A)	Number of Records Reviewed (3B)	Patients with Glycemic Status Assessment >9%, Missing, or No Test During Year (3F)
1b4a	Samoan			
1ca	Black or African American			
1da	American Indian/Alaska Native			
1ea	White			
1fa	More than One Race			
1ga	Unreported/Chose Not to Disclose Race			
	Subtotal Another Hispanic, Latino/a, or Spanish Origin			
	Hispanic, Latino/a, or Spanish Origin, Combined			
1a1o	Asian Indian			
1a2o	Chinese			
1a3o	Filipino			
1a4o	Japanese			
1a5o	Korean			
1a6o	Vietnamese			
1a7o	Other Asian			
1b1o	Native Hawaiian			
1b2o	Other Pacific Islander			
1b3o	Guamanian or Chamorro			
1b4o	Samoan			
1co	Black or African American			
1do	American Indian/Alaska Native			
1eo	White			
1fo	More than One Race			
1go	Unreported/Chose Not to Disclose Race			
	Subtotal Hispanic, Latino/a, or Spanish Origin			
	Total Hispanic, Latino/a, or Spanish Origin			
	Not Hispanic, Latino/a, or Spanish Origin			
2a1	Asian Indian			
2a2	Chinese			
2a3	Filipino			

Line	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3A)	Number of Records Reviewed (3B)	Patients with Glycemic Status Assessment >9%, Missing, or No Test During Year (3F)
2a4	Japanese			
2a5	Korean			
2a6	Vietnamese			
2a7	Other Asian			
2b1	Native Hawaiian			
2b2	Other Pacific Islander			
2b3	Guamanian or Chamorro			
2b4	Samoan			
2c	Black or African American			
2d	American Indian/Alaska Native			
2e	White			
2f	More than One Race			
2g	Unreported/Chose Not to Disclose Race			
	Total Not Hispanic, Latino/a, or Spanish Origin			
	Unreported/Chose Not to Disclose Race and Ethnicity			
h	Unreported/Chose Not to Disclose Race and Ethnicity			
i	**Total**			

Table 7 Cross-Table Considerations:

- Patients with countable visits on Table 5 are generally eligible for inclusion in CQMs reported on Table 7.
- The relationship between the denominators on Table 7 should be verified as reasonable when compared to the total number of patients by age on Table 3A and patients by race and ethnicity on Table 3B.
- The count of patients by diagnosis reported on Table 6A will not be the same counts as on Table 7 due to differences in criteria that must be met for inclusion on Table 7.

Instructions for Table 8A: Financial Costs

Table 8A reports the total accrued costs for all activities attributable to the calendar year that are within the health center's approved scope of project, regardless of source of funding (e.g., the Health Center Program award, patient and third-party payments, other grants and contracts).

The text directly below contains changes to Table 8A from 2025 calendar year reporting to 2026 calendar year reporting:

Several key changes have been made to Table 8A, as outlined below:

- The allocation of facility and non-clinical support services, Column B, has been removed.
- Column A1 has been added to report personnel salary and fringe benefit costs, Column A2 has been added to show other direct costs corresponding to each cost center, and Column A has been updated to report the sum of Columns A1 and A2.
- Enabling Services (Line 11) has been renamed and consolidated to Patient Support Services. Patient support service subcategories (Lines 11a–11h) have been removed.
- The former separate line for Quality improvement (Line 12a) has been removed. QI costs are reported on a new line with Information Technology (Line 14a) costs.
- Information Technology, formerly reported on Line 15, is now reported on a new line (Line 14a) with QI costs.
- Donations (Line 18) has been removed. Donated facilities, services, and supplies are no longer reported in the UDS.
- Non-Clinical Support (Line 15) has been renamed to Other Support Costs.

This marks the conclusion of changes to Table 8A from 2025 calendar year reporting to 2026 calendar year reporting.

TABLE 8A: FINANCIAL COSTS

This table reports the total **accrued** costs for personnel, other associated costs, and total accrued costs for each cost center to accomplish the scope of project.

COLUMN REPORTING REQUIREMENTS

This table has three columns: Personnel Costs (Column A1), Other Costs (Column A2), and the Total Accrued Costs (Column A).

- Report the costs (in U.S. dollars) incurred in the calendar year on the full accrual basis of accounting (accrued costs). This includes payroll-related accruals, pre-paid expenses, depreciation on capital assets, and other accrued costs, regardless of when or if actual cash payments were made.
- Report only the depreciation accrued on capital assets (e.g., facilities and equipment), including those acquired with HRSA's BPHC grants. DO NOT report the full purchase of capital assets.
- Report interest payments (only) on loans based on the acquisition purpose of each loan under the Facility and Support Services section (Facility, Information Technology, and Other Support Costs).
- DO NOT report the repayment of the principal portion of a loan. These are reductions to the loan liability on the Balance Sheet and are not reported anywhere in the UDS Report.

- DO NOT report bad debt write-offs and allowances (actual and estimated) here. Report bad debt write-offs and allowances as an offset (contra revenue) to Patient Services Revenue on Table 9D, Line 15, Column G. Accrued bad debt is the total of actual accounts written off during the period, plus the estimated accrued value of uncollectible receivables (allowance for doubtful accounts) at the end of the period.
- DO NOT allocate overhead, indirect, or other central support service costs. These costs are reported in the Facility and Support Services cost center section, Lines 14 through 16 (Facility, Information Technology, and Other Support Costs). The costs included in these cost centers are detailed in the line descriptions below.
- DO NOT report the value of in-kind, donated services, supplies, or facilities in the UDS Report.

Note: A table summarizing the cost columns is included in FAQ for Table 8A.

Personnel Costs (Column A1)

- Report the accrued direct personnel costs directly attributable to each listed cost center.
- Include salaries, fringe benefits, personnel under contract who are paid on an hourly or FTE basis, interns, residents, preceptors, and all payroll-related accruals (partial month-end payroll, accrued leave or paid time off, etc.) for those whose FTE are reported on Table 5.
- Include the labor cost of personnel under contract who are paid on an hourly or FTE basis that are issued a 1099-Nonemployee Compensation (1099-NEC) who provided services to health center patients under the auspices of the health center and whose FTEs are included on Table 5. Align accrued personnel costs reported on Table 8A with the same service categories as the FTEs reported on Table 5. See Instructions for Table 5 for reporting FTEs by category.
- DO NOT report in Column A1 labor costs of professional service contractors who work independently under their own auspices and are paid by the health center on a fee-for-service basis, including paid referred care (in alignment with Table 5, where no FTE is reported for these contractors). Report professional service contract costs in Other Costs, Column A2.
- If an individual's FTE is split across multiple lines on Table 5, apply the same proportional allocation for that individual's personnel costs.
- See Line Definitions for costs to include in each cost category.

Other Costs (Column A2)

- Report the accrued costs for all other direct (non-personnel) costs directly attributable to each listed cost center. Other direct costs include, but are not limited to, supplies, training, travel, and purchased services (non-personnel).
- Include purchased services (non-personnel) costs paid on a fee-for-service basis, including professional service contracts, paid referred care, vouchered service contracts, and specialty care referral contracts. This includes costs for at-risk or other specialty care from a managed care organization (MCO) contract. Align professional service contract costs on Table 8A with the same service categories listed on Table 5 (no FTEs are reported for contracted personnel paid on a fee-for-service basis).
- Include all direct supplies, laboratories, purchased services (non-personnel), minor equipment, travel, personnel education, meeting registration, uniform laundering, recruitment, membership in professional societies, books, journal subscriptions, and other direct costs for each cost center.

Total Accrued Costs (Column A)

- Sum of Personnel Costs (Column A1) and Other Costs (Column A2). This is automatically calculated in the EHBs.

Note: All UDS calculations involving total cost, such as total costs per patient, are based on Line 17.

COST CENTER LINE REPORTING REQUIREMENTS

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), and Facility and Support Services (Lines 14–16). Report the direct accrued cost for each of the cost centers and section subtotals listed on Lines 1–16. The overall total accrued costs are reported on Line 17, Total Health Center Costs. Subtotals and the overall totals are automatically calculated in the EHBs.

Report the cost of each of the cost centers listed on Lines 1–16.

- Align personnel and fringe costs reported on Table 8A, Column A1, with FTEs and services reported on Table 5. A crosswalk that classifies personnel for various cost line items is available in Appendix B.
- If an individual's FTE is split across multiple lines on Table 5, the same allocation must be used for that individual's personnel costs on this table.

Medical Care (Lines 1 and 2)

This cost center reports all direct medical care service costs and separates the costs for medical laboratory and X-ray (Line 2) from all other medical care costs (Line 1).

Medical Care (Line 1)

- Report all accrued direct personnel salary, fringe, and 1099-NEC contract costs paid on an hourly or FTE basis in Column A1—Personnel Costs, including all payroll-related accruals (i.e., partial month-end payroll, accrued leave, paid time off) associated with personnel reported on Table 5, Lines 1–12, **except** for medical laboratory and X-ray. (Report on Line 2.)
- Report the personnel costs of medical interns, residents, and preceptors who were paid directly or under a health center contract with their teaching institution in Column A1.
- Include costs for medical activities by medical personnel even when they are not directly providing care to patients—activities such as chairing or attending meetings, supervising personnel, writing clinical protocols, designing formularies, setting hours, or approving specialty referrals—in Column A1. The exception to this rule is when a medical director or chief medical officer is engaged in administrative activities at the **corporate level**, in which case the FTE on Table 5 and the associated costs are allocated to the other central support services category (on Table 5, Line 30a, and on Table 8A, Line 15).
- Report all other direct costs, including purchased services (non-personnel), in Column A2—Other Costs—for the provision of medical services.
- Include professional medical service contracts paid on a fee-for-service basis, including the cost of any medical visit paid for directly by the health center, such as vouchered care or at-risk specialty care from a MCO contract or other specialty care, in Column A2.
- DO NOT report the costs of medical laboratories, X-ray, and diagnostic personnel or services (report on Line 2) or allocate any health IT/EHR informatics and QI personnel or other IT/EHR or QI costs. (Report on Line 14a.)

- DO NOT report the costs of intake, patient health records, or billing and collections, as these are considered other central support costs. (Report on Line 15.)

Medical Laboratory and X-ray (Line 2)

- Report all accrued direct personnel salary, fringe, and 1099-NEC contract costs paid on an hourly or FTE basis in Column A1—Personnel Costs—associated with personnel reported on Table 5, Lines 13 and 14 (including sonography, mammography, and any advanced forms of tomography).
- Report all other direct costs, including professional medical laboratory and X-ray service contracts paid on a fee-for-service basis, in Column A2—Other Costs—for the provision of medical laboratory and X-ray services.
- DO NOT include other non-laboratory or non-X-ray medical direct costs, including but not limited to medical non-laboratory and non-X-ray supplies, training, travel, purchased services (non-personnel). (Report on Line 1, Column A2.)
- DO NOT include dental laboratory or dental X-ray costs. (Report as Dental, Line 5.)
- DO NOT include costs for retinography readings by specialists (most commonly for diabetic patients). (Report in Vision Services, Line 9a.)

Total Medical Care Services (Line 4)

Sum of Lines 1 + 2.

Other Clinical Services (Lines 5–10)

This category includes accrued direct personnel and other costs for dental, mental health, substance use disorder, pharmacy, pharmaceuticals, vision, and services rendered by other professional personnel (e.g., chiropractors, naturopaths, occupational and physical therapists, speech and hearing therapists, podiatrists, registered dietitians). All costs for each of the Other Clinical Services are included on a single line, with personnel salary, fringe, and 1099-NEC costs shown in Column A1 and other associated costs (including professional service contracts, paid referred care contracts, vouchered services contracts, supplies, related travel, personnel education expense, meeting registration and travel, uniform laundering, recruitment, membership in professional societies, books, and journal subscriptions for clinical services) in Column A2.

Dental (Line 5)

- Report all accrued direct personnel salary, fringe, and 1099-NEC contract costs paid on an hourly or FTE basis in Column A1—Personnel Costs—associated with personnel reported on Table 5, Lines 16–18.
- Report all other direct costs, including professional dental service contracts paid on a fee-for-service basis, in Column A2—Other Costs—for the provision of dental services (including dental lab and X-ray).

Mental Health (Line 6)

- Report all accrued direct personnel salary, fringe, and 1099-NEC contract costs paid on an hourly or FTE basis in Column A1—Personnel Costs—associated with personnel reported on Table 5, Lines 20a–20c.
- Report all other direct costs, including professional mental health service contracts paid on a fee-for-service basis, in Column A2—Other Costs—for the provision of mental health services.
- If both mental health and substance use disorder services are provided by the health center, allocate the direct cost between the two services according to and in alignment with how these services (FTEs and visits) are allocated for the mental health and SUD categories on Table 5.

Substance Use Disorders (Line 7)

- Report all accrued direct personnel salary, fringe, and 1099-NEC contract costs paid on an hourly or FTE basis in Column A1—Personnel Costs—associated with personnel reported on Table 5, Line 21.
- Report all other direct costs, including professional substance use disorder service contracts paid on a fee-for-service basis, in Column A2—Other Costs—for the provision of substance use disorder services.
- If both mental health and substance use disorder services are provided by the health center, allocate the direct cost between the two services according to and in alignment with how these services (FTEs and visits) are allocated for the mental health and SUD categories on Table 5.

Pharmacy (Not Including Pharmaceuticals) (Line 8a)

- Report all accrued direct personnel salary, fringe, and 1099-NEC contract costs paid on an hourly or FTE basis in Column A1—Personnel Costs—associated with personnel reported on Table 5, Lines 23a–23d.
- Report all other direct costs, not including pharmaceuticals, but including pharmacy service contracts paid on a fee-for-service basis, in Column A2—Other Costs—for the provision of pharmacy services.
- If 340B medications are purchased by or on behalf of the health center and dispensed by a contract pharmacy, report the full dispensing fees and any other pharmacy contract service fees (such as "share of profit," pharmacy benefit manager costs, inventory fees, ordering fees, administrative fees, or a charge for pharmacy computer services) on this line as Other Costs, Column A2.
- Report the full accrued pharmacy cost, regardless of whether the health center pays the full amount, pays a net after subtraction of revenue at the contract pharmacy, or simply receives a reduced net payment from the pharmacy.
- DO NOT include the cost of pharmaceuticals (report on Line 8b).
- DO NOT report the cost of personnel engaged in helping patients become eligible for free pharmaceuticals from manufacturers' pharmacy assistance programs (often called PAPs). (Report as Patient Support Services on Line 11, Column A1).

Pharmaceuticals (Line 8b)

- Report all pharmaceutical costs in Column A2.
- Include pharmaceuticals purchased for direct patient care, including vaccines and medications administered at the health center (e.g., penicillin, Depo-Provera, buprenorphine).
- Report the full cost of 340B medications purchased by or on behalf of the health center and dispensed by a contract pharmacy. This includes 340B medications paid for in full by the health center, as well as the full cost of medications paid for through an agreement whereby the pharmacy first pays for the medications and then deducts the cost from their receipts.
- Report low-value and short-shelf-life medications that are expensed immediately. DO NOT include acquisition of medications charged to an inventory asset account; only include the accrued costs when the inventory item is dispensed.
    - The acquisition of medications, whether through an in-house pharmacy or through a 340B contract pharmacy, that are charged to an inventory asset account are not expensed until dispensed.
    - 340B medications acquired and replenished under a 340B contract pharmacy are charged to an inventory asset account and expensed as the third-party administrator (TPA) issues settlements, which allocates dispensing fees (Line 8a) and medication cost (Line 8b).

- DO NOT include other pharmacy-related supplies here. (Report on Pharmacy [not including Pharmaceuticals], Line 8a, Column A2.)
- DO NOT report the value of donated pharmaceuticals anywhere in the UDS Report.

Note: Personnel Costs, Column A1, is grayed out on Pharmaceuticals, Line 8b.

Other Professional (Line 9)

- Report all accrued direct personnel salary, fringe, and 1099-NEC contract costs paid on an hourly or FTE basis in Column A1—Personnel Costs—associated with personnel reported on Table 5, Line 22, including, but not limited to, podiatry, dietitians, nutritionists, chiropractic, acupuncture, naturopathy, speech and hearing pathology, and occupational and physical therapy. (A more complete list appears in Appendix A.)
- Report all other direct costs, including other professional service contracts paid on a fee-for-service basis, in Column A2—Other Costs—for the provision of other professional and ancillary health care services.
- DO NOT report the cost of vision services or other programs and services, such as WIC, the Program of All-Inclusive Care for the Elderly (PACE), or ADHC. (Report on Line 12, Other Programs and Services.)

Note: Use the "specify" field to detail the other professional costs reported on this line.

Vision (Line 9a)

- Report all accrued direct personnel salary, fringe, and 1099-NEC contract costs paid on an hourly or FTE basis in Column A1—Personnel Costs—associated with personnel reported on Table 5, Lines 22a–22c, including optometry, ophthalmology, and vision support personnel.
- Report all other direct costs, including professional vision service contracts paid on a fee-for-service basis, in Column A2—Other Costs—for the provision of vision services.
- Include costs for retinography (including for diabetic patients) and frames and lenses (including contact lenses) in Other Costs, Column A2.
- Include professional service contract costs for reading retinography results in Column A2.

Total Other Clinical (Line 10)

Sum of Lines 5 + 6 + 7 + 8a + 8b + 9 + 9a.

Patient Support Services and Other Programs (Lines 11–13)

These categories include accrued direct personnel and other costs for patient support services (e.g., case management, health education, eligibility assistance, outreach, transportation, language assistance, community health workers) (Line 11) and other programs (e.g., ADHC, PACE, basic needs, job training programs, fitness programs, Head Start, retail pharmacy, WIC) (Line 12).

Note: Descriptions of the services and personnel that belong in each of these categories are included in the Instructions for Table 5 and in Appendix A.

Patient Support Services (Line 11)

- Report all accrued direct personnel salary, fringe, and 1099-NEC contract costs paid on an hourly or FTE basis in Column A1—Personnel Costs—associated with personnel reported on Table 5, Lines 24–28b, including case management, health education, eligibility assistance, outreach, transportation, language assistance, and community health workers.

- Report all other direct costs, including professional patient support service contracts paid on a fee-for-service basis, in Column A2—Other Costs—for the provision of patient support services.
- Include case management, health education, eligibility assistance, outreach, transportation, language assistance, community health work, and similar patient support activities.
- The patient support services costs reported must be consistent with the FTEs and visits reported on Table 5.

Other Programs and Services (Line 12)

- Report all accrued direct personnel salary, fringe, and 1099-NEC contract costs paid on an hourly or FTE basis in Column A1—Personnel Costs—associated with personnel reported on Table 5, Line 29a.
- Report all other direct costs, including professional other program and services contracts paid on a fee-for-service basis, in Column A2—Other Costs—for the provision of other programs and services.
- Include all in-scope programs and activities NOT classifiable as medical, dental, mental health, substance use disorder, other professional, vision, or patient support services (reported on Lines 1–11).
- Include programs and activities such as WIC, child care centers, ADHC centers, fitness centers, Head Start and Early Head Start, housing, clinical trials, research, employment training, retail pharmacy services provided to non–health center patients, and similar activities.
- Include the cost of leased-out space, personnel, and other supplies.
- Report the cost of facilities and other indirect costs directly allocated as part of the cost reporting for the other programs and services activities. These costs are not tied to health center patient activity and are not included under Facility and Support Services. Examples might include a portion of facility costs for WIC, child care, fitness centers, health center space leased to other organizations, retail pharmacy services provided to non–health center patients, and contracts with other organizations for services provided by health center staff. It is acceptable to report an amount equal to the rental income for leased space, assuming the income approximates the space cost.
- Report the amount of health center grant funds passed through to other agencies if patient activity is not included in the health center's reporting.
- Describe the programs and their costs using the "specify" field. The program descriptions should correspond to the "specify" field on Table 5, Line 29a, where FTEs are reported.

Total Patient Support Services and Other Programs (Line 13)

Sum of Lines 11 + 12.

Facility and Support Services (Lines 14, 14a, and 15)

These categories include accrued direct personnel and other costs associated with the health center's facilities (Line 14), information technology (IT) (Line 14a), and other central supports (Line 15).

Some grant programs limit the portion of grant funds that may be used for indirect central support services. DO NOT consider those limits when completing Lines 14, 14a, and 15. The facility, IT, and other support categories in this table include all personnel working at the health center.

Facility (Line 14)

- Report all accrued direct personnel salary, fringe, and 1099-NEC contract costs paid on an hourly or FTE basis in Column A1—Personnel Costs—associated with the personnel reported on Table 5, Line 31.

- Report all other direct costs, including professional facility service contracts paid on a fee-for-service basis, in Column A2—Other Costs—for the provision of facility services.
- Include all direct and indirect costs of common space (e.g., common waiting areas) in Column A2.
- Include rent on leased facilities and mobile units, insurance on facilities and equipment, depreciation (not asset acquisition costs) on owned facilities, depreciation on furnishings and equipment (non-IT), interest on facility mortgage(s) (not principal) and furnishings and equipment (non-IT) loan(s), utilities (e.g., gas, electric), security, groundskeeping, facility maintenance and repairs, housekeeping and janitorial services, and all other related costs in Column A2.
- DO NOT report the cost of space leased or donated to other entities on this line. Instead, report it as Other Programs and Services costs on Line 12. Additionally, report the rental income associated with these leases on Table 9E, Line 10—Other Revenue.
- DO NOT allocate facility costs to any other cost centers, except for those related to space provided to other programs and services or other entities, as described above.

Information Technology (Line 14a)

- Report all accrued direct personnel salary, fringe, and 1099-NEC contract costs paid on an hourly or FTE basis, in Column A1—Personnel Costs— associated with the FTE reported on Table 5, Line 30c, including health IT/EHR, QI, programming, technical, and related IT services.
- Report all other direct costs, including supplies, related travel, other professional IT service contracts paid on a fee-for-service basis, in Column A2—Other Costs—for the provision of IT and QI services.
- Include health IT/EHR systems-related costs, such as system maintenance contracts, shared among all cost centers. Examples may include personnel systems, billing systems, clearinghouse licenses, data management, software, general ledger systems, word processing applications, software licenses, equipment leases, antivirus software, cloud services, internet service, wide area network (WAN) circuits, IT security, interest on IT software and equipment loans, communication costs (e.g., telephone, internet, videoconferencing), and general IT training.
- Include all accrued costs for QI activities, including design, data analytics, and other quality improvement activities.

Other Support Costs (Line 15)

- Report all accrued direct personnel salary, fringe, and 1099-NEC contract costs paid on an hourly or FTE basis, in Column A1—Personnel Costs—associated with the FTE reported on Table 5, Lines 30a, 30b, and 32, including all central support services, senior leadership (CEO, CFO, CMO, COO, HR Director, et al.), management, fiscal, billing and collections, patient health records, registration and intake.
- Report all other direct costs, including supplies, related travel, other central support service contracts paid on a fee-for-service basis, in Column A2—Other Costs—for the provision of other central support services.
- Include the allocated portion of personnel and fringe costs for the clinical leadership and other personnel as the FTEs are allocated on Table 5 in Column A1.
- Report corporate costs (e.g., directors, officers, and other liability insurance, not including malpractice insurance; audits; legal fees; interest payments on non-facility loans; publications and printing; and other remaining costs not captured in other costs centers in Column A2.
- Report costs attributable to the board of directors, including travel expenses, meetings, directors' and officers' insurance, conference registration fees, and similar expenses, in Column A2. DO NOT allocate medical and other clinical personnel (e.g., medical directors) time to Other Support Costs for time spent chairing or

attending meetings, supervising personnel, writing clinical protocols, designing formularies, setting hours, or approving specialty referrals. This time and cost stays with the medical or other clinical services cost centers.

- DO NOT report bad debt here. Report bad debt write-offs and allowances as revenue adjustments on Table 9D, Line 15.

Total Facility and Support Services Costs (Line 16)

Sum of Lines 14 + 14a + 15.

Total Health Center Costs (Line 17)[26]

Sum of Lines 4 + 10 + 13 + 16.

FAQ FOR TABLE 8A

1. How do we account for donated services?

Donated goods and services are no longer reported on Table 8A or anywhere in the UDS Report.

2. Why do our financial statements NOT tie to the UDS financials?

In 2026, Tables 9D and 9E revenues were changed from the cash basis to the full accrual basis of accounting, in alignment with the full accrual basis for reporting costs on Table 8A. The combination of these tables is designed to closely tie to a health center's financial statements for the calendar year. However, there may be differences for health centers whereby

(1) The UDS Report shows calendar year results, January 1–December 31 data, but the health center's fiscal year may be a different period.

(2) The health center may have activity outside the scope of the federal project that is part of the health center's corporate-wide financial statements but is excluded from the UDS.

3. What do we need to report in the different columns of this table?

Below is a summary of what to include in each column, described in more detail in column reporting requirements.

Personnel Costs (A1)	Other Costs (A2)	Total Accrued Costs (A)
Accrued personnel costs attributable to the calendar year by cost center, whose FTEs or visits are reported on Table 5. Report direct accrued labor costs: • Personnel salaries • Fringe benefits 1099-NEC contractors paid on an hourly or FTE basis	Accrued other (non-personnel) costs attributable to the calendar year by cost center. Report other direct accrued costs: • Supplies • Minor equipment • Depreciation • Interest • Other professional service contracts, including paid referred care and vouchered services, paid fee-for-service • Training	Accrued direct cost of services. Sum of Columns A1 + A2 (done automatically in EHBs).

[26] This is the amount used in HRSA's BPHC calculation of measures involving total cost.

Personnel Costs (A1)	Other Costs (A2)	Total Accrued Costs (A)
	• Travel • Meeting registration • IT costs • Communications • Other non-labor Bad debt write-offs are reported as revenue offsets on Table 9D. DO NOT include repayment of principal on loans.	

4. How are subrecipient and contractor relationships to be reported?

Health center subrecipients are to provide data for all UDS tables and forms to the Health Center Program recipient, which will combine the data and include it with their UDS Report. Regarding Table 8A, report the total cost of subrecipient project operations in the UDS Report of the awarded health center that gave a subaward to the other health center (subrecipient). If the subrecipient is also a Health Center Program recipient, the subrecipient will also report its activity on its own UDS Report.

Activity associated with contracts for services purchased by one health center and provided by another Health Center Program recipient will be reported in the same way as other professional service or referred care contracts. The health center providing the services will report the costs and activity of the services provided. The health center purchasing the services will report the cost and the activity of the services bought.

5. How do we report the cost of shared or common space?

Report the cost of shared and common spaces in Facility, Line 14, Other Costs, Column A2.

6. How do we report the cost of space, personnel, or other items that the health center leased or donated to others?

Report the cost of personnel leased or donated by the health center to others on Line 12, Other Programs and Services, Column A1. Report the cost of space and other items leased or donated by the health center to others on Line 12, Other Programs and Services, Column A2.

7. We pass through funds to another health center, and we do not include the patient activity in our UDS Report. How do we report the funds passed through to the other agency?

When you do not include patient activities occurring at another health center to which you passed grant funds, report the amount passed through to that health center on Line 12, Other Programs and Services, Column A2.

8. How do we report the cost of transportation services that we paid on behalf of a patient?

Report the cost of transportation services, including transportation service vendors, bus tickets, cab fares, and similar transportation support on Line 11, Patient Support Services, Column A2.

9. Where do we report overhead?

Overhead costs are contained in Facility (Line 14), Information Technology (Line 14a), and Other Support Services (Line 15). DO NOT allocate these overhead costs to other cost centers, except for Other Programs and Services (Line 12). For this cost category, report the cost of facilities and other indirect costs directly allocated as part of the cost reporting for the other programs and services activities on Line 12.

TABLE 8A: FINANCIAL COSTS

Calendar Year: January 1, 2026, through December 31, 2026

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 Programs 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)			

Table 8A Cross-Table Considerations:

- The personnel and visits on Table 5 are routinely compared to the costs on Table 8A. See the crosswalk of comparable fields in Appendix B.

Instructions for Table 9D: Accrued Patient Service Revenue

This table reports data on 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.

The Health Center Program Compliance Manual requires that **all** health centers have a fee schedule, based on locally prevailing rates and designed to reasonably cover its costs of operation. Health centers are required to discount these fees (see discussion on sliding fee discounts) based on a patient's income and family or household size. Health centers also must make reasonable efforts to collect payment from patients and third-party payers, consistent with the Health Center Program Compliance Manual requirements.

The text directly below contains changes to Table 9D from 2025 calendar year reporting to 2026 calendar year reporting:

Several key changes have been made to Table 9D, as outlined below:

- The table is revised to follow GAAP and to align the patient services revenue reported with the health centers' accrual-based financial statements to show net patient service revenue.
- Retroactive settlements, receipts, and paybacks (Columns C1–C4) have been removed. The details of Columns C1, C2, and C4 will continue to be accounted for in Collections (Column B) and Adjustments (Column D), in a way that conforms to the health center's recognition of these data. The details of Column C3 will be accounted for in the new Third-Party Incentive Revenue Line 18, Column G.
- The form of payment (non-managed care, capitated managed care, and fee-for-service managed care) lines have been collapsed into a single total line by payer category.
- A new column has been added to report net patient service revenue (charges less adjustments) (Column G).
- Two new lines (as single values—no charges, collections, or adjustments by payer) have been added: Pharmacy Net Patient Service Revenue (Line 17) and Third-Party Incentive Revenue (Line 18).
- Self-Pay, including Sliding Fee, revenue will be collapsed into a single total line, Total Self-Pay (Line 13).
- The column for patient bad debt write-off (formerly Column F) has been removed. Accrued bad debt write-offs and allowances are now reported on Line 15, Column G, which is an offset to Total Net Patient Services Revenue Before Other Patient Service Revenue (Line 16, Column G).

This marks the conclusion of changes to Table 9D from 2025 calendar year reporting to 2026 calendar year reporting.

TABLE 9D: ACCRUED PATIENT SERVICE REVENUE

This table reports charge, collection, and adjustment data for patient services by payer category, bad debt write-offs and allowances, and pharmacy and incentive revenue for patient services provided within the health center's federal scope of project during the calendar year.

ROWS: PAYER CATEGORIES

Five major payer categories are listed for patient service revenue: Medicaid, Medicare, Other Public, Private, and Self-Pay.

Payer categories match insurance categories listed on Table 4. An important difference between the two tables is that Table 4 shows patients' primary medical insurance as of their last visit during the calendar year, while Table 9D reports the patient service charges, collections, and adjustments for all services attributable to that payer as of the end of the calendar year. A crosswalk showing this alignment is available in Appendix B.

Payer Categories

Total Medicaid (Line 3)

- Report charges (Column A), related collections (Column B), and related adjustments (Column D) associated with all services billed to and paid for by Medicaid (Title XIX), including:
  - Medicaid managed care plans that may be run by private insurers. For example, in states with a mandatory Medicaid managed care enrollment and/or a capitated Medicaid program, the health center may have a contract with a private plan like Blue Cross, which administers the Medicaid plan. The payer would be Medicaid, even though the actual payment may come from Blue Cross.
  - EPSDT, which has various names in different states and is a part of Title XIX. The EPSDT program includes some children who are eligible for limited outpatient screening and treatment services only.
  - CHIP, which states may have different names for, if paid through Medicaid.
  - Medicaid expansion programs that provide funds for eligible individuals to buy their own insurance, if it is possible to identify eligible individuals. Otherwise, report as Private.
  - The Medicaid portion of charges for Medicare and Medicaid dually eligible patients.
  - The part of the charge paid by Medicaid for patients enrolled in a Medicaid "share of cost" program.
  - ADHC or PACE if administered by Medicaid. Treat as discussed in Appendix B.

Total Medicare (Line 6)

- Report charges (Column A), related collections (Column B), and related adjustments (Column D) associated with all services billed to and paid for by Medicare (Title XVIII), including:
  - Medicare managed care plans, including Medicare Advantage plans run by private insurers. For example, where the health center has a contract with a private plan like Blue Cross for Medicare Advantage, consider the payer to be Medicare, even though the actual payment may come from Blue Cross.
  - The portion of charges for patients covered through multiple insurances (e.g., Medicare and Medicaid, Medicare and Private) that are first paid for by Medicare.
  - ADHC or PACE if administered by Medicare. Treat as discussed in Appendix B.

Total Other Public (Line 9)

- Report charges (Column A), related collections (Column B), and related adjustments (Column D) associated with all services billed to and paid for based on services provided to eligible patients (e.g., fee-for-service or amount per patient) by state or local government programs, including indigent care programs. Include:
  - CHIP **when paid for through private insurers**. (Report on Line 3 if CHIP is paid through Medicaid.)
  - Voluntary family planning programs such as Title X programs, BCCEDPs (with various state names), and other dedicated state or local programs.

Note: Although these categorical grant programs are considered Other Public payers, patients are generally classified as Uninsured on Table 4. These programs are not considered medical insurance because they DO NOT cover comprehensive primary care.

  - State-run insurance plans.
  - Municipal, county, and state carceral facilities.
  - State or local indigent care programs that reimburse based on services provided to eligible patients. Include Pub. L. 93-638 Compact funds.
  - Public schools and institutions that engage with the health center on a fee-for-service or other service-based contract basis.
- DO NOT include:
  - State or local indigent care programs that are NOT paid for on a service-specific basis (fee-for-service rendered). Report these revenues on Table 9E, Line 6a.
  - Third-party coverage bought through state or federal exchanges (which may be subsidized). Report as Private, Line 12.
  - Patients covered through subsidies from a Medicaid expansion program. Report as Medicaid, Line 3.
- Use the "specify" field to detail the names of the Other Public programs.

Total Private (Line 12)

- Report charges (Column A), related collections (Column B), and related adjustments (Column D) associated with all services billed to and paid for by private (commercial) insurance companies or by other third-party payers, including:
  - Private insurance bought directly by patients (or their family) or obtained through their employer.
  - Insurance bought for public employees or retirees, such as Tricare, Trigon, and the Federal Employees Health Benefits Program, as these are benefits belonging to the patient.
  - Workers' compensation, which is a form of liability coverage for employers.
  - Insurance bought through state exchanges, unless you can identify the patient as being enrolled through subsidies bought from a Medicaid expansion program.
  - Contract payments from other organizations that engage the clinic on a fee-for-service or other reimbursement basis, such as a Head Start program that pays for annual physical exams at a contracted rate or a private school or large company that pays for the provision of medical care at a per-session or other negotiated rate.
  - Supplemental insurance (plans that typically cover some amounts that are not paid or are disallowed by Medicare).

- DO NOT report Medicaid, Medicare, or Other Public managed care plans administered by private insurers as Private.

Total Self-Pay (Line 13)

Report charges (Column A), related collections (Column B), and related adjustments (Column D) (including sliding fee discounts) associated with all services where the patient is responsible. This includes patients receiving sliding fee discounts on their share of responsibility, the patient's share for those with a coverage source, and patients with no coverage source with family/household size and income above 200% of FPG.

- **Self-Pay Sliding Fee:** Report charges (Column A), amounts collected from patients (Column B), and related adjustments (Column D), including the sliding fee discounts applied based on the patient's ability to pay for patients with income and family/household size at or below 200% of the FPG.
    - Include as adjustments (Column D):
        - The discounts applied to patient charges using the health center's sliding fee discount program and schedule.
        - Sliding fee discounts applied to co-payments and deductibles, for insured patients whose charges for which they are responsible were reclassified as a sliding fee.
        - Any prompt pay discounts, hardship discounts, or fee waiver program discounts given to a sliding fee patient.

Note: When a sliding fee discount is used to adjust the patient's share of responsibility for covered services first charged to a third-party coverage source(s), such as Medicare or a private insurance company's co-payment or deductible, first transfer or reclassify the patient's share of the charge to self-pay. To transfer or reclassify, first reduce the third-party charge by the amount due from the patient, then increase the self-pay charges by the same amount.

- **Other Self-Pay:** Report all other charges (Column A), related collections (Column B), and related adjustments (Column D) where the patient is responsible for payment, including:
    - Uninsured, full-pay, self-pay patients.
    - Insured patients who are responsible for co-payments, deductibles, and non-covered service charges. The patient's share of responsibility must be reclassified from the third-party payer line to this line. This includes Medicaid patients enrolled in a "share of cost" program in which they pay some part of the fee as a co-payment or a deductible.
    - Prompt pay discounts and discounts for hardship fee waivers provided to full-pay, self-pay patients and insured patients whose charges are reclassified to Self-Pay, as adjustments in Column D.
- DO NOT report:
    - Amounts due and not collected from the patients that are written off here. (Report as a bad debt write-off on Line 15.)
    - State or local indigent care programs that subsidize services rendered to the uninsured on a service-specific basis (fee-for-service rendered) here. (Report as Other Public, Line 9.)

Total (Line 14)

Sum of Lines 3 + 6 + 9 + 12 + 13.

ROWS: OTHER PATIENT SERVICE REVENUE

Bad Debt Write-Offs and Allowances (Line 15)

Bad debt is the periodic charge to the income statement that adjusts the allowance for doubtful accounts up or down so that it equals the current estimate of uncollectible receivables. Bad debt write-offs and allowances may occur due to the health center's inability to collect payments owed by third-party payers (e.g., service rendered by non-credentialed provider, delayed or improper billing, bankruptcy) or patients (e.g., patients who cannot be located, patient refusal or inability to pay).

- Report on Line 15, Column G, all accrued bad debt write-offs and allowances (contra revenue), including direct write-off and the net amount of estimated allowance for doubtful accounts for the calendar year. Bad debt write-offs and allowances are an offset to patient services revenue, thereby reducing total accrued revenue recognized for the period. Include amounts billed to and defaulted on by any patient or a third-party payer adjusted off to the allowance account and amounts directly written off from patient service accounts during the calendar year from the general ledger. Health centers may use more than one method to determine bad debt write-offs, which may vary by the payer source. Include the total directly written off during the reporting period and the accrual adjustment for the allowance for doubtful accounts.
    - **Allowance Method:** The allowance account is a contra revenue account used to record the reduction in the value of the patient services accounts receivable (bad debt). This method complies with GAAP. Using this method, report the amount by which the allowance account for patient service receivables associated with the revenue on Line 14 increased (record as a positive number—without brackets) or decreased (record as a negative number—in brackets) in the calendar year.
    - **Direct Write-Off Method:** This method records bad debt only when it is confirmed to be uncollectable. It does not follow GAAP because it does not estimate the unrecognized bad debt and may recognize bad debt from prior periods. Use this method only if you do not have an allowance account and cannot make a year-end adjustment as is done in a GAAP-compliant audit.

Net Patient Service Revenue Before Other Patient Service Revenue (Line 16)

Sum of Total, Line 14, Column G, minus Bad Debt Write-Offs and Allowances, Line 15, Column G.

Pharmacy Net Patient Service Revenue (Line 17)

Report the revenue for the calendar year associated with pharmaceuticals dispensed to health center patients by in-house pharmacies and contract pharmacies. Review Appendix B for more information on different pharmacy arrangements. Report on Line 17, Column G:

- Pharmacy net revenue should come from two primary sources: medications dispensed to health center patients by in-house pharmacies and medications dispensed to health center patients by 340B contract pharmacies.
- Combine and report health center patient-associated pharmacy net revenue for the calendar year. DO NOT separate by payer (third-party and patients).
- Net pharmacy revenue should be reported on a full accrual basis and in the same manner as all other service net revenue. Charges are recognized upon the date of service minus any corresponding adjustments including bad debt.
- The net revenue for medications dispensed to patients during a visit may be included here but may be (and are typically) included with medical service revenue.
- 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)

Health centers may be eligible for managed care pool distributions, pay for performance, incentive payments, or quality bonuses. Report on Line 18, Column G:

- Third-party incentive net revenue earned from any payer, which may include managed care risk pool distributions, quality bonuses, and other performance incentives.
- The net incentive revenue using either a full accrual or cash receipts method as determined by GAAP, using the same method in the most recent GAAP-compliant audit and financial statements.
    - Because advance notice of incentive income is generally not given, most incentive revenue may be recognized on a cash basis.
- DO NOT report case management revenue on this line. Report on third-party payer Lines 3, 6, 9, and 12.

COLUMNS: CHARGES, COLLECTIONS, ADJUSTMENTS, AND NET PATIENT SERVICE REVENUE

Charges (Column A)

- Report total accrued, gross charges for patient services provided during the calendar year by each payer category. Charges come from the health center's schedule of fees, typically based on CPT codes.
- Report charges based on the health center's set fee schedule for services, even if some or all of them are written off as contractual adjustments, sliding fee discounts, or bad debt.
- Apply uniform charges across all payer categories for a given service or procedure.
- Include charges for:
    - Ancillary services, such as laboratory and imaging.
    - Supplies and equipment (e.g., eyeglasses, durable medical equipment).

- DO NOT report as charges:
  - Contracted or negotiated rates or amounts net of "contractual adjustments." Instead, report the difference between gross charges and the agreed reimbursement rate from third parties as Adjustments in Column D.
  - Amounts paid by a third-party payer (e.g., Medicaid or Medicare FQHC, G-code, or T-code rates).
  - Amounts generally not billable to or covered by third-party payers (e.g., WIC services, parking charges, transportation, patient support services).
  - Pharmaceuticals dispensed in-house or through a 340B contract pharmacy. (Report these on Line 17, Column G.)

Reclassifying Charges

Services may have been charged to and paid for by more than one source (e.g., a patient may have a part of their charge paid by their primary insurance and may have the rest paid by a secondary insurer or the patient or both). Patient accounting and software systems should be set up to automatically reclassify portions of charges payable by other payers. To reclassify charges:

- Report the charges accepted by the primary payer, along with any negotiated adjustment amount for their part of the services, to that payer line.
- Transfer the charges for the balance to the secondary payer. After the secondary payer claims settles, transfer the balance to a tertiary payer (if one exists) and, eventually, to the patient as Self-Pay, Line 13.
- Report only the amount charged to each payer, reclassifying any part of the charges to secondary or tertiary payers (if they exist).
- DO NOT reclassify charges by using an adjustment and rebilling to another payer category. This will result in an overstatement of total gross charges by reporting the charges twice.

Note: If reclassifying cannot be done automatically, manually transfer the amount rejected from the first payer to the next payer.

Collections (Column B)

- Report gross patient service receipts for the calendar year, including receipts for services that may have been rendered in a prior calendar year, including all forms of receipts.
- Report managed care capitation monthly payments received during the calendar year. DO NOT include capitation as a charge.
- Report case management fees received during the calendar year.
- Report collections for deductibles and co-payments received from patients as Self-Pay, Line 13.
- Report Federally Qualified Health Center (FQHC) cost report settlements, wraparound receipts, court settlements, and other payments received during the calendar year attributable to either the current calendar year or prior years.

Note: Cost report settlements are lump-sum retroactive payments or recoupments based on the filing of a cost report. Wraparound receipts are made periodically and represent the difference between amounts reimbursed and amounts due based upon the approved FQHC visit rates. A supplemental wraparound payment may be made for each visit, including managed care visits, to adjust total payment to equal FQHC cost-based rates. Medicaid, Medicare, and CHIP FQHC cost report settlements and wraparound payments are most common.

- DO NOT report as collections:
    - Pharmaceuticals dispensed in house or through a 340B contract pharmacy. (Report these on Line 17, Column G.)
    - Third-party incentive revenue, including managed care risk pool distributions, quality bonuses, and other performance incentives. (Report these on Line 18, Column G.)

Form of Receipts

Consolidate all forms of accrued revenue to the total line for each third-party payer: Medicaid (Line 3), Medicare (Line 6), Other Public (Line 9), and Private (Line 12). There are four forms of third-party payer payment models: non-managed care fee-for-service, managed care capitated, managed care fee-for-service, and managed care combined capitation and fee-for-service.

- **Non-Managed Care—Fee-for-Service:** A payment model in which procedures and services are separately charged and paid for patients who are not assigned to the health center under a managed care contract. Third-party payers pay some or all of the bill, generally based on agreed-upon maximums or discounts.
- **Managed Care—Capitated:** A payment model in which a health center contracts with an MCO for a list of services. The MCO pays the health center a capitation fee (a set amount, usually paid monthly, for each enrolled patient assigned to the health center) **regardless of whether any services were rendered during the month**. No further direct payment, other than an FQHC rate adjustment, is made if the services rendered are on the list of services covered by the capitation fee in the agreement between the health center and the MCO.
- **Managed Care—Fee-for-Service:** A payment model in which a health center contracts with an MCO, is assigned patients for whom the health center is responsible for providing primary care services and is reimbursed on a fee-for-service (or encounter-rate) basis for covered services.
- **Managed Care—Combined Capitation and Fee-for-Service:** A common payment model in which some of the services covered by the MCO are included under the capitation payment and the rest of the covered services are "carved out" and reimbursed on a fee-for-service basis. Carve-outs may include treatment of specific diseases (e.g., HIV) or specific services (e.g., prenatal care, labor and delivery).

Adjustments (Column D)

Virtually all insurance companies have a maximum amount they pay for a given service, and the health center agrees to adjust the difference between what they charge and that contracted amount. These are reported as contractual adjustments for each third-party payer (Lines 3, 6, 9, and 12). Adjustments also include sliding fee discounts and any waivers and reductions in fees under the Self-Pay category (Line 13). Report:

- Contractual adjustments, including accrued contractual reserves, by payer, Lines 3, 6, 9, and 12. Most of what is reported in this column is contractual, representing the difference between the health center's charge and what the third party will pay for their portion of the service charge.
- The health center's sliding fee discount policies and procedures determine which discounts, if any, to apply to charges owed by patients. Report on Line 13 in Column D:
    - The amount of sliding fee discounts applied to patient charges.
    - Sliding fee discounts applied to co-payments and deductibles, as applicable.
    - Prompt pay discounts and hardship fee waivers.

- Capitated managed care plans typically pay on a per-member, per-month basis and make payments in the current month of enrollment, which means these plans may but most often DO NOT carry any capitation receivables. Capitation plans reporting considerations:
    - Most practice management systems (PMS) will recognize the charges for services. In this case, report the gross charge in Column A and remove it from accounts receivable with an adjustment in Column D.
    - Capitation receipts may be recorded in the general ledger rather than the PMS. In this case, report the gross charge in Column A, remove the adjustments to that charge made in Column D, add the capitation receipts to Column B, and report the difference between the charges for capitated services and the capitations earned as an adjustment in Column D.
- Case management fees, cost report settlements, court settlements, and similar items are usually reported on a cash receipt basis. If so, report the cash received in Collections (Column B) on the proper payer line. Because there is no receivable, offset this amount with an adjustment (without brackets) in Column D.
- Wrap income may be recognized in the same way it is accounted for by the health center. There are variations in how this may be done.
    - Assuming the value of the wrap is in the accounts receivable balance, report the wrap collection in Column B and any necessary adjustment in Column D.
    - Assuming the health center adjusts off any balance after receiving the market rate reimbursement from the MCO, the value of the wrap is not in the current accounts receivable balance.
        - If the wrap income is recognized on a cash receipts basis, report the wrap upon its receipt in Column B and record an adjustment (with brackets or a minus sign) in Column D, which will have the effect of increasing net revenue by the wrap amount.
        - If the wrap income is recognized on an accrual basis or before its receipt, report the estimated wrap as an adjustment (with brackets or a minus sign) in Column D. This will increase net revenue and accounts receivable by the estimated wrap amount. Upon its receipt, record the wrap in Column B and any necessary adjustments in Column D.
- DO NOT report amounts for which another third-party or a patient is billed (e.g., amounts due from patients or "Medigap" payers for co-payments) as adjustments. Transfer these charges from the primary payer to the secondary and subsequent payers.

Note: Charges less adjustments equal net revenue or income before expense. Charges less collections, less adjustments equals the amount by which the amount owed (accounts receivable) increases or decreases for a given transaction or group of transactions. The amount of the adjustment is affected by whether the transaction is recognized on a cash or accrual basis. Adjustments that have the normal effect of reducing the charge are reported without brackets or a minus sign in Column D. Those that have the effect of increasing charges are reported as a negative number (with brackets or a minus sign). Adjustments will not normally exceed charges.

Note: Adjustments, Column D, are grayed out and NOT reported for Bad Debt Write-Offs and Allowances (Line 15) and Other Patient Service Revenue (Lines 17 and 18).

Penalties and Paybacks

Payments may be owed to patients or third-party payers for various reasons, including overpayments or failure to meet utilization or other performance goals. Account for penalties and paybacks in Collections, Column B, and Adjustments, Column D, as follows:

- **Penalty payments not associated with overpayments:** Reduce collections, Column B, by the payment amount and record an adjustment (without brackets—a positive number) for the same amount, Column D.

- **Refunds or paybacks for overpayment:** Reduce collections, Column B, by the amount of the refund or payback. DO NOT record an adjustment in Column D.
- **Penalty paybacks that are recouped by withholding payments:** Record a contractual adjustment (without brackets—a positive number) in Column B. DO NOT record an adjustment in Column D.

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

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).

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).

Total Net Patient Service Revenue (Line 19, Column G)

Sum of Lines 16 + 17 + 18.

FAQ FOR TABLE 9D

1. **How should charges and collections for patients enrolled in a state or local government indigent care program be handled?**

   Report the charges, collections, and adjustments associated with state or local government indigent care programs that reimburse for services rendered on Line 9, Other Public.

   Report the charges for patients covered under the IHS Pub. L. 93-638 Compact funds on Table 9D, Line 9, Column A, and reduce those charges by an equal adjustment on Table 9D, Line 9, Column D.

   Report the charges, collections, and adjustments for IHS patients covered by other payers on the proper payer line on Table 9D.

   Report only those earnings from indigent care programs that pay on a grant, formula-related, or other basis (not service-based), including the earnings under IHS Pub. L. 93-638 Compact funds on Table 9E, Line 6a.

   See cross-table reporting guidance for indigent programs for more details.

2. **Should charges minus collections minus adjustments equal zero?**

   No. Normally, charges less adjustment results in an account receivable, and NOT equal to zero. Charges (Column A) minus collections (Column B) minus adjustments (Column D) equals the change in accounts receivable or the amount by which what is owed to the health center increases or decreases during the calendar year.

3. **We often use our sliding fee discount program to write off the co-payment part of the Medicare charge for our certified low-income patients. How do we record this write-off?**

   Reclassify or transfer the amount of the co-payment from Medicare charges (Line 6, Column A) to Self-Pay charges (Line 13, Column A). Once transferred, report any applicable sliding fee discounts applied to the patient balance in Adjustments, Column D. Use the same process for any other insured sliding fee patient who has a co-payment, deductible, or non-covered service balance.

4. **Our system does not automatically reclassify amounts due from other carriers or from the patient. Do we need to, for example, reclassify Medicare charges that become co-payments or Medicaid charges?**

   Yes. Regardless of whether it is done automatically by your PMS/health IT/EHR or manually, show this reclassification of charges that end up being the responsibility of a party other than the initial party. As a rule, your system will make this adjustment in some way, but you may need to work with your vendor to get a report on the amounts transferred or consult with the UDS Support Center or a UDS Reviewer about how to do this.

5. **How do we report the charges and collections for pharmaceuticals dispensed at our contract pharmacies?**

   Contract pharmacy reporting is discussed at length in Appendix B. In general, report the net revenue the health center earns from contract pharmacies on Line 17.

6. **What is the timing for revenue reporting (charges, collections, adjustments) on Table 9D?**

   Charges are to be reported based on the date of service that occurred in 2026. Collections and adjustments 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 are to be limited to those transactions posted during 2026.

7. **How should we report the charges associated with "G-codes"?**

   G-codes specify a *reimbursement rate* associated with a service or package of services that your health center has described to Medicare. They are NOT reported as charges or with fee schedule charges. (Similar amounts may be paid to you by other third-party payers as well.) For the UDS, report in:

   - Column A: The sum of actual fee schedule/CPT-related charges for visits
   - Column B: What your health center received for payment
   - Column D: The discounted amount disallowed between charges and the amount received

   Remember to reduce the Medicare charges by the co-payment (20% of the allowable charge) and to reclassify them to the secondary payer or the patient. See discussion of reclassifying co-payments.

Note: If both the actual charge and the G-code charge are routinely applied to the visit by your system, you must remove the G-code charges by running a report to get the total for G-code charges for the year and then subtracting this number from the total charges (actual plus G-code). Report the difference in Column A. Reduce Column D by the G-code amount if it was adjusted using a similar process.

8. **Will all the revenue data come from the PMS?**

   Most, but not all, of the data on Table 9D will come from the PMS. Some revenue data that may be recognized as general ledger entries separate from the PMS need to be included on Table 9D. This may include items such as incentive receipts, cost report or other settlements, wrap income, case management fees, capitation income, bad debt write-offs and allowances, and 340B contract pharmacy income, as instructed above.

9. **Do we report Table 9D data on an accrual basis?**

   When possible, report patient service revenue from the PMS and other sources noted on an accrual basis. The goal is to report the data in compliance with GAAP and to equal what the health center's net patient service revenue is on its financial statements and its GAAP-compliant audit. However, this is not appropriate in situations where the income is not reliably predictable, as is sometimes the case with wrap, settlements, and

incentive income, or when the accrued net revenue is not available, which may happen with contract pharmacies' data. The instructions are intended to provide flexibility in how these data are reported, but to guide health centers to report in compliance with GAAP.

TABLE 9D: ACCRUED PATIENT SERVICE REVENUE

Calendar Year: January 1, 2026, through December 31, 2026

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)				

Table 9D Cross-Table Considerations:

- Charges and collections by payer on Table 9D have some relationship to the classification of patients by insurance on Table 4, although there is not a direct match. This is because all service categories and reclassifications are included on Table 9D, while Table 4 is limited to medical insurance as of the patient's last visit. See the crosswalk of field comparisons in Appendix B.
- Other Public charges and collections on Table 9D may include categorical grant payers, such as Title X and BCCEDP, which are NOT insurance. In such cases, patients are usually classified as Uninsured on Table 4, but their associated charges and collections are shown as Other Public on Table 9D.
- Visits for services on Table 5 that are normally billable should be close to but may not equal the billable visits generating the total patient charges reported on Table 9D. Some visits reported on Table 5 are not reimbursable.

Instructions for Table 9E: Other Accrued Revenue

Table 9E reports 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. This table includes all recognized accrued revenue that is not directly tied to the delivery of a specific patient service.

The text directly below contains changes to Table 9E from 2025 calendar year reporting to 2026 calendar year reporting:

Several key changes have been made to Table 9E, as outlined below:

- The table is reported on an accrual basis (instead of a cash receipt basis) per GAAP and should match or approximate the non–patient service revenue recognized on the health center's financial statements or its GAAP-compliant audit.
- Health Center Program grant funding (formerly Lines 1a–1e and Lines 1o–1q) have been combined into a single, total line (now Line 1).
- Two other federal grant lines have been removed: Ryan White Part C HIV Early Intervention (Line 2) and Promoting Interoperability Program (Line 3a). All other non-BPHC federal grants will be reported on Line 5, Total Other Federal Grants.
- 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.

This marks the conclusion of changes to Table 9E from 2025 calendar year reporting to 2026 calendar year reporting.

TABLE 9E: OTHER ACCRUED REVENUE

This table reports the health center's accrued revenue recognized to support in-scope activities not reported on Table 9D: Accrued Patient Service Revenue.

- Report all accrued non–patient service revenue recognized during the calendar year that supported the federally approved scope of project.
- Report accrued revenue for conditional grants, such as the BPHC Health Center Program award(s), as earned once the grant conditions are satisfied. Grant revenue is earned as allowable expenses are incurred against the award and includes grant revenue earned but not drawn down and/or received as of the end of the calendar year.
- Use the **"last party rule"** to classify the revenues. For UDS reporting purposes, the last party rule means that grant, contract, and other funds should always be reported based on the entity from which the health center received them, regardless of the source from which they originated.
- DO NOT report any revenue on both Tables 9D and 9E. This will duplicate the accrued revenue.

Note: Tables 9D and 9E accrued revenue is summed to equal total accrued revenue earned during the calendar year.

HRSA's BPHC GRANTS

Health Center BPHC Grants (Line 1)

- Report **grant revenue earned** during the calendar year from the Health Center Program (section 330) grant, including:
  - Direct BPHC Health Center Program grant funds. This includes all funding types within the Health Center Program Notice of Award.
  - Additional funding, such as quality improvement fund (QIF) awards from HRSA.
  - Amounts that the health center received and passed through to another Health Center Program recipient, including subrecipients. DO NOT reduce the revenue recognized by the amount the health center passed through.
  - Amount of HRSA's BPHC Capital Development Grant, including, but not limited to, Capital Assistance for Hurricane Response and Recovery Efforts (CARE), Capital Assistance for Disaster Response and Recovery Efforts (CADRE), and other Health Center Program capital-related funds.
- This line is grayed out in the EHBs for look-alikes and BHW primary care clinics. They DO NOT receive a Health Center Program (section 330) grant.

OTHER FEDERAL GRANTS

Total Other Federal Grants (Line 5)

Federal grants include only those directly awarded to the health center, paid to the health center from the U.S. Treasury, and for which there is a Federal Notice of Award.

- Report accrued revenue recognized during the calendar year for any other federal grants that are within the scope of project.
- Common other federal grants to include are from the Bureau of Health Workforce (BHW), the Office of Minority Health (OMH), the Indian Health Service (IHS), the Department of Housing and Urban Development (HUD), Federal Communications Commission (FCC), the Substance Abuse and Mental Health Services Administration (SAMHSA), and Congressionally Directed Spending awards.
- Include accrued revenue recognized for Ryan White Part C, Early Intervention Services and Capacity Development Grants. Guidance for reporting funds from other Ryan White titles is in the FAQ for Table 9E.
- Include IHS accrued revenue (not including Pub. L. 93-638 Compact funds) recognized if your health center is dually funded as an IHS/HRSA-funded health center. Report Pub. L. 93-638 Compact earnings on Line 6a, State/Local Indigent Care.
- Include American Rescue Plan (ARP) accrued revenue recognized from other HRSA bureaus or from other federal agencies.
- DO NOT report accrued additional funding from HRSA recognized during the year here. Report these awards under the Health Center BPHC Grants, Line 1.

Note: Use the "specify" field to detail the names and amounts of other federal grants.

NON-FEDERAL GRANTS OR CONTRACTS

State Government Grants and Contracts (Line 6)

- Report accrued revenue recognized during the calendar year for any state government grants or contracts that are within the health center approved scope of project and for which the health center received the funds with no specific tie to services provided.
- This may include state government line-item budgets that support specific health center personnel positions or other costs.
- DO NOT report accrued revenue recognized for funds from state governments that pay based on the amount of health care services provided or on a negotiated fee-for-service or fee-per-visit basis. Report the charges, collections, and adjustments associated with patient services on Table 9D on the Other Public revenue lines.

Note: Use the "specify" field to detail the names and amounts of state government grants and contracts.

State/Local Indigent Care Programs (Line 6a)

- Report the grant earnings from state or local indigent care programs that are designed to support services rendered to indigent patients.
- Include accrued revenue recognized from funds allocated to the health center by tribes from their IHS Pub. L. 93-638 Compact funds.
- DO NOT include accrued revenue from indigent care programs that reimburse on a service-specific basis. Report associated charges, collections, and adjustments on Table 9D, Other Public, Line 9.
- DO NOT include accrued revenue recognized under a contract with a tribal government for services provided to its members. Instead, report as Other Public with associated charges, collections, and adjustments on Table 9D.
- Further guidance is available in Appendix B.

Note: Use the "specify" field to detail the names and amounts of state and local indigent care programs.

Local Government Grants and Contracts (Line 7)

- Report accrued revenue recognized during the calendar year for any local government grants or contracts that are within the approved scope of project and for which there is no specific tie to patient services provided.
- This may include local government line-item budgets that support specific health center personnel positions or other costs.
- DO NOT include accrued revenue recognized for funds from local governments that pay based on amount of health care services provided or on a negotiated fee-for-service or fee-per-visit basis. Report the charges, collections, and adjustments associated with patient services on Table 9D on the Other Public revenue lines.
- DO NOT include grant earnings from local indigent care programs here. Report these on Line 6a.

Note: Use the "specify" field to detail the names and amounts of local government grants and contracts.

Foundation and Private Grants and Contracts (Line 8)

- Report the accrued revenue recognized from foundations or private organizations during the calendar year that covers costs included within the approved scope of project.

- Report accrued revenue (including subrecipient revenue) from a primary care association (PCA), another health center, or another community service provider on this line, even when funds originate elsewhere.

Note: Use the "specify" field to detail the names and amounts of foundation and private grants and contracts.

Total Non-Federal Grants and Contracts (Line 9)

Sum of Lines 6 + 6a + 7 + 8.

Other Revenue (Line 10)

- Report other accrued revenue recognized included in the federally approved scope of project that are unrelated to charge-based services or to grants and contracts described above.
- Include fundraising, pledges, interest revenue, rent from tenants, patient health record fees, individual monetary donations, earnings from vending machines, and retail pharmacy sales to the public (i.e., non–health center patients).
- Include revenue recognized as a gain on the sale of an asset, loan forgiveness, and insurance proceeds that exceed the value of the loss.
- **DO NOT** report:
  - The value of in-kind or other non-monetary donations made to the health center. DO NOT report these anywhere in the UDS Report.
  - The proceeds of any loan received for operations, a mortgage, or other purposes.
  - The receipt or recognition of in-kind "community benefit" from a third party, here or anywhere else on the UDS, unless it is received as a cash donation.
- **DO NOT, under any circumstances,** report revenue or net revenue from a pharmacy contracted to dispense 340B pharmaceuticals on this line (or anywhere on Table 9E). Report all revenue from pharmacy services provided to health center patients on Table 9D, Line 17, and record all expenses on Table 8A, Lines 8a and 8b.

Note: Use the "specify" field to detail the names and amounts of other revenue.

Total Net Revenue (Line 11)

Sum of Lines 1 + 5 + 9 + 10.

FAQ FOR TABLE 9E

1. **We received maternal and child health services funds from the state that originated from the federal government. On which line do we report these funds?**

   Report these accrued grant revenue using the "last party rule". In this instance, report these as state grants on Line 6, because the funds were awarded to the health center by the state for maternal and child health services, even though they may include a mixture of funds originating from the federal government (such as Title V) and the state.

2. We receive various Ryan White–related funds. How do we report these?

This depends on which entity you received Ryan White grants from. Use the following to guide your reporting:

- Report Ryan White Part A grants received from county or city governments on Line 7. If they are first sent to a third party, report the funds on Line 8. Report on Line 5 when the health center is a county or city government entity and the health center received the funds directly from the Ryan White Part A federal program.
- Report Part B grants received from the state on Line 6. If the state funds are first sent to a county or city government, report on Line 7. If the funds are first sent to a non-government third party, report the funds on Line 8.
- Report accrued revenue from the HIV/AIDS Bureau recognized during the calendar year for Ryan White Part C, Part D, or Part F on Line 5.

3. Are there any important issues to keep in mind for this table?

This table reports accrued revenue recognized within the federal scope of project from all sources—except for patient service revenue that is reimbursed on a service-specific basis, which is reported on Table 9D.

The table is now reported following GAAP and should match the non–patient service revenue recognized on the health center's financial statements and its GAAP-compliant audit.

Report accrued revenue for conditional grants, such as the BPHC Health Center Program award, as earned once the grant conditions are satisfied. Grant revenue is earned as allowable expenses are incurred against the award and includes grant revenue earned but not drawn down and/or received as of the end of the calendar year.

Report the accrued revenue for unconditional grants for the prorated period elapsed during the calendar year. For example, an unconditional grant received starting August 1, to provide support over a period of time (e.g., a year or other period), would recognize 5 months of revenue through December 31 for the calendar year UDS Report. If the grant is a lump sum with no specified period of support, the total would be recognized in full at the time the funding is approved.

It is important to clearly and completely state the sources of revenue in the "specify" boxes so reviewers can determine that the income is being classified correctly.

TABLE 9E: OTHER ACCRUED REVENUE

Calendar Year: January 1, 2026, through December 31, 2026

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 Net Revenue** (Sum of Lines 1 + 5 + 9 + 10)	

Table 9E Cross-Table Considerations:

- Pharmacy: Only retail, public pharmacy revenue for non–health center patients is reported on Table 9E, Line 10, and the related cost is reported on Table 8A, Line 12. Follow the guidance for other pharmacy reporting situations as described in Appendix B.
- Only non-service-specific accrued revenue recognized from state or local indigent care programs are reported on Table 9E, while earnings or receipts from indigent care programs that reimburse on a service-specific basis are reported on Table 9D. Follow the detail included in Appendix B to address cross-table reporting requirements.

Appendix A: Listing of Personnel

All line numbers in the following table refer to Table 5. NOT all services delivered by a "provider" count as visits. DO NOT count encounters with "non-providers" as countable visits. Use the Provider definitions to classify personnel as a "provider" or "non-provider."

Personnel by Major Service Category	Provider	Non Provider
Physicians		
Family physicians (Line 1)	X	
General practitioners (Line 2)	X	
Internists (Line 3)	X	
Obstetricians/Gynecologists (Line 4)	X	
Pediatricians (Line 5)	X	
Licensed medical residents—line determined by specialty	X	
Other Specialist Physicians (Line 7)		
Allergists	X	
Cardiologists	X	
Dermatologists	X	
Endocrinologists	X	
Orthopedists	X	
Surgeons	X	
Urologists	X	
Other specialists and sub-specialists	X	
Nurse Practitioners, Physician Assistants/Associates, and Certified Nurse Midwives		
Nurse practitioners (Line 9a)	X	
Nurse practitioner anesthetist (Line 9a)	X	
Physician assistants (Line 9b)	X	
Physician associates (Line 9b)	X	
Certified nurse midwives (Line 10)	X	
Nurses (Line 11)		
Clinical nurse specialists	X	
Home health nurses	X	
Nurse emergency medical services (EMS)/Nurse emergency medical technicians (EMT)	X	
Public health nurses	X	
Registered nurses (RNs)	X	
Visiting nurses	X	
Licensed practical nurses/Licensed vocational nurses		X
Other Medical Personnel (Line 12)		
Birthing assistant		X
Clinic aides/medical assistants (certified and uncertified medical technologists)		X
EMS/EMT personnel (not credentialed as a nurse)		X
Nurse aides/assistants (certified and uncertified)		X
Unlicensed interns and residents		X
Laboratory Personnel (Line 13)		
Laboratory assistants		X
Laboratory technicians		X
Medical technologists		X
Pathologists		X
Phlebotomists		X
X-ray Personnel (Line 14)		
Radiologists		X

Personnel by Major Service Category	Provider	Non-Provider
Radiology assistants		X
Ultrasound technicians		X
X-ray technologists		X
X-ray technicians		X
Dentists (Line 16)		
Oral surgeons	X	
Orthodontists	X	
Periodontists	X	
Dental Hygienists (Line 17)		
Dental hygienists	X	
Dental Therapists (Line 17a)		
Dental therapists	X	
Other Dental Personnel (Line 18)		
Dental aides		X
Dental assistants, advanced practice dental assistants		X
Dental students (including hygienist students)		X
Dental technicians		X
Mental Health (Line 20) **and Substance Use Disorder** (Line 21) **Personnel**		
Psychiatrists (Line 20a)	X	
Psychologists (Line 20a1)	X	
Licensed independent clinical social worker (Line 20a2)	X	
Licensed social workers—clinical (Line 20a2 or 21)	X	
Licensed social workers—psychiatric (Line 20b or 21)	X	
Family therapists (Line 20b or 21)	X	
Licensed master social worker (Line 20b)	X	
RN counselors (Line 20b or 21)	X	
Registered nurses—psychiatric mental health (Line 20b)	X	
Psychiatric mental health nurse practitioners (Line 20b)	X	
Unlicensed mental health providers, including trainees (interns or residents) and "certified" personnel (Line 20c)	X	
Alcohol and substance use disorder counselors (Line 21)	X	
Unlicensed substance use disorder providers, including trainees (interns or residents) and "certified" personnel (Line 21)	X	
Other Professional Health Services Personnel (Line 22)		
Audiologists	X	
Acupuncturists	X	
Chiropractors	X	
Community or behavioral health aides/practitioners	X	
Herbalists	X	
Massage therapists	X	
Naturopaths	X	
Occupational therapists	X	
Orthotists	X	
Physical therapists	X	
Podiatrists	X	
Registered dietitians, including nutritionists/dietitians	X	
Respiratory therapists	X	
Speech therapists/pathologists	X	
Traditional healers	X	
Occupational therapy assistants		X
Physical therapy assistants		X
Vision Services Personnel		
Ophthalmologists (Line 22a)	X	

Personnel by Major Service Category	Provider	Non-Provider
Optometrists (Line 22b)	X	
Ophthalmologist/optometric aides (Line 22c)		X
Ophthalmologist/optometric assistants (Line 22c)		X
Ophthalmologist/optometric technicians (Line 22c)		X
Pharmacy Personnel		
Pharmacists (Line 23a)		X
Clinical pharmacists (Line 23b)		X
Pharmacy technicians (Line 23c)		X
Pharmacist assistants (Line 23d)		X
Pharmacy clerks (Line 23d)		X
Case Managers (Line 24)		
Case managers	X	
Care/referral coordinators	X	
Patient advocates	X	
Home health nurses	X	
Licensed practical nurses/licensed vocational nurses	X	
Public health nurses	X	
Registered nurses	X	
Social workers	X	
Visiting nurses	X	
Health Education Specialists (Line 25)		
Family planning counselors	X	
Home health nurses	X	
Licensed practical nurses/licensed vocational nurses	X	
Patient health educators/specialists	X	
Public health nurses	X	
Registered nurses	X	
Social workers	X	
Visiting nurses	X	
Community and group educators/specialists		X
Eligibility Assistance Services Personnel (Line 26a)		
Benefits assistance workers		X
Certified assisters		X
Eligibility workers		X
Patient advocates		X
Patient navigators		X
Pharmacy assistance program (PAP) eligibility workers		X
Registration clerks		X
Outreach Services Personnel (Line 26b)		
Outreach workers		X
Transportation Services Personnel (Line 26c)		
Drivers, including mobile van drivers		X
Patient transportation coordinators		X
Language Assistance Services Personnel (Line 27b)		
Interpreters		X
Translators		X
Community Health Workers (Line 28a)		
Community health workers		X
Community health advisors or representatives		X
Lay health advocates		X
Peer health promoters/educators		X
Promotores de salud		X

Personnel by Major Service Category	Provider	Non-Provider
Other Patient Support Services Personnel (Line 28b)		
Doula		X
Peer recovery coaches and workers		X
Other patient support services personnel		X
Other Programs and Services (Line 29a)		
Adult day health care, frail elderly support personnel		X
Child care workers		X
Employment/educational counselors		X
Exercise trainers/fitness center personnel		X
Food bank/meal delivery workers		X
Head Start workers		X
Housing assistance workers		X
WIC workers		X
Management and Support Personnel (Line 30a)		
Administrators		X
Chief executive officers/executive directors		X
Chief financial officers/fiscal officers		X
Chief information officers		X
Chief medical officers		X
Directors of marketing		X
Directors of planning and evaluation		X
Enrollment/service representatives		X
Marketing representatives		X
Personnel directors		X
Prior authorization specialists		X
Project directors		X
Operations directors/managers		X
Receptionists		X
Secretaries/administrative assistants		X
Fiscal and Billing Personnel (Line 30b)		
Accountants		X
Bookkeepers		X
Billing clerks		X
Cashiers		X
Data entry clerks		X
Finance directors		X
Information Technology Personnel (Line 30c)		
Data entry clerks		X
Directors of data processing		X
IT help desk technicians		X
Programmers		X
Quality assurance/QI and health IT/EHR design and operation personnel		X
QI nurses		X
QI technicians		X
QI data specialists		X
Statisticians, analysts		X
System administrators		X
Facility Personnel (Line 31)		
Equipment/building maintenance personnel		X
Groundskeepers		X
Housekeeping personnel		X
Janitors/custodians/environmental services personnel		X

Personnel by Major Service Category	Provider	Non-Provider
Security guards		X

Personnel by Major Service Category	Provider	Non-Provider
Patient Registration and Health Records Personnel (Line 32)		
Appointments/scheduling/call center personnel		X
Front desk personnel		X
Medical and dental appointment clerks		X
Medical, dental, health IT patient health records clerks		X
Medical and dental team clerks		X
Medical and dental team secretaries		X
Patient health records clerks		X
Patient health records supervisors		X
Patient health records technicians		X
Patient health records transcriptionists		X
Patient services representatives		X
Registration clerks		X

Appendix B: Special Multi-Table Situations

Several conditions need special consideration in the UDS because they affect multiple tables that must then be reconciled. This appendix presents some situations along with instructions on how to deal with them, including:

- Contracted care that is paid for by the reporting health center
- Services provided by a volunteer provider
- Interns and residents
- WIC
- In-house pharmacy or dispensary services for health center patients
- In-house pharmacy for community (i.e., for non-patients)
- Contract pharmacies
- Clinical dispensing of medications
- ADHC and PACE
- Medi-Medi crossovers
- Certain grant-supported clinical care programs
- State or local indigent care programs
- Workers' compensation
- Tricare, Trigon, and public employees' insurance
- Ryan White
- School-based sites
- CHIP
- Patients served in a carceral setting
- Health IT/EHR personnel and costs
- New start or New Access Point (NAP)
- Relationship between personnel and visits on Table 5 and costs on Table 8A
- Relationship between insurance on Table 4 and revenue on Table 9D
- Relationship between prenatal care on Table 6B and deliveries on Table 7
- Relationship between race and ethnicity on Tables 3B and 7

CONTRACTED CARE

These are services provided on behalf of the health center by another entity via a formal written contract, voucher, or agreement, where the **health center is accountable for paying and/or billing** for the direct care provided via the agreement (generally a contract).

Tables Affected	Treatment
5	Report providers (Column A) if the contract is for a portion of an FTE (e.g., one-day-a-week OB/GYN = 0.20 FTE). Always report visits (Column B or B2), regardless of method of provider payment or location of service (health center's service delivery site or contract provider's office). Services provided by contractors and paid for by or billed through the health center must meet the UDS countable visit definition to be counted on Table 5. DO NOT report FTE if the contract is for a service (e.g., $X per visit or $55 per resource-based relative value unit [RBRVU]), rather than provider time. DO NOT report FTE or visits if the contracted provider directly bills a third-party payer for the service.
6A	Report diagnoses and/or services provided, as applicable, from the encounter form or equivalent form received from the contract provider. Include contracted tests or procedures on Table 6A **only** if the listed services provided to patients are paid for by the health center or if their results are returned to the health center (or contract) provider to evaluate and give results to the patient.
6B, 7	If a contract provider provides any services that are subject to clinical quality measures (CQMs), collect and report all data from the contractor (e.g., last HbA1c from an endocrinologist, sealants placed from a dentist).
8A	Personnel Costs, Column A1: Report the salary, fringe, and 1099-NEC contract cost of a provider on the applicable line. Other Costs, Column A2: Report professional service contract costs (including paid referred care and vouchered service contracts) on the applicable line. DO NOT report a "co-payment" or a "nominal fee" received by the provider from the patient. Report only the sum of what the health center pays.
9D	Column A, Charges: The *health center's* usual, customary, and reasonable (UCR) charge. Column B, Collections: The amount received by the health center and contractor from first and third parties. Column D, Adjustments: The amount disallowed by a third party for the charge (if on Lines 3, 6, 9, and 12). Column E, Sliding Fee Discount: The amount written off for eligible patients per the health center's fiscal policies (Line 13), if applicable. Calculate as UCR charge, minus amount collected from patients, minus amount owed by patients as their share of payment. DO NOT include payment by the health center here.

SERVICES PROVIDED BY A VOLUNTEER PROVIDER

Volunteers are not paid by the health center (although they may be paid by a third party) for services, which they provide on-site. This includes volunteer personnel (including AmeriCorps/HealthCorps, but not the NHSC) who provide services on- or off-site on behalf of the health center. The FTE can be included in the UDS Report when there is a basis for determining their hours.

Tables Affected	Treatment
5	Column A, FTE: Report FTE for services provided by volunteers *on-site* at the health center's service delivery site. FTE must be calculated. Use hours volunteered as the numerator. Because volunteers DO NOT receive paid leave benefits, the denominator is the number of hours that comparable personnel spend doing their job. Reduce a full-time schedule of 2,080 hours (for example) by vacation, sick leave, holidays, and continuing education normally provided to personnel. As a rule of thumb, use hours worked divided by a number somewhere around 1,800. Column A, FTE: DO NOT report FTE for providers who provide services at their own offices. Column B, Clinic Visits, and Column B2, Virtual Visits: Count visits for services provided by a volunteer at a service delivery site in the health center's scope of project and under its control. Include virtual visits when the volunteer provider is assigned to an approved service delivery location, providing services to health center patients, and documenting services in the health center's health IT/EHR.
6A	Report diagnoses and/or services provided on-site or virtually.
8A	Do not report the value of the time donated by volunteers in the UDS.
9D	The charges for their services are treated the same as for paid personnel. DO NOT include charges for volunteer providers who are off-site when those services are outside the scope of project and/or outside the control of the health center.

INTERNS AND RESIDENTS

Health centers often use individuals who are in training, referred to variously as interns or residents depending on their field and their licensing. Medical and dental residents are generally licensed practitioners, while medical and dental interns are generally NOT licensed. Some mental health interns, as well as other providers, may be licensed practitioners who are training for a higher level of certification or licensing. The following provides guidance on reporting of a medical intern and resident. Other service category providers (e.g., dental, mental health) reporting is consistent to medical, but reported in the appropriate service category.

Tables Affected	Treatment
5	Column A: Report licensed interns and residents in the credentialing category they are pursuing. For example, count a family practice resident on Line 1 as a Family Physician. Depending on the arrangement, FTEs may be calculated like any other personnel (if they are being paid by the health center) or like a volunteer (if they are not being paid). See volunteer providers above. Columns B and B2: Report visits between a licensed resident or licensed intern and a patient as visits to that resident or intern. DO NOT credit the visits to the supervisor of the resident or intern, unless an intern is unlicensed and the supervisor is legally responsible for the visit. Report unlicensed medical interns or residents on Line 12 as Other Medical Personnel. Unlicensed interns or residents cannot generate countable visits.

Tables Affected	Treatment
8A	If the intern or resident is paid by the health center or their cost is being paid through a contract that pays a third party for the interns or residents, report the cost in Column A on the correct line (e.g., Line 1 for medical, Line 5 for dental, Line 6 for mental health). If the health center is not paying an intern, resident, or third party, DO NOT report the value of the donated time on Table 8A.

WOMEN, INFANTS, AND CHILDREN (WIC)

Tables Affected	Treatment
ZIP Code, 3A, 3B, 4	DO NOT report individuals whose only encounter with the health center is for WIC services (e.g., nutrition, health education, patient support services) and who receive no other services listed on Table 5 from providers outside of WIC.
5	Report FTE of personnel (Column A) on Line 29a. DO NOT report visits and patients (Columns B, B2, and C).
8A	Personnel Costs, Column A1: Report the total accrued costs for personnel (salary and fringe benefits). Other Costs, Column A2: Report the total non-personnel accrued cost of the program on Line 12. DO NOT include the value of WIC coupons as an accrued cost or donation.
9D	DO NOT report anything associated with the WIC program.
9E	Revenue for WIC programs, though originally federal, generally comes to health centers from the state, though some receive it from a lower-level intermediary. If the health center is receiving WIC funds from a state government, the grant/contract funds received go on Line 6. If the health center is receiving WIC funds from a private entity, report the revenue on Line 8. Specify the source of funds.

IN-HOUSE PHARMACY OR DISPENSARY SERVICES FOR HEALTH CENTER PATIENTS

Include only that part of the pharmacy that is paid by the health center and dispensed by in-house personnel (see below for other situations).

Tables Affected	Treatment
5	Column A, FTE: Report pharmacy personnel according to their position on Lines 23a–23d. If they have only an incidental responsibility to help enroll patients in PAPs, include them on the corresponding pharmacy Line 23a–23d. Include clinical pharmacists on Line 23b even if they spend time outside of the pharmacy. Report personnel other than pharmacists who spend time with PAPs on Line 26a, Eligibility Assistance. Columns B and B2, Visits: The UDS does NOT count encounters with pharmacy personnel as visits, whether it is for filling prescriptions or associated education or other patient/provider support. This is true for clinical pharmacists with expanded clinical privileges, as well. DO NOT count the administration or dispensing of medications as visits.
8A	Line 8a, Column A1, Personnel Costs: Report the salaries and fringe benefits of all pharmacy personnel, reported on Table 5, Lines 23a–23d. Line 8a, Column A2, Other Costs: Report all operating costs of the pharmacy, *other than the cost of medications*, on Line 8a. DO NOT report the cost of personnel engaged in helping patients become eligible for free pharmaceuticals from manufacturers' PAPs. Report this cost as Patient Support Services on Line 11. Line 8b, Column A2, Other Costs: Report the actual cost of medications the health center purchased and administered by clinicians in the health center and those that are dispensed by the health center's in-house pharmacy to health center patients. The acquisition of in-house and 340B medications are charged to an inventory asset account and not expensed until dispensed. Low value and short shelf-life medications may be expensed immediately and should be reported. DO NOT report the value of donated medications. Line 11, Columns A1 and A2: Report in Column A1 the cost of personnel (full-time, part-time, or allocated time) helping patients become eligible for PAPs and report in Column A2 the cost of all related supplies and equipment depreciation.
9D	Line 17, Column G: Report the pharmacy net patient service revenue (charges less contractual and other adjustments for in-house pharmacy operations). Report on a full accrual basis. Report charges recognized for dates of service within the calendar year and apply uniform prices across all payers, along with corresponding receipts and contractual, sliding fee, and other adjustments. Line 13, Columns A and D: Reclassify from Pharmacy Net Patient Service Revenue, Line 17, to Self-Pay, Line 13, material amounts of pharmaceutical dispensing fee charges (Column A) and the associated amount applied to sliding fee patient accounts (Column D).
9E	The charges for medications dispensed to patients go on Table 9D, **NOT** on Table 9E.

IN-HOUSE PHARMACY FOR COMMUNITY (I.E., FOR NON-PATIENTS)

Many health centers that own licensed pharmacies also provide services to members of the community at large who are not health center patients. Careful records must be maintained at these pharmacies to make sure that non-patients DO NOT receive medications bought under section 340B provisions. Some of these pharmacies are totally in scope, while others have their "public" part out of scope. If the public aspect is out of scope, DO NOT report its activities on the UDS. If it is in scope, treat the public part as an "other activity," as follows:

Tables Affected	Treatment
ZIP Code, 3A, 3B, 4	DO NOT include in the patient profile tables community members (non-patients) provided pharmaceuticals.
5	Column A, FTE: Allocate and report a portion of personnel who serve the public on Line 29a: Other Programs and Services.
8A	Line 12: Other Program-Related Services: Report all related personnel in Column A1 and other pharmacy costs, including cost of pharmaceuticals, in Column A2.
9E	Line 10, Other Revenue: Report all revenue from public pharmacy and specify from "Public access pharmacy."

CONTRACT PHARMACY DISPENSING TO HEALTH CENTER PATIENTS, GENERALLY USING 340B PURCHASED MEDICATIONS

Tables Affected	Treatment
5	DO NOT report contract pharmacy personnel, visits, or patients for pharmacy dispensing.
8A	340B medications acquired and replenished under the health center's contract with a 340B contract pharmacy are charged to an inventory asset account and expensed as the TPA issues settlements allocating dispensing fees and medication cost. Line 8a, Column A2: Report payments to pharmacy benefit managers as Other Costs on the Pharmacy (not including pharmaceuticals) line. Line 8a, Column A2: Report any share of profit kept by the contract pharmacy under its agreement with the health center as Other Costs on the Pharmacy (not including pharmaceuticals) line. Line 8a, Column A2: Report the amount the pharmacy charges for dispensing of medications as Other Costs on the Pharmacy (not including pharmaceuticals) line. Line 8b, Column A2: Report the full amount paid for pharmaceuticals, either directly by the clinic or indirectly by the pharmacy, as Other Costs on the Pharmaceuticals line.
9D	Line 17, Column G: Report the pharmacy net patient service revenue (charges less contractual and other adjustments for the contract pharmacy operations). Report on a full accrual basis. Report charges recognized for dates of service within the calendar year and apply uniform prices across all payers, along with corresponding receipts and contractual, sliding fee, and other adjustments. The revenue will only show settled transactions rather than all that occurred during the calendar year, charge data are recognized at the expected reimbursement rate rather than at a uniform fee value, and data are not classified by payer. For these reasons, net revenue may be reported on a cash basis, assuming the contractor is unable or unwilling to account for all settled and pending transactions. Line 13, Columns A and D: Reclassify from Pharmacy Net Patient Service Revenue, Line 17, to Self-Pay, Line 13, material amounts of pharmaceutical dispensing fee charges (Column A) and the associated amount applied to sliding fee patient accounts (Column D).
9E	DO NOT report contract pharmacy revenue on Table 9E. Report pharmacy net revenue on Table 9D.

CLINICAL DISPENSING OF MEDICATIONS

Clinic areas of health centers dispense many pharmaceuticals, including vaccines, allergy shots, contraceptives, and MOUD. This may be a service associated with the visit or, in the case of vaccinations, a community service. These services DO NOT count as a visit even though the patient may be charged.

Tables Affected	Treatment
3A, 3B, 4	DO NOT report the individuals receiving medications as patients if this is the only service they received during the year.
5	DO NOT report these services as visits.
6A	DO NOT report these services on Table 6A if no countable visit services were provided during the year to the individual. If a health center patient who had a countable visit during the year received a medication specified on the table, report the services the patient received on this table.
8A	Report medication costs on Line 8b, Column A2, Pharmaceuticals (not on Line 1, Medical Care). DO NOT report a value of vaccines obtained at no cost through Vaccines for Children or other state or local programs.
9D	Report full charges, collections, adjustments, and discounts, by payers, as appropriate. Note that Medicare has separate flu vaccine rules.
9E	DO NOT report any amount.

ADHC AND PACE

Medicare, Medicaid, and certain other third-party payers often recognize ADHC programs. They involve caring for an infirm, frail, or elderly patient during the day to let family members work, to avoid institutionalization, and to preserve the health of the patient. They are quite expensive and may involve extraordinary per member per month (PMPM) capitation payments but are cost effective compared to institutionalization. Patients who have both Medicare and Medicaid coverage are treated as Medi-Medi, as described below. PACE is even more expansive and may include ADHC services as well as services to support independence for the elderly. Only report ADHC and PACE activities when these programs are part of the health center scope of project and listed on Form 5B.

Tables Affected	Treatment
3A, 3B, 4	Report the individuals seen during the year in ADHC and PACE programs as patients if one or more of their encounters are countable visits.
5	When a medical or mental health provider does a formal, separately billable examination of a health center patient at the ADHC/PACE facility, treat it as any other medical visit. DO NOT count the nursing, observation, monitoring, and dispensing of medication services that are bundled together to form an ADHC service as a visit for the purposes of reporting. Personnel, nonetheless, are included on Line 29a, Other Programs and Services.
6A, 6B, 7	Report the clinical activity provided to patients at ADHC and PACE facilities, on the clinical tables.
8A	If the health center provides and bills medical services separately from the ADHC charge, report the associated costs on Lines 1 and 2, pharmacy costs on Lines 8a–8b, and all other costs on Line 12. Similarly, include PACE costs for medical on Lines 1 and 2, pharmacy costs on Lines 8a–8b, and all other costs on Line 12.
9D	Report ADHC charges and collections on this table, generally as Medicaid and/or Medicare. Because of FQHC procedures, there may also be significant positive or negative adjustments. In addition, see Medi-Medi, below.

MEDI-MEDI/DUALLY ELIGIBLE

Some individuals are eligible for and enrolled in both Medicare and Medicaid (commonly referred to as Medi-Medi or dually eligible). In this case, Medicare is primary and billed first. After Medicare pays its (usually FQHC-associated Z code or geographic-rate-adjusted) fee, the rest is billed to Medicaid, which pays an amount based on policy that varies from state to state. In some states, the bill flows automatically from Medicare to Medicaid. In others, the bill is paid by Medicare with some portion denied, and then the service is rebilled to Medicaid as a secondary payer.

Tables Affected	Treatment
4	Report patients on Line 9, Medicare, since this is the primary payer. DO NOT report as Medicaid. In addition, report these patients on Line 9a, Dually Eligible (Medicare and Medicaid); this line is a subset of the total reported on Line 9, Medicare.
9D	While the entire charge first shows as a Medicare charge, after Medicare makes its payment, the remaining allowable amount is reclassified to Medicaid. Report the payment received from Medicaid on Line 1 in Column B (Collections). Report the difference between the charge and the collection as a positive or negative adjustment, depending on the amount, in Column D (Adjustments). The health center must make sure that the remaining charge is reclassified from Medicare to Medicaid. If your system does not reallocate the charge automatically, it must be done manually.

CERTAIN GRANT-SUPPORTED CLINICAL CARE PROGRAMS

Some programs pay providers on a fee-for-service or fee-per-visit basis under a contract, which may or may not also have a cap on total payments per grant period (often the state fiscal year). They cover a very narrow range of services. Breast and cervical cancer early detection and voluntary family planning programs are the most common, but there are others. In some cases, these programs will also provide support by reimbursing allowable expenses.

Tables Affected	Treatment
4	These programs are **NOT** insurance. They pay for a service, but health centers must classify patients according to their primary health insurance carrier. Most of these programs DO NOT serve insured patients, so most of the patients would be reported on Line 7 as uninsured.
9D	For fee-for-service or fee-per-visit arrangements: Although the patient is likely uninsured, there is an "Other Public" payer for the service. Report the health center's usual and customary charge for the service (NOT the negotiated fee paid by the public entity) on Line 9 in Column A (Charges) and the payment in Column B (Collections). Report the difference between the charge and payment as an adjustment in Column D (Adjustments).
9E	For non-service-related program expenses: Report any support provided by the program that reimburses for specific expenses incurred on the appropriate line on Table 9E, following the last party rule. DO NOT report amounts covering the fee-for-service or fee-per-visit on Table 9E. Fully account for this on Table 9D.

STATE OR LOCAL INDIGENT CARE PROGRAMS AND IHS PUB. L. 93-638 COMPACT

These state or local government programs support indigent care in two ways: Many reimburse directly for services rendered to eligible patients and some provide grant support indirectly based upon a formula or other allocation method. Some of the reimbursement programs set payment caps after which no further reimbursements are made.

Tables Affected	Treatment
4	State and local indigent care programs are NOT considered insurance. Report patients receiving care through these programs on Line 7 as uninsured, unless they have some form of primary medical insurance.
9D	Other Public, Line 9: Indigent Care Programs: Report the health center's fee schedule-based charges (Column A) for each service reimbursable on a service-based basis. Report the indigent care program receipts, along with any patient payments (Column B). Report the difference between the health center charge and the program's allowed amount as a contractual adjustment (Column D). Once a program stops reimbursing because a cap was reached, reclassify the charges to the appropriate payer line, usually Self-Pay (Line 13), along with associated sliding fee. DO NOT report on Table 9D for those programs which award grant funds on a formula or other basis. Other Public, Line 9: IHS Pub. L. 93-638 Compact: Report the charges (Column A) for patients fully covered under an IHS Pub. L. 93-638 Compact, and reduce those charges by an equal amount of adjustments (Column D). Other Public, Line 9: Use the "specify" field to describe the source. Report the charges, collections, and adjustments for tribal groups covered by other payers on the appropriate payer line.
9E	Report the net revenue or amount of grant funds earned from both state or local indigent care programs or IHS Pub. L. 93-638 Compacts on Line 6a for those programs where the support is not a reimbursement on a per-visit or -service basis but rather awards grant funds using a formula or other method. Use the "specify" field to describe the source.

WORKERS' COMPENSATION

Workers' compensation is a form of liability insurance for employers and NOT health insurance for employees.

Tables Affected	Treatment
4	If workers' compensation covers a patient's bills, the patient usually has related insurance. Report that on Table 4 (even if the health center is not billing the insurance). Patients with work-related insurance go on Line 11 (Private). Those **without** any health insurance go on Line 7 (Uninsured).
9D	Report charges, collections, and adjustments for workers' compensation-covered services on Line 12 (Private).

TRICARE, TRIGON, AND PUBLIC EMPLOYEES' INSURANCE

Many government employees have insurance.

Tables Affected	Treatment
4	Report health insurance earned by an employee or retired employee of a public entity on Line 11 (Private), NOT on Line 10a (Other Public Insurance [non-CHIP]).
9D	Report charges, collections, and adjustments on Line 12 (Private), **NOT** on Line 9 (Other Public).

RYAN WHITE

Tables Affected	Treatment
4	Ryan White is not considered medical insurance. Report patients based on their primary medical insurance on the appropriate line. Report Ryan White patients with no other insurance as uninsured.
5	Report staff by their primary function. Do not report staff as Other Programs and Services.
8A	Report costs consistent with reporting of staffing categories on Table 5.
9D	Report the charges, collections, and adjustments for patient services covered by Ryan White funds as Other Public (Line 9).
9E	Report non–patient service income associated with Ryan White programs on the appropriate line of Table 9E, based on last party rule. • Ryan White Part A from county or city governments: Report on Line 7. • Ryan White Part A from a third party: Report on Line 8. • Ryan White Part A from the federal government: Report on Line 5. • Ryan White Part B from the state: Report on Line 6. • Ryan White Part B from a county or city government: Report on Line 7. • Ryan White Part B from a non-government third party: Report on Line 8. • Ryan White Part C from the HIV/AIDS Bureau: Report on Line 5. • Ryan White Part D from the HIV/AIDS Bureau: Report on Line 5. • Ryan White Part F from the HIV/AIDS Bureau: Report on Line 5. Use the "specify" fields to describe the part and which source the health center received the income from.

SCHOOL-BASED SITES

Some health centers have schools in their approved scope of project as a service delivery site where they provide services to patients.

Tables Affected	Treatment
4	Lines 1–6, Income: Obtain information on income from patients. In schools, income should be that of the parent(s) or caregiver(s), or report as "Unknown." In the limited case of minor consent services, patients should be reported as below poverty. In the workplace, income is the patient's family/household income or, if not known, "Unknown" (Line 5). Lines 7–12, Insurance: Record the form of medical insurance the patient has, regardless of the health center's ability to bill that source. (Medicaid often covers children in school-based service sites who may have another provider. Report these children as Medicaid patients.) The school district is not an insurer. Except for confidential minor consent services, students should not be assumed to be uninsured.
5	Report all countable visits meeting the UDS definition. DO NOT reduce or reclassify personnel FTEs for travel time to and from sites.
8A	Report costs in accordance with the service category for which the costs were incurred. DO NOT report costs on Line 12: Other Programs and Services.
9D	Unless the health center charges a visit to a third party such as Medicaid, report the health center's usual and customary charges (Column A) on Line 9 (Other Public) if a government entity or Line 10 (Private) if privately run. Report the amount paid by the contract (school district) in Column B. Report the difference (positive or negative) in Column D (Adjustments).
9E	DO NOT report contract revenue on Table 9E.

THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

CHIP provides health coverage to eligible children through Medicaid and/or separate CHIP programs. CHIP is administered by states, according to federal requirements. The program is funded jointly by states and the federal government.

Tables Affected	Treatment
4	Medicaid: If Medicaid handles CHIP and the enrolled patients are identifiable, report them on Line 8b. If it is not possible to differentiate CHIP administered through Medicaid from regular Medicaid, report the enrolled patients on Line 8a with other Medicaid patients. Non-Medicaid: Report CHIP-enrolled patients in states that DO NOT use Medicaid as "Other Public CHIP" on Line 10b. Assuming they are identifiable, DO NOT report the CHIP enrollees on Line 11 (Private), even though a private insurance plan administers the program.
9D	Medicaid: Report on Line 3 (Medicaid). Non-Medicaid: Report on Line 9 (Other Public). Assuming they are identifiable, DO NOT report CHIP charges, collections, and adjustments on Line 12 (Private), even if a private insurance company administers the program.

PATIENTS SERVED IN A CARCERAL SETTING

Some health centers provide transitional health care services to individuals in carceral settings, including prisons, jails, juvenile justice facilities, or other carceral facilities operated on behalf of a carceral authority. A carceral authority is the state or local government that is responsible for the care and custody of the justice-involved individual. These services are provided to individuals expected to be released from a carceral setting within 90 calendar days. Only include services in this setting if in the health center's approved scope of project. Refer to PIN 2024-05 for policy guidance to support transitions in care for justice-involved individuals reentering the community.

Tables Affected	Treatment
4	Assume justice-involved individuals' income is at or below 100% FPG (Line 1). Unless the institution has arranged for Medicaid enrollment, assume that justice-involved individuals are uninsured.
9D	Report the health center's usual and customary charges for the service in Column A and the payments in Column B. Report the difference between the charge and payment in Column D (Adjustments). Assuming the carceral authority is billed for the patient's services, report on Line 7 (Other Public).
9E	DO NOT report the revenue earned from the carceral authority on Table 9E. Report revenue fully on Table 9D.

HEALTH IT/EHR PERSONNEL AND COSTS

Health IT, including EHR systems (which may be part of an integrated PMS), record clinical activities and help providers manage and integrate patient services. Aspects of the health IT/EHR count in multiple service categories, depending on the function and use.

Tables Affected	Treatment
5	Report personnel who directly or exclusively support health IT/EHR activities, such as documenting services in the health IT/EHR (e.g., scribes), data entry, training, and performing technical assistance functions in the service category for which they perform these functions. Report personnel who indirectly support IT/EHR activities across all service categories under IT, Line 30c. Report personnel dedicating some or all of their time to design, operation, and oversight of QI systems; data specialists; statisticians; and health IT/EHR or medical form designers under IT, Line 30c. Report personnel managing the hardware and software of a practice management billing and collection system under IT, Line 30c.
8A	Report personnel and fringe costs in Column A1 so that it aligns with the FTEs reported on Table 5. Report other costs that directly and exclusively support health IT/EHR and QI activities, such as licenses, depreciation of the hardware and software, software support services, annual fees in the service category to which the costs are directly tied. This may include medical, dental, pharmacy, as well as other service categories. Report other indirect health IT/EHR and QI costs that cannot be directly associated with a particular service or cost center on Line 14a, Column A2.

NEW START OR NEW ACCESS POINT (NAP)

Health center grants or designations awarded for the first time (new start) may be added before October 1 during the calendar year. New starts must submit data for the full calendar year (covering January 1 to December 31). Health center service delivery sites may be added in scope of project at any point during the calendar year through a change in scope (CIS) request or a NAP award. Active, existing health centers must submit data for in-scope activities based on the CIS approval date and/or NAP site implementation date.

Tables Affected	Treatment
Patients by ZIP Code, 3A, 3B, 4	It is understood that a new health center may have never collected some of the data required to be reported in the UDS before the start of Notice of Award, such as Veteran status. Provide the best data available, but for the first year only, you may have some unusual numbers. Work with your UDS Reviewer to explain apparent data inconsistencies.
6B, 7	If the added service delivery site or health center will transition to a new health IT/EHR during the calendar year, gather the information for the year across the two systems and analyze them in a separate database to remove any duplication in the data.

NURSES PROVIDING PATIENT SUPPORT SERVICES

Case management (which is achieved when patients are aided in the management of their upstream drivers of health, including assessment of patient medical and/or social service needs; establishment of service plans; and maintenance of referral, tracking, and follow-up systems) and patient health education are the only countable patient support services, assuming the full UDS countable visit definition is met. Other patient support services, such as outreach, transportation, community health work, and language assistance DO NOT count as visits in the

UDS. It is common for nurses to function as a case manager at the health center and at other approved service delivery sites, such as at a school-based service site.

Tables Affected	Treatment
Patients by ZIP Code, 3A, 3B, 4	If services meet the countable visit definition, report the patient on the patient profile tables. Include the patient's ZIP code of residence, age, sex, race, ethnicity, income status, and primary medical insurance.
4	If the services are provided at approved in-scope school-based service delivery site(s), also report the total number of patients who had a countable visit within any of the seven service categories (e.g., medical, mental health, patient support) on Line 24.
5	When nurses provide case management (rather than medical care services), report the part of these personnel FTE when dedicated as case managers and their case management visit(s) on Line 24.

RELATIONSHIP BETWEEN PATIENT COUNTS ON PATIENT PROFILE TABLES

The patient profile tables provide unique, unduplicated patient counts according to specific patient characteristics. The charts below illustrate the cross-table relationships between the ZIP code Table, and Tables 3A, 3B, and 4, and informs of the tables and sections in which the count of patients must match.

Total unduplicated patients:

ZIP Code Table	Must Equal	Table 3A	Must Equal	Table 3B	Must Equal	Table 4	Must Equal	Table 4
Column F (Total patients by ZIP code by primary medical insurance)	=	Line 39, Columns A+B (Total patients by age and sex)	=	Line 8, Column D (total patients by Hispanic, Latino/a, or Spanish ethnicity and race)	=	Line 6, Column A (total patients by income)	=	Line 12, Columns A+B (total patients by insurance status)

Other patient profile tables relationships:

Table and Component	Must Equal	Table and Component
ZIP Code, Column B (Uninsured)	=	Table 4, Line 7, Columns A+B (Uninsured)
ZIP Code, Column C (Medicaid/CHIP/Other Public)	=	Table 4, Line 8, Columns A+B (Medicaid) + Table 4, Line 10, Columns A+B (Other Public) **Note:** These lines include CHIP.
ZIP Code, Column D (Medicare)	=	Table 4, Line 9, Columns A+B (Medicare)
ZIP Code, Column E (Private)	=	Table 4, Line 11, Columns A+B (Private)
Table 3A, Lines 1–18, Columns A+B (Total patients age 0–17 years)	=	Table 4, Line 12, Column A (total patients age 0–17 years by insurance status)
Table 3A, Lines 19–38, Columns A+B (Total patients age 18 and older)	=	Table 4, Line 12, Column B (total patients age 18 and older by insurance status)

RELATIONSHIP BETWEEN INSURANCE ON TABLE 4 AND REVENUE ON TABLE 9D

The definition of payer groups on Tables 4 and 9D are the same. However, charges, collections, and adjustments on Table 9D do not match the patients reported by on Table 4. Patients on Table 4 are those with medical insurance, and Table 9D includes the charges, collections, and net revenue from all billable services, not just medical. The patients on Table 4 are reported based on their primary medical insurance as of their last visit, which may have changed during the year. In addition to showing all billed services, Table 9D also reclassifies charges to secondary and subsequent payers. Some notable characteristics within these two tables are shown in the chart below.

Primary Third-Party Medical Insurance on Table 4, Line:	Have Revenue Reported on Table 9D, Line:
7: None/Uninsured—Includes patients with no medical insurance at their last visit	13: Sliding Fee—Includes uninsured sliding fee—and Other Self-Pay—Includes uninsured full-pay, self-pay patient (**Note:** It also includes co-pays, deductibles, and uncovered services for insured patients.)
8a and 8b: Medicaid and Medicaid CHIP—Includes Medicaid managed care plans and all forms of state-expanded Medicaid	3: Medicaid—Includes all Medicaid
9: Medicare—Includes Medicare Advantage	6: Medicare—Includes all Medicare
9a: Dually eligible—Includes Medicare and Medicaid	6: Medicare—Includes Medicare as primary payer with secondary balance reclassified to Medicaid
10a: Other Public non-CHIP—Includes state and local government insurance that covers primary care	9: Other Public—Includes state and local government that reimburse on a service basis, such as indigent care programs and categorical grant programs with limited benefits (e.g., voluntary family planning [Title X], EPSDT, and BCCEDP)
10b: Other Public CHIP—Includes CHIP through a private carrier outside of Medicaid	9: Other Public—Includes CHIP through a private carrier outside of Medicaid
11: Private—Includes commercial insurance and insurance purchased from state or federal exchanges (DO NOT include workers' compensation coverage as medical insurance—it is a liability insurance)	12: Private—Charges and collections from contracts with private (commercial) carriers, private schools, Head Start, workers' compensation, and state and federal exchanges

RELATIONSHIP BETWEEN PERSONNEL ON TABLE 5 AND COSTS ON TABLE 8A

The major staffing service categories on Table 5 are consistent with cost categories used for financial reporting and give adequate detail on personnel categories for program planning and evaluation purposes. Personnel classifications should be consistent with cost classifications. The chart below illustrates the relationship between the two tables. The personnel on Table 5 are routinely compared to the costs on Table 8A during the review and analysis process. If there is a reason such a comparison would look unusual (e.g., volunteers on Table 5 result in no cost on Table 8A or paid referred care costs on Table 8A with no corresponding FTEs on Table 5), include an explanation on Table 8A. Note that the cost categories on Table 8A are not in the same sequential order as the personnel categories on Table 5.

FTEs Reported on Table 5, Line:	Have Costs Reported on Table 8A, Line:
1–12: Medical Care	1: Medical Care
13–14: Medical Laboratory and X-ray	2: Medical Laboratory and X-ray
16–18: Dental	5: Dental
20a–20c: Mental Health	6: Mental Health
21: Substance Use Disorder	7: Substance Use Disorder
22: Other Professional	9: Other Professional
22a–22c: Vision	9a: Vision

FTEs Reported on Table 5, Line:	Have Costs Reported on Table 8A, Line:
23a–23d: Pharmacy	8a: Pharmacy
24–28: Patient Support Services	11: Patient Support Services
29a: Other Programs and Services	12: Other Programs and Services
30a–30b and 32: Other Support (Central Services)	15: Other Support (Central Services)
30c: Information Technology	14a: Information Technology
31: Facility	14: Facility

RELATIONSHIP BETWEEN PRENATAL CARE ON TABLE 6B AND DELIVERIES ON TABLE 7

The chart below illustrates the relationship and accounting of prenatal care patients and the birth outcomes to be reported on Tables 6B and 7. A "Yes" means that the information is to be reported in the specified table and section; "No" means the information is NOT to be reported. Because prenatal care and delivery may occur during different calendar years, it would be unusual for the count of prenatal care patients to equal the birth outcomes. The prenatal care patients on Table 6B are routinely compared to the deliveries and birth outcomes on Table 7 during the review and analysis process. If there is a reason such a comparison would look unusual, include an explanation on the appropriate table.

Prenatal Care Patient and Birth Outcome Scenarios	Table 6B, Lines 1–9 (Age and Trimester of Entry)	Table 7, Column 1A (Patients who Delivered)	Table 7, Columns 1B–1D (Birth Outcomes—report each baby separately)
Patients still in prenatal care	Yes	No	No
Patients known to have delivered, with known birth outcomes	Yes	Yes	Yes
Patients known to have delivered, but birth outcomes unknown	Yes	Yes	No
Patients who miscarried	Yes	No	No
Patients with a stillbirth outcome	Yes	Yes	No
Patients lost to follow-up, birth outcomes unknown	Yes	No	No

Note: Health centers are expected to collect and report birth outcomes of prenatal care patients. In situations where this information cannot be obtained, do not report an estimate.

RELATIONSHIP BETWEEN RACE AND ETHNICITY ON TABLES 3B AND 7

The patient population for each CQM on Table 7 is defined in terms of race and ethnicity, and comparisons are made to the race and ethnicity numbers reported on Table 3B. The following table illustrates the crosswalk between the comparable fields across the two tables.

Race	Ethnicity	Table 3B Reference	Table 7 Reference
Asian	Hispanic, Latino/a, or Spanish Origin	Line 1, Column A1–A5	Line 1a
	Not Hispanic, Latino/a, or Spanish Origin	Line 1, Column B	Line 2a
Asian Indian	Hispanic, Latino/a, or Spanish Origin	Line 1a, Column A1–A5	Line 1a1m, 1a1p, 1a1c, 1a1a, or 1a1o
	Not Hispanic, Latino/a, or Spanish Origin	Line 1a, Column B	Line 2a1
Chinese	Hispanic, Latino/a, or Spanish Origin	Line 1b, Column A1–A5	Line 1a2m, 1a2p, 1a2c, 1a2a, or 1a2o
	Not Hispanic, Latino/a, or Spanish Origin	Line 1b, Column B	Line 2a2
Filipino	Hispanic, Latino/a, or Spanish Origin	Line 1c, Column A1–A5	Line 1a3m, 1a3p, 1a3c, 1a3a, or 1a3o
	Not Hispanic, Latino/a, or Spanish Origin	Line 1c, Column B	Line 2a3

Race	Ethnicity	Table 3B Reference	Table 7 Reference
Japanese	Hispanic, Latino/a, or Spanish Origin	Line 1d, Column A1–A5	Line 1a4m, 1a4p, 1a4c, 1a4a, or 1a4o
	Not Hispanic, Latino/a, or Spanish Origin	Line 1d, Column B	Line 2a4
Korean	Hispanic, Latino/a, or Spanish Origin	Line 1e, Column A1–A5	Line 1a5m, 1a5p, 1a5c, 1a5a, or 1a5o
	Not Hispanic, Latino/a, or Spanish Origin	Line 1e, Column B	Line 2a5
Vietnamese	Hispanic, Latino/a, or Spanish Origin	Line 1f, Column A1–A5	Line 1a6m, 1a6p, 1a6c, 1a6a, or 1a6o
	Not Hispanic, Latino/a, or Spanish Origin	Line 1f, Column B	Line 2a6
Other Asian	Hispanic, Latino/a, or Spanish Origin	Line 1g, Column A1–A5	Line 1a7m, 1a7p, 1a7c, 1a7a, or 1a7o
	Not Hispanic, Latino/a, or Spanish Origin	Line 1g, Column B	Line 2a7
Native Hawaiian	Hispanic, Latino/a, or Spanish Origin	Line 2a, Column A1–A5	Line 1b1m, 1b1p, 1b1c, 1b1a, or 1b1o
	Not Hispanic, Latino/a, or Spanish Origin	Line 2a, Column B	Line 2b1
Other Pacific Islander	Hispanic, Latino/a, or Spanish Origin	Line 2b, Column A1–A5	Line 1b2m, 1b2p, 1b2c, 1b2a, or 1b2o
	Not Hispanic, Latino/a, or Spanish Origin	Line 2b, Column B	Line 2b2
Guamanian or Chamorro	Hispanic, Latino/a, or Spanish Origin	Line 2c, Column A1–A5	Line 1b3m, 1b3p, 1b3c, 1b3a, or 1b3o
	Not Hispanic, Latino/a, or Spanish Origin	Line 2c, Column B	Line 2b3
Samoan	Hispanic, Latino/a, or Spanish Origin	Line 2d, Column A1–A5	Line 1b4m, 1b4p, 1b4c, 1b4a, 1b4o
	Not Hispanic, Latino/a, or Spanish Origin	Line 2d, Column B	Line 2b4
Black or African American	Hispanic, Latino/a, or Spanish Origin	Line 3, Column A1–A5	Line 1cm, 1cp, 1cc, 1ca, or 1co
	Not Hispanic, Latino/a, or Spanish Origin	Line 3, Column B	Line 2c
American Indian/Alaska Native	Hispanic, Latino/a, or Spanish Origin	Line 4, Column A1–A5	Line 1dm, 1dp, 1dc, 1da, or 1do
	Not Hispanic, Latino/a, or Spanish Origin	Line 4, Column B	Line 2d
White	Hispanic, Latino/a, or Spanish Origin	Line 5, Column A1–A5	Line 1em, 1ep, 1ec, 1ea, or 1eo
	Not Hispanic, Latino/a, or Spanish	Line 5, Column B	Line 2e
More than One Race	Hispanic, Latino/a, or Spanish Origin	Line 6, Column A1–A5	Line 1fm, 1fp, 1fc, 1fa, or 1fo
	Not Hispanic, Latino/a, or Spanish Origin	Line 6, Column B	Line 2f
Unreported/Chose Not to Disclose Race	Hispanic, Latino/a, or Spanish Origin	Line 7, Column A1–A5	Line 1gm, 1gp, 1gc, 1ga, or 1go
	Not Hispanic, Latino/a, or Spanish Origin	Line 7, Column B	Line 2g
Unreported/Chose Not to Disclose Race	Unreported/Chose Not to Disclose Ethnicity	Line 7, Column C	Line h

Appendix C: Health Center Health Information Technology (Health IT) Capabilities and Other Data Elements Form

INTRODUCTION

The Health IT Capabilities and Other Data Elements Form collects information through a series of questions on the health center's health IT capabilities, including health center's implementation of an ASTP/ONC-certified EHR, prescription medication monitoring, medications for opioid use disorder, voluntary family planning, telehealth, and value-based purchasing contracts. The Health IT Capabilities and Other Data Elements Form must be completed and submitted as part of the UDS submission.

The text directly below contains changes to Appendix C from 2025 calendar year reporting to 2026 calendar year reporting:

Several key changes have been made to Appendix C, as outlined below:

- Several questions specific to EHR implementation have been removed, as follows: Questions 1a, 1a2, 1a3, 1c, 1c1, and 10.
- Upstream drivers of health screening questions (Questions 11, 11a, 12, 12a, and 12b) have been removed, with aspects incorporated into Table 6A.
- Certain questions (previously on the Other Data Elements Form) have been moved here, as follows: medications for opioid use disorder (MOUD) will be reported as Question 14, telehealth will be reported as Questions 15a, 15a1, 15a2, and 15a3, and voluntary family planning is reported as Question 16.
- Three new questions about alternative payment models have been added (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).

This marks the conclusion of changes to Appendix C from 2025 calendar year reporting to 2026 calendar year reporting.

QUESTIONS

The following questions appear in the EHBs. Complete them before you file the UDS Report. Reporting requirements for the questions appear on-screen in the EHBs as you complete the form. Respond to each question based on your health center status **as of December 31, 2026**.

1. Did your health center have an electronic health record (EHR) system installed and in use, at least for medical care, by December 31?

a. Yes, installed at all service delivery sites and used by all providers	b. Yes, but only installed at some service delivery sites or used by some providers	c. No
• For the purposes of this response, "providers" mean all fully trained medical providers, including physicians, nurse practitioners, physician assistants/associates, and certified nurse midwives. • Although some or all dental, mental health, or other providers may also be using the system, as may medical support personnel, this is not required to choose response (a). • For the purposes of this response, "all service delivery sites" means all permanent service delivery sites where medical providers serve health center medical patients regularly. • It DOES NOT include administrative-only locations, hospitals or nursing homes, mobile vans, or sites used on a seasonal or temporary basis. • Check this option if a few newly hired, untrained personnel are the only ones not using the system.	• Select option (b) if one or more permanent service delivery sites did NOT have the EHR installed or in use (even if this is planned), or if one or more fully trained medical providers (as defined in selection [a]) do not yet use the system. • When determining if all providers have access to the system, the health center should also consider part-time and locum providers who serve clinic patients. • DO NOT select this option if the only medical providers who did not have access were those who were newly hired and still being trained on the system.	• Select "no" if no EHR was in use on December 31, even if you had the system installed and training had started. • If the health center bought an EHR but has not yet put it into use, answer "no."

If more than one EHR is used, answer "Yes," to Question 1 and select "a" if they are used at all service delivery sites and used by all providers or select "b" if they are used at some service delivery sites or used by some providers.

If "Yes, but only installed at some service delivery sites or used by some providers" is selected, a box expands for health centers to identify how many service delivery sites have the EHR in use and how many (medical) providers are using it. Please enter the number of service delivery sites (as defined under question 1) where the EHR is in use and the number of providers who use the system (at all service delivery sites). Include part-time and locum medical providers who serve clinic patients. Count a provider who has separate login identities at more than one service delivery site as just one provider.

If response to Question 1 is "c. No," skip to Question 13. If response is "a" or "b," continue to next question.

This next set of questions seeks to understand which EHR vendor product was in use, how broad system access was, and what features were available and in use. DO NOT include PMS or other billing systems, even though they can often produce UDS data.

Health centers are to indicate the vendor and ASTP-/ONC-certified health IT product list number, available on the Certified Health IT Product List (CHPL). If you cannot find the CHPL ID within your Health IT/EHR system, please reach out to your EHR vendor for support. If you have more than one EHR (if, for example, you acquired another practice with its own EHR), report the EHR that will be the successor system or the EHR used for capturing primary medical care.

1a. Question removed.

1a1. List the vendor's name for your health center's primary EHR system.

1a2. Question removed.

1a3. Question removed.

1a4. List the CHPL product ID number for your health center's primary EHR system.

Note: The CHPL product ID number is a standardized number that shows your certified product and version. Step-by-step instructions for using the CHPL to find your system are available in the CHPL Public User Guide.

1b. Did you switch to your current EHR from a previous system during the calendar year?

a. Yes

b. No

1c. Question removed.

1c1. Question removed.

1d. Question removed.

1e. Question removed.

2. Question removed.

3. Question removed.

4. Which of the following key providers/health care settings does your health center electronically exchange clinical or patient information with? (Select all that apply.)

   a. Hospitals/emergency rooms

   b. Specialty providers

   c. Other primary care providers

   d. Laboratory tests or imaging studies

   e. Health information exchange (HIE)[27]

[27] HIEs are typically state or regional data exchanges that support information sharing between different organizations, provider types, and technology vendors. More information on HIEs can be found on the Health Information Exchange webpage.

f. Community-based organizations

g. None of the above *(Please select "None of the above" only if none of the other options apply.)*

h. Other (please describe _____)

5. Does your health center engage patients through health IT in any of the following ways? (Select all that apply.)

   a. Patient portals

   b. Kiosks

   c. Secure messaging between patient and provider

   d. Online or virtual scheduling

   e. Automated electronic outreach for care gap closure or preventive care reminders

   f. Application programming interface (API) provides patient access to their health record through Mobile Health (mHealth) apps[28]

   g. Other (please describe _____)

   h. No, we DO NOT engage patients using health IT *(Please select "No, we DO NOT engage patients using health IT" only if none of the other options apply.)*

6. Question removed.

7. Question removed.

8. Question removed.

9. Question removed.

10. Question removed.

11. Question removed.

11a. Question removed.

12. Question removed.

12a. Question removed.

12b. Question removed.

13. Does your health center integrate a statewide Prescription Drug Monitoring Program (PDMP) database into the health information systems, such as health information exchanges, EHRs, and/or pharmacy dispensing software (PDS) to streamline provider access to information on patients' controlled substance prescriptions?

   a. Yes

   b. No

   c. Not sure

[28] More information can be found on How APIs in Health Care can Support Access to Health Information: Learning Module

14. Medications for Opioid Use Disorder (MOUD)

    a. How many providers, on-site or with whom the health center has agreements, are eligible to treat opioid use disorder with medications specifically approved by the U.S. Food and Drug Administration (FDA) (i.e., buprenorphine, methadone, naltrexone) for that indication during the calendar year?

    b. During the calendar year, how many patients received MOUD from a provider accounted for in Question 14a? _____

    Note: The number of patients on Question 14b must be the same as the number of patients reported on Table 6A, Line 26c3.

15. Did your organization use telehealth to provide services remotely (virtually)?

    a. Yes

    If "Yes" is selected, proceed to questions 15a1–15a3.

    15a1. Who did you use telehealth to communicate with? (Select all that apply.)

    a. Patients at a different location than the provider (e.g., home telehealth, satellite locations)

    b. Specialists outside your organization (e.g., specialists at referral centers)

    15a2. What telehealth technology(s) did you use? (Select all that apply.)

    a. Real-time telehealth (e.g., live videoconferencing)

    b. Store-and-forward telehealth (e.g., secure email with photos or videos of patient examinations)

    c. Remote patient monitoring (e.g., electronic transmission of data from patients to health care providers, such as vital signs, pulse, blood pressure)

    d. Mobile Health (mHealth) (e.g., patient technologies, like smartphones and tablet apps)

    15a3. What services were delivered remotely? (Select all that apply.)

    a. Primary care

    b. Oral health

    c. Mental health

    d. Substance use disorder

    e. Dermatology

    f. Chronic conditions

    g. Disaster management

    h. Consumer health education

    i. Provider-to-provider consultation

    j. Radiology

    k. Nutrition and dietary counseling

    l. Other (Please describe _____)

    b. No.

    If you did not deliver services remotely, please comment on why. (Select all that apply.)

    a. Have not considered/unfamiliar with telehealth

b. Policy barriers (Select all that apply.)
   i. Lack of or limited reimbursement
   ii. Credentialing, licensing, or privileging
   iii. Privacy and security
   iv. Other (Please describe _____)
c. Inadequate broadband/telecommunication service (Select all that apply.)
   i. Cost of service
   ii. Lack of infrastructure
   iii. Other (Please describe _____)
d. Lack of funding for telehealth equipment
e. Lack of training in using telehealth to deliver services
f. Not needed
g. Other (Please describe _____)

16. How many health center patients were screened for voluntary family planning, including contraceptive methods, using a standardized screener during the calendar year? _____

17. What payor arrangements do you have for value-based purchasing (VBP) contracts? (Select all that apply.)
    a. Medicare (Original/fee-for-service [FFS])
    b. Medicare Advantage
    c. Medicaid (FFS)
    d. Medicaid Managed Care
    e. Commercial health insurers
    f. Marketplace health insurers
    g. Our health center DOES NOT have VBP contracts (If selected, skip Questions 18 and 19.)
    h. Other (Please describe _____)

18. Please list the types of Alternative Payment Models your health center is involved in. (Select all that apply.)
    a. Medicaid managed care shared savings
    b. Pay-for-performance
    c. Shared savings
    d. Shared risk
    e. Capitation
    f. Don't know
    g. Other (Please describe _____)

19. What percentage of your health center's revenue during the year is tied to value-based payment contracts?
    a. 0%
    b. 1-5%
    c. 6-10%
    d. 11-15%
    e. 16-20%
    f. >20%

20. For individuals under 19 years of age, does your health center provide services that use puberty blockers, sex hormones, or surgical procedures* for the purpose of transforming their physical appearance to align with an identity that differs from their sex?
    a. Yes
    b. No
    c. Not applicable

    * Puberty blockers may include GnRH agonists and other interventions, to delay the onset or progression of normally timed puberty in an individual. Sex hormones may include androgen blockers, estrogen, progesterone, or testosterone. Surgical procedures may include alteration or removal of an individual's sex organs.

FAQ FOR APPENDIX C: HEALTH CENTER HEALTH IT CAPABILITIES AND OTHER DATA ELEMENTS FORM

1. **What do we do if our health center acquired a new EHR system and we need to use two different systems to report a full calendar year UDS Report?**

   Health centers must submit one UDS Report that includes unduplicated data for the entire scope of services included in the grant or designation for the calendar year. It is expected that health centers that transition from one EHR to another during the calendar year can report unduplicated counts of patients, visits, and other activity. To complete the UDS Report as accurately as possible, your health center will need to have access to both systems and merge results. Health centers should set up a process to pull and transfer data from the previous EHR system during the merger process. This may require pulling data from the two systems into a separate database to remove any duplication in the data. This can be a time-consuming process, and it is recommended that health centers begin this process as soon as the year ends or once the transition has been completed to make sure they have enough time to complete it before the submission due date.

2. **We use multiple EHRs across our health center that are then aggregated into a single analytics platform or data warehouse for UDS reporting. How should we respond to the questions on this form?**

   Respond to Question 1 and its sub-questions 1a1 and 1a4 based on the primary EHR used by your medical providers. For example, provide the vendor and CHPL product ID number for the primary EHR used by your medical providers.

   Respond to Questions 4 and 5 based on your entire EHR and health IT ecosystem. Your responses should state where data are exchanged from any of the systems in use at your health center and for what purposes the data from those systems are used.

3. **If a patient is given a screener for voluntary family planning, but they do not respond to the questions, do we count the patient as screened for Question 16?**

   No. Count only patients who completed (some of or all of) the screener. Do not count the patient for this question if a screener was given to the patient and they did not respond to any of the screening questions.

4. **What is considered a standard screener for the family planning response?**

   Use of a standardized screener tool (i.e., a consistent set of questions that are asked of individual patients uniformly for the purposes of collecting information to assess the individual's voluntary family planning or interest in contraceptive services).

5. **When reporting on providers eligible to treat opioid use disorder in Question 14, should we count providers with the authority to treat OUD, or only those who actually treated OUD during the calendar year?**

   Report on providers with authority to treat OUD with medications approved by the FDA.

Appendix D: Workforce Form

INTRODUCTION

The Workforce Form collects information through a series of questions on health center workforce. It is important to understand the current state of health center workforce training and staffing models to better support recruitment and retention of health center professionals.

The text directly below contains changes to Appendix D from 2025 calendar year reporting to 2026 calendar year reporting:

There are no key changes to this form.

This marks the conclusion of changes to Appendix D from 2025 calendar year reporting to 2026 calendar year reporting.

QUESTIONS

Report on these data elements as part of your UDS submission. Topics include health professional education/training (DO NOT include continuing education units or on-the-job career and skill development) and satisfaction surveys. Respond to each question based on your health center status **as of December 31, 2026.**

1. Does your health center provide any health professional education/training that is a hands-on, practical, or clinical experience?
   a. Yes
   b. No

1a. If yes, which categories describe your health center's role in the health professional education/training process? (Select all that apply.)
   a. Sponsor[29]
   b. Training site partner[30]
   c. Other (please describe _____)

2. If yes, please indicate the range of health professional education/training offered at your health center and how many individuals you have trained in each category within the calendar year. (Do not answer this question if your response to question 1 was No.)

Workforce form reporting considerations:

- Training refers to a formal agreement with an institution, not scenarios of informal shadowing.
- Pre-graduate/certificate training includes student clinical rotations or externships.
- Post-graduate training includes a residency, fellowship, or practicum.
- Include non-health-center individuals trained by your health center.

[29] A sponsor hosts a comprehensive health profession education and/or training program, the implementation of which may require partnerships with other entities that deliver focused, time-limited education and/or training (e.g., a teaching health center with a family medicine residency program).
[30] A training site partner delivers focused, time-limited education and/or training to learners in support of a comprehensive curriculum hosted by another health profession education provider (e.g., month-long primary care dentistry experience for dental students).

- Line 1, below, is the count of individuals, regardless of their specialty. Lines 1a–1f are to account for the multiple specialties that an individual has received or may be receiving training for during the calendar year (e.g., an Internist + other specialty).
- Line 25, Other, may include students interested in health care (e.g., internships, master's-level placements); students enrolled in specialized training (e.g., such as radiology, social work, phlebotomy, physical therapy, or occupational therapy; pharmacy technicians; and community health workers).

Individuals Trained	Pre-Graduate/Certificate (A)	Post-Graduate Training (B)
Medical		
1. Physicians		
a. Family Physicians		
b. General Practitioners		
c. Internists		
d. Obstetrician/Gynecologists		
e. Pediatricians		
f. Other Specialty Physicians		
2. Nurse Practitioners		
3. Physician Assistants/Associates		
4. Certified Nurse Midwives		
5. Registered Nurses		
6. Licensed Practical Nurses/ Vocational Nurses		
7. Medical Assistants		
Dental		
8. Dentists		
9. Dental Hygienists		
10. Dental Therapists		
10a. Dental Assistants		
Mental Health and Substance Use Disorder		
11. Psychiatrists		
12. Clinical Psychologists		
13. Clinical Social Workers		
14. Professional Counselors		
15. Marriage and Family Therapists		
16. Psychiatric Nurse Specialists		
17. Mental Health Nurse Practitioners		
18. Mental Health Physician Assistants/Associates		
19. Substance Use Disorder Personnel		
Vision		
20. Ophthalmologists		
21. Optometrists		
Other Professionals		
22. Chiropractors		
23. Dietitians/Nutritionists		
24. Pharmacists		
25. Other (please describe _____)		

3. Provide the number of health center personnel serving as preceptors[31] at your health center: ____
4. Provide the number of health center personnel (non-preceptors) supporting ongoing health center training programs: ____
5. How often does your health center conduct satisfaction surveys to **providers** (as identified in Appendix A, Listing of Personnel) working for the health center? Report only provider surveys here. (Select one.)
   a. Monthly
   b. Quarterly
   c. Annually
   d. We DO NOT currently conduct provider satisfaction surveys
   e. Other (please describe _____)
6. How often does your health center conduct satisfaction surveys for general personnel (as identified in Appendix A, Listing of Personnel) working for the health center (report provider surveys in question 5 only)? (Select one.)
   a. Monthly
   b. Quarterly
   c. Annually
   d. We DO NOT currently conduct personnel satisfaction surveys
   e. Other (please describe _____)

[31] A preceptor is a teacher or experienced professional who helps students and staff learners apply theory to practice.

Appendix E: Health Center Resources

Several resources are available to help health centers with UDS reporting criteria, or EHBs system questions:

Description	Contact	Email or Web Form	Phone
UDS reporting questions	UDS Support Center	udshelp330@bphcdata.net or BPHC Contact Form Select: UDS Reporting > UDS Reporting and > the most applicable subcategory	866-837-4357 (866-UDS-HELP)
EHBs account and user access questions	Health Center Program Support	BPHC Contact Form Select: Technical and System Support > EHBs Tasks and Technical Issues > Create Account	877-464-4772
EHBs technical issues with UDS Reports	Health Center Program Support	BPHC Contact Form Select: Technical and System Support > EHBs Tasks and Technical Issues > Other EHBs Submission Types	877-464-4772

Visit HRSA's BPHC UDS Technical Assistance webpage to access this manual and other data and resources, including:

- A complete set of the UDS tables and forms (Note that the table view within EHBs may look different but has the same fields.),
- Notifications of changes to reporting criteria included in the PAL,
- Training opportunities, and
- Other reporting materials and guidance.

Subscribe to the Primary Health Care Digest for timely updates and reminders about UDS reporting.

Visit HRSA's BPHC Strategic Partnerships webpage for descriptions and lists of Health Center Controlled Networks (HCCNs), National Technical Assistance Programs (NTAPs), and Primary Care Associations (PCAs) that may help health centers with UDS reporting.

UDS PRODUCTION TIMELINE AND REPORT AVAILABILITY

Health centers can access their current-year and prior-year UDS Reports, as well as several standard reports, through the EHBs web link.

- UDS Preliminary Reporting Environment (PRE): October–December 2026
- UDS annual data collection and reporting: January 1–February 15, 2027
- Deadline for submitting a complete UDS Report: February 15, 2027
- UDS reporting freeze: March 31, 2027

Standard UDS Reports are available in EHBs, as shown below.

UDS Report Level	Timing	Description	Recipient	Look-Alike	PCAs & NTAPs
Health Center UDS Data Tables (Submitted/ Finalized)	January (available after initial submission)	Provides health center with data for each of the 11 UDS tables, Health IT and Other Data Elements form, and Workforce form. Available in HTML format.	HC	HC	Not available
UDS Data File	January (available after initial submission)	Provides health center with data for each of the 11 UDS tables, Health IT and Other Data Elements form, and Workforce form. Available in XML and Excel formats.	HC	HC	Not available
Health Center Trend Report	July/August	Compares the health center's performance for key measures (in three categories: Access, Quality of Care/Health Outcomes, and Financial Cost/Viability) with national and state averages over a 3-year period. Available in HTML format for recipients and look-alikes. Available in HTML, ZIP, or PDF file for PCAs and NTAPs.	HC, S, N	HC, N	HC, S, N
UDS Summary Report	July/August	Summarizes and analyzes the health center's current UDS data using measures across various tables of the UDS Report. Available in HTML format for recipients and look-alikes. Available in HTML, Excel, ZIP, or PDF file for PCAs and NTAPs.	HC, S, N	HC, N	HC, S, N
UDS Rollup Report	July/August	Compiles annual data reported by health centers and gives summary data for patient characteristics, socioeconomic characteristics, staffing, patient diagnoses and services rendered, quality of care, health outcomes, financial costs, and revenue. Available in HTML format for recipients and look-alikes. Available in HTML, ZIP, or PDF file for PCAs and NTAPs.	S, N	N	S, N
Performance Comparison Report	September	Summarizes and analyzes the health center's latest UDS data, giving details at recipient or look-alike, state, national, urban, and rural levels with trend comparisons and percentiles. Available in HTML format for recipients and look-alikes. Available in HTML, ZIP, or PDF file for PCAs and NTAPs.	HC, S, N	HC, N	HC, S, N
Data Dumps	July/August	Provides all UDS data at a health center level for all health centers associated with the PCA state or region. NTAPs receive data for all health centers. Available in Excel format.	Not available	Not available	HC

Abbreviations indicate geographies and detail level for which each report is available.

HC=Health Center, S=State, N=National

PUBLICLY AVAILABLE UDS DATA

Finalized UDS data are available to the public, as shown below.

- UDS state and national summary tables and Health Center Program recipient and look-alike data profiles will be available in the HRSA Data Warehouse in August 2027.
- Service area data will be available on the HRSA Data and Reporting website in August 2027.
- Annual performance data in Excel will be available in the Electronic Reading Room in August 2027.

UDS CQMS AND NATIONAL PROGRAMS CROSSWALK

The following table crosswalks the UDS CQMs and other national programs using these measures. Specification details and eCQM flowsheets are available at the eCQI Resource Center. Use the Assistant Secretary for Technology Policy/Office of the National Coordinator Issue Tracking System to report issues or ask questions about eCQM specifications.

ID	Measure Title	Measure Steward	CMS eCQM	CMS Medicaid Core Set	Healthy People 2030	MIPS/ QPP	CMIT Measure ID
Table 6B, Line 7	**Early Entry to Prenatal Care**	n/a	n/a	n/a	MICH-08	No	n/a
Table 6B, Line 10	**Childhood Immunization Status**	National Committee for Quality Assurance	CMS117v14	Child Core	n/a	Yes	124
Table 6B, Line 11	**Cervical Cancer Screening**	National Committee for Quality Assurance	CMS124v14	Adult Core	C-09	Yes	118
Table 6B, Line 11a	**Breast Cancer Screening**	National Committee for Quality Assurance	CMS125v14	Adult Core	C-05	Yes	93
Table 6B, Line 12	**Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents**	National Committee for Quality Assurance	CMS155v14	Child Core	n/a	Yes	760
Table 6B, Line 13	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan**	Centers for Medicare & Medicaid Services	CMS69v14	n/a	n/a	Yes	594
Table 6B, Line 14a	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**	National Committee for Quality Assurance	CMS138v14	Adult Core	n/a	Yes	596

ID	Measure Title	Measure Steward	CMS eCQM	CMS Medicaid Core Set	Healthy People 2030	MIPS/ QPP	CMIT Measure ID
Table 6B, Line 17a	**Statin Therapy for the Prevention and Treatment of Cardiovascular Disease**	Centers for Medicare & Medicaid Services	CMS347v9	n/a	n/a	Yes	700
Table 6B, Line 18	**Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet**	National Committee for Quality Assurance	CMS164v7 (no updated eCQM)	n/a	n/a	No	405
Table 6B, Line 19	**Colorectal Cancer Screening**	National Committee for Quality Assurance	CMS130v14	n/a	C-07	Yes	139
Table 6B, Line 20	**HIV Linkage to Care**	n/a	n/a	n/a	HIV-04	No	n/a
Table 6B, Line 20a	**HIV Screening**	Centers for Disease Control and Prevention	CMS349v8	n/a	n/a	Yes	324
Table 6B, Line 21	**Preventive Care and Screening: Screening for Depression and Follow-Up Plan**	Centers for Medicare & Medicaid Services	CMS2v15	Adult Core	MHMD-08	Yes	672
Table 6B, Line 21a	**Depression Remission at Twelve Months**	Minnesota Community Measurement	CMS159v14	n/a	n/a	Yes	190
Table 6B, Line 22a and 22b	**Sealant Receipt on Permanent First Molars**	Dental Quality Alliance - American Dental Association	SFM-CH-A	Child Core	OH-10	No	830
Table 6B, Lines 23a and 23b	**Initiation and Engagement of Substance Use Disorder Treatment**	National Committee for Quality Assurance	CMS137v14	Adult Core	n/a	Yes	394
Table 6B, Line 24	**Falls: Screening for Future Fall Risk**	National Committee for Quality Assurance	CMS139v14	n/a	n/a	Yes	257
Table 7, Section A	**Low Birth Weight**	Centers for Disease Control and Prevention	n/a	n/a	n/a	No	413
Table 7, Section B	**Controlling High Blood Pressure**	National Committee for Quality Assurance	CMS165v14	Adult Core	HDS-05	Yes	167

ID	Measure Title	Measure Steward	CMS eCQM	CMS Medicaid Core Set	Healthy People 2030	MIPS/ QPP	CMIT Measure ID
Table 7, Section C	**Diabetes: Glycemic Status Assessment Greater Than 9%**	National Committee for Quality Assurance	CMS122v14	Adult Core	D-03	Yes	204

n/a = Not applicable, CMIT = CMS Measures Inventory Tool, MIPS = Merit-based Incentive Payment System, QPP = Quality Payment Program

Appendix F: Glossary

Accrual basis: Method of accounting that recognizes income when it is earned and expenses when they are incurred.

Adjustment: The difference between the health center fee schedule charge and the amount paid or reimbursed by a payer for any given patient service transaction. There may be multiple adjustments on a single transaction.

Aged and disabled former migratory and seasonal agricultural workers: As defined in section 330 (g)(1)(B), individuals who have previously been migratory agricultural workers but who no longer work in agriculture because of their age or disability.

Bad debt: Amounts owed by a patient or third-party payer that the health center has determined to be uncollectable and has formally written off as a direct write-off or as a contra allowance.

Case management: The coordination of support and enabling (patient support) services to meet the ongoing needs of a patient. At a minimum, these services include an assessment of factors affecting health (e.g., medical, social, housing, or educational), counseling and referrals to address identified needs, and periodic follow-up of services. Case management includes assistance with the management of a patient's upstream drivers of health, including assessment of patient medical and/or social service needs; establishment of service plans; and maintenance of referral, tracking, and follow-up systems.

Cash basis: Method of accounting that recognizes income when the payment is received and expense when cash is disbursed.

Change in accounts receivable: Charges minus collections minus adjustments, or the amount by which what is owed to the health center increases or decreases during the calendar year.

CHIP: The Children's Health Insurance Program (CHIP) is a federally funded program that provides primary health care coverage for children and, on a state-by-state basis, others, especially pregnant women, mothers, or parents of these children. CHIP coverage can be provided through the state's Medicaid program, contracts with private insurance plans, or both.

Clinical quality measure (CQM): A standardized metric used to evaluate how effectively health care providers deliver high-quality, evidence-based patient care.

Contracted personnel: People who work under contract for the health center, as opposed to being a salaried employee. They DO NOT have withholding taxes deducted from their paychecks, and they have their income reported to the Internal Revenue Service (IRS) on a 1099 form.

Cost center: Unit of the health center's accounting where costs associated with that unit are charged and accumulated for accounting purposes.

Countable visit: A documented encounter in the patient health record between a patient and a licensed or credentialed provider who exercises their independent professional judgment in the provision of services to the patient. (Virtual visits are allowable for each of the service categories.)

CQM Denominator: The group of patients or encounters that meet the initial criteria for inclusion and represent the population eligible to be evaluated by the measure.

CQM Numerator: The subset of patients or encounters within the denominator that meet the measure's performance criteria, typically representing the success or desired clinical outcomes or actions.

Drawdown (noun): The amount of grant dollars in cash transferred by HHS to the health center in response to a formal request for awarded grant funds.

Draw down (verb): A request through the HHS PMS system for awarded and available grant funds to be transferred by HHS to the health center.

Dually eligible: A patient enrolled in both Medicare and Medicaid, with Medicare being the primary insurance.

Electronic health record (EHR): A digital system that stores and manages a patient's health information, enabling authorized providers to access, update, and share clinical data across health care settings.

Ethnicity: A person's self-identified cultural affiliation, distinct from race. In the UDS, this is used to indicate whether or not a person is of Hispanic, Latino/a, or of Spanish origin.

Exceptions: As used in clinical quality measure reporting, allowable reasons within the denominator for not meeting the measure's requirements, acknowledging valid clinical, patient-centered, or system-related factors that justify why the expected care was not provided.

Exclusions: As used in clinical quality measure reporting, specific conditions or circumstances that remove certain patients from the measure's denominator because the measure criteria are not appropriate for them.

Federal poverty guidelines: An annual notice issued by HHS of the annual income thresholds, defined by the number of persons in the family/household, at or under which individuals are defined as being in poverty. Three separate schedules are issued: one for people residing in the 48 contiguous states and the District of Columbia, one for those in Alaska, and one for those in Hawaii. Health centers in U.S. territories use the 48 contiguous state schedule.

Fee-for-service: A method of charging for services and paying reimbursements to providers based upon the charge for procedures, visits, or other services rendered.

Fee schedule: A listing of the health center's uniform charges for its goods and services.

First trimester (prenatal care): Women who are estimated to be pregnant up through the end of the 13th week after the first day of their last menstrual period, or when they were clinically found to have been in their first trimester based on documented estimated date of delivery (EDD).

Full-time equivalent (FTE): The fraction of time for which an individual is paid during the calendar year. Full-time (as defined by the health center) is equal to 1.00 FTE (half-time is equal to 0.50 FTE, and so on). FTE may be used in aggregate to describe the availability of a group of personnel in a service category.

Full-time personnel: People generally employed 40 hours per week, but subject to organizational definitions. Full-time personnel generally receive benefits, have withholding taxes deducted from their paychecks, and have their income reported to the IRS on a W-2 form. Personnel may or may not have a contract. Personnel are full time when they are so defined in their contract and/or when their benefits show this status.

Gross charges: The sum of the full, undiscounted health center fees for a product, a service rendered, or a set of services rendered under a global charge.

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

Homeless: A person who lacks housing (without regard to whether the individual is a member of a family), including individuals whose primary residence during the night is at a location classified as unfit for human habitation (e.g., street, field, abandoned building), a supervised public or private facility that provides temporary

living accommodations, a day-to-day temporary and unstable living arrangement in someone else's home (doubled up), in transitional housing, or in permanent supportive housing.

Income: Money received through earnings from work and other sources.

Indigent care programs: State or local programs that earmark dollars to pay in whole or in part for services rendered to people who are uninsured and experiencing poverty. Indigent care programs include 638 compact programs for tribal groups.

Initial population: As used in clinical quality measure reporting, the target group for a specific performance measure, involving patients or events who share a common set of specified characteristics, for which patients will be drawn from for evaluation.

Last party rule: Reporting of grant and contract cash receipts based on the entity from which the health center received them, rather than the source from which they originated.

Locum tenens: People who work at the health center on an as-needed basis, when the health center cannot hire full- or part-time personnel, until the position is filled, or to serve during a period of increased demand. Locums are uniquely identifiable because they work for an agency and the health center pays the agency rather than the individual. They DO NOT receive benefits from the health center (although they may from the agency they work for) and may not be covered by the health center's professional liability insurance.

Look-alike: A formal designation by HRSA of a health center that meets the Health Center Program requirements but does not receive Health Center Program section 330 funding.

Managed care: A system in which a fee ("capitation") is paid under contract to a health center by a private or public organization to provide a defined range of services to patients assigned to the health center. "Fee-for-service" managed care is a reimbursement for an assigned set of patients for whom the health center is responsible for providing primary care services.

Measurement period: The defined span of time, established by the steward of a measure, during which patient data are evaluated to determine performance on a CQM.

Medicaid: Joint federal/state-run programs operating under the guidelines of Titles XIX (Medicaid) and XXI (CHIP) of the Social Security Act.

Medicaid expansion: A program created by the Affordable Care Act that makes Medicaid available to more patients on a state-by-state basis, subject to adoption by the state.

Medicare: Federal health insurance program for people 65 years of age or older, people with blindness, people with a disability, and people with end-stage renal disease (Title XVIII of the Social Security Act).

Migratory agricultural workers: For the purposes of health centers receiving a Health Center Program award or designation under section 330(g) of the Public Health Service Act, individuals whose principal employment is in agriculture, who have been so employed within 24 months of their last visit of the calendar year being reported, and who set up a temporary abode for the purposes of such employment. This includes the family members (who themselves may or may not migrate) of the individuals described above and individuals who are no longer employed in migratory agriculture because of age or disability.

National Health Service Corps (NHSC) assignees: Clinicians who either received an NHSC scholarship or are receiving NHSC loan repayment who are obligated to repay that support by serving at an approved facility in a designated health professional shortage area.

New Access Point: A health center's newly approved service delivery site.

New Start: A health center that has received HRSA Health Center funding for the first time during the calendar year.

Paid referred care contract providers: Providers who are contracted to provide services to referred health center patients at locations other than the health center's approved service delivery sites.

Part-time personnel: People employed for a period less than what the health center defines as full-time. They receive benefits as specified by the health center's policy, have withholding taxes deducted from their paychecks, and have their income reported to the IRS on a W-2 form. Part-time personnel may or may not have a contract.

Patient: An individual who has at least one countable visit during the calendar year.

Patient service revenue: The revenue attributable to the provision of patient services within the scope of federal project.

Patients' use of services: The extent to which patients accessed available services (see "Services provided" definition).

Penalty/paybacks: Payments made by health centers to refund overpayments, or payments due to failure to meet utilization, failure to provide agreed-upon services, failure to serve assigned patients in a specified period, or failure to meet other performance goals required by the payer.

Preceptor: A teacher or experienced professional who helps students and staff learners apply theory to practice.

Prenatal care (first visit): The first date a patient has a visit with a physician, NP, PA, or CNM who conducts a comprehensive prenatal exam to start pregnancy-related health care.

Provider: An individual who exercises independent professional judgment in the provision of services rendered to the patient, assumes primary responsibility for assessing and/or treating the patient for the care provided at the visit, and documents services in the patient's health record.

Public housing: Includes agency-developed, -owned, or -assisted low-income housing, including mixed-finance projects but excludes housing units with no public housing agency support other than Section 8 housing vouchers.

Race: A socio-political construct not based on biological or genetic factors.

Reclassify (as used in billing systems): Transfer of amounts due from one payer to another payer, including the patient.

Reconciliations (as used in billing systems): Lump-sum retroactive adjustments based on the filing of a settlement report.

Referral provider: Clinicians or entities outside the health center to whom the health center refers patients for services not provided internally.

Residents/trainees: Individuals in training for a license or certification who provide services at the health center under the supervision of a more senior individual. Many of these trainees (especially medical and dental residents) already have licenses.

Revenue: The money generated by a business before expenses are deducted.

School-based service site: A health center (fixed or mobile) located on or next to school grounds (including pre-school, kindergarten, and primary through secondary schools) that provides health services.

Screening: A test to check for a disease or health condition in the absence of signs and symptoms. Screening tests DO NOT diagnose illness, and those who test positive typically need more evaluation with diagnostic tests or procedures.

Seasonal agricultural workers: For the purposes of health centers receiving a Health Center Program award or designation under section 330(g) of the Public Health Service Act, individuals whose principal employment is in agriculture on a seasonal basis and who DO NOT meet the definition of a migratory agricultural worker.

Second trimester (prenatal care): Women who were pregnant and estimated to be between the start of the 14th week and the end of the 27th week after the first day of their last menstrual period, or when they were clinically found to have been in their second trimester based on documented EDD.

Self-pay: A payment by a patient that covers (in whole or in part) the cost of services rendered and is NOT directly paid by a third-party payer to the health center for these services. It is also used in the UDS to designate patients who make or are required to make such payments.

Service Categories: Provision of countable visit services provided to patients in any of the following areas of care. Whenever possible, major service categories are defined to be consistent with definitions used by CMS. Service categories that may show visits and patients include:

- **Medical Services:** Clinical activities performed by medical personnel (physicians, PAs, NPs, CNMs, or nurses) for the prevention, diagnosis, and treatment of illness or injury within the scope of primary or specialty care.
- **Dental Services:** Oral health care activities provided by dentists, dental hygienists, or dental therapists, encompassing diagnostic, preventive, and restorative procedures.
- **Mental Health Services:** Clinical services provided by licensed professionals for the diagnosis, treatment, and counseling of a patient's emotional, psychological, and social well-being.
- **Substance Use Disorder (SUD) Services:** Clinical activities specifically designed for the prevention and treatment of substance use disorders, including counseling and MOUD provided by specialized clinicians.
- **Other Professional Services:** Specialized health care services provided by licensed professionals that do not fall under medical, dental, mental health, substance use disorder, or vision categories, such as podiatry, chiropractic, or physical therapy.
- **Vision Services:** Specialized clinical activities for eye health, including diagnostic exams and the provision or fitting of corrective lenses.
- **Patient support services:** Non-clinical support services to facilitate health care access, such as case management, health education, eligibility assistance, outreach, transportation, language assistance, and community health work.

Services provided: Availability and use of care that a patient may receive from the health center.

Sex: An individual's immutable biological classification as either male or female.

Sliding fee discount: A discount applied to the fee schedule that adjusts fees based on patients' ability to pay based on their income and family/household size.

Special medically underserved population: Three section 330 funding types defined by law: Migratory and Seasonal Agricultural Workers [MSAW] [330(g)] funding, Homeless Population [HP] [330(h)] funding, and/or Residents of Public Housing [RPH] [330(i)] funding.

Standing order: Written protocol that authorizes designated members of the health care team (e.g., nurses) to complete certain clinical tasks without having to first obtain a physician or advanced practice provider order.

Telehealth: Use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, health administration, and public health.

Third trimester (prenatal care): Women who were estimated to be pregnant for 28 weeks or longer after the first day of their last menstrual period, or when they were clinically found to have been in their third trimester based on documented EDD.

Third-party payer: An insurer or other entity that reimburses the health center for services rendered to patients.

Veteran: Discharged (under conditions other than dishonorable) individuals who served in the active military, naval, or air service, which includes the Air Force, Army, Coast Guard, Marine Corps, Navy, and Space Force, or as a commissioned officer of the Public Health Service or National Oceanic and Atmospheric Administration. This also includes individuals who served in the National Guard or Reserves on active-duty status.

Volunteers: Individuals who work at the health center but are NOT paid for their work.

Wraparound payments: Periodic payments to FQHCs to reimburse the shortfall between the amounts paid by the payer and the health center's established FQHC or prospective payment system (PPS) visit rate.

Appendix G: Acronyms

- ADA: American Dental Association
- ADHC: adult day health care
- AMA: American Medical Association
- AMI: acute myocardial infarction
- APRN: advanced practice registered nurse
- ASCVD: atherosclerotic cardiovascular disease
- ASTP: Assistant Secretary for Technology Policy
- BCCEDP: Breast and Cervical Cancer Early Detection Program
- BDI, BDI-II: Beck Depression Inventory
- BDI-PC: Beck Depression Inventory-Primary Care
- BHW: Bureau of Health Workforce
- BMI: body mass index
- BP: blood pressure
- BPHC: Bureau of Primary Health Care
- CABG: coronary artery bypass graft
- CAD-MDD: Computerized Adaptive Diagnostic Test for Major Depressive Disorder
- CADRE: Capital Assistance for Disaster Response and Recovery Efforts
- CARE: Capital Assistance for Hurricane Response and Recovery Efforts
- CASA: Clinic Assessment Software Application
- CAT-DI: Computerized Adaptive Testing Depression Inventory
- CCO: coordinated care organizations
- CDC: Centers for Disease Control and Prevention
- CEO: chief executive officer
- CES-D: Center for Epidemiologic Studies Depression Scale
- CFO: chief financial officer
- CHC: Community Health Center (funding)
- CHIP: Children's Health Insurance Program
- CIO: chief information officer
- CIS: change in scope
- CME: continuing medical education
- CMO: chief medical officer
- CMS: Centers for Medicare & Medicaid Services
- CNM: certified nurse midwife
- CoCASA: Comprehensive Clinic Assessment Software Application
- COO: chief operations officer
- COVID-19: coronavirus disease 2019
- CPT: Current Procedural Terminology
- CQM: clinical quality measure
- CSDD: Cornell Scale for Depression in Dementia
- CT: computerized tomography
- DADS: Duke Anxiety-Depression Scale
- DEPS: Depression Scale
- DNA: deoxyribonucleic acid
- DO: Doctor of Osteopathic Medicine
- DRE: digital rectal exam
- DT, DTaP, DTP: diphtheria, tetanus, pertussis
- eCQI: Electronic Clinical Quality Improvement
- eCQMs: electronic clinical quality measures
- EHBs: Electronic Handbooks
- EHR: electronic health record
- EKG: electrocardiogram
- EMS: emergency medical service
- EMT: emergency medical technician

- ENDS: electronic nicotine delivery systems
- EPSDT: Early and Periodic Screening, Diagnostic, and Treatment
- ESRD: end-stage renal disease
- FAQ: frequently asked question
- FDA: U.S. Food and Drug Administration
- FIT: fecal immunochemical test
- FOBT: fecal occult blood test
- FPG: federal poverty guidelines
- FQHC: Federally Qualified Health Center
- FTC/TAF: emtricitabine/tenofovir alafenamide
- FTC/TDF: emtricitabine/tenofovir disoproxil fumarate
- FTE: full-time equivalent
- GAAP: generally accepted accounting principles
- GDS: Geriatric Depression Scale
- gFOBT: guaiac fecal occult blood test
- GMI: glucose management indicator
- HAM-D: Hamilton Rating Scale for Depression
- HbA1c: Hemoglobin A1c
- HCFA: Health Care Financing Administration
- HCPCS: Healthcare Common Procedure Coding System
- Health IT: health information technology
- HEDIS: Healthcare Effectiveness Data and Information Set
- HHS: U.S. Department of Health and Human Services
- Hib: haemophilus influenza type B
- HIV: human immunodeficiency virus
- HMO: health maintenance organization
- HP: Homeless Population (funding)
- HPV: human papillomavirus
- HR: human resources
- HRSA: Health Resources and Services Administration
- HUD: U.S. Department of Housing and Urban Development
- ICD: International Classification of Diseases
- iFOBT: immunochemical-based fecal occult blood test
- IHS: Indian Health Service
- IPV: inactivated polio vaccine
- IRS: Internal Revenue Service
- IT: information technology
- IVD: ischemic vascular disease
- LAL: Health Center Program look-alike
- LBW: low birth weight
- LCSW: licensed clinical social worker
- LDL-C: low-density lipoprotein cholesterol
- MCO: managed care organization
- MD: medical doctor
- MFQ: Mood Feeling Questionnaire
- MIPS: Merit-based Incentive Payment System
- MMR: measles, mumps, and rubella
- MOUD: medications for opioid use disorder
- MSAW: Migratory and Seasonal Agricultural Workers (funding)
- NAICS: North American Industry Classification System
- NAP: New Access Point
- NCHS: National Center for Health Statistics
- NHSC: National Health Service Corps
- NP: nurse practitioner
- OB/GYN: obstetrician/gynecologist
- OMB: Office of Management and Budget
- OMH: Office of Minority Health

- ONC: Office of the National Coordinator for Health Information Technology
- PA: physician assistant/associate
- PACE: Program of All-Inclusive Care for the Elderly
- PAL: Program Assistance Letter
- PAP: pharmacy assistance program
- PC-DMIS: personal computer dimensional measurement inspection software
- PCI: percutaneous coronary intervention
- PCV: pneumococcal conjugate vaccine
- PDMP: Prescription Drug Monitoring Program
- PDS: pharmacy dispensing software
- PECS: patient electronic care system
- PHQ: Patient Health Questionnaire
    - PHQ-9M: PHQ modified for teens
    - PHQ-A: PHQ for adolescents
- PHS: Public Health Service (Act)
- PMPM: per member per month
- PMS: practice management system
- PPD: purified protein derivative
- PPS: prospective payment system
- PRAPARE: Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences
- PRE: Preliminary Reporting Environment
- PrEP: pre-exposure prophylaxis
- PRIME MD: Primary Care Evaluation of Mental Disorders
- PSC-17: Pediatric Symptom Checklist
- PTSD: post-traumatic stress disorder
- QI: quality improvement
- QID-SR: Quick Inventory of Depressive Symptomatology Self-Report
- RBRVU: resource-based relative value unit
- RN: registered nurse
- RPH: Residents of Public Housing (funding)
- RV: rotavirus
- SAMHSA: Substance Abuse and Mental Health Services Administration
- SARS-CoV-2: strain of severe acute respiratory syndrome-related coronavirus
- SBIRT: Screening, Brief Intervention, and Referral to Treatment
- SNAP: Supplemental Nutrition Assistance Program
- SRO: single-room occupancy
- SSI: Supplemental Security Income
- SUD: substance use disorder
- TAF/FTC: tenofovir alafenamide fumarate/emtricitabine
- TANF: Temporary Assistance for Needy Families
- TDF/FTC: tenofovir disoproxil fumarate/emtricitabine
- UCR: usual, customary, and reasonable
- UDS: Uniform Data System
- VSAC: Value Set Authority Center
- VZV: varicella zoster virus
- WE CARE: Well Child Care, Evaluation, Community Resources, Advocacy Referral, Education
- WIC: Women, Infants, and Children (program)

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