HRSA
Health Resources & Services Administration

Reporting Uniform Data System (UDS) Financial and Operational Tables

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Vision: Healthy Communities, Healthy People

Opening Remarks

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Health Resources and Services Administration (HRSA)

Agenda

- Review reporting requirements for Uniform Data System (UDS) financial tables and related operational tables
- Review UDS terminology for financial and operational tables
- Review some common case examples
- Discuss common reporting questions

HRSA Health Center Program

Objectives of the Webinar

By the end of this webinar, participants will be able to:

- Understand reporting requirements for the UDS financial tables and related operational tables.
- Identify strategies to check data for accuracy.
- Access additional reporting support.

UDS Training and Technical Assistance (TTA) Resources

- **UDS reporting resources available on the BPHC website**
- **UDS Manual:**
  - Definitions and instructions specific to the UDS are in the 2024 UDS Manual.
- **Year-over-year changes:**
  - 2024 Program Assistance Letter (PAL)
  - UDS Changes Webinar (held June 5, 2024)
- **Electronic Handbooks (EHBs) access and resources** available on the Reporting Guidance page of the UDS TTA resources site.

Uniform Data System (UDS) Training and Technical Assistance

Last updated: July 11, 2023

Announcement

Calendar year 2023 UDS reporting submission

All health centers are required to submit a full, aggregated UDS Report through HRSA's Electronic Handbooks (EHBs) by February 15, 2024. Additionally, beginning with 2023 UDS reporting, health centers may also voluntarily submit de-identified patient-level data (UDS+) using Health Level Seven International (HL7®) developed Fast Healthcare Interoperability Resources (FHIR®) version release 4 (R4) standards. View updates about UDS patient-level submission (UDS+) on the UDS Modernization Overview and UDS Modernization FAQ webpages.

UDS test cooperative stakeholder group

Health centers, Primary Care Associations (PCAs), Health Center-Controlled Networks (HCCNs), and health information technology (IT) vendors are welcome to join the UDS Test Cooperative (UTC) stakeholder group. To join, contact us through the BPHC Contact Form and select Uniform Data System (UDS), UDS Modernization, then How to Join the UDS Test Cooperative.

Featured Resources

- **2022 UDS Trends Webinar Registration**
  A detailed overview of 2022 UDS data trends
- **2023 UDS Final Program Assistance Letter (PAL) (PDF - 553 KB)**
  An overview of final updates to the CY 2023 UDS reporting
- **2023 UDS Manual (PDF - 2 MB)**
  Provides health centers with detailed reporting instructions and example data tables that support calendar year 2023 UDS reporting, including information about voluntary UDS patient-level submission (UDS+)
- **2023 UDS Tables PDF (PDF - 1 MB) and Excel (XLSX - 386 KB)**
  Resources to help health centers prepare UDS submissions in advance with an organized, standard structure
- **2023 UDS Reporting Changes TA Webinar Recording and Presentation (PDF - 2 MB)**

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Overview of Data Collected in UDS Tables

Patient Profile

Captures the demographic information of health center patients who received in-scope services.

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

Services and Clinical Outcomes

Captures personnel, visits, services, and outcomes related to all in-scope services provided to health center patients.

Tables 5, 6A, 6B, and 7

Costs and Revenues

Captures the financial costs and revenues (both patient service generated and other) related to in-scope services.

Tables 8A, 9D, and 9E

All data are reported for the *full calendar year*, Jan. 1, 2024, through Dec. 31, 2024.

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Overview of Financial Tables

Table 8A: Financial Costs	Table 9D: Patient Service Revenue	Table 9E: Other Revenue
Costs related to personnel, classified by cost center, aligned with service areas on Table 5	Charges, by payer, related to services provided to patients, typically aligned with patient insurance on Table 4	Federal grant revenue, including health center funding and COVID-19 supplemental funding from HRSA BPHC
Costs related to services/contracts, by cost center, aligned with service areas on Table 5	Collections, by payer, related to services provided to patients	State/local grant revenue
Pharmaceutical costs	Adjustments, by third-party payer, related to services provided to patients	Private/foundation revenue
Costs for facilities and non-clinical support services	Revenue, by third-party payer, classified as capitated managed care, fee-for-service managed care, and non-managed care	Cash donations
Value of donated facilities, services, and supplies	Sliding fee discounts for patients and bad debt for patients	Receipts from indigent care programs

Table 8A: Financial Costs

Financial Costs

Table 8A Columns

Column A

Accrued Cost

- Expenses incurred during the calendar year.
- Includes personnel and all other costs.
- Excludes bad debt and principal payments.

Column B

Allocation of Facility and Non-Clinical Support Services

- Allocation of facility and non-clinical support services (Column A, Lines 14 and 15) to each cost center in Column B, Lines 1–13.
- Note: Total of Column B must equal Column A, Line 16.

Column C

Total Cost After Allocation of Facility and Non-Clinical Support Services

- Includes all direct costs and the cost center's share of overhead cost. Represents total cost to operate services. Sum of Columns A + B (automated in Electronic Handbooks [EHBs]).
- Can be used to calculate cost per visit and cost per patient.
- All in-kind non-cash donations are reported on Line 18.

Financial Costs

Table 8A, Column A

Column A

Accrued Cost

- Expenses incurred during the calendar year.
- Includes personnel and all other costs.
- Excludes bad debt and principal payments.

Column B

Allocation of Facility and Non-Clinical Support Services

- Allocation of facility and non-clinical support services (Column A, Lines 14 and 15) to each cost center in Column B, Lines 1–13.
- Note: Total of Column B must equal Column A, Line 16.

Column C

Total Cost After Allocation of Facility and Non-Clinical Support Services

- Includes all direct costs and the cost center's share of overhead cost. Represents total cost to operate services. Sum of Columns A + B (automated in Electronic Handbooks [EHBs]).
- Can be used to calculate cost per visit and cost per patient.
- All in-kind non-cash donations are reported on Line 18.

Accrued Costs in Column a

Accrued costs are those costs incurred by a given cost center during the calendar year, including the following:

- Staff costs (salary, fringe benefits, continuing medical education, etc.)
- Paid referred care
- Supplies
- Depreciation of equipment
- Software or systems
- Interest payments on any loans
- Costs for contracted care, etc.

Accrued costs do not include the following:

- Costs for anything incurred outside the calendar year
- Bad debt related to the provision of patient service
- Loan principal payments
- Costs for services the health center did not pay for directly (e.g., services for which the health center referred a patient, but for which the third-party provider billed directly)
- Gross costs for capitalized expenses

Detailed guidance for where certain grants and revenue are to be reported is in the UDS Manual, beginning on page 153.

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Table 8A Lines Align with Services on Table 5

FTEs and Visits Reported on Table 5, Line:	Have **Costs** Reported on Table 8A, Line:
1–12: Medical Personnel	1: Medical Personnel
13–14: Medical Lab and X-ray	2: Medical Lab 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
23a–23d: Pharmacy	8a: Pharmacy
24–28: Enabling	11a–11h: Enabling
24: Case Managers	11a: Case Management
25: Health Education Specialists	11d: Health Education
26: Outreach Workers	11c: Outreach
27: Transportation Personnel	11b: Transportation
27a: Eligibility Assistance Workers	11e: Eligibility Assistance
27b: Interpretation Personnel	11f: Interpretation Services
27c: Community Health Workers	11h: Community Health Workers
28: Other Enabling Services	11g: Other Enabling Services
29a: Other Programs and Services	12: Other Program-Related Services
29b: Quality Improvement Personnel	12a: Quality Improvement
30a–30c and 32: Non-Clinical Support Services	15: Non-Clinical Support Services
31: Facility Personnel	14: Facility

Takeaway: Each line on Table 5 has a *corresponding* line for related costs on Table 8A.

This table is available in **Appendix B** of the UDS Manual (page 194).

FTE: full-time equivalent

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Medical Cost Center
Table 8A, Lines 1–3, Column A

Line 1: Medical personnel salary and benefits

- **Includes** costs for all personnel directly attributable to the medical department, including medical providers and medical assistants.
- **Includes** contracted or vouchered medical services.
- Does **not** include value of volunteers.

Line 2: Medical lab and X-ray direct costs

- **Includes** medical lab and X-ray services provided directly by the health center and those under contract.
- Does **not** include costs for medical lab and X-ray provided directly by a referred care provider that bills directly to the patient, or dental lab and X-ray costs.

Line	Cost Center	Accrued Cost (a)
	Financial Costs of Medical Care	
1	Medical Personnel	
2	Lab and X-ray	
3	Medical/Other Direct	
4	**Total Medical Care Services** (Sum of Lines 1 through 3)	

Line 3: Non-personnel direct medical costs

- **Includes** costs for anything else directly attributable to the medical department that are NOT personnel costs.
- Does **not** include value of donated goods.
- Does **not** include any pharmacy or pharmaceutical costs, such as cost of medications.

Other Cost Centers

Table 8A, Lines 5–8b, Column A

Line 5: Dental

- **Includes** dental personnel costs, contracted dental care, and electronic dental record costs.

Line 6: Mental Health

- **Includes** mental health personnel, supplies, and software used specifically by the mental health department.

Line 7: Substance Use Disorder

- **Includes** substance use disorder services personnel, supplies, and software.

Line 8a: Pharmacy

- **Includes** pharmacy personnel and the dispensing and administrative fees for 340B contractors.
- Does **not** include the cost of drugs.

Line 8b: Pharmaceuticals

- **Includes** the cost of medications administered in-house or via contract pharmacy.
- Does **not** include the value of donated drugs or dispensing and administrative fees of contract pharmacy.

Do not include volunteer personnel or donated supplies or facilities on any of these lines (this slide and previous!).

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Key Considerations

Reporting Various Costs Related to Pharmacy

Lines 8a and 8b: Pharmacy and Pharmaceuticals

There are several considerations to be sure these are reported accurately:

- Dispensing and administrative fees for contract pharmacy (e.g., 340B) are reported on Column A, Line 8a, Pharmacy, **separate from the cost of drugs**.
- The cost of medications administered by in-house clinicians is reported on Line 8b, not in Medical.
- Overhead costs for contract pharmacy program are first reported in Line 15, Column A (Non-Clinical Support) and ***then*** allocated to Line 8a, Pharmacy, in Column B.
- Report assistance establishing eligibility for pharmacy assistance programs on Line 11e, not in Pharmacy.
- Donated drugs are reported on Line 18, Donated Facilities, Services, and Supplies; value at 340B prices.

Pharmacy Lines on Table 8A

Line	Cost Center	Accrued Cost (a)
	Financial Costs of Other Clinical Services	
8a	Pharmacy (not including pharmaceuticals)	
8b	Pharmaceuticals	

Other Cost Centers

Table 8A, Lines 9 and 9a, Column A

Line 9: Other Professional

- **Includes** costs for other professional and ancillary health care services, such as dietician, nutrition, podiatry, chiropractic, acupuncture, naturopathy, speech and hearing pathology, or occupational and physical therapy.
  - FTEs for personnel reported here *must* be on Line 22 of Table 5.
- Does **not** include other professional costs that are to be included in programs reported under "Other Program-Related Services" (Line 12) such as Women, Infants, and Children (WIC), job training, etc.

Line 9a: Vision

- **Includes** vision personnel (FTEs on Line 22d on Table 5) and supplies.
- Does **not** include donated time of optometrists or other vision professionals.

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Other Cost Centers

Table 8A, Lines 11a–11h, Column A

Lines 11a–11h:

Enabling Services

- **Includes** costs such as those for education materials, transportation vouchers, and translation/ interpretation services, **in addition to personnel costs**.
- Each cost is reported on the line for the area or service where the cost was incurred.
- Reporting here must align with Enabling FTEs on Lines 24–29 on Table 5.

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
	Financial Costs of Enabling and Other Services			
11a	Case Management			
11b	Transportation			
11c	Outreach			
11d	Health Education			
11e	Eligibility Assistance			
11f	Interpretation Services			
11g	Other Enabling Services (specify___)			
11h	Community Health Workers			
11	**Total Enabling Services** (Sum of Lines 11a through 11h)			
12	Other Program-Related Services (specify___)			
12a	Quality Improvement			
13	**Total Enabling and Other Services** (Sum of Lines 11, 12, and 12a)			

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Other Cost Centers

Table 8A, Lines 12, Column A

Line 12:
Other Program-Related Services

- **Includes** all costs for FTEs on Table 5, Line 29, Column A and Children (WIC), child care centers, housing, clinical trials, employment training, space leased to others, and retail pharmacy services provided to non-health-center patients.
- Describe the program costs using the "specify" field.

Other Program-Related Services (here and on Table 5) captures in-scope items and programs that are ***not*** medical, dental, behavioral, vision, enabling, or other professional health services.

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
	Financial Costs of Enabling and Other Services			
11a	Case Management			
11b	Transportation			
11c	Outreach			
11d	Health Education			
11e	Eligibility Assistance			
11f	Interpretation Services			
11g	Other Enabling Services (specify___)			
11h	Community Health Workers			
11	**Total Enabling Services** (Sum of Lines 11a through 11h)			
12	Other Program-Related Services (specify___)			
12a	Quality Improvement			
13	**Total Enabling and Other Services** (Sum of Lines 11, 12, and 12a)			

Other Cost Centers

Table 8A, Line 12a, Column A

Line 12a: Quality Improvement (QI)

- **Includes** costs of personnel dedicated to any or all of the following:
  - QI program
  - Health information technology (health IT)/electronic health record (EHR) system development
  - Report or data design
- Do **not** allocate portions of costs and time for QI personnel attending meetings, conducting peer reviews, or designing or interpreting QI findings to other service categories; **all those QI costs go here.**

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
	Financial Costs of Enabling and Other Services			
11a	Case Management			
11b	Transportation			
11c	Outreach			
11d	Health Education			
11e	Eligibility Assistance			
11f	Interpretation Services			
11g	Other Enabling Services (specify___)			
11h	Community Health Workers			
11	**Total Enabling Services** (Sum of Lines 11a through 11h)			
12	Other Program-Related Services (specify___)			
12a	Quality Improvement			
13	**Total Enabling and Other Services** (Sum of Lines 11, 12, and 12a)			

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Knowledge Check: Accrued Costs

Which of these costs *will be* reported on Table 8A in the Calendar Year (CY) 2024 UDS Report?

A. Costs for contracted providers that occurred in CY 2024.
B. Principal payments on a loan made by the health center in CY 2024.
C. Interest payments on loans in CY 2024.
D. Depreciation of the health center's medical equipment.
E. Options A, B, and C
F. Options A, C, and D

Knowledge Check: Accrued Costs

Which of these costs *will be* reported on Table 8A in the Calendar Year (CY) 2024 UDS Report?

A. Costs for contracted providers that occurred in CY 2024.
B. Principal payments on a loan made by the health center in CY 2024.
C. Interest payments on loans in CY 2024.
D. Depreciation of the health center's medical equipment.
E. Options A, B, and C
F. Options A, C, and D

Remember:

Principal payments on capitalized expenses (e.g., property or equipment) are not reported on the UDS; only interest and depreciation are reported on Table 8A.

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Frequently Asked Questions (FAQs): Accrued Costs

? How do we allocate costs for clinical staff who split time in administrative/non-clinical duties? For example, a Chief Medical Officer (CMO) who also sees patients?

Crosswalk Tables 5 and 8A for costs and FTE; determine how this staff is reported on Table 5 and reflect that on Table 8A, too. Generally, a provider who is a CMO will have the vast majority of their time on the relevant medical provider line on Table 5; then whatever small portion of FTE is for corporate functions is reported on Line 30a. On Table 8A, a similar portion of their cost would be reported as non-clinical, for the corporate activities performed.

? Do community health workers (CHWs) go under Other Professional Services on Table 8A?

No, CHW costs are part of enabling services and have their own line in the Enabling Services section. On Table 8A, CHWs are reported on Line 11h; on Table 5, they are reported on Line 27c.

Other Professional Services includes dieticians, podiatrists, etc.—not CHWs.

? Does interpretation/ translation (Line 11f) only include services provided by staff employed by the health center?

No, it is *not* only health center personnel.
Line 11f could include the cost for translation systems/software, outsourced interpretation services, interpretation staff, or any combination of these.

Financial Costs: Allocation of Overhead

Table 8A, Column B

Column A

Accrued Cost

- Expenses incurred during the calendar year.
- Includes personnel and all other costs.
- Excludes bad debt and principal payments.

Column B

Allocation of Facility and Non-Clinical Support Services

- Allocation of facility and non-clinical support services (Column A, Lines 14 and 15) to each cost center in Column B, Lines 1–13.
- Note: Total of Column B must equal Column A, Line 16.

Column C

Total Cost After Allocation of Facility and Non-Clinical Support Services

- Includes all direct costs and the cost center's share of overhead cost. Represents total cost to operate services. Sum of Columns A + B (automated in EHBs).
- Can be used to calculate cost per visit and cost per patient.
- All in-kind non-cash donations are reported on Line 18.

Facility and Non-Clinical Support Services (Overhead)

Table 8A

Facility and non-clinical support service expenses are referred to as **overhead**. These costs are reported on Table 8A, Column A, in Lines 14 and 15; Line 16 is the total of the two. This total is then allocated as overhead in Column B.

Line	Cost Center	Accrued Cost (a)
	Facility and Non-Clinical Support Services and Totals	
14	Facility	
15	Non-Clinical Support Services	
16	**Total Facility and Non-Clinical Support Services** (Sum of Lines 14 and 15)	

Line 14: Facility

Includes facility personnel costs, rent or depreciation, mortgage interest payments, utilities, security, groundskeeping, janitorial services, maintenance, etc.

Line 15: Non-Clinical Support Services

Includes personnel such as corporate administration, billing, revenue cycle, medical records, and intake personnel, as well as facility and liability insurance, legal fees, practice management system, and direct non-clinical support costs (travel, supplies, etc.).

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Allocating Facility and Non-Clinical Support Services (Overhead) Table 8A, Column B

Line	Cost Center	Accrued Cost (a)
	Facility and Non-Clinical Support Services and Totals	
14	Facility	
15	Non-Clinical Support Services	
16	**Total Facility and Non-Clinical Support Services** (Sum of Lines 14 and 15)	

- All overhead costs are allocated to cost centers in Column B.
- Overhead costs that are directly associated with a cost center should be allocated first.
- The remaining overhead costs should be allocated using a proportional method, such as the proportion of square footage that each cost center uses (for facility costs) and percent of total accrued costs of each cost center (for non-clinical support costs).

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)
	Financial Costs of Medical Care		
1	Medical Personnel		
2	Lab and X-ray		
3	Medical/Other Direct		
4	**Total Medical Care Services** (Sum of Lines 1 through 3)		
	Financial Costs of Other Clinical Services		
5	Dental		
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)		
	Financial Costs of Enabling and Other Services		
11a	Case Management		
11b	Transportation		
11c	Outreach		
11d	Health Education		
11e	Eligibility Assistance		
11f	Interpretation Services		
11g	Other Enabling Services (specify___)		
11h	Community Health Workers		
11	**Total Enabling Services** (Sum of Lines 11a through 11h)		
12	Other Program-Related Services (specify___)		
12a	Quality Improvement		
13	**Total Enabling and Other Services** (Sum of Lines 11, 12, and 12a)		

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Allocating Facility and Non-Clinical Support Services (Overhead) to Cost Centers

Step 1

Allocate Line 14, Facility

- Allocate facility costs to each cost center based on either actual facility costs for that cost center or the percentage of total square footage the cost center uses.
- Any facility costs that are specific to non-clinical support services are allocated to Line 15.

Step 2

Allocate Line 15, Non-Clinical Support Services attributable to specific cost centers

- Allocate any non-clinical support costs attributable to a specific cost center to that cost center.
  - For example, decentralized front desk personnel, billing and collection systems and personnel, etc. are allocated to the service they work in.
- Consider lower allocation of overhead to contracted services.

Step 3

Allocate remaining costs to cost centers

Allocate remaining costs using a consistent approach, commonly based on the proportion of direct costs or of visits.

Use the simplest allocation method that produces a result comparable to a more complex method. If possible, use at least a three-step allocation method.

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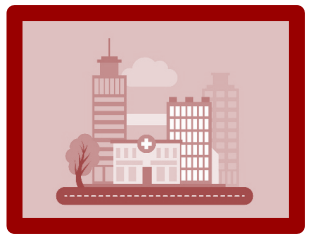
Overhead Allocation Example: First Step

Total Facility Costs on Line 14, Column A: $70,000

Site A
2,500 square feet
80% medical, 20% admin



Site B
3,500 square feet
57% dental, 29% mental health, 14% admin

Site C
6,500 square feet
31% medical, 31% dental, 15% mental health, 23% admin

	Medical (Lines 1–3)	Dental (Line 5)	Mental Health (Line 6)	Admin (Line 15)	Total Square Feet
Site A	2,000	-	-	500	2,500
Site B	-	1,995	1,015	490	3,500
Site C	2,015	2,015	975	1,495	6,500
Total square feet for cost center	4,015	4,010	1,990	2,485	12,500
% of total square footage (SF)	32%	32%	16%	20%	100%
% total SF * total facility costs	32%*$70K	32%*$70K	16%*$70K	20%*$70K	100%*$70K
Facility Allocation	$22,400	$22,400	$11,200	$14,000	$70,000

Note that Admin = Non-Clinical Support; Also note that Administration facility costs are allocated to non-clinical support and then allocated with non-clinical support services in the second step.

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Overhead Allocation Example: Next Steps

Line 15: Non-Clinical Support Services are $250,000.

Plus $14,000 of allocated facilities costs (as shown in last slide).

Total of $264,000 of non-clinical support costs to be allocated.

First, distribute non-clinical support costs to the applicable service, where possible. Next, distribute remaining non-clinical support costs ($34,000).

Cost Center	Total to Be Allocated to Cost Center in Column b
Medical (Lines 1–3)	$75,000
Dental (Line 5)	$105,000
Mental Health (Line 6)	$50,000
Total Allocated in This Step	$230,000
Remaining Non-Clinical Support Costs to Be Allocated	$34,000

Cost Center	Percent of Costs in Column a	Allocation
Medical (Lines 1–3)	30.8%	$10,458.70
Dental (Line 5)	44.6%	$15,170.65
Mental Health (Line 6)	24.6%	$8,370.65
Total	100%	**$34,000**

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Overhead Allocation Example: Total of $320,000

Cost Center	Step 1 Allocated Facility Costs	Step 2 Allocated Non-Clinical Support Services	Step 3 Allocated Remaining Costs	Total Overhead Costs to Be Reported in Column B for Cost Center
Medical (Lines 1–3)	$22,400	$75,000	$10,459	$107,859
Dental (Line 5)	$22,400	$105,000	$15,171	$142,571
Mental Health (Line 6)	$11,200	$50,000	$8,370	$69,570
Total Overhead	$56,000	$230,000	$34,000	$320,000

UDS Overhead Cost Allocation Methods resource is available on the Financials page of the UDS TTA site.

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Knowledge Check: Allocating Costs on Table 8A

What costs are allocated in Column B of Table 8A?

A. Column B includes allocation of facility and non-clinical support services costs (Lines 14 and 15).
B. Column B includes allocation of total accrued costs (Line 17).
C. Column B includes allocation of facility, non-clinical support services costs, and value of donated facilities, services, and supplies (Lines 14, 15, and 18).

Answer: Allocating Costs on Table 8A

What costs are allocated in Column B of Table 8A?

A. **Column B includes allocation of facility and non-clinical support services costs (Lines 14 and 15).**
B. Column B includes allocation of total accrued costs (Line 17).
C. Column B includes allocation of facility, non-clinical support services costs, and value of donated facilities, services, and supplies (Lines 14, 15, and 18).

FAQs: Overhead Allocation

? What if contracted services are performed on site at our health center? Do we allocate overhead costs?

You would allocate a small amount of overhead to the contracted services, amounting to the cost for any space used for contracted services as well as any costs for administering the contracted care (e.g., accounting and contract management).

? Can we just allocate our facility and non-clinical support costs based on portion of costs or portion of visits?

While that is permitted, it is definitely not recommended! Using a single-step allocation method like this will not accurately reflect the total costs that a given service area uses to provide the services. Remember, the total costs (including overhead) are used to calculate cost per visit and cost per patient.

Financial Costs: Total Cost

Table 8A, Column C

Column A

Accrued Cost

- Expenses incurred during the calendar year.
- Includes personnel and all other costs.
- Excludes bad debt and principal payments.

Column B

Allocation of Facility and Non-Clinical Support Services

- Allocation of facility and non-clinical support services (Column A, Lines 14 and 15) to each cost center in Column B, Lines 1–13.
- Note: Total of Column B must equal Column A, Line 16.

Column C

Total Cost After Allocation of Facility and Non-Clinical Support Services

- Includes all direct costs and the cost center's share of overhead cost. Represents total cost to operate services. Sum of Columns A + B (automated in EHBs).
- Can be used to calculate cost per visit and cost per patient.
- All in-kind non-cash donations are reported on Line 18.

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Table 9D: Patient Service Revenue

Table 9D: Reporting Patient Service Revenue

Patient Service Revenue (*Columns*)

- **Column A:** Charges for services in the year
- **Column B:** Collections on a cash basis
- **Columns C1–C4:** Reconciliations
- **Column D:** Contractual adjustments
- **Column E:** Self-pay sliding fee discounts
- **Column F:** Self-pay bad debt

By Payer (*Rows*)

- **Lines 1-3:** Medicaid
- **Lines 4–6:** Medicare
- **Lines 7-9:** Other Public
- **Lines 10-12:** Private
- **Line 13:** Self-Pay

By Form of Payment *(Breakout of rows)*

- Non-managed care
- **Sub-line a:** Managed Care, Capitation
- **Sub-line b:** Managed Care, Fee for Service

Third-Party Payers

A third-party payer is any entity, other than the patient, reimbursing the health center for patient services. The patient and the health center are parties directly involved with the service. An outside payer is a "third-party payer." **In the UDS, these categories are as follows:**

Medicaid

- Any state Medicaid program, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), adult day health care (ADHC), and Program of All-inclusive Care for the Elderly (PACE), if administered by Medicaid
- Medicaid managed care organizations (MCOs) or Medicaid programs administered by third-party or private payers
- Children's Health Insurance Program (CHIP), when administered by Medicaid

Medicare

- Any Medicare program or other program administered by Medicare
- Medicare managed care programs, including Medicare Advantage run by private payers
- ADHC or PACE, if administered by Medicare

Other Public

- CHIP, when paid for through private insurers
- State- or county-run insurance plans
- Public programs paying for limited services, like cancer screening programs, Title X, etc.
- Service contracts with municipal or county jails, state prisons, public schools, or other public entities

Private

- Insurance provided by employers
- Tricare, Trigon, Federal Employees Health Benefits Program
- Insurance purchased through state exchanges or by individuals
- ***Not*** Medicaid or Medicare programs administered by commercial payers

HRSA Health Center Program

Patient Service Revenue

Forms of Payment

Non-Managed Care	A payment model in which procedures and services are separately charged and paid. Third-party payers pay some or all of the bill, generally based on agreed-upon maximums or discounts.
Managed Care	Revenue from organizations that meet the UDS definition of managed care: payers with which the health center has a *contractual managed care agreement to provide a range of services to patients assigned to the health center*; paid fee-for-service or capitated.
Managed Care—Capitated	A managed care payment model in which a health center contracts with an MCO for a specified set of services, for which the managed care plan pays the health center a set amount for each patient assigned to the health center. This is called a capitation fee and is typically paid per member per month.
Managed Care—Fee-for-Service	A managed care payment model in which a health center contracts with an MCO, is assigned patients for whose care it is responsible through that MCO, and is reimbursed on a fee-for-service (or encounter-rate) basis for covered services.

Managed Care

- **Managed care (either capitated or fee-for-service) refers to those payers with which the health center has a contractual managed care agreement to provide a range of services to patients assigned to the health center.**
  - Typically, these agreements include:
    - Responsibility for managing the care of a set of assigned patients.
    - Expectation that health center provide specified services to assigned patients.
- This generally requires **regular review and reclassification of insurers in your system** to be sure that only those with whom you have contractual managed care agreements are categorized as managed care for UDS reporting.

Managed care does not refer to all managed care plans from which you received payment. Managed care refers to payments for patients *assigned to the health center through managed care plans*.

The health center might serve patients and receive payment from a third-party payer that the health center does not have a managed care contract with. In these cases, that is not a managed care patient or reimbursement for the health center, as that patient is assigned to another provider for managed care purposes.

UDS Managed Care Reporting and Relationship across Tables 4 and 9D, available on the Financials page of the UDS TTA site.

Managed Care Example

- The health center is part of a Medicaid MCO.
- Through the MCO, the health center has assigned patients or attributed lives.
- The MCO sets goals and offers incentives for certain screenings or tasks.
- The care the health center provides to MCO patients is paid fee-for-service (FFS); if the health center meets the goals set or does the other specified screenings or tasks, the MCO pays out incentives to the health center.

Reported on Table 9D, Line 2b Medicaid Managed Care FFS

- Charges in Column A, based on Fee Schedule.
- All revenue received from the plan in the year is reported on Line 2b in Column B.
- The portion of the revenue that was incentive payments is *also* reported in Column C3 of Line 2b.
- Report adjustments, less incentives, in Column D.

Patient Service Revenue

Table 9D, Columns A and B

Charges (a)

- Charges are the amount at which each service rendered to patients in the calendar year is valued, **according to the health center's fee schedule**. Charges for any given procedure are recognized and reported at the same amount across all payers.
- Charges are captured by third-party and self-pay payer for all patient services rendered in the health center's scope of service in the calendar year (January 1 through December 31).
- Charges are reclassified in accordance with co-pay or co-insurance responsibility; for example, if a patient is responsible for 20% of the charge, then 80% of the charge is on the third-party payer line and 20% of the charge is moved to the self-pay line.

Collections (b)

Collections are the **total cash received in the calendar year** (January 1 through December 31) for services provided to patients, regardless of when those services were rendered.

Collections include:

- Reimbursement for services provided to patients from third-party payers and patients.
- Managed care FFS or capitation payments.
- Payment for grant-covered services from public entities.
- Health center reconciliation or wraparound payments.
- Quality incentives or pay-for-performance (P4P) bonuses.

Retroactive Settlements, Receipts, and Paybacks

Table 9D, Columns C1–C4

- Collections, in Column B, *include* Retroactive Settlements (retros), Receipts, and Paybacks, which are *also* reported in Columns C1–C4.
- Retros, wraps, and incentives in Columns C1–C4 are *part* of collections but are not *all* collections.

Collection of Reconciliation/ Wraparound *Current* Year (c1)	Collection of Reconciliation/ Wraparound *Previous* Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty/Payback (c4)
Federally Qualified Health Center (FQHC) prospective payment system (PPS) reconciliations and wraparound payments for current year	FQHC PPS reconciliations and wraparound payments for prior years (anytime before current year)	• Managed care pool distributions • P4P • Other incentive payments • Quality bonuses • Value-based payments	Paybacks or deductions by payers because of overpayments or penalty *(report as a positive number)*

HRSA Health Center Program

Patient Service Revenue

Table 9D, Column D

Adjustments (d)

- Adjustments are **contractual discounts granted as part of an agreement with a third-party payer** and are reported in Column D.
- Virtually all insurers have a maximum amount they pay for a given service, and in contracting with that insurer, the health center agrees to write off the difference between what they charge and that contracted amount. That difference is the contractual adjustment.
- Adjustments have the effect of reducing the amount to be collected and are generally reported in Column D as a positive number.
  - However, reconciliation, wraparound, and incentive payments reported in Columns C1–C3 are subtracted from Column D, which **may result in a negative number**. This happens when collections, as a result of wraps or incentives, are larger than initial charges.
- Adjustments ***do not*** include "clean up" or write-offs of prior-year accounts receivable or unpaid claims for third-party payers.

Example

- A patient gets a service for which the fee schedule charge is $228 and the negotiated reimbursement amount received is $150.
- $228 is in Column A, $150 in Column B, and then the adjustment in Column C is $78 (the difference between the fee schedule and the negotiated rate, reported as a positive number).
- If the health center later in the year gets related wrap payment of $90 to bring reimbursement up to PPS rates, then that $90 is added to Column B and *also* reported in Column C1. That same value is subtracted from the initial adjustment (so, initial adjustment $78 minus $90), so the final adjustment in Column D is -$2.

Patient Service Revenue

Table 9D, Line 13

Self-Pay

- Self-pay refers to charges or the portion of charges that **are the responsibility of the patient** (rather than a third-party payer) and includes related collections and write-offs.
  - Includes charges incurred by uninsured patients, including those covered by indigent care programs, written off as sliding fee discounts, and/or written off as patient bad debt.
  - Includes co-payments, deductibles, and charges to insured individuals for uncovered services that become the patient's personal responsibility.
- **Self-Pay charges** (Column A) may then be paid by the patient and recorded as **Collections** (Column B), written off as **Sliding Fee Discounts** (Column E) based on patient income and family size, or written off as **Bad Debt** (Column F) when uncollectable (including inability to locate persons, patient's refusal, or inability to pay regardless of income).
  - Self-pay does *not* include third-party payer bad debt.

HRSA Health Center Program

Table 9D: Revenue Timing

New FAQ added to the UDS Manual in 2024 clarifies the timing for revenue reporting (charges, collections, adjustments) on Table 9D, Patient Service Revenue

Charges in Column A are to be reported based on the date of service and limited to **dates of service** that occurred in 2024.

Collections and **adjustments** (Columns B, C1–C4, and D) are reported based on **posting date** and limited to transactions posted in 2024.

This acknowledges that there is likely to be some timing difference between these.

Table 9D Revenue and Table 4 Insurance

Payer categories are generally aligned with patient insurance categories, but remember that payment may be received from a different payer than the patient's primary medical insurance.

Table 4	
Line	**Principal Medical Insurance**
7	**Uninsured**—No medical insurance at last visit
8a and 8b	**Medicaid** and Medicaid CHIP
9a and 9	Dually Eligible and **Medicare**
10a	**Other Public** non-CHIP—State and local government insurance
10b	**Other Public** CHIP (not paid by Medicaid)
11	**Private**

Table 9D	
Line	**Revenue Source**
13	**Self-Pay**—Include co-pays and deductibles, state and local indigent care programs
1–3	**Medicaid**
4–6	**Medicare**
7–9	**Other Public**—State and local government insurance; and also include patient service revenue from programs with limited benefits
7–9	**Other Public**
10–12	**Private**

HRSA Health Center Program

FAQs: Table 9D

? Our system does not automatically reclassify amounts due from other carriers or the patient. Must we reclassify charges that become either co-payments or other third-party payer charges?

Yes. Regardless of whether it is done automatically by your systems or manually, reflect this reclassification of charges that end up being the responsibility of a payer other than the initial party.

? Where do health centers record the encounter rate adjustment for Medicare G-codes?

Report charges based on the health center fee schedule only, not G-codes. The amounts received through Medicare, including adjusted rates of reimbursement, are included in Column B.

Page 167 of the UDS Manual includes more detailed instructions.

Table 9E: Other Revenue

Other Revenue
Table 9E

- This table is reported on a **cash basis:** amount drawn down (not award) in the year.
- Report based on the **entity dollars were received from** (called the last party rule).

Report **non-patient-service receipts** or funds drawn down in 2024.

- Include revenue that supported activities described in your health center scope of services.
- Report funds by the entity from which you received them.
- Complete “specify” fields.

The total amount reported on Tables 9E and 9D represents total revenue supporting the health center’s scope of services.

Revenue Categories
Table 9E, Lines 1a–3b

Lines 1a through 1q	**BPHC Grants**	• Funds received **directly from BPHC**, including funds passed through to another agency
		  • Include 330 grant(s) and supplemental funds drawn down in the year.
		  • Include the amounts directly received under the various COVID-19 funding streams. *Only report amounts drawn down in the current calendar year.*

Lines 2 through 5	**Other Federal Grants**	• Grants received directly from the federal government other than BPHC (e.g., Department of Housing and Urban Development [HUD], Centers for Disease Control and Prevention [CDC], Substance Abuse and Mental Health Services Administration [SAMHSA])
		  • Ryan White Part C
		  • EHR incentive payments: Include Promoting Interoperability funds when received by the health center
		  • Provider Relief Fund

Line	Source	Amount (a)
	HRSA's BPHC Grants (Enter Amount Drawn Down—Consistent with PMS 272)	
1a	Migrant Health Center	
1b	Community Health Center	
1c	Health Care for the Homeless	
1e	Public Housing Primary Care	
1g	**Total Health Center** (Sum of Lines 1a through 1e)	
1k	**Capital Development Grants**, including School-Based Service Site Capital Grants	
1l	Coronavirus Preparedness and Response Supplemental Appropriations Act (H8C)	
1m	Coronavirus Aid, Relief, and Economic Security Act (CARES) (H8D)	
1n	Expanding Capacity for Coronavirus Testing (ECT) (H8E and LAL ECT)	
1o	American Rescue Plan (ARP) (H8F, L2C, C8E)	
1p	Expanding COVID-19 Vaccination (ECV) (H8G)	
1p2	Other COVID-19-Related Funding from HRSA's BPHC (specify _____)	
1q	**Total COVID-19 Supplemental** (Sum of Lines 1l through 1p2)	
1	**Total HRSA's BPHC Grants** (Sum of Lines 1g + 1k + 1q)	
	Other Federal Grants	
2	Ryan White Part C HIV Early Intervention	
3	Other Federal Grants (specify _____)	
3a	Medicare and Medicaid EHR Incentive Payments for Eligible Providers	
3b	Provider Relief Fund (specify _____)	
5	**Total Other Federal Grants** (Sum of Lines 2 through 3b)	

HRSA Health Center Program

BPHC COVID-19 Funding Lines

Table 9E, Lines 1l–1q

Line	Source	Amount (a)
	HRSA's BPHC Grants (Enter Amount Drawn Down—Consistent with PMS 272)	
1a	Migrant Health Center	
1b	Community Health Center	
1c	Health Care for the Homeless	
1e	Public Housing Primary Care	
1g	**Total Health Center** (Sum of Lines 1a through 1e)	
1k	**Capital Development Grants**, including School-Based Service Site Capital Grants	
1l	Coronavirus Preparedness and Response Supplemental Appropriations Act (H8C)	
1m	Coronavirus Aid, Relief, and Economic Security Act (CARES) (H8D)	
1n	Expanding Capacity for Coronavirus Testing (ECT) (H8E and LAL ECT)	
1o	American Rescue Plan (ARP) (H8F, L2C, C8E)	
1p	Expanding COVID-19 Vaccination (ECV) (H8G)	
1p2	Other COVID-19-Related Funding from HRSA's BPHC (specify _____)	
1q	**Total COVID-19 Supplemental** (Sum of Lines 1l through 1p2)	
1	**Total HRSA's BPHC Grants** (Sum of Lines 1g + 1k + 1q)	

Lines 1l through 1p2 capture COVID-19-related funding *from HRSA BPHC* and should only include amounts drawn down in 2024.

- **Report the amount drawn down in the year.** These funds were awarded by HRSA BPHC between 2020 and 2023; if those funds were drawn down by your health center in 2024, then they are reported in the current UDS Report.
  - Lines 1l–1n were awarded in 2020.
  - Line 1o was awarded in 2021.
  - Line 1p was awarded in 2022.
  - Line 1p2, which includes COVID-19 Bridge Funding from BPHC, was awarded in late 2023.
- See detailed guidance on COVID-19 funding here.

Non-Federal Grants Revenue Categories

Table 9E, Lines 6–10

	**Line 6** **State and Local Government**	Funds received from a state or local government, taxing district, or sovereign tribal entity
	**Line 6a** **State/Local Indigent Care Programs**	Funds received from state/local indigent care programs that subsidize services rendered to patients who are uninsured (e.g., New Mexico Tobacco Tax Program)
	**Line 8** **Foundation/Private**	Funds from foundations and private organizations (e.g., hospital, United Way)
	**Line 10** **Other Revenue**	Miscellaneous non-patient-related revenues (e.g., cash donations, medical record revenue, vending machine revenue)

Examples:
Are These Funds Reported on Table 9E? Where?

The health center received Title V maternal and child health service funds from the state health department, but the funds originated from HRSA Maternal and Child Health Bureau (MCHB).

We received a notice of award for $1 million in Bridge funding. Where do we report this?

The health center received money from the local United Way as part of building a community-based exchange to address social determinants of health (SDoH).

Examples:
Are These Funds Reported on Table 9E? Where?

The health center received Title V maternal and child health service funds **from the state health department**, but the funds originated from HRSA MCHB.

Line 6, State Government Grants and Contracts.

We received a notice of award for $1 million in Bridge funding. Where do we report this?

Determine how much of that funding was drawn down during the year, and report that amount on Table 9E, Line 1p2, Other COVID-19-Related Funding from BPHC.

The health center received money from the local United Way as part of building a community-based exchange to address SDoH.

Report this grant funding on Line 8, Foundation/Private Grants/Contracts

HRSA Health Center Program

FAQs: Table 9E

How does the UDS Table 9E financial reporting differ from our health center financial statements?

Table 9E reports all non-patient-service-related revenue on a cash basis, and health centers will recognize this revenue on an accrual basis in their financial statements.

How do we report grant funds for which we have only received (or drawn down) part of the award amount?

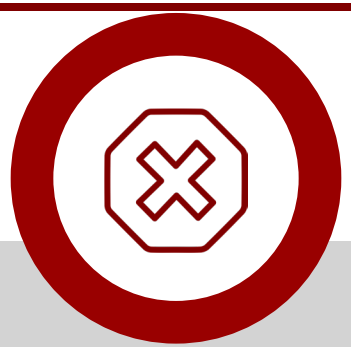
Table 9E collects information on cash receipts for the calendar year. For a grant, report the cash amount **received** during the calendar year. Do not report the award amount unless the full award was paid/drawn down during the year.

How do we report funding that we receive from an organization that received a grant, which they "pass through" to our health center?

Use the "last party rule" to classify the receipts. Grant, contract, and other funds are reported based on the entity from which the health center **received** them, regardless of the source from which they originated.

Key Reminders for Other Revenue on Table 9E

- Report all grant funds and non-patient-service payments received during the calendar year on Table 9E.
- Forgiven loans are not reported on Table 9E.
- Be sure all revenue is reported based on whom your health center received the money from, not where the funding originated.



- **Do not** report 340B or contract pharmacy revenue on Table 9E; report on Table 9D according to guidance on page 188 of the UDS Manual.
- **Do not** report payer incentives or other incentives for patient care on Table 9E; report on Table 9D in both Column B and Column C3.

Detailed guidance for where certain grants and revenue are to be reported is in the UDS Manual, beginning on page 171.

HRSA Health Center Program

Resources and Updates

Find Resources to Help: Financials

The HRSA BPHC UDS Resources site Financials section includes the following resources:

- Table 8A Fact Sheet
- Table 9D Fact Sheet
- Table 9E Fact Sheet
- UDS Overhead Cost Allocation Methods
  UDS Managed Care Reporting and Relationship Across Tables 4 and 9D

And much more!

HRSA
Health Resources & Services Administration

UDS Data Modernization and UDS Patient Level Data (UDS+)

Health Resources and Services Administration (HRSA), Bureau of Primary Health Care (BPHC)

Vision: Healthy Communities, Healthy People

Why are we modernizing UDS?

- Leverage developments in health information technology (health IT) over the last decade that allow us to advance health equity efforts while reducing reporting burden
- Standardize data collection using FHIR resources to automate and reduce the technical burden for health centers
- Improve the fidelity and integrity of data and enable more robust analyses to improve equitable access to high quality, cost-effective care for our patients
- Drive quality improvement for vulnerable and historically underserved population groups
- Allow HRSA to better administer the Health Center Program and better serve its patients

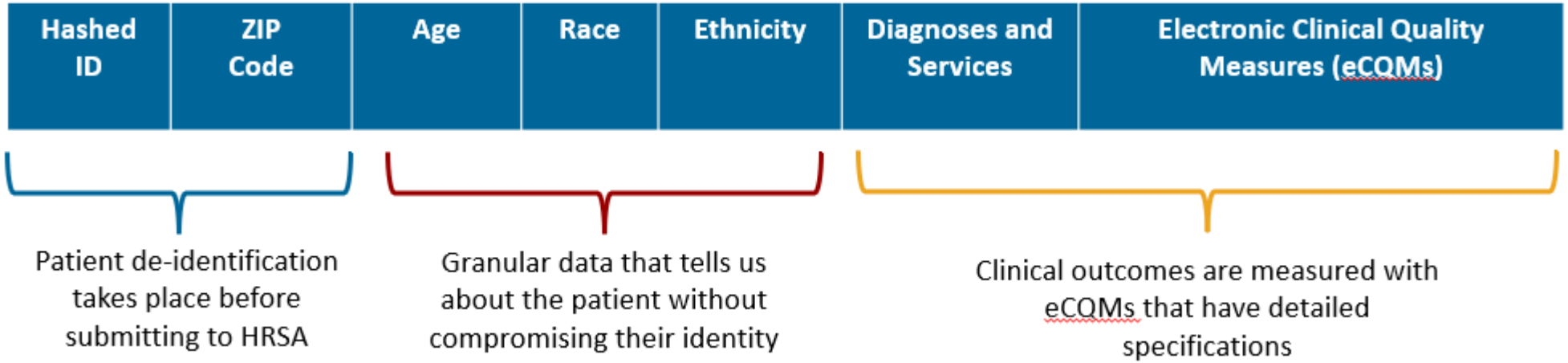
UDS Patient Level Submission (UDS+)

UDS+ is...

- De-identified patient level data
- Applicable to UDS Tables Patients by ZIP Code, 3A, 3B, 4, 6A, 6B, and 7
- Submitted via FHIR

UDS+ is not...

- Full copies of data directly from patients' electronic medical records



For more information, visit: Uniform Data System (UDS) Modernization Initiative

HRSA Health Center Program

UDS+ 2024 Reporting Year: Submission Requirements

2024 UDS+ Submissions Due by April 30, 2025

1. Submit data for your ***medical*** patients.

2. Submit ***all*** the demographic tables data:
   - **Table:** Patients by ZIP Code
   - **Table 3A:** Patients by Age and by Sex Assigned at Birth
   - **Table 3B:** Demographic Characteristics
   - **Table 4:** Selected Patient Characteristics

   (Managed Care Utilization lines are NOT required for UDS+ CY 2024 reporting)

3. Submit ***one eCQM*** from the measures listed below:
   - **Table 6B:** Quality of Care Measures
     - Breast Cancer Screening
     - Cervical Cancer Screening
     - Colorectal Cancer Screening
   - **Table 7:** Health Outcomes and Disparities
     - **Controlling High Blood Pressure***
     - Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

   ** Recommended measure*

HRSA Health Center Program

2024 Calendar Year: UDS & UDS+ Reporting

All health centers are **required** to submit **aggregated** UDS data by **February 15, 2025**.

- Submit aggregated UDS data through EHBs, using the traditional submission method.
- Include all UDS tables and appendices.
- This will be the official submission of record.

All health centers will be required to submit a minimum amount of **patient-level data (UDS+) by April 30, 2025**.

- Submit UDS+ data via FHIR.
- Include, at a minimum, only demographic data and one eCQM for medical patients.
- UDS+ submission supports system capacity building and progress toward full implementation.

EHBs will remain the submission of record.

HRSA Health Center Program

How can health centers prepare for UDS+?

UDS TEST COOPERATIVE

Join the UTC for continued UDS+ updates and resources.

HL7® FHIR®

Review:

- HL7.org
- HL7® FHIR® resources page
- UDS+ FHIR Implementation Guide (IG)

ENGAGEMENT

Visit the UDS Modernization Initiative webpage for up-to-date UDS+ information.

Encourage your health IT vendors to join the UTC and participate in UDS+ testing before 2025.

Submit questions through the BPHC Contact Form by selecting **Uniform Data System (UDS) > UDS Modernization > Patient-Level Submission (UDS+).**

HRSA Health Center Program

Questions and Answers

Thank You!

Bureau of Primary Health Care (BPHC)

Health Resources and Services Administration (HRSA)

udshelp330@bphcdata.net or Health Center Program Support

1-866-837-4357

bphc.hrsa.gov

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