HRSA
Health Resources & Services Administration

Reporting Uniform Data System (UDS) Financial and Operational Tables

November 7, 2023, 1:00–2:30 p.m. ET

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Bureau of Primary Health Care (BPHC)

Vision: Healthy Communities, Healthy People

Opening Remarks

Lorraine Burton

Data and Evaluation

Office of Quality Improvement

Bureau of Primary Health Care (BPHC)

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.

Poll

How familiar are you with the UDS financial tables?

A. I am not familiar. The basics will be helpful to learn.
B. I am not very familiar. Gaining a better understanding will be helpful.
C. I am somewhat familiar. Learning about the tables in more detail will be helpful.
D. I am very familiar with these tables. I would like to learn about any changes this year that impact UDS reporting.

UDS Training and Technical Assistance (TTA) Resources

- **Now available: UDS reporting resources on the BPHC website**
- **UDS Manual:**
  - Definitions and instructions specific to the UDS are in the 2023 UDS Manual.
- **Year-over-year changes:**
  - 2023 Program Assistance Letter (PAL)
  - UDS Changes Webinar (held June 6, 2023)

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 is reported for the *full calendar year*, Jan. 1, 2023, through Dec. 31, 2023.

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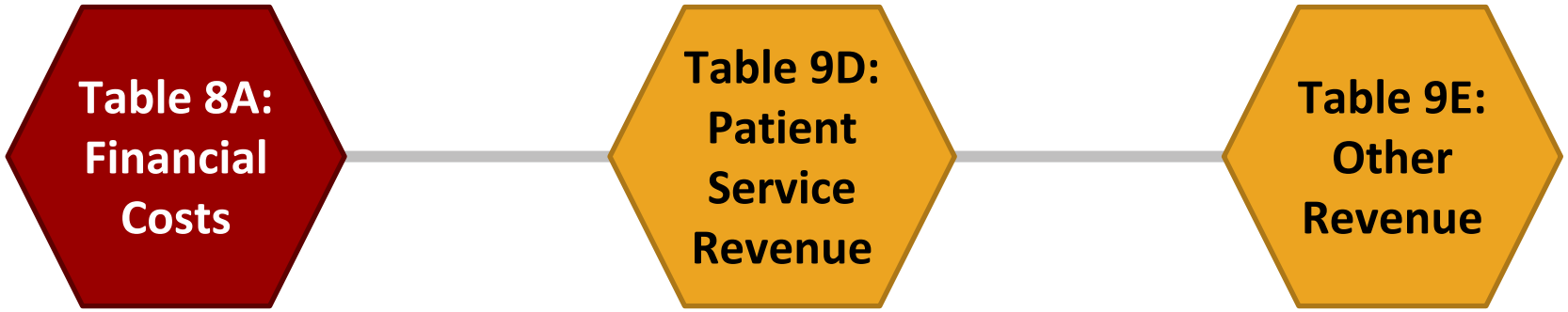
Overview of Financial Tables

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 discount 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

Accrued Cost

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

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.

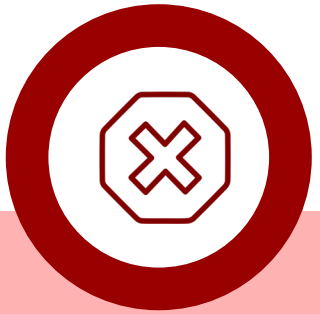
Total Cost After Allocation of Facility and Non-Clinical Support Services

- 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.

Accrued Costs

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 195).

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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 that lab/radiology bills directly to the patient, unpaid medical lab and X-ray provided directly by a referred care provider, 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: **Other than personnel direct medical** costs

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

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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.

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Key Considerations

Reporting Various Costs Related to Pharmacy

Pharmacy and Pharmaceuticals are reported on Lines 8a and 8b. There are several considerations to be sure these are reported accurately:

- Dispensing and administrative fees for contract pharmacy (e.g., 340B) are reported on 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.
- Administrative or overhead costs for a contract pharmacy program should be 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	

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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 podiatry, chiropractic, acupuncture, naturopathy, speech and hearing pathology, or occupational and physical therapy.
- Does **not** include other professional costs that may be included in programs reported under "Other Program-Related Services" (Line 12), such as Women, Infants, and Children (WIC), Healthy Start, fitness centers, clinical trials, etc.

Line 9a: Vision

- **Includes** vision personnel and supplies.
- Does **not** include donated time of optometrists.

Other Cost Centers

Table 8A, Lines 11a–13, Column A

Lines 11a–11h, Line 11: Enabling Services

- **Includes** costs such as those for education materials, taxi vouchers, and translation/interpretation services, in addition to personnel costs.

Line 12: Other Program-Related Services

- **Includes** costs such as those for 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.

Line 12a: Quality Improvement (QI)

- **Includes** costs of personnel dedicated to the QI program and/or health information technology (health IT)/electronic health record (EHR) system development.
- 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. **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) 2023 UDS Report?

A. Health center staffing costs that occurred in CY 2023.
B. A loan principal payment made by the health center in CY 2023.
C. Interest payments on loans in CY 2023.
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) 2023 UDS Report?

A. Health center staffing costs that occurred in CY 2023.
B. A loan principal payment made by the health center in CY 2023.
C. Interest payments on loans in CY 2023.
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.

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 full-time equivalent (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 most of their time on a medical provider line on Table 5; then corporate time 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.

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

Facility and non-clinical support service expenses are referred to as overhead expenses. In the UDS, these are reported on Table 8A, Column A, in Lines 14 and 15. (Line 16 is the total.)

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.).

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 ascribable 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

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% medical, 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	-	2,000	1,000	500	3,500
Site C	2,000	2,000	1,000	1,500	6,500
Total Square Feet (SF)	4,000	4,000	2,000	2,500	12,500
% of total SF	32%	32%	16%	20%	100%
% total SF times 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

Administration facility costs are allocated to non-clinical support and then allocated with non-clinical support services in 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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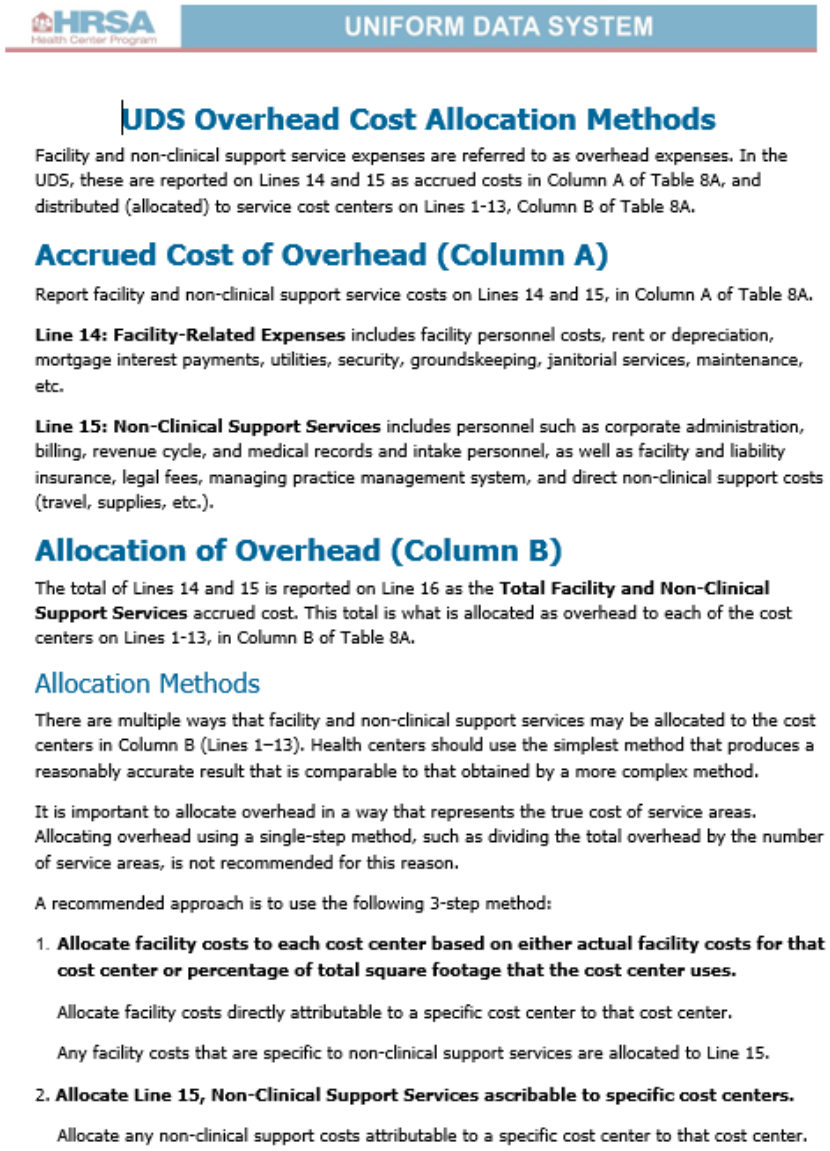
Overhead Allocation Example: Total of $320,000

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

New Resource!

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



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UDS Overhead Cost Allocation Methods

Facility and non-clinical support service expenses are referred to as overhead expenses. In the UDS, these are reported on Lines 14 and 15 as accrued costs in Column A of Table 8A, and distributed (allocated) to service cost centers on Lines 1-13, Column B of Table 8A.

Accrued Cost of Overhead (Column A)

Report facility and non-clinical support service costs on Lines 14 and 15, in Column A of Table 8A.

Line 14: Facility-Related Expenses 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, and medical records and intake personnel, as well as facility and liability insurance, legal fees, managing practice management system, and direct non-clinical support costs (travel, supplies, etc.).

Allocation of Overhead (Column B)

The total of Lines 14 and 15 is reported on Line 16 as the **Total Facility and Non-Clinical Support Services** accrued cost. This total is what is allocated as overhead to each of the cost centers on Lines 1-13, in Column B of Table 8A.

Allocation Methods

There are multiple ways that facility and non-clinical support services may be allocated to the cost centers in Column B (Lines 1–13). Health centers should use the simplest method that produces a reasonably accurate result that is comparable to that obtained by a more complex method.

It is important to allocate overhead in a way that represents the true cost of service areas. Allocating overhead using a single-step method, such as dividing the total overhead by the number of service areas, is not recommended for this reason.

A recommended approach is to use the following 3-step method:

1. **Allocate facility costs to each cost center based on either actual facility costs for that cost center or percentage of total square footage that the cost center uses.**

   Allocate facility costs directly attributable to a specific cost center to that cost center.

   Any facility costs that are specific to non-clinical support services are allocated to Line 15.

2. **Allocate Line 15, Non-Clinical Support Services ascribable to specific cost centers.**

   Allocate any non-clinical support costs attributable to a specific cost center to that cost center.

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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*)	By Payer (*Rows*)	By Form of Payment (incl. Sub-lines a & b)
• **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	• **Lines 1-3:** Medicaid • **Lines 4–6:** Medicare • **Lines 7-9:** Other Public • **Lines 10-12:** Private • **Line 13:** Self-Pay	• Non-managed care • **Sub-line a:** Managed care • **Sub-line b:** Non-managed care

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
- 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 private payers

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

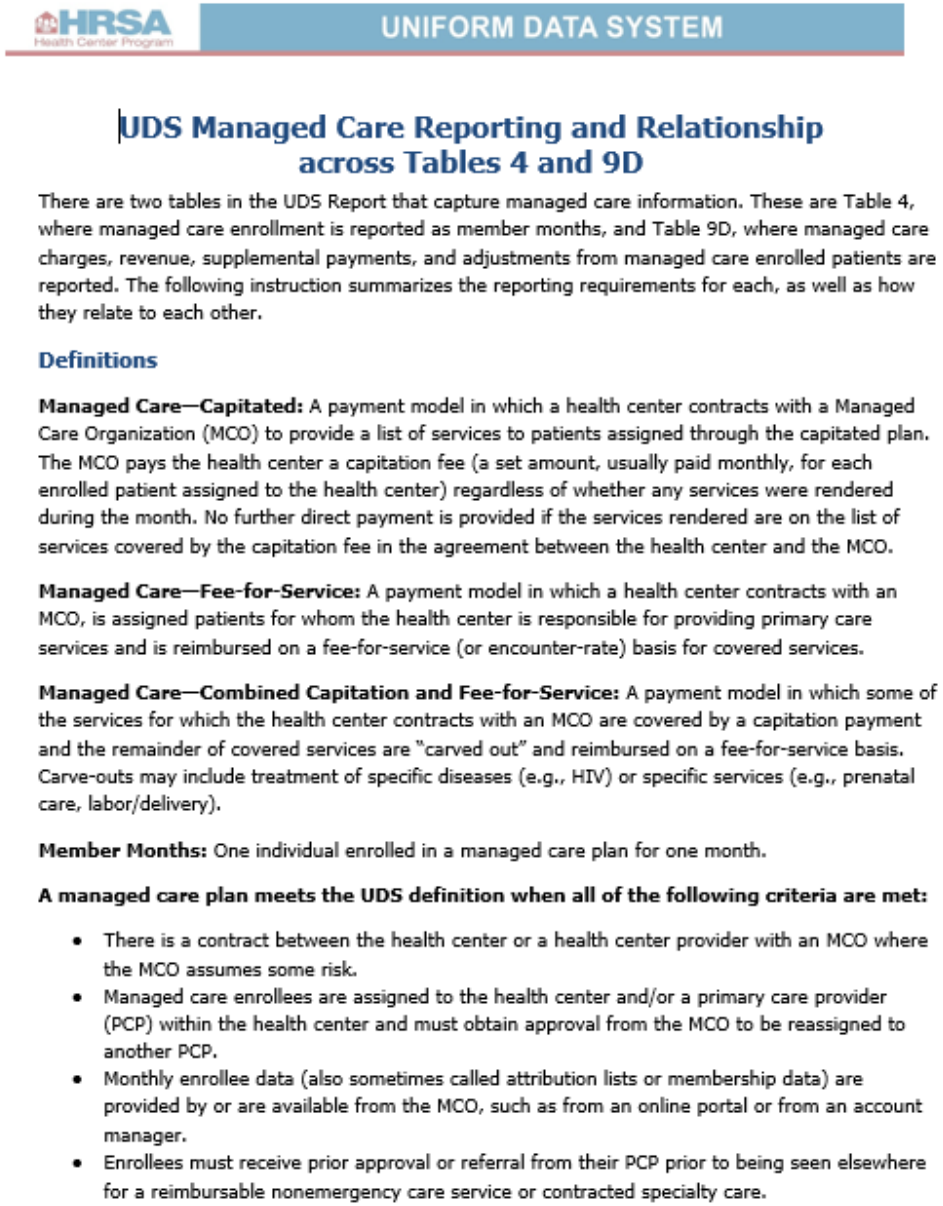
- **Managed care (either capitated or fee-for-service) refers to those payers with which the health center has a contractual managed care agreement to provide a range of services to patients assigned to the health center.**
  - Typically, these agreements include:
    - Responsibility for managing the care of a set of assigned patients.
    - Requirement for patients to receive specific care from the health center.
- 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 other words, patients are assigned to another provider's managed care plan (not assigned to one of your providers for managing care).

New Resource!

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



HRSA Health Center Program | UNIFORM DATA SYSTEM

UDS Managed Care Reporting and Relationship across Tables 4 and 9D

There are two tables in the UDS Report that capture managed care information. These are Table 4, where managed care enrollment is reported as member months, and Table 9D, where managed care charges, revenue, supplemental payments, and adjustments from managed care enrolled patients are reported. The following instruction summarizes the reporting requirements for each, as well as how they relate to each other.

Definitions

Managed Care—Capitated: A payment model in which a health center contracts with a Managed Care Organization (MCO) to provide a list of services to patients assigned through the capitated plan. 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 is provided 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 payment model in which some of the services for which the health center contracts with an MCO are covered by a capitation payment and the remainder of 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/delivery).

Member Months: One individual enrolled in a managed care plan for one month.

A managed care plan meets the UDS definition when all of the following criteria are met:

- There is a contract between the health center or a health center provider with an MCO where the MCO assumes some risk.
- Managed care enrollees are assigned to the health center and/or a primary care provider (PCP) within the health center and must obtain approval from the MCO to be reassigned to another PCP.
- Monthly enrollee data (also sometimes called attribution lists or membership data) are provided by or are available from the MCO, such as from an online portal or from an account manager.
- Enrollees must receive prior approval or referral from their PCP prior to being seen elsewhere for a reimbursable nonemergency care service or contracted specialty care.

Reclassifying Charges

What is reclassifying the self-pay portion of charges?

Reclassifying charges refers to transferring the amounts due from one payer to another payer, in this case the patient.

Why is reclassifying necessary?

Health centers are expected to reclassify charges to the appropriate payer, with particular attention to the self-pay portion of the charge, down to the self-pay line.

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 or capitation payments.
- Payment for grant-covered services from public entities.
- Health center reconciliation or wraparound payments.
- Quality bonuses or pay-for-performance (P4P) bonuses.

Retroactive Settlements, Receipts, and Paybacks

Table 9D, Columns C1–C4

	Retroactive Settlements, Receipts, and Paybacks (c)			
Amount Collected This Period (b)	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)
Payments reported in C1–C4 are part of Column B total, but do not equal Column B	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**.
- Virtually all insurance companies have a maximum amount they pay for a given service, and the health center agrees to write off the difference between what they charge and that contracted amount. These are considered contractual adjustments.
- On Table 9D, 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.
- Adjustments for third-party payers are reported in Column D.

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.

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**—Include patient service revenue from programs with limited benefits
7–9	**Other Public**
10–12	**Private**

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?

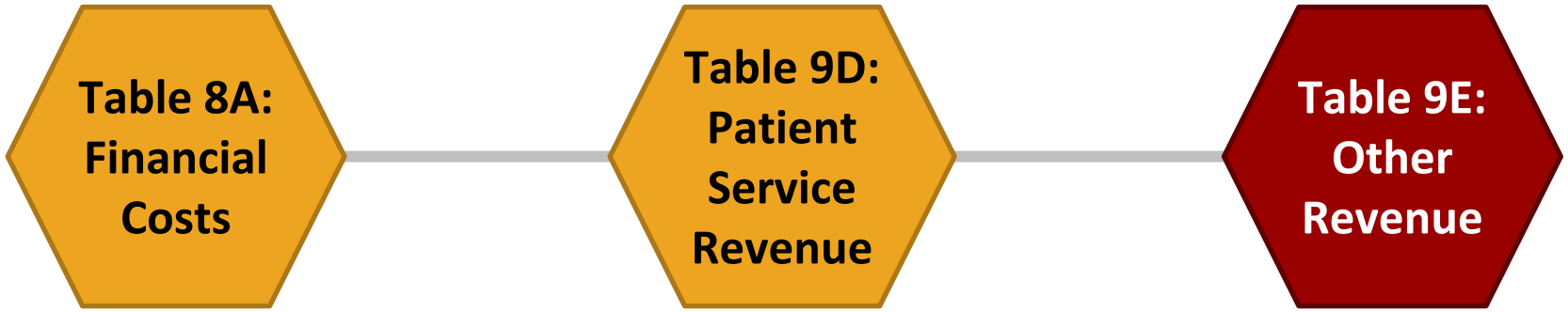
Yes. Regardless of whether it is done automatically by your systems or manually, reflect this reclassification of charges that end up being the responsibility of a payer other than the initial party.

? 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 166 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 2023.

- 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.

Find guidance for common health center funding awards related to the COVID-19 pandemic on the BPHC UDS TTA site Financials section.

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

Lines 1a–1q

- **BPHC Grants:** Funds received directly from BPHC, including funds passed through to another agency
  - Include 330 grant(s) drawn down in the year.
  - Include the amounts directly received under the various COVID-19 funding streams. *Only report amounts drawn down in 2023.*

Lines 2–3b

- **Other Federal Grants:** Grants received directly from the federal government other than BPHC (e.g., HUD, CDC, SAMHSA)
  - Ryan White Part C.
  - EHR incentive payments: Include Promoting Interoperability funds, including funds paid directly to providers and turned over to the health center (exception to last party rule).
  - Provider Relief Fund.

Line	Source	Amount (a)
	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)	
1p2	Other COVID-19-Related Funding from BPHC (specify _____)	
1q	**Total COVID-19 Supplemental** (Sum of Lines 1l through 1p2)	
1	**Total 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)
	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)	
1p2	Other COVID-19-Related Funding from BPHC (specify_____)	
1q	**Total COVID-19 Supplemental** (Sum of Lines 1l through 1p)	
1	**Total 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 2023.

- **Report the amount drawn down in the year.** These funds were awarded between 2020 and 2023; if those funds were drawn down in 2023, 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 2023.
- **NEW Line 1p:** Expanding COVID-19 Vaccination (ECV). ECV funding was awarded in Dec. 2022. The amount drawn down in CY 2023 is reported on Line 1p.
- See detailed guidance on COVID-19 funding here.

HRSA Health Center Program

Non-Federal Grants Revenue Categories
Table 9E, Lines 6–10

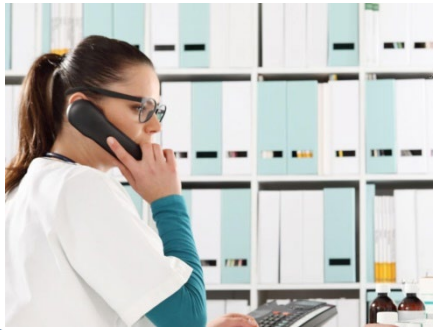
- **State and Local Government:** Funds received from a state or local government, taxing district, or sovereign tribal entity (e.g., state public health grant)
- **State/Local Indigent Care Programs:** Funds received from state/local indigent care programs that subsidize services rendered to patients who are uninsured (e.g., New Mexico Tobacco Tax Program)
- **Foundation/Private:** Funds from foundations and private organizations (e.g., hospital, United Way)
- **Other Revenue:** Miscellaneous non-patient-related revenues (e.g., cash donations, medical record revenue, vending machine revenue)
  - Do not report bad debt recovery or 340B revenue here—these revenues are reported on Table 9D.

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

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

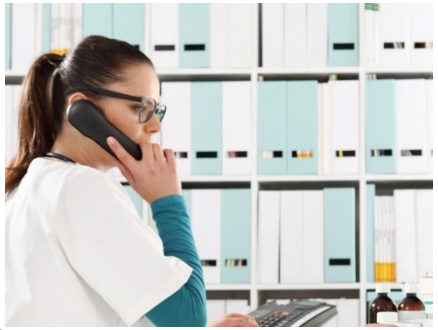
1. We receive Title V maternal and child health service funds from the state health department, and these funds originated from the Maternal and Child Health Bureau (MCHB). On which line do we report these funds?

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



3. We have a public pharmacy that provides services to members of the community (not health center patients). The pharmacy is in-scope. Where do we report this?

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



1. We receive Title V maternal and child health service funds from the state health department, and these funds originated from MCHB. On which line do we report these funds? **Line 6, State Government Grants and Contracts.**

2. 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.**

3. We have a public pharmacy that provides services to members of the community (not health center patients). The pharmacy is in-scope. Where do we report this? **Report all revenue from the public pharmacy on Line 10, Other Revenue. Include "public access pharmacy" in the "specify" field.**

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 used (or drawn down) part of the award amount?

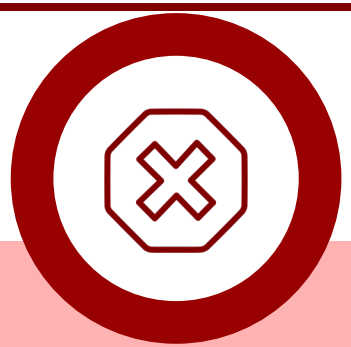
Table 9E collects information on cash receipts for the calendar year. For a grant, report the cash amount received during the calendar year. Do not report the award amount (unless the full award was paid/drawn down during the year).

? 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 should always be 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 187 of the UDS Manual.
- **Do not** report P4P incentives or other incentives for patient care on Table 9E; report on Table 9D in Column C3.

Detailed guidance for where certain grants and revenue are to be reported is in the UDS Manual, beginning on page 170.

HRSA Health Center Program

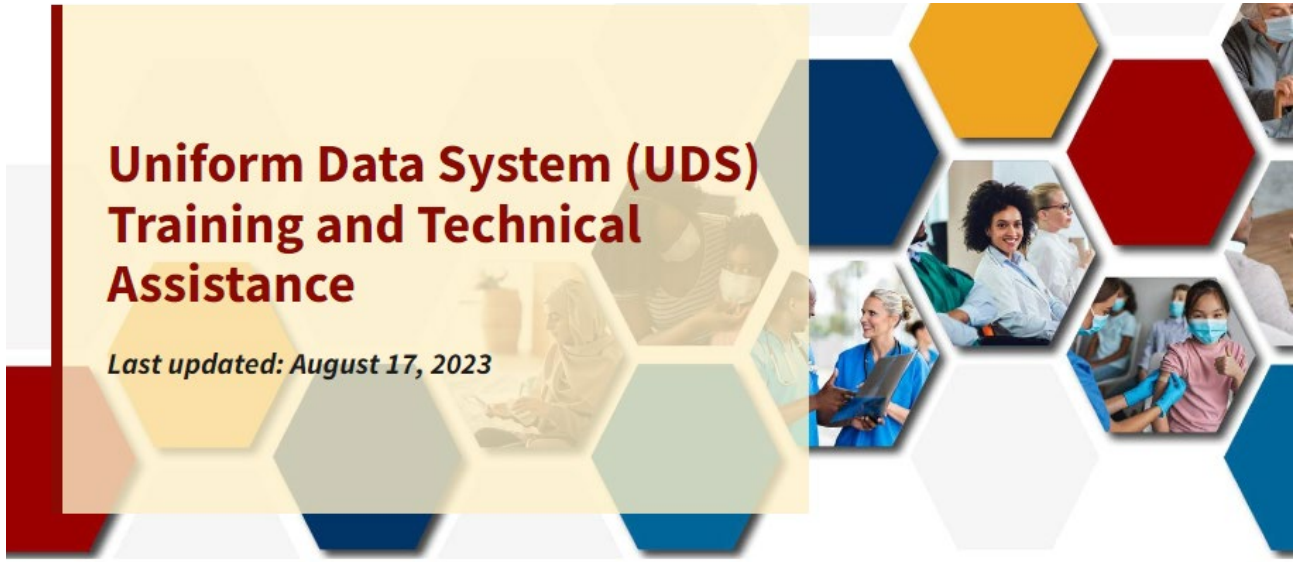
Resources and Updates

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
- COVID-19 Funding Reporting Guidance
- UDS Overhead Cost Allocation Methods (new!)
- UDS Managed Care Reporting and Relationship Across Tables 4 and 9D (new!)

And much more!



HRSA Health Center Program

Support Available

Description	Contact	E-mail or Web Form	Phone
UDS reporting questions	UDS Support Center	udshelp330@bphcdata.net or BPHC Contact Form Select: UDS Reporting and most applicable subcategory	866-837-4357 (866-UDS-HELP)
EHBs account and user access questions	Health Center Program Support	BPHC Contact Form Select: Technical Support, EHBs Tasks/Technical Issues, EHBs Privileges	877-464-4772
EHBs technical issues with UDS Reports	Health Center Program Support	BPHC Contact Form Select: Technical Support, EHBs Tasks/Technical Issues, Other EHBs Submission Types	877-464-4772
UDS+ FHIR R4 IG and API (UDS Modernization) technical support	Health Center Program Support	BPHC Contact Form Select: UDS Modernization	877-464-4772

Preliminary Reporting Environment Launch

- **The 2023 Uniform Data System (UDS) Preliminary Reporting Environment (PRE) is now open.**
- Learn more about the PRE from this technical assistance webinar:

  Uniform Data System Reporting 2023 - Preliminary Reporting Environment

  November 9, 2023

  1:30 – 3:00 PM ET

  Register

View Accessing Uniform Data System (UDS) Reporting Guidance Resources on the Electronic Handbooks for additional instructions.

HRSA Health Center Program

UDS Modernization Updates

UDS Modernization Initiative

Reduce Reporting Burden

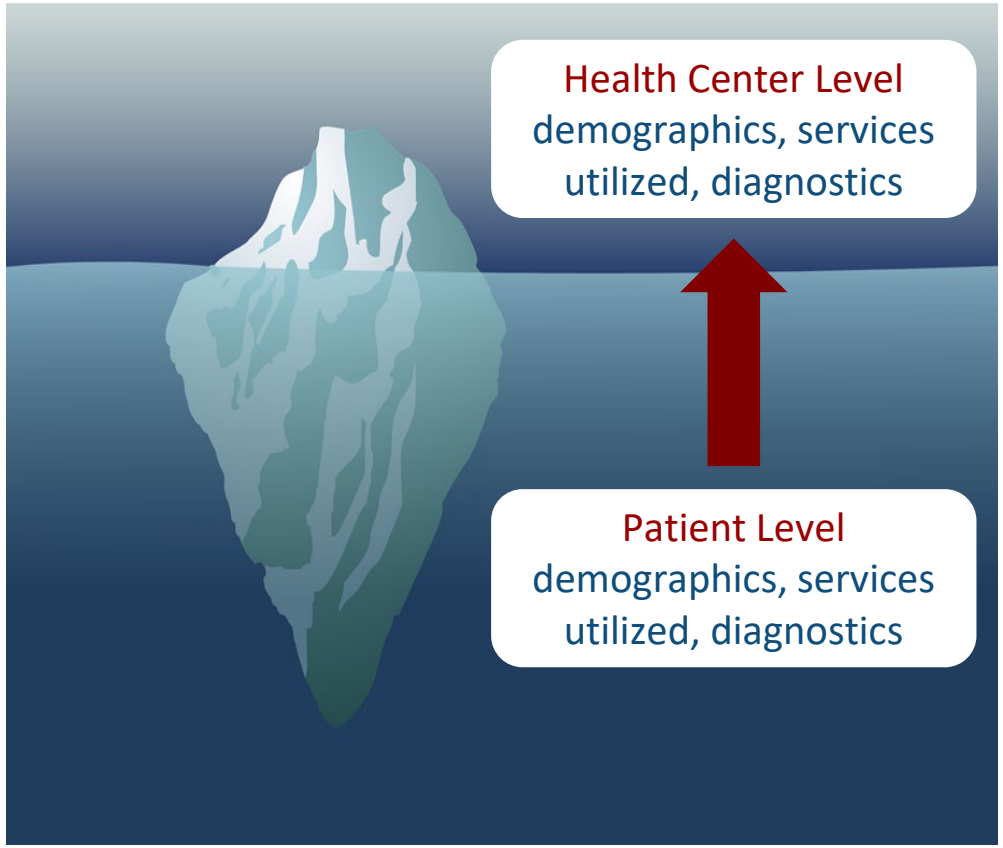
Automate data submission, provide enhanced UDS reporting capabilities, promote transparency, and integrate stakeholder feedback.

Better Measure Impact

Improve the quality of UDS data to reflect improvements in patient-centered care and an evolving primary health care setting.

Promote Transparency

Provide an open, transparent decision-making process on UDS changes such as measure selection, information technology, and reporting improvements.



Benefits of UDS+

Patient-level data collection will enable HRSA to better:

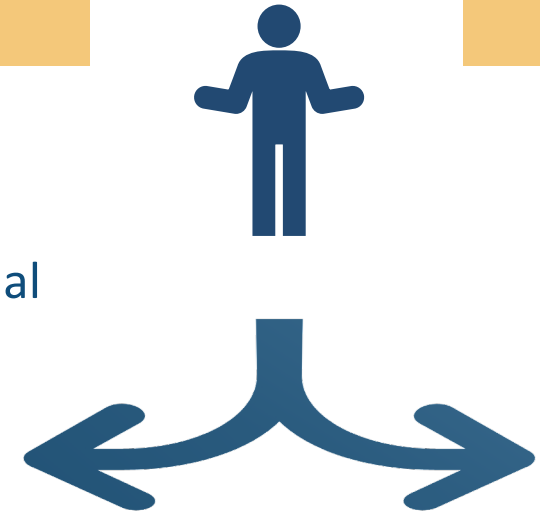
- Articulate the **unique characteristics** and **needs** of health center patients
- Illustrate the **breadth and depth** of health center **services** and their impact on **health outcomes**
- Inform **TTA, research and evaluation**, and **health equity** work
- Improve **preparedness** for public health emergencies
- Improve ability to communicate the **complexity of the patient populations** health centers serve and provide **evidence for aligned reimbursements** for care provided
- Inform **investments and interventions** based on trends identified in patient-level data (e.g., targeted needs of specific communities/patients, social determinants of health)

2023 Calendar Year: UDS Reporting

All health centers are **required** to submit **aggregated** UDS data.

Health centers also have the **option** to submit **patient-level data (UDS+)**.

- 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



UDS+ FHIR Implementation Guide provides architectural details and technical reporting specifications for submission.

2023 Calendar Year: Optional UDS+ Submission

1. Submit data for your entire universe of patients (not a subset)

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

3. Submit ***all or part of*** the clinical tables data
   - **Table 6A**: Selected Diagnoses and Services Rendered – optional
   - **Table 6B**: Quality of Care Measures – submit 2 or more eCQMs from this table
   - **Table 7**: Health Outcomes and Disparities – submit 2 or more eCQMs from this table

2023 Calendar Year: Optional UDS+ Submission cont'd

- The UDS Test Cooperative (UTC) suggests health centers may be the most ready to submit these eCQMs:
  - **Table 6B: Quality of Care Measures**
    - ✔ Cervical Cancer Screening
    - ✔ Colorectal Cancer Screening
  - **Table 7: Health Outcomes and Disparities**
    - ✔ Controlling High Blood Pressure
    - ✔ Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

REMEMBER:

Submit both demographic and clinical data for the entire patient population, not a subset of patients

- Health centers may choose any eCQM from these tables as long as they submit at least two measures from each table

Resources

For the latest UDS Test Cooperative (UTC) and UDS+ information, please subscribe to the Primary Health Care Digest and visit the UDS+ technical assistance webpages:

- UTC
- UDS Modernization Initiative
- UDS Modernization FAQ

Submit a ticket via the BPHC Contact Form to:

- Join the UTC
- Access the UDS+ Health Center Program Community
- Participate in a readiness assessment to discuss UDS+ submissions use cases
- Learn more about the UDS+ FHIR Implementation Guide

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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