Uniform Data System (UDS) Reporting Requirements

Annual Training

Calendar Year 2025

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Agenda

1. Welcome and Logistics
2. Review of Tables and Forms
3. Tips for Success
4. Review of Available Technical Assistance (TA) and Closing

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Overview of the Uniform Data System (UDS)

Key Facts about UDS Reporting

Health centers, look-alikes, and certain BHW awardees funded or designated before Oct. 2025 all complete a UDS Report.

The UDS includes 11 tables and 3 forms that provide an annual snapshot of all in-scope activities reported on the Universal Report, and, if applicable, Grant Reports.

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

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

All health centers complete their UDS Report between Jan. 1 and Feb. 15, 2026; the report covers health center services in the calendar year from Jan. 1 to Dec. 31, 2025.

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Value of the UDS

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

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

Communicate Importance
Demonstrates to administrators and the public the work of the Health Center Program.

Inform Consistently
Provides consistent, reliable data over time, supporting evaluation of progress and decision-making.

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Overview of UDS Report

Four Primary Sections, Eleven Tables, and Three Forms

Patient Demographic Profile

ZIP Code: by Medical insurance
Table 3A: Age, sex
Table 3B: Race, ethnicity, language
Table 4: Income, medical insurance, managed care, special medically underserved populations

Clinical Services and Outcomes

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

Financial Performance

Table 8A: Financial costs
Table 9D: Patient service-related charges, collections, and adjustments
Table 9E: Other revenue

Other Forms

Appendix D: Health Information Technology (Health IT) Capabilities
Appendix E: Other Data Elements (ODE)
Appendix F: Workforce

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Health Center Program Grants and Designations

Some health centers have a single Health Center Program funding stream, also called a 330 grant: Community Health Center (CHC) funding, Homeless Population (HP) funding, Migratory and Seasonal Agricultural Workers (MSAW) funding, or Residents of Public Housing (RPH) funding.

Some health centers have more than one Health Center Program award: these health centers have two or more awards, in any combination of CHC, HP, MSAW, and/or RPH.

Some health centers have a Health Center Program look-alike (LAL) designation or are **Bureau of Health Workforce (BHW) awardees**. These health centers do not have a Section 330 grant.

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

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Overview of UDS Reporting Requirement

Universal Report

- Reported by *all* health centers.
- Includes full UDS Report, 11 tables and 3 forms.
- All patients, services, and related information within the calendar year that are in-scope for the Health Center Program award are reported.
- All health centers who **only have a single Health Center Program award or LAL designation** report just a Universal Report.

Grant Report

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

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Overview of Universal Reporting Requirement vs. Grant Reporting Requirement

The table from pages 11–12 of the 2025 UDS Manual provides a detailed overview. An excerpt is depicted to the right.

Table	Data Reported	Universal Report	Grant Reports
Table 4: Selected Patient Characteristics	Patients by income (as measured by percentage of the federal poverty guidelines [FPG]) and primary third-party medical insurance; the number of "special medically underserved population" patients receiving services; and managed care enrollment, if any	X	X
Staffing and Utilization			
Table 5: Staffing and Utilization	The annualized full-time equivalent (FTE) of program personnel by position, in-person and virtual visits by provider type, and patients by service type	X	Partial (excludes FTE)
Table 5 Addendum: Selected Service Detail Addendum	Mental health services provided by medical providers; substance use disorder (SUD) services provided by medical and mental health providers	X	
Clinical			
Table 6A: Selected Diagnoses and Services Rendered	Visits and patients for selected medical, mental health, SUD, vision, and dental diagnoses and services	X	X
Table 6B: Quality of Care Measures	Clinical quality of care measures	X	
Table 7: Health Outcomes	Health outcome measures	X	
Financial			
Table 8A: Financial Costs	Direct and indirect expenses by cost categories	X	
Table 9D: Patient Service Revenue	Full charges, collections, and adjustments by payer type; sliding fee discounts; and patient bad debt write-offs	X	
Table 9E: Other Revenue	Other, non–patient service revenue	X	
Other			
Appendix D: Health Information Technology (Health IT) Capabilities Form	Health IT capabilities, including the use of electronic health record (EHR) information, and health-related needs	X	
Appendix E: Other Data Elements Form	Medications for opioid use disorder (MOUD), telehealth, outreach and enrollment assistance, and voluntary family planning	X	
Appendix F: Workforce Form	Health center workforce training and use of satisfaction surveys for provider and other personnel	X	

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

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If your health center has a ***single*** grant or designation, only the universal report is completed.

If your health center has ***multiple*** 330 grants, then the universal report ***and*** grant reports are completed.

Reporting Timeline

Fall
Preliminary Reporting Environment (PRE) opens on Oct. 30, 2025

Jan. 1, 2026
UDS Report is available in EHBs

Feb. 15, 2026
Deadline for each health center to submit UDS Report in EHBs

Mar. 31, 2026
Last day for UDS data changes as part of review process

Submission Period | *Review Period* | *Outlier Period*

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Administering Program Conditions and Questionable Ratings

Health centers must demonstrate program compliance with these requirements:

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

At the end of the review period, all tables and forms need to be marked as acceptable or questionable.

A questionable rating means that:

- Data do not align with the reporting requirements in the 2025 UDS Manual,
- Data are missing (i.e., required data are not collected),
- Data are not limited to or do not capture the whole health center scope of project as required, or
- Significant outlier data cannot be explained.

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Key Definitions

Understanding Terms Foundational to the UDS

Health Center Scope

UDS Definition: Health center scope of project is a health center's approved service sites, services, providers, service area, and target populations.

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

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Example of Health Center Scope

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

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

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Health Center Patient

UDS Definition: A person who has at least one countable visit, reported on Table 5, in one or more service category during the calendar year, is a **health center patient**.

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

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Countable Visit

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

- Visits can be **clinic (in person) or virtual**; the requirements to be countable are the same for each.
- Only **certain personnel are classified as providers** and can therefore generate countable visits.
  - Appendix A of the UDS Manual specifies which personnel (by line on Table 5) can be providers in the UDS.
  - Page 66 spells out Personnel lines that cannot have visits.
- A countable visit in *any* service category on Table 5 makes someone a health center patient in the UDS.
  - Starting on Page 55 of the UDS Manual personnel categories are outlined by the different service categories reported in the UDS
- An encounter is a countable visit when it is **one-to-one with a provider and a patient**.
  - Exception: Mental health and substance use disorder (Lines 20a–21) allow group visits.

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

Keep the Big Picture in Mind

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

Identify Patients Served in Your Health Center Scope
A "health center patient" is a patient with a UDS countable visit (on Table 5) in the calendar year.

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

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

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

Complete Forms
Appendix D (Health IT Capabilities), Appendix E (ODE), and Appendix F (Workforce) reflect the realities of these in the calendar year and align with other data elements.

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Overview of the UDS Tables and Forms

Understanding What Data Are Reported and Why

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

Understanding Who You Are Serving

Overview of Patient Characteristic Tables

1. **ZIP Code:** Patients by **ZIP code** and **primary medical insurance**
2. **Table 3A:** Patients by **age** and **sex**
3. **Table 3B:** Patients by **race** and **ethnicity** and patients **with limited English proficiency***
4. **Table 4:** Patients by **income as a percentage of poverty guideline**, patients by **primary medical insurance**, **managed care**, and **special medically underserved population status***

All sections of these tables except those with an asterisk (*) equal each other, as they describe the same group of patients by different characteristics.

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Health Center Program Uses of Patient Characteristic Data

ZIP Code Table
This information is used to monitor service area information, both for individual health centers and for the program.

Table 4: Income
Income as a percentage of the federal poverty guideline (FPG) helps understand poverty levels and contextualize sliding fee discounts.

Tables 3A and 4: Total Patient Count
Patient targets for service area competitions are measured against total patients reported on the UDS.

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Patients by ZIP Code Table

ZIP Code (a)	None/Uninsured (b)	Medicaid/ CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
Other ZIP Codes					
Unknown Residence					
Total					

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Patients by ZIP Code Table

- Report total patients by **ZIP code of residence** and **primary medical insurance**.
- Rows are ZIP codes (which you will enter or import); columns are primary medical insurance categories.
  - List all ZIP codes from which your health center has 11 or more patients in 2025 in Column A.
- Combine the count of all patients from ZIP codes with 10 or fewer patients into the Other ZIP Codes line.
- Use the **patient's local address** for migratory and seasonal agricultural workers, people in a carceral facility, and those from other countries; use **clinic address** for homeless populations who do not have another identified address.

Keys to remember:

- There is **no unknown primary medical insurance**; all patients must have primary medical insurance as of their last visit in the year captured.
- Medicaid, Children's Health Insurance Program (CHIP), and Other Public are combined in Column C here; they are separate on Table 4.
- Total patients' ZIP code by medical insurance **must equal** counts of patients by insurance on Table 4.

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Table 3A: Patients by Age and by Sex

Abbreviated Table

Line	Age Groups	Male Patients (a)	Female Patients (b)
1	Under age 1		
2	Age 1		
3	Age 2		
4	Age 3		
5	Age 4		
6	Age 5		
7	Age 6		
8	Age 7		
9	Age 8		
…	…		
26	Ages 25–29		
27	Ages 30–34		
28	Ages 35–39		
29	Ages 40–44		
30	Ages 45–49		
31	Ages 50–54		
32	Ages 55–59		
33	Ages 60–64		
34	Ages 65–69		
35	Ages 70–74		
36	Ages 75–79		
37	Ages 80–84		
38	Age 85 and over		
39	**Total Patients** (Sum of Lines 1–38)		

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Patients by Age and by Sex

Table 3A

Report all patients by **age** and by **sex**.

- Rows/lines are age; columns are sex.
- Use age as of December 31, 2025.

Keys to remember:

- All **patients** must be reported as either male or female for sex.
- Patients by age in Table 3A must equal insurance by age groups (0–17 years old and 18 and older) in Table 4.
- Information is used for cross-table comparisons.

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Table 3B: Demographic Characteristics

Race and Ethnicity

	Patients by Race and Hispanic, Latino/a, or Spanish Ethnicity									
Line	Patients by Race	Yes, Mexican, Mexican American, Chicano/a (a1)	Yes, Puerto Rican (a2)	Yes, Cuban (a3)	Yes, Another Hispanic, Latino/a, or Spanish Origin (a4)	Yes, Hispanic, Latino/a, Spanish Origin, Combined (a5)	Total Hispanic, Latino/a, or Spanish Origin (a) (Sum Columns a1+a2+a3+a4+a5)	Not Hispanic, Latino/a, or Spanish Origin (b)	Unreported / Chose Not to Disclose Ethnicity (c)	Total (d) (Sum Columns a+b+c)
1a	Asian Indian									
1b	Chinese									
1c	Filipino									
1d	Japanese									
1e	Korean									
1f	Vietnamese									
1g	Other Asian									
1	Total Asian (Sum Lines 1a+1b+1c+1d+1e+1f+1g)									
2a	Native Hawaiian									
2b	Other Pacific Islander									
2c	Guamanian or Chamorro									
2d	Samoan									
2	Total Native Hawaiian/Other Pacific Islander (Sum Lines 2a+2b+2c+2d)									
3	Black or African American									
4	American Indian/Alaska Native									
5	White									
6	More than one race									
7	Unreported/Chose not to disclose race									
8	**Total Patients** (Sum of Lines 1 + 2 + 3 to 7)									

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Ethnicity, Race, and Language

Table 3B, Lines 1–8

- Report all patients by **ethnicity and race**.
- Rows/lines are race categories; columns are ethnicity categories.
  - **All patients are reported by both race *and* ethnicity.**
- If **race is known or recorded, but ethnicity is not**, report in Column B, Not Hispanic, Latino/a, or Spanish Origin.
- If a patient **identifies or selects multiple races**, report on Line 6.
- If a patient **identifies multiple ethnicities**, report in Column A5.
- **Report only patients with unknown race *and* unknown ethnicity on Line 7, Column C.**

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Table 3B

Subcategories for Race and Ethnicity

Race: Subcategories for Asian and Other Pacific Islander:

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

** If a patient chooses multiple racial subcategories within one race or does **not** have a subcategory recorded, report in the "Other" line for that racial group*

Ethnicity: Subcategories for Hispanic, Latino/a, or Spanish Origin:

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

Remember that race is reported on **rows/lines** of Table 3B. Line 1 is the **total** Asian patients.

Ethnicity is reported in the **columns** of Table 3B. Column A is the **total** Hispanic, Latino/a, or Spanish Origin patients.

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Table 3B: Demographic Characteristics

Patients Best Served in a Language Other than English

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

- If the patient's primary language is ***not*** English, then they are reported on this line.
- Line 12 is the *subset of total patients,* made up of just those with limited English proficiency.

Line	Patients Best Served in a Language Other than English	Number (a)
12	Patients Best Served in a Language Other than English	

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Race, Ethnicity, and Language

Keys to Remember for Race, Ethnicity, and Language Reporting

- Race, ethnicity, and language are to be self-reported by patients or caregivers.
- Report patients who trace their ancestry to any of the original peoples of Europe, the Middle East, or North Africa on Line 5, White.
- Patients can select more than one race; patients who select multiple races are reported on More than One Race (Line 6).
- Report patients who are of Hispanic, Latino/a, or Spanish origin but for whom granularity of ethnicity is not known, and patients who select more than one listed ethnicity (e.g., Mexican and Puerto Rican), in Column A5: "Hispanic, Latino/a, Spanish Origin, Combined."
- Report patients with *known* race but *unknown* ethnicity as **Not Hispanic, Latino/a, or Spanish Origin** (Column B).

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Table 4: Selected Patient Characteristics

Income

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

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Income as a Percentage of FPG

Table 4, Lines 1–6

- Report **all patients** by income as a percentage of FPG on Lines 1–5.
  - This cannot be limited to just patients applying for sliding fees.
- Report income based on FPG (requires **income and family/household size**).
- Report each patient's **most recent income within 12 months** of the last visit in the calendar year.
  - If income information has not been collected/confirmed in that period, report the patient's income as Unknown (Line 5).
- Income, for this section of Table 4, can be patient self-reported.
- Do not use insurance or other patient characteristics as a proxy for income as a percentage of FPG.

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Table 4: Selected Patient Characteristics

Third-Party Medical Insurance and Managed Care

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

Line	Managed Care Utilization	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	TOTAL (e)
13a	Capitated Member Months					
13b	Fee-for-service Member Months					
13c	**Total Member Months** (Sum of Lines 13a + 13b)					

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Primary Medical Insurance

Table 4, Lines 7–12

- Report **all patients by primary medical insurance** on Lines 7–11.
  - Use **medical** insurance at the patient's last visit in the year.
  - Only **comprehensive, portable medical insurance** is counted on this table.
  - Dually eligible patients are those who have both Medicare and Medicaid; they are reported on both Line 9a and Line 9. (Line 9a is a subset of Line 9.)

Keys to Remember

- There is no Unknown medical insurance category. All patients need to be reported by medical insurance.
- Include patients who did not receive medical services in the year.
- Programs that cover a limited set of services are not considered comprehensive medical insurance.
- It is important to understand how CHIP is administered in your area to report it accurately.
- Patients by insurance and age must be equal across tables (ZIP and 3A).

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Primary Medical Insurance Categories

Table 4, Lines 7–12

None/Uninsured
No medical insurance as of the last visit. Does not necessarily mean their services were not covered!

Medicaid
Medicaid and Medicaid managed care programs. Includes Medicaid plans administered by commercial insurers.

CHIP
CHIP may be paid by Medicaid; if so, report on Line 8b. If it's paid with other state dollars, report on Line 10b.

Medicare
Include Medicare, Medicare Advantage, and Dually Eligible. Note that Dually Eligible patients are ALSO reported on Line 9a.

Other Public Insurance
Comprehensive, portable state and/or local public insurance that covers a broad set of services and is not paid by Medicaid. Not grants!

Private Insurance
Commercial insurance such as that from an employer, insurance purchased on the federal or state exchanges, and insurance purchased for public employees or retirees.

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Categorizing Medical Insurance on Table 4

Patient Only Has Dental and Mental Health Visits

Example: A patient is seen for only dental and mental health at the health center in the calendar year, and they do ***not*** have insurance that covers those visits.

The patient **needs to be reported on this table by their medical insurance even if they were only seen for non-medical care,** so that information needs to be collected.

Note from the UDS Manual: If a patient's medical insurance is not known but they have Medicaid, Private, or Other Public dental insurance at the time of their last visit, you may assume they have the same kind of medical insurance.
If they *do not* have dental insurance at the time of their last visit, you may *not* assume they are Uninsured for medical care. You must determine whether they have *medical* insurance.

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Categorizing Medical Insurance on Table 4

Patient Whose Insurance Changes During the Year

Example: A patient is seen at the health center several times in the year. At the **first two visits**, they have Medicaid medical coverage; at the **last visit**, they have a commercial medical plan.

The patient is reported by their medical insurance as of the last visit in the calendar year, so this patient is reported as privately insured on Line 11 of Table 4.

Remember that the determining factor is not where reimbursement for the last visit of the year comes from, but what medical insurance the patient has at the time of that last visit.

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Managed Care

Table 4, Lines 13a–13c

Report **total member months** for individuals assigned to the health center by managed care plan(s).

Each month that someone is **assigned to the health center** by a managed care plan is one member month.

Only report medical or comprehensive managed care that includes medical care; don't report member months for non-medical plans.

There are two types of managed care: **Capitated** (Line 13a) and **Fee-for-Service (FFS)** (Line 13b)

Capitated managed care plans pay a flat fee per member per month for a negotiated set of services. Sometimes other services are paid FFS.

FFS managed care plans pay per service rendered for assigned patients.

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Managed Care: Keys to Remember

Managed care organizations (MCOs) may have multiple plans.
An MCO may have Medicaid plans, Medicare plans, and/or other plans. Patients must be reported by the correct type of plan.

Health centers often need to actively collect these lists monthly from payers.

Compare with patients by insurance elsewhere on Table 4.
Member months generally correspond with insurance in a reasonable way. For example, if a health center has a very small Medicare population, generally there are not huge Medicare member months.

Compare with charges and revenue on Table 9D.
Look for reasonable relationships. If member months are low as an estimated portion of patients here, generally managed care revenue on Table 9D would be low as a portion of total revenue.

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Table 4: Selected Patient Characteristics

Special Medically Underserved Populations

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

[1]Residents of public housing refers to patients who are served at a health center located in or immediately accessible to a public housing site.

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Special Medically Underserved Populations

All health centers report the following lines to the extent that there are health center patients who meet the definitions:

- **Line 16:** Total Migratory and Seasonal Agricultural Workers or Their Family Members
- **Line 23:** Total Homeless Population
- **Line 24:** Total School-Based Service Site Patients
- **Line 25:** Total Veterans
- **Line 26:** Total Residents of Public Housing

Lines 16, 23, and 25 are **patient-identified**.
Lines 24 and 26 are **site-based**.

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Special Medically Underserved Populations

Award-Specific Lines: Migratory and Seasonal Agricultural Worker (MSAW) Awardees (330g)

Health centers with an **MSAW award** report greater detail on the patients served by this grant:

- **Line 14:** Migratory Agricultural Workers or Their Family Members
  - Principal employment is in agriculture and establish a temporary home for that work.
- **Line 15:** Seasonal Agricultural Workers or Their Family Members
  - Principal employment is in agriculture on a seasonal basis and do not establish a temporary home for that work.

Include **health center patients** seen during the year who…

- Had such work as their principal employment within 24 months of their last visit in the calendar year
- Are aged or disabled out of such employment
- Are family members of either of the above

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Special Medically Underserved Populations

Award-Specific Lines: Homeless Population (HP) Awardees (330h)

Health centers with an **HP award** report greater detail on the patients served by this grant on the following lines:

- Shelter, Line 17
- Transitional Housing, Line 18
- Doubled Up, Line 19
- Street, Line 20
- Permanent Supportive Housing, Line 21a
- Other, Line 21
- Unknown, Line 22

Detailed descriptions of each begin on Page 45 of the 2025 UDS Manual.

- For HP awardees, the sum of Lines 17 through 22 = Line 23.
- Report housing arrangement as of the **first visit** of the calendar year.
- Include patients who, at any point that they were seen during the calendar year, experienced homelessness in the prior 12 months.

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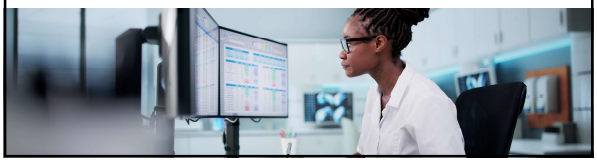
Key Resources to Assist with Reporting Patient Characteristics

1. Pages 23–52 of the 2025 UDS Manual
2. UDS Reporting Webinars: Understanding UDS Patient Characteristics Tables for Quality Improvement, Sept. 23, 2025
3. Patient Characteristics resources on the UDS Technical Assistance site
4. UDS Support Center: 866-UDS-HELP or udshelp330@bphcdata.net

Tables 5, 6A, 6B, and 7

Understanding Services Provided and Their Outcomes



Overview of Clinical Services and Clinical Quality Indicators

1. **Table 5:** Full-time equivalents (FTEs) across 11 service categories, visits and patients across 7 service categories, and integrated mental health (MH) and substance use disorder (SUD)
2. **Table 6A:** Visits and patients who received selected diagnoses and selected services in the calendar year
3. **Table 6B:** Prenatal care and 16 clinical quality measures (primarily process measures)
4. **Table 7:** Three clinical quality outcome measures, each reported by race and ethnicity of patients

Table 5:
FTEs, Visits, and Patients

Uniform Data System

Table 5: Staffing and Utilization Lines 1–22

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1	Family Physicians				
2	General Practitioners				
3	Internists				
4	Obstetrician/Gynecologists				
5	Pediatricians				
7	Other Specialty Physicians				
8	**Total Physicians** (Lines 1–7)				
9a	Nurse Practitioners				
9b	Physician Assistants				
10	Certified Nurse Midwives				
10a	**Total NPs, PAs, and CNMs** (Lines 9a–10)				
11	Nurses				
12	Other Medical Personnel				
13	Laboratory Personnel				
14	X-ray Personnel				
15	**Total Medical Care Services** (Lines 8 + 10a through 14)				
16	Dentists				
17	Dental Hygienists				
17a	Dental Therapists				
18	Other Dental Personnel				
19	**Total Dental Services** (Lines 16–18)				
20a	Psychiatrists				
20a1	Licensed Clinical Psychologists				
20a2	Licensed Clinical Social Workers				
20b	Other Licensed Mental Health Providers				
20c	Other Mental Health Personnel				
20	**Total Mental Health Services** (Lines 20a–c)				
21	**Substance Use Disorder Services**				
22	**Other Professional Services** • Audiologists • Chiropractors • Community and Behavioral Health Aides/Practitioners (CHAPs and BHAPs) • Podiatrists • Registered Dieticians, including Dieticians and Nutritionists • Therapists, including Massage, Occupational, Physical, Respiratory, and Speech Therapists and Speech Pathologists • Traditional Medicine Providers, including Acupuncturists and Naturopaths • Other professional services (specify:)				

Table 5: Staffing and Utilization Lines 22–34

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
22a	Ophthalmologists				
22b	Optometrists				
22c	Other Vision Care Personnel				
22d	**Total Vision Services** (Lines 22a–c)				
23a	Pharmacists				
23b	Clinical Pharmacists				
23c	Pharmacist Technicians				
23d	Other Pharmacy Personnel				
23	**Pharmacy Personnel** (Lines 23a–d)				
24	Case Managers				
25	Health Education Specialists				
26	Outreach Workers				
27	Transportation Personnel				
27a	Eligibility Assistance Workers				
27b	Interpretation Personnel				
27c	Community Health Workers				
28	Other Enabling Services (specify:)				
29	**Total Enabling Services** (Lines 24–28)				
29a	**Other Programs and Services** Personnel for these programs: • Adult, elderly, and youth programs, such as ADRC, child care, PACE • Basic needs, such as shelters/housing, food, and clothing • Employment, vocational, AmeriCorps or other job training programs • Fitness or exercise programs • Head Start or Healthy Start • Public/Retail pharmacies • Research • Support group services • WIC • Other programs and services (specify:)				
29b	**Quality Improvement Personnel**				
30a	Management and Support Personnel				
30b	Fiscal and Billing Personnel				
30c	IT Personnel				
31	Facility Personnel				
32	Patient Support Personnel				
33	**Total Facility and Non-Clinical Support Personnel** (Lines 30a–32)				
34	**Grand Total** (Lines 15+19+20+21+22+23+29+29a+29b+33)				

Understanding the Service Categories

Table 5

FTEs, visits, and patients on Table 5 are reported across categories that reflect function and services provided.

- Medical Care Services (Lines 1–15)
- Dental Services (Lines 16–19)
- Mental Health Services (Lines 20a–20c)
- Substance Use Disorder Services (Line 21)
- Other Professional Health Services (Line 22)
- Vision Services (Lines 22a–22d)
- Pharmacy Services (Line 23a–23d)
- Enabling Services (Lines 24–29)
- Other Programs and Services (Line 29a)
- Quality Improvement Personnel (Line 29b)
- Non-Clinical Support Services (Lines 30a–32)

- FTEs are reported in each service category for which your health center has services.
- Service categories that can have providers and therefore generate **countable visits and patients** are:
  - Medical
  - Dental
  - MH
  - SUD
  - Other Professional
  - Vision
  - Enabling
- Patients can have visits in one or more service categories in the year.

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Service Categories That *Can* Have Countable Visits

Examples of Some Provider Types in Each

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

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

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

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

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

Enabling (Lines 24–29): Case Managers, Health Education Specialists

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

Service Categories That Do *Not* Have Countable Visits

Examples of Personnel FTEs in Each

Pharmacy (Lines 23a–23d)

Pharmacists, Clinical Pharmacists, Pharmacy Techs

Other Programs and Services (Line 29a)

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

Quality Improvement (Line 29b)

Quality Improvement (QI), Data Analysts, Business Intelligence, Data Services

Non-Clinical Support (Lines 30a–32)

Management, Finance, Billing, IT, Front Desk, Call Center

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Four Columns of Table 5

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

Column B: Clinic Visits
The number of in-person countable visits for each personnel category during the calendar year

Column B2: Virtual Visits
The number of virtual countable visits for each personnel category during the calendar year

Column C: Patients
The number of patients for whom visits are reported in the given service area

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Updates and Clarifications to Table 5 Instructions

Clarification
Refined instructions on how to report personnel with multiple roles.
Updated FAQ #8 to clarify how to report behavioral health providers who provide both MH and SUD services.
Added note clarifying that if a medical provider (for example, PA) **exclusively** provides another service (e.g., SUD or mental health treatment), does not provide medical care as part of their position, and has board certification or **certification** of added qualification in the specific service area, report them in the respective category of service they provide.
Outlined common roles for Other Professional (Line 22) and Other Programs and Services (Line 29a) in more detail in the instructions and on the table.
Added example CPT codes for identifying virtual visits.
Added a note clarifying that "A visit does not need to be billable to be counted on the UDS Report. Countable visits can include services for which there is no charge or that are funded by grants, as long as they meet the countable visit definition."

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UDS Uniform Data System

Reporting Personnel on Table 5

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

Report all personnel in terms of annualized FTEs.

Reporting Personnel FTEs

Table 5

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

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

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

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

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

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

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Where Do These Personnel Go on Table 5?

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

This nurse's FTE is reported in Column A, on either NURSE (Line 11), if part of the medical team, OR on CASE MANAGER (Line 24) if they do this for an assigned group of patients such as patients with high risk scores or diabetic patients.
These services do *not* meet the definition of countable visits, so there are no related visits reported on Table 5.

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

This staff person's FTE is reported on OUTREACH, Line 26, Column A.
This is *not* a provider line, so there are no related visits reported on Table 5.

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

This contracted personnel's FTE is reported on Eligibility Assistance, Line 27a in Column A, based on hours paid. This is *not* a provider line, so there are no related visits reported on Table 5.

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Calculating FTEs for Column A

Employees with full benefits

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

Calculate base hours for full-time:

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

Calculate this staff person's paid hours:

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

Calculate FTE for this person:

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

Employees with no or reduced benefits

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

Calculate base hours for full-time:

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

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

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

2,080 – 336 = 1,744

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

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

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IMPORTANT KEY:
FTE and visit reporting on Table 5 ties closely to costs on Table 8A.

Excerpt of Table 5

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

Excerpt of Table 8A

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

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UDS Uniform Data System

Reporting Visits on Table 5

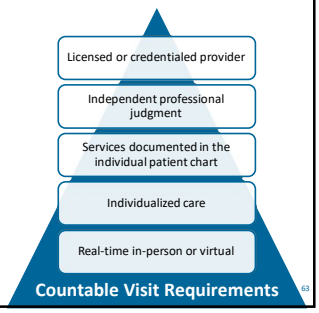
A visit is a documented contact between an individual and a licensed or credentialed provider who exercises their independent, professional judgment in the provision of services to that individual, either virtually or in person.

This definition of visits determines who to count as a patient here on Table 5 and on all other tables that include health center patients.

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

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

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



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Reporting Visits

Table 5

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

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Differentiating Column B and B2

Clinic Visits (Column B)

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

Virtual Visits (Column B2)

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

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

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

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Guidance for Multiple Visits in One Day

1. On any given day, a patient may have only one visit per service category per provider counted on the UDS.
   - Remember, service categories that have countable visits are Medical, Dental, MH, SUD, Other Professional, Vision, and Enabling.
2. If multiple providers in a single service category (e.g., two medical providers) deliver multiple services at the *same location* on a single day, count only one visit.
3. If services are provided by *two different providers* located at *two different sites* on the same day, count two visits.
   - A virtual visit and a clinic visit are considered to be two different sites and may both be counted as visits, even when they occur on the same day.

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Contacts That Do Not, Alone, Count as Visits

Screenings or Outreach	Group Visits	Tests/Ancillary Services	Dispensing/ Administering Medications	Health Status Checks
Information sessions for prospective patients	Patient education classes	Drawing blood	Dispensing medications from a pharmacy	Follow-up tests or checks (e.g., patients returning for HbA1c tests)
Health presentations to community groups	Health education classes	Laboratory	Giving injections	Wound care
Immunization drives	*Exception: behavioral health group visits*	Imaging	Providing narcotic agonists or antagonists or a mix	Taking health histories

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Reporting Patients on Table 5

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

Only those who meet this definition are reported on Table 5, and then only those in Column C of Table 5 are reported on the demographic tables and clinical tables.

Counting Patients in Column C

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

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

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

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

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Table 5:
Selected Service Detail Addendum

UDS Uniform Data System

Table 5: Staffing and Utilization
Selected Service Detail Addendum

Line	Personnel by Major Service Category: Mental Health Service Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
20a01	Physicians (other than Psychiatrists)				
20a02	Nurse Practitioners				
20a03	Physician Assistants				
20a04	Certified Nurse Midwives				
Line	**Personnel by Major Service Category: Substance Use Disorder Detail**	**Personnel (a1)**	**Clinic Visits (b)**	**Virtual Visits (b2)**	**Patients (c)**
21a	Physicians (other than Psychiatrists)				
21b	Nurse Practitioners (Medical)				
21c	Physician Assistants				
21d	Certified Nurse Midwives				
21e	Psychiatrists				
21f	Licensed Clinical Psychologists				
21g	Licensed Clinical Social Workers				
21h	Other Licensed Mental Health Providers				

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Addendum Captures *Integrated Behavioral Health*

Lines 20a01–20a04

Integrated MH Services

Captures the number of **medical visits** that *included* **MH** services within the medical visit.

Lines 21a–21h

Integrated SUD Services

Captures the number of **medical and MH visits** that *included* **SUD services** provided within medical or MH visits.

*Remember, everything on the Addendum is part of what is **already reported elsewhere** on Table 5 representing behavioral health care integrated into certain types of visits.*

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Reporting MH/SUD Services Provided in Medical Visits

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)
1	Family Physicians			
2	General Practitioners			
3	Internists			
4	Obstetrician/Gynecologists			
5	Pediatricians			
7	Other Specialty Physicians			
8	**Total Physicians** (Lines 1–7)			
9a	Nurse Practitioners			
9b	Physician Assistants			
10	Certified Nurse Midwives			
10a	**Total NPs, PAs, and CNMs** (Lines 9a–10)			

Line	Personnel by Major Service Category: Mental Health Service Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)
20a01	Physicians (other than Psychiatrists)			
20a02	Nurse Practitioners			
20a03	Physician Assistants			
20a04	Certified Nurse Midwives			

Line	Personnel by Major Service Category: Substance Use Disorder Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)
21a	Physicians (other than Psychiatrists)			
21b	Nurse Practitioners (Medical)			
21c	Physician Assistants			
21d	Certified Nurse Midwives			

Medical FTEs, visits, and patients are reported in the medical section of the main part of Table 5 (shown above left). Those same providers, visits, and patients ***may also*** be reported on the MH/SUD addendum ***if/when*** MH and/or SUD services were provided during those medical visits (shown above right).

The example of physicians and certified nurse midwives are highlighted, but the same is true for the other medical provider types (NPs and PAs).

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Reporting Personnel in Addendum

In Column A1 of the **Addendum of Table 5**, report the ***number*** of providers in each section who provided integrated services.

- **Medical** providers can be counted once in each section of the addendum, if they provide both **MH *and* SUD services**.
- **MH** providers can be counted only once in the addendum, in the **SUD section of the addendum**.
- **The number of** *personnel* on the addendum is *unlikely* to equal the FTE reported in the corresponding line on the main part of Table 5.
  - Look at the number of personnel per FTE for reasonableness. For example, if there are 11.5 physician FTEs on the main part of Table 5 and 119 physician personnel in the MH section of the addendum, then the average FTE per physician is *less than 0.1*.

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Identifying Services to Include in Addendum

Include, at minimum, all countable visits with specified providers that included the ICD-10-CM codes specified on Table 6A:

- SUD: Table 6A, Lines 18–19a
- MH: Table 6A, Lines 20a–20d

Then, you will report the **number of providers of each type** listed on the addendum that provided those visits and the number of **patients who made up those visits**.

Line	Diagnostic Category	Applicable ICD-10-CM Code or Value Set Object Identifier (OID)
	Selected Mental Health Conditions, Substance Use Disorders, and Exploitations	
18	Alcohol-related disorders	**ICD-10:** F10-, G62.1, K70-, O99.31-
19	Other substance-related disorders (excluding tobacco use disorders)	**ICD-10:** F11- through F19- (exclude F17-), G62.0, O99.32-
19a	Tobacco use disorder	**ICD-10:** F17-, O99.33-, Z72.0
20a	Depression and other mood disorders	**ICD-10:** F30- through F39-
20b	Anxiety disorders, including post-traumatic stress disorder (PTSD)	**ICD-10:** F06.4, F40- through F42-, F43.0, F43.1-, F43.8-, F93.0
20c	Attention deficit and disruptive behavior disorders	**ICD-10:** F90- through F91-
20d	Other mental disorders, excluding drug or alcohol dependence	**ICD-10:** F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0- and F43.1-), F50- through F99- (exclude F55-, F84.2, F90-, F91-, F93.0, F98-), O99.34-, R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0

Excerpt of Table 6A

Visits reported on Lines 18–19a that were with **medical** or **MH** providers are reported on the SUD detail section of the Table 5 addendum.

Visits reported on Lines 20a–20d that were with **medical providers** are reported on the MH detail section of the Table 5 selected service addendum.

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SUD Treatment Provided in MH Visits to Report on Addendum

MH FTEs, visits, and patients are reported on Lines 20a–20b of the main part of Table 5. These MH personnel, visits, and patients **may also** be reported on the addendum ***if/when*** they also included SUD services.

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
20a	Psychiatrists				
20a1	Licensed Clinical Psychologists				
20a2	Licensed Clinical Social Workers				
20b	Other Licensed Mental Health Providers				
20c	Other Mental Health Personnel				
20	**Total Mental Health Services** (Lines 20a–c)				
21	**Substance Use Disorder Services**				

Line	Personnel by Major Service Category: Substance Use Disorder Detail	Persons el (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
21a	Physicians (other than Psychiatrists)				
21b	Nurse Practitioners (Medical)				
21c	Physician Assistants				
21d	Certified Nurse Midwives				
21e	Psychiatrists				
21f	Licensed Clinical Psychologists				
21g	Licensed Clinical Social Workers				
21h	Other Licensed Mental Health Providers				

Line 21 in the main part of Table 5 fully captures **SUD FTEs, visits, and patients. These personnel, visits, and patients are *not* repeated in the addendum.**

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Clarification for Common Challenges

MH visits are on **Table 5** (Line 20, Column B + Column B2 plus Lines 20a01 through 20a04, Column B + Column B2)

Visits with MH diagnoses are on **Table 6A**, Lines 20a–20d, Column A.

Important relationship between these two: if there are diagnoses on Table 6A, there must be related visits somewhere on Table 5!

SUD visits are on **Table 5** (Line 21, Column B + Column B2 plus Line 21a–21h, Column B + Column B2)

Visits with SUD diagnoses are on **Table 6A**, Lines 18–19a, Column A

It is possible (though rare) to have SUD visits on Line 21 without SUD diagnoses on Table 6A, but there cannot be SUD on the Addendum without diagnoses on Table 6A.

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Remember, no visits reported in the MH service area of Table 5 are repeated in the MH portion of the addendum.

Similarly, no SUD visits reported on Line 21 are repeated in the SUD section of the addendum.

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Example:
Integrated MH in a Medical Visit

A family physician sees a patient in person with a diagnosis of depression and manages the patient's depression medication during the medical visit.

This visit is counted twice across the two sections in Table 5: *once* in the medical section of the main part of Table 5 and *once* in the MH portion of the addendum.

Table 5, Staffing and Utilization: The family physician FTE is reported in Line 1, Column A of Table 5. The visit is reported on Line 1, Column B.

Table 5, Selected Service Detail Addendum, MH Service Detail: Due to the integrated behavioral health, the family physician is *also* counted as one personnel in Line 20a01, Column A1, and the visit is *also* counted in Line 20a01, Column B.

In no case is a visit to be reported twice on the main part of Table 5. The visit and patient need to also be reported on the relevant lines in Table 6A.

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Example:
Integrated MH and SUD in a Medical Visit

An NP sees a patient for a routine visit and during that visit addresses the patient's anxiety diagnosis and tobacco use disorder.

This visit is counted three times across the two sections in Table 5: *once* in the medical section of the main part of Table 5, *once* in the MH portion of the addendum, and *once* in the SUD portion of the addendum.

Table 5, Staffing and Utilization: The NP FTE is reported in Line 9a, Column A of the main part of Table 5. The visit is reported on Line 9a, Column B, and the patient is included in Line 15, Column C.

Table 5, Selected Service Detail Addendum: Due to the integrated MH and SUD treatment, the provider, patient, and visit are reported on both the NP line of the MH portion of the addendum and the NP line of the SUD portion of the addendum.

In no case is a visit to be reported twice on the main part of Table 5. The visit and patient need to also be reported on the relevant lines in Table 6A.

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Example:
Integrated SUD in MH Visit

A licensed clinical psychologist sees a patient via telehealth for depression complicated by an alcohol-related disorder.

This visit is counted twice across the two sections in Table 5: *once* in the MH section of the main part of Table 5 and *once* in the SUD portion of the addendum.

Table 5, Staffing and Utilization: Report the depression treatment services visit and clinical psychologist FTE on Line 20a1, and report the patient in the total on Line 20. The visit would be in Column B2, because it's a virtual visit.

Table 5, Selected Service Detail Addendum, SUD Service Detail: Due to the integrated SUD services, report the alcohol-related treatment provided by the clinical psychologist (personnel, visit, and patient) on Line 21f. The visit would be in Column B2, because it's a virtual visit.

In no case is a visit to be reported twice on the main part of Table 5. The visit and patient need to also be reported on the relevant lines in Table 6A.

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Table 6A:
Selected Diagnoses and Services Rendered

Uniform Data System

Table 6A: Selected Diagnoses and Services Rendered
Example Diagnoses: Lines 7–14a

Line	Diagnostic Category	Applicable ICD-10-CM Code or Value Set Object Identifier (OID)	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
	Selected Other Medical Conditions			
7	Abnormal breast findings, female	**ICD-10:** C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.81, D05-, D24-, D48.6-, D49.3, N60- through N65-, R92-		
8	Abnormal cervical findings	**ICD-10:** C53-, C79.82, D06-, N87.0, N87.1, N87.9, R87.61- (exclude R87.615 and R87.616), R87.629, R87.810, R87.820		
9	Diabetes mellitus	**ICD-10:** E08- through E13-, O24- (exclude O24.4) **OID:** 2.16.840.1.113762.1.4.1219.35		
10	Heart disease (selected)	**ICD-10:** I01-, I02- (exclude I02.9), I20- through I25-, I27-, I28-, I30- through I52-, Q24-		
11	Hypertension	**ICD-10:** I10- through I16-, O10-, O11- **OID:** 2.16.840.1.113762.1.4.1222.1547 (includes all codes other than O11-)		
12	Contact dermatitis and other eczema	**ICD-10:** I80.13-, L20.89, L23- through L25-, L30- (exclude L30.1, L30.3, L30.4, L30.5)		
13	Dehydration	**ICD-10:** E86-		
14	Exposure to heat or cold	**ICD-10:** T33-, T34-, T67-, T68-, T69-, W92-, W93-, X30-, X31-, X32-		
14a	Overweight and obesity	**ICD-10:** E66-, Z68- (exclude Z68.1, Z68.20 through Z68.24, Z68.51, Z68.52) **OID:** 2.16.840.1.113762.1.4.1222.35 (includes all E66- codes except E66.3)		

Table 6A: Selected Diagnoses and Services Rendered
Example Services Rendered: Lines 21–24

Line	Service Category	Applicable ICD-10-CM, CPT-4/EPLA, or HCPCS Code	Number of Visits (a)	Number of Patients (b)
	Selected Diagnostic Tests/Screening/Preventive Services			
21	HIV test	**CPT-4:** 86689, 86701 through 86703, 87389 through 87391, 87534 through 87539, 87806 **HCPCS:** G0432 through G0435, G0475 **OID:** 2.16.840.1.113762.1.4.1056.50		
21a	Hepatitis B test	**CPT-4:** 80074, 86704 through 86707, 87340, 87341, 87350, 87467, 87912 **HCPCS:** G0499		
21b	Hepatitis C test	**CPT-4:** 80074, 86803, 86804, 87520 through 87522, 87902 **HCPCS:** G0472		
21c	Novel coronavirus (SARS-CoV-2) diagnostic test	**CPT-4:** 87426, 87428, 87635, 87636, 87637, 87811 **HCPCS:** U0001, U0002 **CPT PLA:** 0202U, 0223U, 0225U, 0240U, 0241U		
21d	Novel coronavirus (SARS-CoV-2) antibody test	**ICD-10:** Z01.84 **CPT-4:** 86318, 86328, 86408, 86409, 86413, 86769 **CPT PLA:** 0224U, 0226U		
21e	Pre-Exposure Prophylaxis (PrEP)-associated prescribing and management	**ICD-10:** Z29.81		
22	Mammogram	**ICD-10:** Z12.31 **CPT-4:** 77061, 77062, 77063, 77065, 77066, 77067 **HCPCS:** G0279		
23	Pap test	**ICD-10:** R87.619, R87.629, Z01.41-, Z01.42, Z12.4 (exclude Z01.411 and Z01.419) **CPT-4:** 88141 through 88153, 88155, 88164 through 88167, 88174, 88175 **HCPCS:** G0123, G0143, G0144, G0145, G0147, G0148, P3000		
24	Selected immunizations: hepatitis A; haemophilus influenzae B (HiB); pneumococcal, diphtheria, tetanus, pertussis (DTaP) (DTP) (DT); measles, mumps, rubella (MMR); poliovirus; varicella; hepatitis B	**CPT-4:** 90371, 90389, 90396, 90632, 90633, 90634, 90636, 90644, 90645, 90646, 90647, 90648, 90669, 90670, 90671, 90677, 90684, 90696, 90698, 90700, 90701, 90702, 90703, 90704, 90705, 90706, 90707, 90708, 90710, 90712, 90713, 90714, 90715, 90716, 90720, 90721, 90723, 90730, 90731, 90732, 90739, 90740, 90743, 90744, 90745, 90746, 90747, 90748, 90759		

Table 6A

Captures selected **diagnoses and services provided to health center patients** (those reported on patient demographic tables), not to the general public.

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

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

- Diagnoses are Lines 1 through 20f.

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

- Services and procedures are Lines 21 through 34.

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Key Notes for Table 6A

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

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

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

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Three New Measures

Line 26c2: Tobacco use cessation pharmacotherapies
OID: 2.16.840.1.113883.3.526.3.1190

Column A = Number of visits at which the above tobacco use cessation services were provided and coded in alignment with the value set provided.

Column B = Number of patients who had one or more visits reported in Column A for this line.

Line 26c3: Medications for opioid use disorder (MOUD)
OID: 2.16.840.1.113762.1.4.1046.269

Column A = Number of visits at which the above MOUD services were provided and coded in alignment with the value set provided.

Column B = Number of patients who had one or more visits reported in Column A for this line.

Line 26f: Alzheimer's disease and related dementias (ADRD) screening
CPT-4: 99483
OID: 2.16.840.1.113883.3.526.3.1006

Column A = Number of visits at which the above ADRD screenings were provided and coded in alignment with the CPT or value set provided.

Column B = Number of patients who had one or more visits reported in Column A for this line.

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Cross-Table Relationships and Clarifications

For the Three New Measures

Line 26c2

Tobacco use cessation pharmacotherapies

Reporting in Column A and Column B of this line is a subset of the same column on Line 26c, Smoke and tobacco use cessation counseling.

This means that a cell on Line 26c2 cannot be larger than the same cell on Line 26c. `

Line 26c3

Medications for opioid use disorder (MOUD)

The number of patients reported on Column B of Line 26c3 of Table 6A, Medications for opioid use disorder (MOUD), **equals** the number of patients reported as receiving **MOUD on Question 1b on Appendix E: Other Data Elements**. The criteria for the two elements are the same, so the same number is reported in both places.

Line 26f

Alzheimer's disease and related dementias (ADRD) screening

Resources for this screening:

- National Institutes of Health resources for professionals
- HRSA BHW training modules

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Other Table 6A Updates

Annual Code Update

Applicable ICD-10-CM Codes, Value Set Object Identifiers (OIDs), CPT-4, and HCPCS codes have been updated for 2025. Be sure you have the July 10 version of the 2025 UDS Manual!

New FAQ for Line 26e

Report on patients in the age range specified in the Early Childhood Development Notice of Funding Opportunity who had childhood development screenings and evaluations using the listed ICD-10 or CPT-4 codes.

Line 21e

This line's label has been updated to Pre-Exposure Prophylaxis (PrEP)-associated prescribing and management. The intent of the line has not changed, just the label!

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

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

Tables 6B and 7:
Quality of Care Measures

UDS Uniform Data System

Table 6B: Quality of Care Measures
Example: Lines 13, 14a, and 17a

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

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

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

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Table 7: Health Outcomes
Section A: Deliveries and Birth Weight (1)

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

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Table 7: Health Outcomes
Example: Section B: Controlling High Blood Pressure

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

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Table 7: Health Outcomes
Example: Section C: Diabetes: Glycemic Status Assessment Greater Than 9%

Line	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (2a)	Number of Records Reviewed (2b)	Patients with Glycemic Status Assessment >9%, Missing, or No Test During Year (2f)
	Mexican, Mexican American, Chicano/a			
1a1m	Asian Indian			
1a2m	Chinese			
1a3m	Filipino			
1a4m	Japanese			
1a5m	Korean			
1a6m	Vietnamese			
1a7m	Other Asian			
1b1m	Native Hawaiian			
1b2m	Other Pacific Islander			
1b3m	Guamanian or Chamorro			
1b4m	Samoan			
1cm	Black or African American			
1dm	American Indian/Alaska Native			
1em	White			
1fm	More than One Race			
1gm	Unreported/Chose Not to Disclose Race			
	Subtotal Mexican, Mexican American, Chicano/a			
	Puerto Rican			
1a1p	Asian Indian			
1a2p	Chinese			
1cp	Black or African American			
1dp	American Indian/Alaska Native			
1ep	White			
1fp	More than One Race			
1gp	Unreported/Chose Not to Disclose Race			
	Subtotal Puerto Rican			

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Understanding CQM Reporting

Tables 6B and 7 are both CQM tables.

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Key Information About CQMs

Tables 6B and 7

- Measures are defined centrally as electronic clinical quality measures (eCQMs).
- eCQMs are standardized measures that are designed to use data from electronic health record (EHR) and other health IT systems for reporting.
- UDS clinical quality measures align with eCQMs wherever possible.

- eCQMs are updated annually, nationwide. For most measures, 2025 is v13.
- UDS measures that are eCQMs align with the annual updates.
- Those annual updates sometimes have impact on reporting.

- There is one eCQM newly required on the UDS this year: Initiation and Engagement of Substance Use Disorder Treatment (CMS137v13).
- This measure is reported as two CQMs.

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Components of Each Clinical Measure

Tables 6B and 7

DENOMINATOR

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

NUMERATOR

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

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

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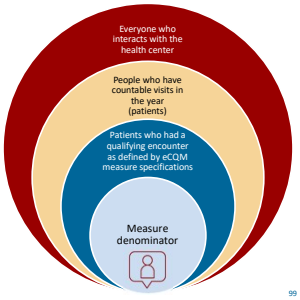
What Is Reported in the Denominator of Each Measure?

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



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Eligibility for Each CQM

For someone to be included in a measure denominator…

1. They must have a Countable Visit on Table 5.

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

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

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

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

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New CQM on Table 6B

Initiation and Engagement of Substance Use Disorder Treatment (CMS137v13), reported on Lines 23a and 23b of Table 6B.

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Table 6B: New Measure

Initiation and Engagement of Substance Use Disorder Treatment (CMS137v13)

This measure will be reported across two new lines on Table 6B:

- Line 23a: Patients with a new SUD episode who **initiated treatment**.
- Line 23b: Patients with a new SUD episode who **engaged in ongoing treatment**.

Line	Initiation and Engagement of Substance Use Disorder (SUD) Treatment	Total Patients Aged 13 and Older Diagnosed with a New SUD Episode (a)	Number of Records Reviewed (b)	Number of Patients who Received SUD Treatment (c)
23a	MEASURE: Percentage of patients with a new SUD episode who **initiated treatment**, including either an intervention or medication for the treatment of SUD, within 14 days of the new SUD episode			
23b	MEASURE: Percentage of patients with a new SUD episode who **engaged in ongoing treatment**, including two additional interventions or medication treatment events for SUD, or one long-acting medication event for the treatment of SUD, within 34 days of the initiation			

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Initiation and Engagement of Substance Use Disorder Treatment (CMS137v13)

Denominator (same for Column A of both Lines 23a and 23b): Patients 13 years of age and older as of the start of the measurement period who were diagnosed with a new SUD episode during a visit between Jan. 1 and Nov. 14 of the measurement period (calendar year).

Numerator 1 (Line 23a, Column C): Initiation of Treatment: Includes either an intervention or medication for the treatment of SUD within 14 days of the new SUD episode.

Numerator 2 (Line 23b, Column C): Engagement in ongoing SUD treatment within 34 days of initiation:
Includes either
- A long-acting SUD medication on the day after the initiation through 34 days after the initiation of treatment, *or*
- One of the following options on the day after the initiation of treatment through 34 days after the initiation of treatment: a) two engagement visits, b) two engagement medication treatment events, or c) one engagement visit and one engagement medication treatment event.

A patient *must* first meet the criteria for Numerator 1 (Initiation) to be considered for Numerator 2 (Engagement).

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Example of Patient in Initiation and Engagement of Substance Use Disorder Treatment Measure

Patient Name: Sarah Chen **Date of Birth:** April 15, 1998 (Age 27 at the start of the measurement period)
Measurement Period: January 1, 2025–December 31, 2025

On March 5, 2025, Sarah Chen, who is 27 years old, presents to her primary care provider with symptoms consistent with opioid use disorder (OUD). After a thorough assessment, she is diagnosed with a new episode of OUD.

This diagnosis falls within the January 1 to November 14 window of the measurement period. **With this, she is in the denominator (Column A).**

On March 12, 2025 (7 days after diagnosis, within the 14-day window), Sarah has a follow-up appointment where she is prescribed buprenorphine, a U.S. Food and Drug Administration (FDA)-approved medication for OUD and receives her first dose.

This constitutes the initiation of medication treatment for her SUD. **With this, she is in numerator 1, Column C on Line 23a.**

In the 34-day period following initiation on March 12, 2025, Sarah has the following:

Mar. 20, 2025: Sarah attends an individual counseling session with an SUD therapist (Engagement Visit 1).

Apr. 5, 2025: Sarah has a follow-up telehealth visit with her prescribing physician to discuss her medication and progress, and her buprenorphine prescription is refilled (Engagement Medication Treatment Event 1).

With these two engagement visits within 34 days of initiation, she is in Numerator 2, Column C on Line 23b.

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Updates to Existing CQMs

Tables 6B and 7, both CQM tables, have clinical measure updates.

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Table 6B: Update to Existing Measure

Breast Cancer Screening (CMS125v13)

The Breast Cancer Screening measure includes revised denominator exclusion language for the advanced illness criteria.

2024 Denominator Exclusions	2025 Denominator Exclusions
Exclude patients 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria: • Advanced illness with two outpatient encounters during the measurement period or the year prior • OR advanced illness with one inpatient encounter during the measurement period or the year prior • OR taking dementia medications during the measurement period or the year prior	Exclude patients 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria: • Advanced illness **diagnosis** during the measurement period or the year prior • OR taking dementia medications during the measurement period or the year prior

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Table 6B: Update to Existing Measure

Body Mass Index (BMI) Screening and Follow-Up Plan (CMS69v13)

Updates clarify the timing of documentation of exception criteria.

2024 Guidance	2025 Guidance
This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided at the time of the qualifying encounter and the measure-specific denominator coding.	This measure may be reported by eligible **clinicians** who perform the quality actions described in the measure based on the services provided at the time of the qualifying encounter **or during the measurement period** and the measure-specific denominator coding.
Not applicable	**If a patient meets exception criteria for the denominator (i.e., the patient refuses height or weight measurement or has a documented medical reason for not documenting BMI or a follow-up plan), an eligible clinician must document those criteria on the same day as the qualifying encounter.**

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Table 6B: Update to Existing Measure

Colorectal Cancer Screening (CMS130v13)

The Colorectal Cancer Screening measure includes revised denominator exclusion language for the advanced illness criteria.

2024 Denominator Exclusions	2025 Denominator Exclusions
Exclude patients 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria: • Advanced illness with two outpatient encounters during the measurement period or the year prior • OR advanced illness with one inpatient encounter during the measurement period or the year prior • OR taking dementia medications during the measurement period or the year prior	Exclude patients 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria: • Advanced illness **diagnosis** during the measurement period or the year prior • OR taking dementia medications during the measurement period or the year prior

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Table 6B: Update to Existing Measure

Screening for Depression and Follow-Up Plan (CMS2v14)

The guidance statement has been updated to reflect the calendar year (CY) 2024 removal of the denominator exclusion for prior diagnosis of depression.

2024 Guidance	2025 Guidance
The intent of the measure is to screen for new cases of depression in patients who have never had a diagnosis of bipolar disorder. Patients who have ever been diagnosed with bipolar disorder prior to the qualifying encounter used to evaluate the numerator will be excluded from the measure regardless of whether the diagnosis is active or not.	The intent of the measure is to **screen all patients for depression** except those with a diagnosis of bipolar disorder. Patients who have ever been diagnosed with bipolar disorder prior to the qualifying encounter will be excluded from the measure regardless of whether the diagnosis is active or not.

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Table 7: Update to Existing Measure

Controlling High Blood Pressure (CMS165v13)

The Controlling High Blood Pressure measure includes revised denominator exclusion language for the advanced illness criteria.

2024 Denominator Exclusions	2025 Denominator Exclusions
Exclude patients 66–80 by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria: • Advanced illness with two outpatient encounters during the measurement period or the year prior • OR advanced illness with one inpatient encounter during the measurement period or the year prior	Exclude patients 66–80 by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria: • Advanced illness **diagnosis** during the measurement period or the year prior

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Table 7: Update to Existing Measure

Diabetes: Glycemic Status Assessment Greater than 9% (CMS122v13)

The Diabetes Glycemic Status Assessment measure includes revised denominator exclusion language for the advanced illness criteria. (It also has a new name!)

2024 Denominator Exclusions	2025 Denominator Exclusions
Exclude patients 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria: • Advanced illness with two outpatient encounters during the measurement period or the year prior • OR advanced illness with one inpatient encounter during the measurement period or the year prior	Exclude patients 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria: • Advanced illness **diagnosis** during the measurement period or the year prior

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Tables 6B and 7: Prenatal Care and Birth Outcome Measures

UDS Uniform Data System

Prenatal and Birth Outcome Measures

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

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

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

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Maternal Care: Prenatal & Birth Outcome Measures

Table 6B: Prenatal Care Patients	Table 7: Deliveries	Table 7: Birth Outcomes
Report all prenatal care women who received prenatal care services (either from the health center directly or its referral network) in the year by age as of Dec. 31 and by trimester of entry (based on last menstrual period or documented estimated date of delivery).	Report all prenatal care patients who delivered during the calendar year by race and ethnicity of the woman delivering. Include stillbirths and multiple births, each as one delivery. Miscarriages are not reported as deliveries.	Report babies according to their birth weight in grams by race and ethnicity of the baby. Multiple births are reported separately by birth weight of each baby. Stillbirths are not reported in the birth outcome section.

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Prenatal Care Reporting

Table 6B

Line 0

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

Lines 1–6

Report all prenatal care patients by their age as of Dec. 31, 2025 (not age when prenatal care began!). Note that patients may be included in prenatal counts two years in a row if their care crossed years; they would be reported as a different age in each.

Lines 7–9, Columns A and B

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

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Deliveries and Birth Outcomes

Table 7, Lines 0 and 2

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

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Deliveries and Birth Outcomes

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

Deliveries

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

Birth weights

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

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

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Key Resources to Assist with Reporting Staffing, Utilization, and Clinical Care

1. Pages 53–148 of the 2025 UDS Manual
2. UDS Reporting Webinars: Four webinars covering these tables in Oct. and Nov. 2025, archived on the Reporting Training page
3. Staffing and Utilization and Clinical Care resources on the UDS Training and Technical Assistance site
4. UDS Support Center: 866-UDS-HELP or udshelp330@bphcdata.net

Tables 8A, 9D, and 9E

Understanding Costs and Revenues within Health Center Scope

Overview of Financial Tables

1. **Table 8A:** Costs, both direct and overhead, incurred in the year for the health center scope of project.
2. **Table 9D:** Patient-related charges and adjustments from the calendar year; patient-related revenue received in the year.
3. **Table 9E:** Other revenue (non-patient-service generated) by the entity from which the revenue was received in the year.
4. Note that each of these have **important cross-table relationships**.

Table 8A: Financial Costs

Uniform Data System

Table 8A: Financial Costs

Lines 1–13

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 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			
6	Mental Health			
7	Substance Use Disorder			
8a	Pharmacy (not including pharmaceuticals)			
8b	Pharmaceuticals			
9	Other Professional (specify___)			
9a	Vision			
10	**Total Other Clinical Services** (Sum of Lines 5 through 9a)			
	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**			

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Table 8A: Financial Costs

Lines 14–19

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)
	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)			
17	**Total Accrued Costs** (Sum of Lines 4 + 10 + 13 + 16)			
18	Value of Donated Facilities, Services, and Supplies (specify___)			
19	**Total with Donations** (Sum of Lines 17 and 18)			

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Financial Costs

Financial costs are reported across 3 columns, in Columns A–C, and 11 cost centers, captured in Lines 1–15.

Cost Center (Lines 1–15)

Cost centers mirror the service categories on Table 5.

Accrued Cost (Column A)

Accrued direct costs, including cost of personnel, benefits, supplies, equipment, depreciation, etc.

Allocation of Facility and Non-Clinical Support Services (Column B)

Costs reported in Lines 14 + 15, Column A, are allocated as overhead to Lines 1–13 in Column B.

Total Cost (Column C)

Sum of Columns A + B; represents full cost to operate service area.

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Tables 5 and 8A Crosswalk

Critically important to complete these tables together!

Excerpt of Table 8A

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)	
	Financial Costs of Other Clinical Services	
5	Dental	
6	Mental Health	
7	Substance Use Disorder	
8a	Pharmacy (not including pharmaceuticals)	
8b	Pharmaceuticals	
9	Other Professional (specify___)	

Excerpt of Table 5

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

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Examples of Aligning Table 5 and Table 8A

A health center has an NP-led team that sees behavioral health patients, primarily those who have alcohol use disorder or OUD.

The health center decides to report these staff in the MH lines on Table 5; the costs for these staff need to be in the MH cost area on Table 8A.

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

The health center decided this nurse belongs on the Nurse line of Table 5 (Line 11) based on duties; the costs for this nurse must be reported on Line 1, Medical Personnel, on Table 8A.

A health center has a WIC and Healthy Start program, which are considered Other Programs and Services (meaning they are not directly a part of the health services).

Any staff are reported on Line 29a of Table 5; all costs (staff and otherwise) are on Line 12 of Table 8A.

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Costs by Cost Center

There Is a Single Line for Each Service Area/Cost Center

Lines 5–13 (excluding 8a–8b): Each line represents a single service area/cost center. In that line, report direct expenses including personnel (employed and contracted), benefits, contracted services, supplies, and equipment.

Clarifications as to what goes on the following lines:

- **Line 12:** Other Program-Related Services includes space within health center rented out, WIC, retail pharmacy to non-patients, etc.
- **Line 12a:** Personnel who support use of EHR and quality improvement

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Costs by Cost Center

There Is a Single Line for Each Service Area/Cost Center *Except the Following*:

Line 1: Medical personnel salary, wages, and benefits, including:

- Paid medical interns or residents
- Vouchered or contracted medical services

Line 2: Medical lab and X-ray direct expense

Line 3: Non-personnel medical expenses, including health IT/EHR, supplies, CMEs, and travel

Line 8a: Pharmacy (not including pharmaceuticals, which are reported on Line 8b)

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Facility and Non-Clinical Support Services

Table 8A, Lines 14 and 15, Column A

- **Facility, Line 14, Column A:** Facility-related expenses, including direct personnel costs, rent or depreciation, mortgage interest payments, utilities, security, groundskeeping, janitorial services, maintenance, etc.
  - Includes personnel whose FTEs are reported on Table 5, Line 31.
- **Non-Clinical Support Services, Line 15, Column A:** Costs for all personnel whose FTE is reported on Table 5, Lines 30a–30c and 32, including corporate administration, billing collections, medical records and intake personnel; facility and liability insurance; legal fees; practice management system; and direct non-clinical support costs (travel, supplies, etc.).
  - Include malpractice insurance in the service categories, not here.
- **Total Facility and Non-Clinical Support Service Costs, Line 16:** The amount to be allocated in Column B to Lines 1–13.

The Total of Facility and Non-Clinical Support Service costs (the amount in Line 16, Column A) is the amount that is allocated in Column B of this table, to Lines 1 through 13 as overhead.

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Allocating Overhead Expenses to Column B

Three-Step Method

Step 1 **Allocate Facility** *(Amount from Line 14, Column A)*
- Identify square footage used by each cost center and cost per square foot.
- Distribute square footage costs to each cost center across Column B.

Step 2 **Allocate Non-Clinical Support Services** *(Amount from Line 15, Column A)*
- Distribute non-clinical support costs to the applicable service area/cost center.
  - Include decentralized front desk personnel, billing and collection systems and personnel, etc.
  - Consider lower allocation of overhead to contracted services.

Step 3 **Allocate Remaining Overhead Costs Using Straight-Line Method**
- Straight-line method means allocating non-clinical support costs based on the proportion of net costs for each service category.

There are multiple ways that facility and non-clinical support services (Lines 14 and 15, Column A) may be allocated to the cost centers in Column B (Lines 1–13).

Use the simplest method that accurately portrays the use of facility and non-clinical support services and distribution of costs.

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Reporting Donations Across Tables 8A and 9E

Donated Facilities, Services, Supplies

- Donations of vaccines, pharmaceuticals, tests, etc.
- Volunteer time or in-kind services
- Health center space that is provided at no cost; donated facilities

Reported on Line 18, Column C of Table 8A

Cash Donations

- Cash received from individuals or philanthropy as a gift to the health center
- Direct monetary donations
- Revenue from fundraising programs or activities

Reported on Line 10 of Table 9E

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Table 9D: Patient Service Revenue

UDS Uniform Data System

Understanding Where Revenue Is Reported

Table 9D

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

- FFS reimbursement
- Per member per month (PMPM) or capitated payments
- Incentive or quality payments, shared saving distributions
- Payments from patients

Table 9E

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

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

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Reporting Table 9D, Patient Service Revenue

Columns

Charges, Collections, Adjustments

- **Column A:** Charges for patient services in the year, according to fee schedule
- **Column B:** Collections (e.g., payments, reimbursements) received in the year
- **Columns C1–C4:** Reconciliations
- **Column D:** Contractual adjustments
- **Column E:** Self-pay sliding fee discounts
- **Column F:** Self-pay bad debt

Lines

By Payer

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

Sub-lines

By Payment Type

- Non-managed care
- **Sub-line a:** Managed care, capitation
- **Sub-line b:** Managed care, fee for service

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UDS Uniform Data System

Table 9D Columns: Charges and Collections

Table 9D columns are where charges, revenue/collections, adjustments, sliding fees, and bad debt are reported.

Column A: Full Charges

Table 9D

Full Charges This Period (a)	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)	Adjustments (d)	Sliding Fee Discounts (e)	Bad Debt Write-Off (f)

- **Column A: Full Charges:** Total billable charges across all services, reported on the payer line from which it was received:
  - Undiscounted, unadjusted, gross charges for services owed by payer
  - Based on health center fee schedule
  - Charges for services provided during the calendar year, including pharmacy charges
- Do not include:
  - "Charges" where no collection is attempted or expected (e.g., enabling services, donated pharmaceuticals, free vaccines)
  - Capitation or negotiated rate; must be unadjusted charges according to your fee schedule
  - Charges for Medicare G-codes
    - To learn more about Centers for Medicare & Medicaid (CMS) payment codes, visit the CMS website.

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Illustration of Full Fee Schedule Charges, Not G-Code

Rev Code	Description	HCPC	Service Dates	Service Units	Total Charges	Charge goes on Table 9D, Column A
0521	FQHC visit, estab pt	**G0467 Payment code**	01022025	1	Facility's payment code charge	**No** (because it's not the fee schedule charge for services)
0521	Office/ outpatient visit, estab pt	**99213, Qualifying visit**	01022025	1	Actual fee schedule charge	**Yes**
0300	Incident to service	**XXXX**	01022025	1	Actual fee schedule charge	**Yes**
	Total				Sum of charges	**No** (because it includes the G-code amount)

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Column B: Collections

Table 9D

Full Charges This Period (a)	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)	Adjustments (d)	Sliding Fee Discounts (e)	Bad Debt Write-Off (f)

Column B: Collections: Include **all payments** received in 2025 **related to services to patients**:

- Capitation payments
- Contracted payments
- Payments from patients
- Third-party insurance
- Retroactive settlements, receipts, and payments

- Include pay for performance (P4P), quality bonuses, and other incentive payments tied to patient care.
- Payer incentives (such as for conducting certain screenings or improving on CQMs) are included in the collections reported here in Column B.

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Columns C1–C4: Retroactive Settlements, Receipts, and Paybacks

Table 9D

	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** *(based on filing of cost report)* • **Wraparound payments** *(additional amount per visit to bring payment up to FQHC level)*	• **FQHC PPS reconciliations** *(based on filing of cost report)* • **Wraparound payments** *(additional amount per visit to bring payment up to FQHC level)*	• **Managed care pool distributions** • **Pay for performance (P4P)** • **Other incentive payments** • **Quality bonuses** • **Value-based payments**	**Paybacks or deductions by payers because of overpayments or penalty** *(report as a positive number)*

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Column D: Adjustments

Table 9D

Full Charges This Period (a)	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)	Adjustments (d)	Sliding Fee Discounts (e)	Bad Debt Write-Off (f)

Column D: Adjustments: Agreed-upon reductions/write-offs in payment by a third-party payer:

- Reduce by amount of retroactive payments in C1, C2, and C3.

+ Add paybacks reported in C4.

- May result in a negative number (most common with large retroactive payments in C1–C3).
- For *managed care capitated lines* (2a, 5a, 8a, and 11a) *only*, adjustments equal the difference between charges and collections (Column D = A – B).

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Table 9D: Revenue Timing

- **Charges** in Column A are to be reported based on the date of service and limited to **dates of service** that occurred in the 2025 calendar year.
- **Collections** and **adjustments** (Columns B, C1–C4, and D) are reported based on **posting date** and limited to transactions posted in calendar year 2025.
- This acknowledges that there is likely to be some timing difference between the columns.

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Column E: Sliding Fee Discounts

Table 9D

Full Charges This Period (a)	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)	Adjustments (d)	Sliding Fee Discounts (e)	Bad Debt Write-Off (f)

Column E: Sliding Fee Discounts: Reductions in patient charges based on their ability to pay.

- Based on the patient's documented income and family/ household size (per FPG), including uninsured patients with income below 2X the FPG.
- **Applicable *only* to charges reported in Column A of Line 13, Self-Pay.**
- May be applied to insured patients' co-payments, deductibles, and non-covered services.
- May not be applied to past-due amounts.

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Column F: Bad Debt Write-Off

Table 9D

Full Charges This Period (a)	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)	Adjustments (d)	Sliding Fee Discounts (e)	Bad Debt Write-Off (f)

Column F: Bad debt: Amounts owed by patients considered to be uncollectable and formally written off during 2025, regardless of when service was provided.

- Report only **patient bad debt** (not third-party payer bad debt):
  - ***Only related to charges reported in Column A of Line 13, Self-Pay.***
  - **Third-party payer bad debt is not reported in the UDS.**
- Do not change bad debt to a sliding discount.
- Discounts (e.g., to specific groups of patients, cash discounts) or forgiveness is not patient bad debt (or a sliding discount).

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Understanding Adjustments, Sliding Fee, and Bad Debt

Adjustments (Column D)

- Difference between the health center's full fee schedule charge and the amount a payer actually paid or reimbursed for a patient service (less retroactive settlements and receipts).
- **Only for third-party payers (Lines 1–12)**

Sliding Fee (Column E)

- Reduction in charges owed by patients based on their ability to pay, which is determined by their income and family/household size.
- **Only for Self-Pay, Line 13**

Bad Debt Write-Offs (Column F)

- Amounts owed by patients that are deemed uncollectible and formally written off. Can arise due to inability to locate patient, patient refusal to pay, patient inability to pay (for charges not subject to a sliding fee discount or even after a sliding fee discount has been granted).
- **Only for Self-Pay, Line 13**

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Table 9D Rows: Payer and Payment Type

Each line on Table 9D is a different payer and payment type, which needs to align with the payer the claim was submitted to and origin of the payment.

Table 9D: Patient Service Revenue

Each third-party payer category is four lines: non-managed care, managed care capitation, managed care FFS, and then total for the payer. Private lines (Lines 10–12) are not shown here but have the same structure.

Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Net Patient Service Revenue: Collections of Reconciliation/ Wraparound Current Year (c1)	Net Patient Service Revenue: Collections of Reconciliation/ Wraparound Previous Years (c2)	Net Patient Service Revenue: Collections of Other Payments: PAP, Risk Pools, etc. (c3)	Net Patient Service Revenue: Penalty/ Payback (c4)	Adjustments (d)	Sliding Fee Discounts (e)	Bad Debt Write-Off (f)
1	Medicaid Non-Managed Care									
2a	Medicaid Managed Care (capitated)									
2b	Medicaid Managed Care (fee-for-service)									
3	**Total Medicaid** (Sum of Lines 1 + 2a + 2b)									
4	Medicare Non-Managed Care									
5a	Medicare Managed Care (capitated)									
5b	Medicare Managed Care (fee-for-service)									
6	**Total Medicare** (Sum of Lines 4 + 5a + 5b)									
7	Other Public, including Non-Medicaid CHIP, Non-Managed Care									
8a	Other Public, including Non-Medicaid CHIP, Managed Care (capitated)									
8b	Other Public, including Non-Medicaid CHIP, Managed Care (fee-for-service)									
9	**Total Other Public** (specify__) (Sum of Lines 7 + 8a + 8b)									

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Payments Are Reported as One of Three Types

Non-Managed Care

Procedures and services that were **separately charged for a patient who is not assigned to the health center through a managed care plan** and that were paid for by a third-party payer.

The third-party payers pay some or all of the bill based on agreed-upon maximums or discounts.

Managed Care Capitation

The revenue from health center contracts with an MCO for a specified set of services, under 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 FFS

The revenue from health center contracts with an MCO under which a set of patients is **assigned** to the health center, the health center is responsible for their care, and the health center is **reimbursed on an FFS (or encounter-rate) basis for covered services to patients assigned to the health center through the plan**.

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Payer Categories for Patient Service Revenue

Table 9D Lines 1–13

Medicaid

Any charges to or payment from Medicaid or a Medicaid MCO for health center patient services, which can include any of the following:

- Reimbursement
- Incentive payments
- Reconciliation payments
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
- Adult day health care (ADHC)
- PACE

Medicare

Any charges to or payment from Medicare, Medicare managed care programs, or Medicare Advantage.

- Includes health center pharmacy, ADHC, or PACE

Other Public

Any charges to or payment for patient services from:

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

Private

Any charges to or payment for patient services from:

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

Self-Pay

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

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

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

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

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

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

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Common Revenue Examples

Some plans are both capitated and FFS—a set of services are covered by the PMPM payment, and other services are billed and reimbursed FFS.

The charges and reimbursement from this plan is reported according to how it is billed/paid; split across the two managed care lines for the relevant payer type.

Uninsured patients may have their services covered by limited programs like Title X, Ryan White, or a screening program grant.

The charges and revenue are reported based on the payer. So, though the patient is uninsured on Table 4, charges and revenue are on Line 7, Other Public Non-Managed Care, here on Table 9D.

Workers' comp or auto insurance may cover certain claims for certain patients.

Here on Table 9D, the charges and revenue are reported based on the payer, so these are Private Non-Managed Care charges and revenues, reported on Line 10 here.

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Examples: Reclassifying a Portion of a Charge

Table 9D

Remember, when the responsibility for charges **changes** or **is split**, the charges in Column A **need to be reclassified** to reflect that.

A patient is seen, saying their insurance has not changed, but the claim is denied by the payer because the patient was no longer enrolled with them. The charges then need to be reclassified to their current payer or to Self-Pay.

A patient with Medicare is seen, and they have a supplemental plan that pays the 20 percent co-pay. That 20 percent of the charge needs to be reclassified to the secondary payer.

A claim is submitted to a private insurer for services to a patient. The patient has not yet met their deductible, so the insurer pays only a small portion of claim, then the remainder is billed to the patient. This deductible portion is reclassified to Self-Pay.

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Table 9E: Other Revenue

UDS Uniform Data System

Other Revenue

Table 9E

- Report **non-patient-service receipts** or funds drawn down in the calendar year.
  - Include income that supported activities described in your health center scope of services.
  - Report funds by the entity from which the health center received them.
    - For example, a screening program for latent tuberculosis may be funded by a city health department, with the funds originating from the Centers for Disease Control and Prevention (CDC). The health center receives the money from the city health department and therefore reports the funding on Line 7, Local Government.
  - Complete "specify" fields where they appear, clearly explaining what's included in the line.
- The total amount reported on Tables 9E and 9D represents total revenue supporting the health center's scope of services.

This table is reported on a **cash basis**—amount received or drawn down (not awarded) in the year.

Report based on the **entity dollars were received from** (called the last party rule).

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BPHC Grant Lines

Table 9E, Lines 1a–1q

- **BPHC Grants:** Funds your health center received directly from BPHC, including funds passed through to another agency.
  - Include 330 grant(s) drawn down in the year in Lines 1a through 1e.
    - Include BPHC supplemental awards, such as Behavioral Health Service Expansion and Primary Care HIV Prevention, in the row along with BPHC health center program award (e.g., Line 1b)
  - Capital development grants from BPHC are reported on Line 1k.
    - Include Capital Development Building Capacity Program (CBA), Capital Development – Immediate Facility Improvements Program (CBB), Patient Centered Medical Home, Facilities Improvement Program (CBC), and Health Infrastructure Investment Program (CBD)

Line	Source	Amount (a)
	HRSA's BPHC Grants (Enter Amount Drawn Down—Consistent with FFR)	
1a	Migratory and Seasonal Agricultural Workers	
1b	Community Health Center	
1c	Homeless Population	
1e	Residents of Public Housing	
1g	**Total Health Center** (Sum of Lines 1a through 1e)	
1k	**Capital Development Grants**	
1o	American Rescue Plan (ARP) (HSF, L2C, CSE)	
1p2	Other COVID-19-Related Funding from HRSA's BPHC (specify_____)	
1q	**Total COVID-19 Supplemental** (Sum of Lines 1o + 1p2)	
1	**Total BPHC Grants** (Sum of Lines 1g + 1k + 1q)	

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Other Federal Grants

Table 9E, Lines 2–3b

Line 2: Ryan White Part C received directly by the health center

- Other Ryan White funding is reported elsewhere, based on the entity it is received from (city, state).

Line 3: Other Federal Grants: Grants and contracts received directly from the federal government other than BPHC

- Include Department of Housing and Urban Development, CDC, Substance Abuse and Mental Health Services Administration, and others.

Line 3a: Promoting Interoperability Program

- Because Medicaid Promoting Interoperability ended in 2022, transitioned to Merit-based Incentive Payment System's (MIPS) Promoting Interoperability Performance Category; Promoting Interoperability Program dollars are uncommon.

Line	Source	Amount (a)
	Other Federal Grants	
2	Ryan White Part C HIV Early Intervention	
3	Other Federal Grants (specify _____)	
3a	Promoting Interoperability Program	
5	**Total Other Federal Grants** (Sum of Lines 2 through 3a)	

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Non-Federal Grants Revenue Categories

Table 9E, Lines 6–9

- **Line 6: State Government Grants and Contracts:** Funds received from a state (e.g., state public health grant, screening grant from the state)
- **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 7: State Government Grants and Contracts:** Funds received from a local government (e.g., city or town), taxing district, or sovereign tribal entity
- **Line 8: Foundation/Private Grants and Contracts:** Funds from foundations and private organizations (e.g., hospital, United Way, university)

Line	Source	Amount (a)
	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)	

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Other Revenue

Table 9E, Line 10

Other Revenue: Miscellaneous non-patient-service-related revenues including cash donations, medical record revenue, and vending machine revenue.

Other Revenue on Line 10 *includes*:

- Cash donations
- Medical record revenue
- Interest income
- Rent revenue
- Public/retail pharmacy revenue (not 340B)

Other Revenue on Line 10 does *not* include:

- Bad debt recovery
- 340B revenue
- Payer incentives
- Investment losses
- In-kind services and goods
- Payments that belong elsewhere on Table 9E

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Common Revenue Examples

The health center received Behavioral Health Service Expansion (BHSE) supplemental funding from BPHC. Where is this reported?

Within the Health Center Program award, Table 9E, Lines 1a through 1e.

The health center received funding from a local foundation for building out social referrals. Where is this reported?

Table 9E, Line 8, foundations/private grants and contracts.

A local benefactor made a sizable donation to the health center. Where is this reported?

May depend on how the donation was received (one lump sum?); likely to be reported on Table 9E, Line 10, Other Revenue.

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Key Resources to Assist with Reporting Financial Tables

1. Pages 149–180 of the 2025 UDS Manual
2. UDS Reporting Webinars : Reporting UDS Financial and Operational Tables, Nov. 13, 2025
3. Financial resources on the UDS Technical Assistance site
4. UDS Support Center: 866-UDS-HELP or udshelp330@bphcdata.net

Other Forms: Appendices D, E, and F

Understanding More About How and What Your Health Center Does

Health Center Health IT Capabilities Form

Appendix D

Health Center Health IT Capabilities

Appendix D

A series of approximately 15 questions that assess:

- **EHR adoption and use in your health center**
  - How widely is the EHR used in the organization?
  - What EHR? Is it certified EHR technology? Did you switch?
  - Do you use more than one system?
- **Data exchange**
  - What other health care entities do you exchange information with?
  - What else do you use health IT/EHR for?
- **Screening for individual patients' health-related needs**
  - Note that this screening refers specifically to screening for information *not* reported elsewhere on the UDS.
- **Integration of Prescription Drug Monitoring Program**

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> **Much of the information on the Health IT form can be gathered and entered into the PRE in the fall, with the exception of the health-related needs screening.**

Reporting on Screening for Patients' Health-Related Needs

Health IT Form, Appendix D

Questions 11 and 12: Report whether the health center collects information on health-related needs (beyond data reported elsewhere in the UDS) and, **if yes**, which screening tool is used in Question 12.

Question 11a: Report the total number of patients screened for health-related needs in the year.

Question 12a: Report the **number of health center patients who screened positive** in four areas:

- ❑ Food insecurity
- ❑ Housing insecurity
- ❑ Financial strain
- ❑ Lack of transportation/ access to public transportation

The crosswalk available on this page identifies the relevant questions, and what constitutes a positive screen, on each listed standardized screener.

Do not use proxies (such as low income or Medicaid enrollment) to report needs; use only recorded screening results.

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ODE Form

Appendix E

ODE Form

Appendix E: Four Sections

Telemedicine

MOUD

Outreach and Enrollment Assistance

Voluntary Family Planning

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Telemedicine Reporting

ODE Appendix E, Question 2

Do you use telemedicine [telehealth]?
Meaning, do you provide clinical services via remote technology?

Who do you use telemedicine to communicate with?
Patients?
Specialists?

What telehealth technologies do you use?
Real time, store-and-forward, remote patient monitoring, mobile health?

What services are provided via telemedicine?
Primary care, oral health, MH, SUD, dermatology, etc.?

If you do not offer telemedicine services, why not?
Policy barriers, inadequate broadband, lack of funding/training, etc.?

Keys to Remember

- Limit your responses to clinical services provided via telehealth.
- It is possible to respond **Yes** to telemedicine questions here without having virtual visits on Table 5—if you use remote patient monitoring or eConsults, for example.
- Reflect your health center's services during the calendar year.

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MOUD Reporting

ODE, Appendix E

Question 1a

Report the **number of providers who provided MOUD** to health center patients in the year.

- The medications this question refers to are those approved by the FDA for MOUD: buprenorphine, methadone, and naltrexone.

Question 1b

- Report the **number of patients who received MOUD** from the providers in Question 1 response.
- This number is **the same** as what is reported in Table 6A, Line 26c3, Column B.

- Limit reporting to health center providers (those staff or contractors providing in-scope services) and health center patients.
- This information relates to information on Tables 5 and 6A, for example:
  - All providers are in Column A of Table 5.
  - Patients with OUD are included in Line 19 of Table 6A.

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Outreach and Enrollment Assists Reporting

ODE, Appendix E

Question 3: Report **the number of assists provided during the calendar year by all trained assisters** working on behalf of the health center.

- Outreach and enrollment assists are defined as customizable education sessions about third-party primary care health insurance coverage options (one-on-one or small group) and any other assistance provided by a health center assister to facilitate enrollment.
- Assisters include certified application counselors or equivalent who are health center staff, contracted personnel, or volunteers.

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Voluntary Family Planning Screening

ODE, Appendix E

Question 4: Report the **total number of patients screened for voluntary family planning.**

- Limit reporting to health center patients and to those screened with a standardized screener.

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Workforce Form

Appendix F

Workforce Form

Appendix F

Professional Education/Training

- Report health professional training/education occurring in the health center by category.
- Report training whether it is pre-graduate/ certificate or post-graduate.
- Report preceptor and support staff for training programs.
- Note that this is *not* internal staff training like continuing education, CMEs, or first aid training, but training of the future health professional workforce.

Satisfaction Surveys

- Report provider satisfaction survey frequency.
- Refer to Appendix A of the UDS Manual regarding who is a provider.
- Report general personnel satisfaction survey frequency.
- Note that this is satisfaction of personnel, not patient satisfaction surveys.

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Professional Education/Training Reporting

Workforce Form, Appendix F

A health center hosts a family medicine resident for a 12-month rotation starting July 2025.

This resident is reported in Line 1a in Column B as a family physician doing post-graduate training.

A health center provides a clinical internship site for an NP student for 16 weeks during the spring 2025 semester.

This NP is reported on Line 2 in Column A as an NP doing pre-graduate training.

A health center had a health policy graduate student who interned with the health center's data analytics team for 6 weeks during the summer of 2025.

This graduate student is reported on Line 25 in Column A.

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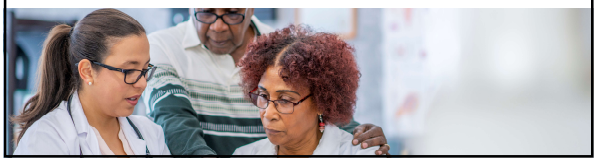
Key Resources to Assist with Reporting the Other Forms (Appendices)

1. Pages 203–215 of the 2025 UDS Manual
2. UDS Reporting Webinars
3. Appendices resources on the UDS Technical Assistance site
4. UDS Support Center: 866-UDS-HELP or udshelp330@bphcdata.net

Wrapping Up

Setting Up for Success



Setting Up for Success

Resources | Supports | Tips | Closing

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UDS Technical Assistance Resources

- Uniform Data System (UDS) Technical Assistance site includes:
  - UDS Manual
  - Final Program Assistance Letter
  - Training Schedule
  - Reporting Guidance
  - Pages for Each Section of the UDS Report

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UDS Reporting Trainings

Understanding UDS Patient Characteristics Tables for Quality Improvement
Tues. Sept. 23, 2025, 2:00–3:30 p.m. ET

The Foundation of the UDS: Counting Visits
Wed., Oct. 1, 2025, 2:00–3:30 p.m. ET

UDS Clinical Tables Part 1: Screening and Preventive Care Measures
Tues., Oct. 14, 2025, 2:00–3:30 p.m. ET

UDS Clinical Tables Part 2: Maternal Care and Children's Health
Tues., Oct. 21, 2025, 2:00–3:30 p.m. ET

UDS Clinical Tables Part 3: Chronic Disease Management
Wed., Oct. 29, 2025, 2:00–3:30 p.m. ET

Preliminary Reporting Environment (PRE)
Wed., Nov. 5, 2025, 1:00–3:00 p.m. ET

Reporting UDS Financial and Operational Tables
Thurs., Nov. 13, 2025, 2:00–3:30 p.m. ET

Successful Submission Strategies
Wed., Jan. 14, 2026, 2:00–3:30 p.m. ET

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

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Supports Available in Early 2026

UDS Support Line

Year round, with additional coverage in February.

- 866-UDS-HELP
- udshelp330@bphcdata.net

Strategies for Successful Submission Webinar (register)

January 14, 2026

- **Using available tools:** Learn how to use the **EHBs** and its various reports, like the Health Center Trend Report and Comparison Tool, to review your data.
- **Auditing your data:** We'll walk through how to conduct your own data review using the Data Audit Report and other tools. This includes learning how to find and fix errors in the EHBs.
- **Working with your reviewer:** Get tips on how to collaborate effectively with your UDS reviewer to ensure a smooth and successful submission.

UDS Office Hours

January and February 2026

The one-hour virtual office hours are an opportunity for health centers to submit UDS reporting-specific questions in advance and have those answered live. The questions and answers are intended to be timely as health centers are actively completing UDS reports.

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Tips for Success

Start with personnel on Table 5

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

Align costs with Table 5

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

Countable visits create health center patients

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

Health center patients comprise counts of services, diagnoses, and measures throughout.

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Complete the Evaluation

2025 UDS Annual State/Territory-Based Training Evaluation

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Q&A

What questions do you have for us?

Thank You!

Call the UDS Support Line at 1-866-837-4357.

Email at udshelp330@bphcdata.net

Contact using the BPHC Contact Form.

Please fill out the evaluation form after the webinar!