Health Resources and Services Administration
Supporting Statement A

Uniform Data System

OMB Control No. 0915-0193 – Revision

Terms of Clearance: None

A. Justification

1. Circumstances Making the Collection of Information Necessary

The Health Resources and Services Administration (HRSA) is requesting OMB approval to revise the forms used to collect data in the Uniform Data System (UDS).

HRSA utilizes UDS for the required annual reporting by Health Center Program recipients (those funded under section 330 of the Public Health Service (PHS) Act), Health Center Program look-alikes (entities meeting requirements of, but not funded under, section 330 of the PHS Act), and Nurse Education, Practice, Quality and Retention (NEPQR) and Advanced Nursing Education (ANE) Program recipients (specifically those funded under the practice priority areas of sections 831(b) and 811 of the PHS Act). The UDS forms are currently approved under OMB Control No. 0915-0193, and the current expiration date is September 30, 2026.

To keep the UDS instrument relevant and responsive to the Health Center Program's needs and Administration priorities, HRSA will implement changes for the performance year 2026 UDS data collection. The 2026 updates include removals, additions, and revisions across the Clinical, Financial, and Operational Tables, as well as the Appendices. The changes also continue the alignment of clinical quality measures to electronic specifications. Collectively, these updates reflect HRSA's continued efforts to reduce administrative burden and modernize the UDS instrument, resulting in the need to update the UDS instrument and, in turn, the performance reporting requirements.

HRSA is proposing the following modifications to the 2026 instrument from the 2025 version:

Table 4: Selected Patient Characteristics

Removal:

- **Managed Care Utilization** - UDS measures associated with managed care member months, *Capitated Member Months, Fee-for-Service Member Months,* and *Total Member Months* (Lines 13a—13c) will be removed to reduce the reporting burden, given variations in payer structures and payment arrangements across health centers.

Table 5: Staffing and Utilization and Selected Service Detail Addendum

Removal:

- **Selected Service Detail Addendum** – Detailed reporting elements related to integrated mental health and substance use disorder service delivery (Lines 20a01 – 21h) will be removed to streamline reporting and reduce burden on health centers. Mental health and substance use disorder services will continue to be reported in the core part of Table 5.

Addition:

- **Staffing and Utilization**- Specific mental health personnel types, including *Psychiatric Mental Health Nurse Practitioners* (PMHNPs), will be added as drop-down options to Line 20b, *Other Licensed Mental Health Providers*. This addition will allow for more accurate classification of licensed mental health providers and better reflect the composition of the behavioral health workforce.

Table 6A: Selected Diagnoses and Services Rendered

Removals:

- **Various Clinical Measures -** Clinical measures associated with various diagnoses and selected services rendered are being removed from Table 6A to streamline reporting, reduce burden, and eliminate potential redundancies where similar information is captured elsewhere in the UDS. The specific measures proposed for removal are indicated below:

    - Respiratory conditions related to COVID-19 (Line 6a)
    - Abnormal breast findings, female (Line 7)
    - Abnormal cervical findings (Line 8)
    - Contact dermatitis and other eczema (Line 12)
    - Novel coronavirus (SARS-CoV-2) diagnostic test (Line 21c)
    - Novel coronavirus (SARS-COV-2) antibody test (Line 21d)
    - Mammogram (Line 22)
    - Pap test (Line 23)
    - Sealants (Line 30)
    - Oral surgery (extractions and other surgical procedures) (Line 33)
    - Rehabilitative services (Endo, Perio, Prostho, Ortho) (Line 34)

Additions:

- **Type I Diabetes** - A new measure is being added as line 9a to identify the number of patients with Type 1 Diabetes. This addition will help address key data gaps and improve HRSA's understanding of the distinct care and resource needs of patients with Type 1 Diabetes.

- **Intellectual and Developmental Disabilities** - A new measure is being added as line 20g to capture the number of patients with intellectual and developmental disabilities. Available data indicate that this population may experience lower rates of access to preventive and chronic care, including fewer screenings, lower utilization of dental care, and higher rates of undiagnosed or unmanaged conditions. Capturing this information will improve understanding of the prevalence of persons with intellectual and developmental disabilities in the Health Center Program and support efforts to enhance health care access and quality of care for individuals who require complex, coordinated services.

- **Autism Spectrum Disorder Screening** - A new measure is being added as line 26g to capture the number of patients screened for autism spectrum disorder. This measure will help assess the extent to which health centers are implementing recommended developmental screening practices and connecting children and families to needed support services.

- **Patient Support Services** - Four new measures are being added as lines 35-38 to capture the number of patients receiving case management, eligibility assistance, transportation, and language assistance services to better understand the range of non-clinical services that facilitate access to care and contribute to improved patient outcomes.

- **Upstream Drivers of Health** - Four new measures are being added as lines 39-42, transitioning from Appendix C (formerly Appendix D) to the UDS core tables, to identify the number of patients who are screened for, and who receive, services addressing upstream drivers of health. These or similar measures are now being elevated to the core reporting set to support standardized data collection. Integrating these measures within the core tables will enhance the ability to monitor how health centers identify and address patients' access to and utilization of services.

Table 6B: Quality of Care Measures

Addition:

- **Fall Risk Screening** – One new measure is being added as line 24 to capture the number of patients 65 years of age and older who were screened for future fall risk, in alignment with electronic clinical quality measure CMS139v14. Incorporating a fall risk screening measure aligns the UDS with national quality and preventive care efforts, including routine fall risk assessments conducted during Medicare Initial and Annual Wellness Visits. This alignment supports harmonization across federal programs, enables HRSA to better understand the needs and resources required to support the growing aging population served by the Health Center Program, and inform technical assistance for health centers.

Table 6B: Quality of Care Measures and Table 7: Health Outcomes

Updates:

- **Clinical Quality Measures** - Tables 6B and 7 collect UDS clinical quality measures, and where applicable, clinical quality measures will be updated in alignment with specifications of the issued performance year 2026 electronic clinical quality measures. These specifications were released by the Centers for Medicare & Medicaid Services on May 8, 2025, for use by eligible providers. Aligning clinical performance measures across national programs promotes data standardization, quality, and transparency, and decreases the reporting burden for providers and organizations participating in multiple federal programs.

TABLE 8A: FINANCIAL COSTS

Removals:

- **Allocation of Facility and Non-Clinical Support Services** - *Allocation of Facility and Non-Clinical Support Services*, Column B, and the requirement to report overhead costs on Table 8A will be removed.

- **Enabling Services** - Costs of each type of enabling service (Lines 11a, 11b, 11c, 11d, 11e, 11f, 11g, and 11h) will be removed. These costs will be consolidated into a single line to reflect all *Patient Support Services* costs (Line 11) (previously known as Enabling Services).

- **Donations** - Line 18, *Value of Donated Facilities, Services, and Supplies (specify)*, will be removed.

  These updates are being made to reduce the reporting burden and address stakeholder feedback.

TABLE 9D: ACCRUED PATIENT SERVICE REVENUE

Removals:

- **Retroactive Settlements, Receipts, and Paybacks** - revenue associated with Columns c1—c4 for classification of types of collections will be removed:
  - Collection of Reconciliation/Wraparound Current Year (c1)
  - Collection of Reconciliation/Wraparound Previous Years (c2)
  - Collection of Other Payments: Pay for Performance, Risk Pools, etc. (c3)
  - Penalty/Payback (c4)

  These collections will be consolidated into a single column to reflect all Collections (Column B).

- **Payer Category** – Form of payment (non-managed care, capitated managed care, and fee-for-service managed care) lines have been collapsed into a single total line by the third-party payer. *Total Medicaid* (Line 3), *Total Medicare* (Line

6), *Total Other Public (specify)* (Line 9), and *Total Private* (Line 12) will be reported, and the following lines will be removed as a result:

- Medicaid Non-Managed Care (Line 1)
- Medicaid Managed Care (capitated) (Line 2a)
- Medicaid Managed Care (fee-for-service) (Line 2b)
- Medicare Non-Managed Care (Line 4)
- Medicare Managed Care (capitated) (Line 5a)
- Medicare Managed Care (fee-for-service) (Line 5b)
- Other Public, including Non-Medicaid Children's Health Insurance Program (CHIP), Non-Managed Care (Line 7)
- Other Public, including Non-Medicaid CHIP, Managed Care (capitated) (Line 8a)
- Other Public, including Non-Medicaid CHIP, Managed Care (fee-for-service) (Line 8b)
- Private Non-Managed Care (Line 10)
- Private Managed Care (capitated) (Line 11a)
- Private Managed Care (fee-for-service) (Line 11b)

- **Sliding Fee** – Sliding fee associated with Line 13, Column E for classification of sliding fee discounts provided to patients has been collapsed into the existing single total Self-Pay line (Line 13) and will be reported as Adjustments (Column D).

- **Patient Bad Debt** – Bad debt write-off associated with patients previously reported in Line 13, Column F has been removed and will be reported with all third-party payer bad debt write-offs and allowances (Line 15, Column G).

  These updates are being made to reduce the reporting burden and address stakeholder feedback.

Additions:

- **Bad Debt Write-Offs and Allowances** – A new line will be added as an offset to *Net Patient Service Revenue* for accrued *Bad Debt Write-Offs and Allowances* (Line 15, Column G).

- **Net Patient Services Revenue** - A new column and line will be added for *Net Patient Service Revenue (Charges Less Adjustments)* (Line 16, Column G).

- **Pharmacy Net Patient Service Revenue** - A new line will be added to reflect all *Pharmacy Net Patient Service Revenue* (Line 17, Column G).

- **Third-Party Incentive Revenue** - A new line will be added to reflect all *Third-Party Incentive Revenue* (Line 18, Column G).

  These updates are being made to reduce reporting burden and to better assess financials in alignment with generally accepted accounting principles and health centers' financial statements.

TABLE 9E: OTHER ACCRUED REVENUE

Removals:

- **HRSA's Bureau of Primary Health Care (BPHC) Grants** - Health Center Program grant funding sources (formerly Lines 1a—1e) and other BPHC funding detail lines (formerly Lines 1k—1q) will be removed. Grants with active funding will be aggregated and reported on a single, total line: *Total Health Center BPHC Grants* (Line 1).

- **Other Federal Grants** - Specific federal grant funding sources (formerly Lines 2, 3, and 3a) will be removed. All non-BPHC federal grants will be reported on Line 5, *Total Other Federal Grants (specify).*

  These updates are being made to align with supplemental funding being rolled into the base Health Center Program funding, remove outdated supplemental funding lines, reduce the reporting burden, and to better assess financials in alignment with generally accepted accounting principles and health centers' financial statements.

APPENDIX C (formerly Appendices D and E): HEALTH CENTER INFORMATION TECHNOLOGY (HEALTH IT) CAPABILITIES AND OTHER DATA ELEMENTS

Removals:

- **Appendix C (formerly Appendix D): Health IT Capabilities** - Several questions specific to Electronic Health Records implementation (Questions 1a, 1a2, 1a3, 1c, 1c1, and 10) will be removed from Appendix C (formerly Appendix D).

- **Appendix C (formerly Appendix D): Health IT Capabilities** - Upstream Drivers of Health screening questions (Questions 11, 11a, 12, 12a, and 12b) will be removed from Appendix C (formerly Appendix D).

- **Appendix C (formerly Appendix E): Other Data Elements** – The former Appendix E will be removed, and certain data elements from the former Appendices D and E will be consolidated into a single appendix, which will be redesignated as Appendix C. Outreach and enrollment assists (formerly Appendix E, Question 3) will also be removed (aspects will be incorporated in the Table 6A Patient Support Services addition).

  These updates are being made to reduce the reporting burden and address stakeholder feedback.

Additions:

- **Appendix C (formerly Appendices D and E): Health Center IT Capabilities and Other Data Elements** - Three questions on Alternative Payment Models (APM) will be added to Appendix C (Questions 17—19), to include:

    - What payor arrangements do you have for value-based purchasing (VBP) contracts?
    - Please list the types of Alternative Payment Models (APMs) your health center is involved in.
    - What percentage of your health center's revenue during the year is tied to value-based payment contracts?

    HRSA is adding new data elements to capture health centers' participation in APMs to improve understanding of the evolving payment landscape within the Health Center Program. As health centers increasingly engage in payment arrangements that emphasize value, care coordination, and outcomes, collecting information on APM participation will provide valuable insight into the range and scope of these models and inform technical assistance to support health centers' adoption of APMs.

2. Purpose and Use of Information Collection

HRSA requires the collection of information through UDS to monitor and evaluate the performance of health centers under PHS Act section 330, Health Center Program look-alikes, and select NEPQR and ANE recipients under PHS Act sections 831(b) and 811. These data aid in program compliance, guide quality improvement initiatives, and inform federal health policy decisions. HRSA also leverages UDS data to assess the impact of health centers and NEPQR and ANE recipients on patient health outcomes and to allocate funding and resources effectively across these programs. To keep this instrument relevant and responsive to the Health Center Program's needs and the evolving health care landscape, periodic updates are essential.

One of many ways UDS data actively drives quality improvement efforts is with the identification of expanded opportunities for targeted technical assistance related to the management of chronic conditions among health center patients. For instance, one of the primary inclusion criteria for the selection of health centers for participation in the National Hypertension Control Initiative (NHCI) was UDS ranking of a health center with less than 50% hypertension control among their patients with hypertension. This UDS data point in combination with health information technology (HIT) capability, patient health/digital literacy, and workforce (care team) support allowed for the development of technical assistance that over 3.5 years resulted in national hypertension control rates increasing from 2020 to 2024 (57.98% to 67.42%). This use case of UDS data highlights the importance of ensuring that updates not only address program priorities but also drive meaningful improvements in health center performance.

Further, UDS data are compared with national health-related data and benchmarks to explore potential differences between health center patient populations and the U.S. population at-large. Comparisons to national data and benchmarks include

the National Health Interview Survey[1] , National Health and Nutrition Examination Survey[2], Healthy People 2030 [3] objectives, Centers for Medicare & Medicaid Services Merit-based Incentive Payment System (MIPS)[4], and the Centers for Disease Control and Prevention's Million Hearts[5] initiative.

Data elements collected within the UDS rely on self-attestation by the health center staff responsible for submission. Health centers are required to certify, to the best of their knowledge and belief, that the data reported are true, accurate, and complete. This certification process is conducted through HRSA's Electronic Handbooks grants management system, where health centers formally attest to the validity of their submissions prior to final report submission. If a health center fails to comply with Federal statutes, regulations, or the terms and conditions of a Federal award, including the timely, accurate, and complete submission of UDS data, HRSA may impose conditions on the federal award, including the suspension and/or debarment of the health center. In addition, failure to submit a complete UDS report by the specified deadline may result in conditions or restrictions being placed on a Health Center's award, such as requiring prior approval of drawdowns of Health Center Program award funds and/or limiting eligibility to receive future base and/or supplemental funding.

3. Use of Improved Health Information Technology and Burden Reduction

The data collection plan for HRSA's UDS has been designed to streamline data reporting and minimize respondent burden by aligning measures with standardized formats and leveraging health centers' HIT and electronic health records (EHRs) for efficient data extraction. Advancements in EHR technology have been proceeding at a rapid pace. HIT can help health centers achieve quality and efficiency goals, and the use of EHRs streamlines and simplifies health center reporting of UDS measures. At present, 99% of health centers have EHRs installed. Broader adoption of EHR systems has furthered the need to share data across settings, providers, and networks to support care quality and patient outcomes. The integration of these electronic systems decreases the time and effort that would be required to complete manual data extraction for reporting UDS data.

4. Efforts to Identify Duplication and Use of Similar Information

The information collected by these forms is unique to the above-referenced programs. Information is not captured in the same form and format elsewhere. There are no other existing sources that could be used for monitoring performance and administration of HRSA's Health Center and NEPQR/ANE Programs.

Furthermore, in Fall 2025, HRSA undertook a comprehensive UDS streamlining effort to identify and address areas of duplication across the instrument, retire measures with outdated or no longer maintained specifications, and standardize quality measures

1 https://www.cdc.gov/nchs/nhis/index.htm
2 https://www.cdc.gov/nchs/nhanes/index.htm
3 https://health.gov/healthypeople
4 https://qpp.cms.gov/
5 https://millionhearts.hhs.gov/

by transitioning non-codified measures to nationally recognized, code-based specifications. This review resulted in the removal of several duplicative data elements, consolidation of overlapping reporting fields, and alignment of measure definitions with federal partners (e.g., CMS). Collectively, these efforts will reduce reporting burden for health centers while improving the overall quality, usability, and comparability of the data collected.

5. Impact on Small Businesses or Other Small Entities

This activity does not have a substantial impact on small entities or small businesses. Though, recognizing that healthcare providers may be considered small businesses, HRSA is committed to limiting the reporting burden associated with UDS submissions. Efforts to reduce this burden include streamlining data collection processes through the integration of electronic health records to report on electronically specified clinical quality measures, offering comprehensive technical assistance, and providing clear guidance to ensure efficient and accurate reporting. These measures, in addition to those identified in question three, are designed to support small entities in meeting reporting requirements with minimal disruption to operations.

6. Consequences of Collecting the Information Less Frequently

UDS data are required to be submitted annually by health centers and certain NEQPR and ANE recipients to effectively monitor program performance, assess emerging trends, promptly respond to changing health care needs, and administer program funds. For look-alikes, UDS data are used to monitor program performance and for designation and recertification decisions. While less frequent reporting might appear to reduce burden, it could instead increase challenges as health centers and certain NEQPR and ANE recipients may need to reconstruct data for longer periods, leading to potential inaccuracies, increased workload, or knowledge transfer gaps.

7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

The request fully complies with the regulation.

8. Comments in Response to the Federal Register Notice/ Outside Consultation

Section 8A: Comments in Response to the Federal Register Notice

A 60-day Federal Register notice was published on 12/10/2025 for public comment with a close period of 2/09/2026. The 60-day FRN was published in the *Federal Register*, volume 90, No. 235; pp. 57205-57208. A 30-day Federal Register notice was published on 6/16/2026 for public comment with a close period of 7/16/2026. The 30-day FRN was published in the *Federal Register*, volume 91, No. 115; pp. 36146-36149.

HRSA received 16 comments on the 60-day FRN. Comments received can be

organized into the following thematic categories:

- **Maintain COVID-related measures (Two Comments):**

    - Stakeholders recommended reconsideration of the proposed removal of several COVID-related measures in *Table 6A: Selected Diagnoses and Services Rendered,* including *Respiratory conditions related to COVID-19, Long COVID*, *Novel coronavirus (SARS-CoV-2) disease, Novel coronavirus (SARS-CoV-2) diagnostic test,* and *Novel coronavirus (SARS-CoV-2) antibody test*, emphasizing the importance of continued tracking for surveillance, resource allocation, and monitoring impacts on special medically underserved populations. Of the five COVID-related measures included in the current 2025 UDS, HRSA will retain two measures in response to stakeholder feedback, while three measures will be removed as part of broader streamlining efforts.

- **Recognize Psychiatric Mental Health Nurse Practitioners (PMHNPs) distinctly (One Comment):**

    - One stakeholder requested to specify PMHNPs separately in *Table 5: Staffing and Utilization* due to their significant role in delivering mental health services and managing high patient volume. In response to this feedback, PMHNPs will be added to line Table 5, line 20b, under *Other Licensed Mental Health Providers*.

- **Include additional case management codes (Two Comments):**

    - Commenters also requested enhancements to the Case Management codes under *Table 6A: Patient Support Services* to include Advance Primary Care Management (APCM) codes (G0556, G0557, G0558) and T1016, to capture broader case management services beyond Medicare. Based on stakeholder feedback, these codes will be added to Table 6A, line 35, *Case Management.*

- **Adjust Substance Use Disorder Initiation/Engagement eCQM for health center realities (Two comments):**

    - Commenters recommended reconsideration of the substance use disorder (SUD) measure, *Initiation and Engagement of SUD Treatment*, which was introduced in the 2025 UDS instrument. Stakeholders noted that electronic clinical quality measures (eCQM) do not align with health center data capabilities, resulting in misclassification of ongoing SUD treatment and understated health center performance. Commenters specifically noted the reporting challenges with the measure's definition of a "new SUD episode", which does not account for care received outside the health center and may inadvertently include patients in the denominator. Commenters also expressed that due to scope-of-practice limitations and operational challenges, there may be constraints in meeting the initiation

and engagement timeframes outlined in the measure.

As 2025 was the first year of implementation for the SUD eCQM, HRSA recognizes that health centers may require time to fully operationalize workflows and reporting processes. HRSA will continue to provide technical assistance and monitor implementation and assess the measure's ongoing relevance as additional data become available. Regarding proposed changes to the specifications for a measure, reporting specifications are set by the measures steward and cannot be modified. Measure stewards for each UDS clinical quality measure are listed in Appendix E (formerly Appendix G) of the forthcoming 2026 UDS Manual, which HRSA plans to release in summer 2026.

- **General objection to proposed changes (One comment):**
    - One commenter expressed the need for transparency regarding the rationale for proposed measurement changes. HRSA maintains open communication channels (e.g., All-Programs webcasts, newsletters, tailored technical assistance calls) and will continue to provide support on UDS reporting to ensure stakeholders understand the rationale and best practices for implementing UDS instrument changes.
- **Support for overall UDS streamlining / burden reduction (Six comments):**
    - Commenters conveyed broad approval and support for HRSA's proposed measurement alignment, elimination, and simplification efforts, noting that these changes are expected to meaningfully reduce administrative reporting burden.
- **Consideration regarding mental health and substance use disorder tracking (Three comments):**
    - In response to the proposed removal of Table *5: Selected Services Detail Addendum*, stakeholders requested that the decision be reconsidered, noting potential underreporting of integrated mental health and substance use disorder services that are delivered by non-psychiatric and non-licensed professional counselor providers. Additionally, stakeholders expressed that the removal of the *Selected Services Detail Addendum* would impair accurate performance assessment and collaborative care tracking. HRSA maintains that the measures in this section are not used to assess compliance with grant performance requirements, and related reporting in the main part of Table 5 would remain unchanged. Given areas of duplication, HRSA is exploring ways to capture unduplicated data on integrated care for a future iteration of the UDS instrument.
- **Patient support services and upstream drivers of health reporting implications: (Two comments):**

- Commenters applauded the transition of patient support services and upstream drivers of health measures from the appendices to *Table 6A: Selected Services and Diagnosis Rendered* but identified potential challenges of these additions if certified health information technology can't automate extraction, leading to an increase in administrative and operational burden. As with any new reporting requirement, HRSA anticipates an initial transition period and will continue to provide technical assistance and guidance to support implementation. HRSA will also monitor early reporting experience to assess burden and inform future refinements in 2027.

- **Lifestyle Medicine proposals (One comment):**

  - One commenter recommended incorporating lifestyle measures into the UDS instrument to strengthen preventative care and whole-person health. The stakeholder specifically proposed a variety of related measures reflecting upstream risks and outcomes, standardized lifestyle medicine assessments, Type 2 diabetes remission, deprescribing outcomes, and community supports. HRSA appreciates the thoughtful suggestion and will continue to evaluate these recommendations for alignment with Administration and HRSA priorities for a future UDS instrument.

- **Financial and Service Reporting Transparency (Two comments):**

  Commenters requested reconsideration of the removal of grant-level reporting in *Table 9E: Other Revenue* and the consolidation of line items in *Table 8A: Financial Costs*. Commenters noted that maintaining grant-level reporting is necessary to promote transparency and accountability by demonstrating how federal resources are utilized to support health centers. Further, it was noted that the proposed consolidation and removal of Table 8A line items will reduce visibility into critical health center services. HRSA notes that these removals reflect an effort to reduce reporting burden by modernizing and streamlining the instrument and eliminating redundancies where comparable data may be collected in other grant financial reporting forms, including Health Center Program Forms (OMB No. 0915-0285 - Revision).

- **Desire to retain multiple Table 6A clinical measures (One comment):**

  - Stakeholders expressed a desire to retain several *Table 6A: Selected Diagnoses and Services Rendered* measures, including abnormal breast cancer and cervical cancer findings, contact dermatitis and other eczema, mammograms, Pap tests, sealants, and oral surgery. HRSA is removing these measures from Table 6A due to redundancies where similar information is captured elsewhere in the UDS instrument. For example, the abnormal breast cancer findings measure is also similarly reflected in Table 6B's Breast Cancer Screening measure (CMS125v13).

- **Clarifications on Tables 8A/9D/9E (Three comments):**

    - Commenters also expressed the need for additional reporting guidance clarification across multiple tables, including tables 8A, 9D, and 9E, particularly related to managed care dynamics, including treatment of insured patient copays in payer mix. HRSA will provide detailed reporting instructions for the relevant tables, consistent with standard practice, in the forthcoming 2026 UDS Manual release, which HRSA plans to release in summer 2026.

Section 8B: Outside Consultation

During UDS measurement development, input on the instrument's content and wording was sought from fewer than 10 health center subject matter experts and stakeholders HRSA also consulted on the availability of data, the clarity of instructions and record keeping, disclosure, reporting format, and the data elements to be recorded and reported. HRSA has ongoing engagements (e.g., UDS Technical Advisory Board, UDS Test Cooperative Steering Committee) with health center stakeholders. Stakeholders represent individuals with expertise in health center operations, clinical quality reporting, and data management. Cooperative agreement relationships, such as Primary Care Associations, Health Center Controlled Networks, and National Technical Assistance Partners, are also leveraged for stakeholder input. Input is used to assess the appropriateness of proposed new measures for the UDS instrument, ensuring the burden associated with implementing these measures remains minimal and manageable.

9. Explanation of any Payment/Gift to Respondents

Respondents will not receive any payments or gifts; reporting is a requirement of Health Center Program funding and for maintaining their designation as a look-alike. Additionally, NEQPR and ANE recipients are prohibited from receiving any gifts or payments in exchange for submitting UDS data.

10. Assurance of Confidentiality Provided to Respondents

Given its current state of reporting at the aggregate level, the UDS does not involve the reporting of personally identifiable information about individuals. While these aggregate data are derived from underlying patient-level information, no individual-level data are submitted or publicly disclosed.

In addition, certain UDS data elements included in the appendices are designed to capture health center-level information (e.g., whether a health center offers or conducts specific services or activities). These questions pertain to organizational capacity and service availability and do not require or involve the collection, retrieval, or reporting of individually identifiable patient health information.

HRSA recognizes that aggregate reporting is informed by patient-level data and,

accordingly maintains appropriate safeguards (e.g., data suppression rules for data made available to the public) to protect confidentiality and privacy to the extent allowed by law, even as aggregate results are made publicly available. Independently, HRSA requires that health centers maintain and disclose patient data in accordance with applicable federal and state privacy laws, including the health insurance portability and accountability act (HIPAA), and only share as permitted or required for public health reporting, oversight, program administration, or any of the twelve national priority purposes.[6]

11. Justification for Sensitive Questions

The UDS is designed to extract data from existing medical records rather than through direct patient questioning or interviews. Data elements included in the instrument, such as those related to alcohol or drug use, are derived from standardized coding systems, including Current Procedural Terminology (CPT) and International Classification of Diseases (ICD) codes, which are documented during clinical care. As such, the information is based on provider-recorded diagnoses and services rather than responses to specific questions posed directly to patients. HRSA utilizes UDS data that may be sensitive in nature (i.e., substance use disorder) to guide resource allocation and funding opportunities, in addition to measuring health center performance on key quality measures related to substance use disorder care and treatment. Sensitive UDS data are handled with heightened safeguards, including suppression of small counts (e.g., <16) to mitigate the risk of patient identification.

In the 2026 UDS instrument, HRSA is proposing to add a question to the appendices to inquire whether health centers provide services that use puberty blockers, sex hormones, or surgical procedures, to individuals under 19 years of age, for the purpose of transforming their physical appearance to align with an identity that differs from their sex. The inclusion of this question is not intended to implement or respond to ongoing litigation associated with the related Executive Orders 14168 and 14187. While the subject matter may intersect with broader Administration policy considerations reflected in the Executive Orders, this data element is being collected for independent programmatic purposes. Specifically, it is intended to capture the breadth of integrated primary care services offered by health centers. The question does not rely on, nor is it contingent upon, the outcome of any related court proceedings.

In addition, the proposed question collects information regarding the provision of services at the health-center level and does not involve the collection of information from individual patients or the use of patient medical records. As such, it does not result in, nor is intended to result in, discrimination against individual patients. Responses reflect organizational service delivery practices only. Furthermore, health centers' responses to this question will not be used to determine eligibility for, or the amount of, federal funding. Funding determinations for health centers are governed by Section 330 of the Public Health Service Act and UDS or similar performance reports, which do not condition funding on responses to individual data elements of this nature. Data collected will be used solely for aggregate analysis and program administration purposes.

6 Summary of the HIPAA Privacy Rule | HHS.gov

Additionally, the Notice of Court Order for *PFLAG v. Trump*, 8:25-cv-337-BAH (D.Md.) from March 4, 2025 states that the defendants "are enjoined from conditioning, withholding, or terminating federal funding under Section 3(g) of EO 14168 and section 4 of EO 14187, based on the fact that a healthcare entity or health professional provides gender-affirming medical care to a patient under the age of nineteen" while the case is being decided. Similarly, the Notice of Court Order for *Washington v. Trump*, 2:25-cv-244-LK (W.D. Wash.) has a similar requirement prohibiting certain actions by the Defendants in the case within the Plaintiff states of Washington, Oregon, Minnesota, and Colorado, which went into effect the evening of February 28, 2025. The April 18, 2026 ruling by the United States District Court for the District of Oregon in the case of Oregon v. Kennedy, 6:25-cv-2409-MTK (D. Or.) maintains this requirement, prohibiting the implementation of any policy that "supersedes or purports to supersede" professionally recognized standards of health care as defined by 42 C.F.R. § 1001.2.

Consistent with the considerations outlined above, responses to this question will not be used in any funding determination decisions for health centers.

12. Estimates of Annualized Hour and Cost Burden

12a. Estimated Annualized Burden Hours:

Form Name	Number of Respondents*	Number of Responses per Respondent	Total Responses	Average Burden per Response (in hours)	Total Burden Hours
Universal Report	1,596.00	1.00	1,596.00	184.20	293,983.20
Grant Report	419.00	1.22	511.18	20.80	10,632.54
Total	2,015.00	--	2,107.18	--	304,615.74

*The estimated number of respondents for the Universal Report consists of 1,356 Health Center Program recipients, 170 Health Center Look-alikes, and 70 NEPQR and ANE recipients. The estimated number of respondents for the "Grant Report" is based on the number of reports submitted by health centers in 2025: 337 (1 report), 71 (2 reports), 11 (3 reports).

The burden estimates for completing the UDS have been determined based on HRSA's experience, minor modifications proposed by commenters, and feedback received from outside consultation and key stakeholders. For 2025 UDS reporting, HRSA estimates that approximately 1,596 respondents completed the Universal Report, and a subset of those respondents (419) also completed the Grant Report, as described below. For this collection, respondents are defined as the entity receiving HRSA funding or designation. HRSA is requesting that the organization respond, not an individual person for themselves.

The UDS report is completed by all Health Center Program award recipients, look-alikes, and – certain NEPQR and ANE award recipients. The Universal Report is completed by all recipients and look-alikes, and the Grant Award Report is completed by a subset of recipients who receive multiple grant awards. Look-alikes DO NOT receive regular federal funding under section 330 of the PHS Act but meet the Health Center Program requirements for designation under the program (42 U.S.C. 1395x[7] (aa)(4)(A)(ii) and 42 U.S.C. 1396d(l)(2) (B)(ii)).

The average burden per response for completing the Universal Reporting is estimated to take 184 hours, and an estimated 21 hours for the Grant Report.

The Grant Report is completed by a subset of Health Center Program award recipients[8] who receive funding to serve migratory and seasonal agricultural workers, funding to serve homeless populations, and funding to serve residents of public housing. These grant reports are a subset of the universal report and are estimated to take 21 hours to complete. Organizations that receive multiple funds are required to

7 https://uscode.house.gov/view.xhtml?req=(title:42%20section:1395x%20edition:prelim)
8 https://data.hrsa.gov/topics/healthcenters/uds/special-populations

report on the different special medically underserved populations they serve, as the statutory authorities for ANE (42 U.S.C. 296j), NEPQR (42 U.S.C. 296p), and the Health Center program (42 U.S.C. 254b) specify the importance of improving access in medically underserved areas.

12b.

The forms are expected to be completed by a Medical Records Specialist, who has a median hourly wage of $24.59 per hour. This amount is multiplied by 2 to adjust for overhead benefits, for a total hourly median wage of $49.18.

Estimated Annualized Burden Costs:

Form Name	Estimated Number of Respondents	Type of Respondent	Average Total Burden Hours	Hourly Median Wage	Estimated Total Respondent Costs
Universal Report	1,596.00	Medical Records Specialist[9]	293,983.20	$49.18	$14,458,093.78
Grant Report	419.00	Medical Records Specialist	10,632.54	$49.18	$522,908.32
Total	2,015.00	--	304,615.74	--	$14,981,002.10

13. Estimates of Other Total Annual Cost Burden to Respondents or Recordkeepers/Capital Costs

Health center respondents may incur additional annual operation and maintenance costs for programming or re-programming their health information technology systems to generate data in the required UDS reporting format.

14. Annualized Cost to the Federal Government

The estimated annual cost to the government for contracts providing technical assistance and data reporting support, data processing, editing, and verification is $3,000,000. Additionally, UDS reporting is supported by a team of FTEs, where a portion of their time is dedicated to UDS. The estimated annual cost to the government for this composition of FTE time is $439,743 and through another contract, about $3,000,000 to support the IT Systems programming, testing, and interface currently used by health centers to submit annual UDS reports. Total estimated annual costs to the government are $6,439,743.

15. Explanation for Program Changes or Adjustments

9 https://data.bls.gov/oesprofile/?major_group=290000&occupation=292072&measure=01&areas=INDUSTRY,STATE,MSA.

In 2026, the estimated total burden hours for this ICR are approximately 304,616 hours, compared to 2025, when the burden was estimated at 377,317 hours—a decrease of approximately 72,701 hours collectively across health centers or an average of 42 hours per health center. This decrease is primarily attributable to HRSA's streamlining efforts, which were undertaken to reduce provider burden.

16. Plans for Tabulation, Publication, and Project Time Schedule

Respondents submit their information between January 1 and February 15 of the calendar year and report on patient demographics, clinical measures, and financials related to primary care services provided to patients served by health centers, and ANE and certain NEPQR recipients over the previous calendar year. For example, the 2025 UDS data were reported January 1 through February 15 of 2026. From February 15 to March 31, UDS reports are reviewed for data quality and consistency. Statistical analyses are conducted with the information collected. Please see Supporting Statement B for more detailed information. Summary descriptive reports of the information collected have historically been prepared and published by August of the calendar year on HRSA's data website: https://data.hrsa.gov/tools/data-reporting.

17. Reason(s) Display of OMB Expiration Date is Inappropriate

The OMB number and expiration date will continue to be displayed on the back cover of the UDS Manual's electronic file.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.