NATIONAL ASSOCIATION OF Community Health Centers

February 9, 2026

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5600 Fishers Lane, Room 13N82
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RE: Health Resources and Services Administration (HRSA) Uniform Data System (UDS), OMB No. 0915-0193 – Revision

To Whom It May Concern:

On behalf of the 1,512 Community Health Centers (CHCs), I am writing today regarding the proposed changes to the Uniform Data System. At a time when CHCs are facing unprecedented burden and financial strain, we appreciate HRSA's efforts to modernize reporting and reduce administrative burden while preserving the accountability and value of UDS data for program oversight and assessment of the CHC Program.

For the past 55 years, the National Association of Community Health Centers (NACHC) has been the leading national, nonpartisan organization dedicated to supporting CHCs (also known as Federally Qualified Health Centers) as the Employer, Provider, and Partner of choice in all communities, as well as the foundation of the primary health care system in the United States with our committed 326,000 primary care workforce, and the 34 million patients we served in 2024. For 60 years, CHCs have provided high-quality, affordable, comprehensive care – including primary, preventive, dental, behavioral health, pharmacy, vision, and other essential health services at over 17,000 locations across rural and nonrural communities. This includes 1 in 3 rural residents and 1 in 2 in poverty. As our nation's largest primary care system, there is strong evidence, including from the Congressional Budget Office, that our work saves lives and also saves Medicaid and Medicare billions annually by reducing costly emergency, inpatient, and specialty care.[1] Research shows that every dollar invested in primary care yields a 13-to-1 return in overall health system savings.[2]

NACHC appreciates the opportunity to comment on HRSA's proposed changes to the Uniform Data System (UDS). NACHC supports CHCs through research, training, technical assistance, and convening activities, and has a strong interest in ensuring that UDS reporting remains accurate, useful, and practical to implement.

NACHC supports HRSA's continued alignment of UDS clinical quality and outcomes measures with the Centers for Medicare & Medicaid Services (CMS) electronic clinical quality measure

[1] Volerman A, Carlson B, Wan W, Murugesan M, Asfour N, Bolton J, Chin MH, Sripipatana A, Nocon RS. Utilization, quality, and spending for pediatric Medicaid enrollees with primary care in CHCs vs non-CHCs. BMC Pediatr. 2024 Feb 8;24(1):100. doi: 10.1186/s12887-024-04547-y. PMID: 38331758; PMCID: PMC10851548.
[2] https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/PCPCH-Program-Implementation-Report-Final-Sept-2016.pdf

(eCQM) specifications. Alignment across federal reporting programs reduces duplicative reporting and allows CHCs to rely on a single set of data definitions, thereby improving the comparability of performance data. These efficiencies are significant given ongoing workforce shortages and increasing administrative demands on CHCs. CHCs are struggling to retain and recruit staff due to provider shortages, competitive salary gaps, and persistent burnout among healthcare workers, resulting in CHC patients going without needed care.[3] A 2024 survey showed 55% of CHCs had difficulty filling open positions.[4] Alignment of measures can save staff time by reducing the need for training and review of the appropriate measures. Given the technical complexities, it is often harder for CHCs to recruit for roles that help support quality measure reporting.

To ensure that alignment results in meaningful burden reduction for CHCs, NACHC encourages HRSA to maintain close and ongoing synchronization with CMS measure updates. When UDS specifications differ from CMS eCQM definitions, clear, timely crosswalks from HRSA that explain the differences and their implications for reporting would greatly support CHCs. Advanced notice of anticipated changes and early technical guidance and training would also help CHCs plan for system updates and workflow adjustments while minimizing disruption and reporting challenges. NACHC appreciates the proposed removal of the member months data elements from Table 4, which will significantly reduce manual and duplicative data collection activities for CHCs. While these data elements have at times served as a compliance mechanism encouraging regular payer roster reconciliation, a process that can support value-based care (VBC) roster management, the burden of manually pulling rosters each month from multiple payer portals is substantial. The removal would be a significant burden reduction for CHCs, especially those operating with limited staff.

However, we have concerns regarding the proposed elimination of the selected services addendum in Table 5. HRSA has historically relied on UDS data to track outcomes associated with federal behavioral health funding, and the selected services addendum is the primary mechanism for capturing behavioral health services delivered by non-psychiatrist and non-Licensed Professional Counselor (LPC) providers, including primary care-based behavioral health. Eliminating this addendum risks substantial underreporting of the behavioral health services that CHCs provide at the state and national levels and may discourage collaborative care outcome tracking. NACHC is concerned that this could result in CHCs being unfairly assessed on their Section 330 grant performance because behavioral health services are not adequately represented. NACHC also has concerns about removing "Quality Improvement (QI) – Table 5, Line 29b, Quality Improvement Personnel" and instead reporting QI personnel under "Line 30c, Information Technology Personnel." Quality Initiatives personnel and IT (information technology) personnel, while they complement each other's work, have vastly different job functions and focuses. QI staff seek to improve processes, patient outcomes, and clinical care by identifying inefficiencies, whereas IT staff create the technological infrastructure, data systems, and support tools such as Electronic Health Records (EHRs) that track and automate improvements to those inefficiencies. We request that these continue to be reported separately to ensure sufficient understanding of the CHC workforce across these different jobs.

[3] https://www.nachc.org/wp-content/uploads/2026/01/policy-papers_chc-workforce_jan-2026.pdf
[4] https://www.nachc.org/wp-content/uploads/2024/10/2024-FinChallanges-PulseSurvey-Report-08.14.24.pdf

Additionally, NACHC supports several proposed changes to Table 6. We strongly support modernizing Table 6A to include distinct measures for Type 1 Diabetes (Line 9a). Distinguishing Type 1 diabetes is essential for accurate risk adjustment and quality benchmarking, as the clinical management and resource intensity differ significantly from Type 2 diabetes. Over 3.3 million CHC patients have a diagnosis of diabetes mellitus; understanding the breakdown between Type 1 and Type 2 will help CHCs better plan and serve these different patient populations.

NACHC also supports the new measures added in Health-Related Social Needs (Lines 39-42) in Table 6. Transitioning these four health-related needs measures into the UDS' core tables, previously included in the UDS Appendix D, reinforces the "whole person" care model that CHCs specialize in. Furthermore, this aligns with USCDI v3.1[5] (United States Core Data for Interoperability), ensuring that Electronic Health Record (EHR) adhere to terminology and coding standards, as required for compliance with many value-based payment contracts. Given the increased movement towards value-based care, these data are crucial for better understanding and meeting patients' needs to achieve improved outcomes at lower cost. It also reinforces that vendors support the extraction of this important data, including through the PRAPARE tool, a national standardized patient risk assessment tool, co-designed by NACHC to engage patients in assessing and addressing non-clinical factors of health.[6]

However, the transition of Health-Related Needs Services to Table 6A presumes that these screenings are captured as structured data (SNOMED/LOINC) within the EHR. We request that HRSA ensure these definitions strictly align with the USCDI v3.1[7] standards, or higher, to ensure that CHCs can leverage certified health IT for automated reporting, rather than reverting to manual chart abstraction.

NACHC supports several of the proposed financial reporting changes, which represent substantial improvements for many CHCs. Shifting Table 9D from cash-based to accrual-based reporting will better align UDS financial reporting with standard accounting practices and reduce confusion and reconciliation challenges for CHCs. We also support adding a distinct line item for third-party alternative payment model (APM) revenue, which will improve transparency around emerging payment arrangements. Additionally, consolidating Medicaid and Medicare reporting into total program categories, rather than separating fee-for-service and managed care, may reduce complexity and confusion for CHCs in states with varied payment structures and better reflect how revenue is managed operationally.

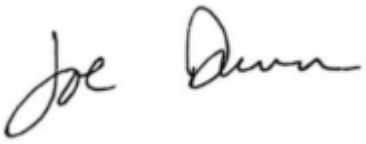
Additionally, we urge HRSA to carefully consider the proposed revisions to Table 9E: Other Revenue. While we recognize the intent to streamline reporting and reduce administrative burden, eliminating or reducing grant-level reporting elements could limit HRSA's ability to monitor how federal grant funds are used to support core CHC services. Grant-level indicators have historically provided important insight into the allocation and use of federal resources, supporting transparency, program oversight, and consistent trend analysis across reporting years. This data has also helped ensure program monitoring continuity by allowing HRSA to track the use of federal funds consistently over time, even as funding structures, reporting requirements, and policy

[5] https://isp.healthit.gov/sites/default/files/USCDI-Version-3-1_2025_508.pdf
[6] https://prapare.org/the-prapare-screening-tool/
[7] https://isp.healthit.gov/sites/default/files/USCDI-Version-3-1_2025_508.pdf

priorities evolve. This is especially important given that Section 330 (g), (h) and (i) of the Public Health Service Act provides funding to specific CHCs to provide care for special medically underserved populations.[8] Tracking this data is crucial to validate how CHCs remain compliant with federal statutory requirements. Therefore, NACHC encourages HRSA to retain a limited, targeted set of grant-level data elements that balance reporting efficiency with the need for accountability and meaningful financial oversight.

Thank you for the opportunity to comment on these proposals. NACHC appreciates HRSA's continued engagement with stakeholders and its commitment to improving the usability and relevance of UDS reporting. Pairing the proposed changes in this information collection request with clear crosswalks, targeted technical assistance, and transparency regarding implications for program monitoring will help ensure that UDS remains a valuable tool for both CHCs and HRSA. If you have any questions about our comments, please contact Dr. Peter Shin, Chief Science Officer and Vice President of Data Analytics, at pshin@nachc.org.

Sincerely,



Joe Dunn
Chief Policy Officer

[8] https://www.nachc.org/wp-content/uploads/2023/02/Section-330-statute-as-of-March-2018-Clean.pdf