February 9, 2026

U.S. Department of Health and Human Services
Health Resources and Services Administration
HRSA Information Collection Clearance Officer
5600 Fishers Lane, Room 13N82
Rockville, MD 20857

Re: Comments on Health Resources and Services Administration (HRSA) Uniform Data System (UDS), OMB No. 0915-0193 − Revision

To Whom it May Concern,

The Mid-Atlantic Association of Community Health Centers (MACHC) appreciates the opportunity to comment on Program Assistance Letter (PAL) 2025-05. MACHC values HRSA's continued efforts to improve financial reporting clarity and transparency within the Health Center Program and recognizes the agency's responsiveness to long-standing reporting challenges.

MACHC is the federally designated Primary Care Association, serving Maryland and Delaware's nineteen Federally Qualified Health Centers (FQHCs). As vital, community-driven primary care providers, health centers serve more than 360,000 people in Maryland and 41,000 in Delaware, respectively.

MACHC strongly endorses HRSA's decision to separate Pharmacy Net Patient Service Revenue from Net Patient Service Revenue. Pharmacy revenue, including in-house and contract pharmacy services, differs significantly from revenue generated through core clinical services. Clearly distinguishing pharmacy net patient service revenue will enhance the accuracy of health centers' financial reports, clarifying how service lines affect overall financial sustainability. This adjustment will also enable better analysis by policymakers, regulators, and stakeholders. Overall, this change is a significant improvement that will help health centers better explain financial structures and meet the growing demand for information related to pharmacy operations.

To further strengthen the usefulness of patient revenue by payer data, MACHC recommends clarification regarding the reporting of patient payments associated with insured visits. Under current conventions, patient payments collected at the point of service for insured patients may be classified as self-pay, which can overstate uninsured revenue and understate contributions from public and private insurers. For example, a Medicaid patient who pays a $5 copayment at the point of service generates revenue that is attributable to Medicaid. However, under current UDS reporting requirements, the copayment is reported as self-pay, making Medicaid revenue appear lower than it actually is, while self-pay revenue is overstated.

MACHC recommends clarifying that patient payments attributable to insured visits should be reported within the corresponding insurance category rather than as self-pay. Because these payments are part of the total reimbursement for an insured encounter, reporting them as self-pay can distort payer mix and understate reimbursement from public and private insurers. This

approach would present a more complete picture of payer mix and payment adequacy, strengthening the usefulness of the data for financial planning, benchmarking, and policy analysis.

Together, isolating pharmacy net patient service revenue and clarifying the treatment of insured patient payments would help health centers track payment adequacy across payers with greater precision. These changes would also promote greater transparency in health care reporting, enabling health centers to respond more effectively to requests for financial information and to engage more meaningfully with legislators and agency officials about health center financing and sustainability.

The association is happy to speak with HRSA staff to discuss these comments, share reporting examples, and highlight related work currently underway at MACHC that may be informative to HRSA's efforts. MACHC appreciates HRSA's ongoing collaboration with the health center community and thoughtful consideration of these comments and looks forward to continued partnership.

Sincerely,

Delaney McGonegal

Delaney McGonegal
Director, Health Policy & Analytics
Maryland Association of Community Health Centers