*Health centers must comply with legal and regulatory requirements to receive financial support under the Health Center Program, including requirements related to governance authority and oversight. This series – **Governing Board Responsibilities and How to Do Them** – addresses several of the main governance requirements of the Health Center Program and for each describes board responsibilities and actions to meet and comply with requirements. Each document in the series provides guidance on:*

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1 Assess & Monitor Needs of Target Population

The mission, goals, and plans for a health center should be based on the needs of the target population served by the health center. The Health Resources and Services Administration's Bureau of Primary Health Care (HRSA/BPHC) requires that grantees of the Health Center Program document the needs of their target population and update their service area when appropriate. The governing board is required to oversee the organization's progress in meeting its mission and goals and should expect to see a periodic update to a written needs assessment document prior to engaging in a strategic planning effort.

Goals for the Needs Assessment

- Presents a thorough description of the service area, the characteristics, needs, and perceptions of the target and patient populations, and identifies the barriers to care, the resources available, the gaps in service, and the external factors affecting these conditions;
- Provides a sound basis for defining and adapting the mission, goals, and plans of the health center;
- Complies with the BPHC program requirements.

Governing Board's Responsibilities

- Assure there is a written needs assessment that is periodically updated;
- Assure there's an ongoing process in place to regularly monitor the needs of the target population and the external factors that may affect the organization's ability to meet those needs;
- Assure there is a board committee assigned to oversee the needs assessment and strategic planning functions;
- Assure the needs of the target and patient populations are used in strategic planning to define and adapt the health center's mission, goals, and plans including the establishment of its sites, services, and service area.

Program Requirements

In order to receive and continue receiving financial grant support from HRSA/BPHC, health centers are required by law to:

- Demonstrate and document the needs of their target population and update their service area when appropriate;
- Provide that the governing board has the authority to oversee the operations of the health center including measuring and evaluating the organization's progress in meeting its annual and long-term program and financial goals, developing long range strategic plans, ongoing review of the organization's mission and bylaws, evaluating patient satisfaction, and monitoring organizational assets and performance;
- Provide that the governing board establish the general policies for the health center

Described in **Public Health Service Act** (42 U.S.C. 254b), Section 330(k)(2) *Applications - Description of Need*, Section(k)(3)(J) *Applications - Requirements*, and the **Code of Federal Regulations** 42 CFR Part 51c.304 - that defines operating requirements.

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Information for the Governing Board to Review

The committee designated by the board to oversee the strategic planning function will usually take the lead in reviewing the needs assessment process and will be the primary reviewer of the information identified below.

- ❑ **Written needs assessment:** The health center is periodically required to reassess the service area and the needs of its target and patient populations. This should be summarized in a written needs assessment. Normally this reassessment will occur prior to the governing board engaging in a strategic planning effort. It is also advisable for the needs assessment to be reasonably current prior to the submission of the Section 330 service area competition (SAC) grant application, which minimally will occur every five years. Significant changes in the service area that affect need may also require a reassessment. This might involve changes in reimbursement, grant opportunities, industry, population, primary care capacity, and other factors.

- ❑ **Service area maps:** A service area map should reveal the geographic boundaries of the service area approved by BPHC and the numbers of current patients by zip code and possibly census tract. Health centers are currently required to report the number of patients with one or more reportable visits by zip code as part of the Uniform Data System (UDS) report submitted each calendar year.

- ❑ **Service area overlap:** The absence or presence of other health centers or other safety net providers such as rural health clinics or critical access hospitals serving residents of the approved service area should be reported to the governing board as part of the needs assessment and planning process. The BPHC “UDS Mapper” software uses the patient data by zip code to show the extent to which patients are seen by each health center grantee serving any particular zip code tabulation area (ZCTA). This is a useful tool for identifying underserved areas and opportunities for expansion. Health centers with overlapping service areas are expected to consider opportunities for collaboration and sharing resources.

- ❑ **The grant application and need for assistance (NFA) worksheet scores:** Section 330 grant applications include the need for the health center as an important evaluation criterion. Knowing these scores for the most recent competitive application provides a good picture of the relative need for the health center compared to other health centers and the organization’s ability to compete for health center funding. Management should report these results and the NFA worksheet to the committee designated to oversee the needs assessment function.

1 Assess & Monitor Needs of Target Population

Questions for the Governing Board to Ask

1. **Is the needs assessment in writing and is it up to date?** In order to demonstrate that the organization is complying with the requirement to document the needs of its target population the needs assessment should be in writing and reflect current need. A reassessment should be conducted minimally every five years or when strategic planning is undertaken or when external, factors materially change the needs of the target population.

2. **Is the needs assessment complete?** Does the written needs assessment thoroughly describe the geographic characteristics of the service area; the demographic characteristics of the target, special, and patient populations; the perceptions of the patient, special and target populations; the health resources available, the gaps in service and the barriers to care; and the status of external factors affecting these conditions.

3. **Are the needs of special populations considered?** Special populations include migrant and seasonal farmworkers and their families, homeless, at-risk schoolchildren, and residents of public housing. Grantees who receive funding designated for serving special populations are required to address the needs of these populations separately. This should also be done when special populations are present in the service area in significant numbers.

4. **Are people with special health needs considered?** Health centers whose target or patient populations include significant numbers of those with special health needs such as HIV/AIDS, pregnancy, dental health, behavioral health, and substance abuse should separately address the needs of those populations.

5. **What are the barriers to care?** Barriers to care can include cultural differences, language, illiteracy, geographic obstacles, distance, transportation, poverty, unemployment and similar factors. Health centers should attempt to eliminate or minimize these barriers where possible.

6. **Is the approved service area accurate or should it be revised?** The service area should comprise the locations where the large majority of the patients originate. If this is not the case, consideration should be given to changing the approved service area by filing a change in scope application with BPHC.

7. **Is there service area overlap with other health centers or safety-net providers?** Areas within or adjacent to the approved service area that are underserved should be considered for expansion opportunities. If other safety net providers are serving patients within the approved service area, opportunities for collaboration should be strongly considered.

8. **Are all of the center's services available to all residents of the service area?** Health centers that receive section 330(e) funds are required to make all the services offered available to all residents of the service area to the extent they are able.

9. **Is the health center's mission, its goals, plans and its sites, services and service area aligned with the needs of the target population?** Health centers should be serving the needs of their target populations.

10. **What are the need scores for the most recent competitive application and the NFA worksheet?** The need scores from the most recent competitive application provide an indication of both the absolute need for the health center and its relative need compared to other health centers.

For More Information

PROGRAM REQUIREMENTS
http://bphc.hrsa.gov/about/requirements/index.html

SERVICE AREA OVERLAP POLICY
http://www.bphc.hrsa.gov/policiesregulations/policies/pin200709.html

DATA RESOURCES FOR DEMONSTRATING NEED FOR PRIMARY CARE SERVICES
http://www.hrsa.gov/grants/apply/assistance/NAP/dataresourceguide.pdf

NEED FOR ASSISTANCE WORKSHEET
http://www.hrsa.gov/grants/apply/assistance/sac/
Scroll down to Program Specific Forms: Form 9.

UDS MAPPER
http://www.udsmapper.org/about.cfm

HEALTH CENTER SERVICES POLICY
http://www.bphc.hrsa.gov/policiesregulations/policies/services.html
Scroll down to Special Populations.

HEALTH CENTER COLLABORATION POLICY GUIDANCE
http://bphc.hrsa.gov/policiesregulations/policies/pal201102.html

SECTION 330 OF THE PUBLIC HEALTH SERVICE ACT
Authorizing Legislation of the Health Center Program
http://bphc.hrsa.gov/policiesregulations/legislation/index.html

HEALTH CENTER PROGRAM REGULATIONS
Federal rules to operate a health center funded under the Health Center Program
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2 Approve Health Center Program Grant Application

The federal Health Center Program grant application is the document that defines the financial and program plans for the health center and is a principal reference used by the Health Resources and Services Administration's Bureau of Primary Health Care (HRSA/BPHC) to exercise its oversight of the grantee. The governing board has a legal obligation to formally approve the proposed activities compared to the budget requested in the application. The budget is generally assigned to the board's finance committee and the program goals, objectives, and work plan to the board's program committee. This guidance focuses on the review and approval of the program proposed in the application. Guidance #4 in this series discusses the grant budget approval process.

Goals for the Section 330 Grant Application

- Accurately reflects the organization's mission and its financial and program goals;
- Maintains or increases the organization's service capacity;
- Is prepared in a timely fashion in advance of its submission due date;
- Receives a high score from application reviewers and results in funding for the maximum project period time-frame;
- Results in no "grant conditions for non-compliance" with program requirements.

Governing Board's Responsibilities

- Assure that the health center has a realistic plan for achieving the organization's annual and long-term goals, including clinical and financial performance measures, factors that might impact on performance, and one or more actions intended to improve performance;
- Assure that the grant budget accurately reflects the expected revenues and cost of operations;
- Assure that the health center maintains and to the extent possible increases its service capacity;
- Review and approve the application and document approval in the board meeting minutes;
- Regularly evaluate and revise the program and financial projections as necessary.

Health Center Program Requirements

In order to receive and continue receiving federal financial grant support from HRSA/BPHC, health centers are required by law to:

- Provide that the governing board has the authority to oversee the operations of the health center including approving the annual health center grant application and budget , and measuring and evaluating the organization's progress toward achieving its annual and long term program and financial goals.

Described in Section 330(k)(3)(H) of the **Public Health Service Act** – the Federal law that authorizes the Health Center Program, and in the **Code of Federal Regulations** that defines operating requirements – 42 CFR Part 51c.304.

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2 **Approve Health Center Program Grant Application**

Information for the Governing Board to Review

While the governing board has a legal obligation to approve the federal Health Center Program grant application, it should be understood that there are a variety of grant offerings made by HRSA/BPHC, all of which must be reviewed and approved by the governing board. Similarly, the health center organization may be conducting other major grant or contractual programs and as a matter of policy, the board must approve these commitments in advance of their submission. The information suggested below is generic but represents the kind of information the health center governing board's program committee or the committee assigned this responsibility should receive.

- ❑ **Relevant grant program guidance:** The Health Center Program issues a specific guidance for the budget period renewal grants, the service area competition grants, and other grant offerings. Similarly, other grant programs usually do the same. The board's program and finance committees should have access to the program guidance requirements in order to assess whether the application is fulfilling application requirements. This may include the required forms, other instructions, and review criteria.

- ❑ **Notice of grant award for <u>current</u> budget period:** The notice of grant award identifies any conditions placed upon the award, the length of the current project period, the amount of federal funding, and similar items. The governing board should be aware of conditions placed upon the current award, whether these were adequately satisfied, and whether there are any conditions outstanding.

- ❑ **Site visit reports or reviews from the awarding agency:** Any technical assistance; reports from the project officer, Division of Financial Integrity, Inspector General, or other site visit reports or reviews conducted by the awarding agency since the last competitive application should be examined. If compliance or performance improvement recommendations were made, the application should satisfactorily address these matters. Similarly, competitive applications are reviewed and scored with comments by an Objective Review Committee (ORC) comprised of independent reviewers. The ORC's scoring and comments are provided to the grantee. This document should be reviewed and any weaknesses identified in the prior application should be corrected.

- ❑ **Draft copies of the grant application**: This should include the program narrative, budget, and any other required forms. Since it is not uncommon for health centers to work up to the deadline preparing applications, the challenge for the governing board is to be involved in the process sufficiently far enough in advance to exercise some level of meaningful oversight.

  The board should avoid being put in the untenable position of having to either ratify an application at the 11th hour or prevent it from being submitted on time. As with the budget process, this requires the committee representatives being involved in reviewing components of the application while it is being prepared.

- ❑ **The identification and justification for any new or changed components to the program being included in the application:** Any new component or significant change such as a new, deleted, or relocated site, or an expansion or contraction of a service or service area should be separately considered and justified by management and receive prior approval from BPHC.

- ❑ **Final copy of the grant application:** Final approval of the HRSA/BPHC grant application should involve a review of the final copy of the program narrative, budget, and forms and attachments required by the applicable guidance by the responsible committees. A copy of the final application may be made available for inspection by the full board, but it is typical for the full board to rely upon the work and recommendation of its committees along with the support of management.

2 Approve Health Center Program Grant Application

Questions for the Governing Board to Ask

1. **Does the application clearly address the review criteria identified in the application guidance so that a good score is likely?** The presentation should be concise and clearly address the review criteria so that the HRSA/BPHC Review Committee can easily find the justification needed to assign a good score to each section.

2. **Are there current compliance issues likely to be found in the current application or any unresolved grant conditions from the previous Notice of Grant Award (NGA)?** Current HRSA/BPHC policy stipulates that applications receiving one or more recommended conditions will receive a three year project period and those with an unresolved condition on their NGA will receive a one year project period.

3. **Does the application propose reasonable health service and financial goals?** Health centers are required to set project period goals for **eight clinical and five financial measures** in their grant application. The baselines and goals the organization has set should be part of the application review and approval process.

4. **Are there any changes being proposed in the application that require prior HRSA/BPHC approval?** Additions and deletions of sites, services, and service areas are to be approved in advance by HRSA/BPHC by filing a **change in scope application** . This process requires filing a written request and a budget showing that the change can be accommodated without any addition of federal funds. Any changes of this nature should not be included in the annual HRSA/BPHC grant application without having received prior approval.

5. **Is the application well written?** As noted above, the presentation should be concise, clearly address the review criteria, demonstrate compliance with program requirements, be in keeping with the proscribed format, be complete, show consistent data and projections, and be carefully proofread.

6. **Could the health center benefit from an external review or assistance?** If the health center has had compliance issues or received a poor score previously, the board and management should consider arranging external support to help with the preparation or to conduct a preliminary review of a draft.

2 Approve Health Center Program Grant Application

For More Information

HEALTH CENTER PROGRAM REQUIREMENTS
http://bphc.hrsa.gov/about/requirements/index.html

SECTION 330 OF THE PUBLIC HEALTH SERVICE ACT
Authorizing Legislation of the Health Center Program
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HEALTH CENTER CLINICAL AND FINANCIAL PERFORMANCE MEASURES
http://bphc.hrsa.gov/policiesregulations/performancemeasures/index.html

DEFINING SCOPE OF PROJECT & POLICY FOR REQUESTING CHANGES
http://bphc.hrsa.gov/policiesregulations/policies/pin200801process.html

HEALTH CENTERS OPEN GRANT OPPORTUNITIES
Scroll down to Primary Health Care and Program Details.
http://www.hrsa.gov/grants/index.html

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3 Adopt a Sliding Fee Discount Program

One of the main purposes of the Health Center Program is to provide grant support to health centers so they can care for people without the means to pay. Grant support allows health centers to offer sliding fee discounts to reduce barriers for individuals with low annual income. The governing board is responsible to adopt policies for financial management practices including a system to assure eligibility for services and criteria for partial payment schedules.

Goals of a Sliding Fee Discount Program

- Reduces barriers for individuals with annual income below 200% poverty;
- Operates based on policies and procedures that are well-defined and understood by staff and patients for consistent administration and efficient management;
- Properly identifies those who are eligible for the sliding fee and other reimbursement programs, such as Medicaid and the Children's Health Insurance Program (CHIP);
- Is supported by the practice management system.

Governing Board's Responsibilities

- Assure that the health center has a system in place to identify and enroll those patients who are eligible for the sliding fee discount program;
- Assure that the schedule of sliding fee discounts and the sliding fee discount program policies comply with the HRSA/BPHC program requirements;
- Guided by patient board members, assure that patients are aware of the sliding fee discount program and that the program does not unintentionally create barriers to care;
- Approve the fee schedule and schedule of discounts and review and update the fee and discount schedule on a regular basis.

Health Center Program Requirements

In order to receive and continue receiving financial grant support from the Health Resources and Services Administration, Bureau of Primary Health Care (HRSA/BPHC), health centers are required by law to:

- Have a system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay. For individuals and families with annual income:
  - Below 100% of the Federal poverty guideline ($10, 890 for a single person in 2011), zero or only nominal fees may be charged;
  - Between 101% and 200% of poverty, fees must be charged in accordance with a sliding discount policy based on family size and income;*
  - Over 200 % of poverty, no discounts may be applied.*
- Establish a protocol to make reasonable effort to collect payments.
- Assure that no person will be denied coverage because of inability to pay.

Described in Section 330(k)(3)(G) of the **Public Health Service Act** – the Federal law that authorizes the Health Center Program, and in the **Code of Federal Regulations** that defines operating requirements – 42 CFR Part 51c.303(f).

***Note**: The asterisk indicates these requirements are recommended, **but not required**, for grantees that receive funds solely for Health Care for the Homeless (section 330(h)) and/or Public Housing Primary Care (section 330(i)) Programs.*

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Adopt a Sliding Fee Discount Program

Information for the Governing Board to Review

The health center governing board or finance committee should receive and review the following documents prior to approving the center's sliding fee discount program:

- ❑ **Sliding Fee Discount Policy:** This health center policy defines the terms and practices used to administer the program, including the health center's *sliding fee discount application form* that patients complete and the *sliding fee discount schedule* showing the discount provided each income grouping or sliding fee class. The federal regulations do not define "nominal," nor are there requirements for specific percents of discounts for uninsured and underinsured patients with income between 101-200% of the federal poverty guidelines.

  Often centers have a brochure for patients that can be used to describe sliding fee discounts available for various services the health center provides, how a patient applies for fee discounts, other eligibility assistance offered, and other discounts that may be available for referred ancillary and specialty services.

- ❑ **Most Recent DHHS Federal Poverty Guidelines**: The U.S. Department of Health and Human Services (DHHS) uses **Federal Poverty Guidelines** to determine eligibility for a number of programs, including the Health Center Program. The Guidelines are updated each year and announced in a Federal Register notice.

Questions for the Board to Ask

1. **Does the health center's sliding fee discount policy reflect the most recent poverty guidelines?** The policy should be updated each year to define 100% of poverty based on the most recent DHHS poverty guidelines.

2. **Does the sliding fee discount policy comply with the program requirements contained in the Health Center Program law?** These are:

   - Fees charged to patients with incomes at or below 100% of the current poverty guidelines must either be zero or nominal, which is insignificant or minimal. The board should assure that if co-payments are added to nominal fees for each lab test, prescription, x-ray or other service, the total fee must still be nominal for those with incomes at or below 100% poverty.
   - Discounts must be offered for those with income between 101% and 200% of the poverty guideline. The policy and schedule should define how many income groupings there will be within this range and the discount provided to each group. The number of income groupings between 101% and 200% of poverty varies, but as few as two, 101% - 150% and 151% - 200% of the poverty guideline can simplify the program without any negative effect on collections.
   - No fee discounts are to be provided to patients with annual income above 200% of the poverty guideline.

3. **Are patients aware of the availability of discounts for those with a financial hardship?** Signs written in languages spoken by the patients should be posted in the lobby and cashier's desk announcing the availability of discounts as well as a description of how the sliding fee scale works. As noted, some centers make brochures about sliding fee discounts available to patients.

Adopt a Sliding Fee Discount Program

4. **Does the policy clarify the length of time an individual is eligible for fee discounts?** The eligibility term is usually one year and set to renew as of the date the application for eligibility is approved. Eligibility terms of less than one year are permitted but rarely used and are more costly to administer.

   There are other matters the sliding fee discount policy should address for it to work effectively and achieve the goals stated above. Some of these that should be reviewed by the governing board are discussed below.

5. **How does the policy define "income" and "family"?** The Federal Register notice does not define either what income is to be counted or whose income is to be included in the household or family. There is discretion here, but income is often defined as the gross income reported for federal income tax purposes. This includes gross wages, tips, social security disability, veteran payments, alimony, child support, military, unemployment, and public aid. The individuals whose income is to be included is often defined as the head of household, the spouse, and their dependants. The definition of dependent varies but often is either tied either to the IRS rules or alternatively to those individuals the applicant is legally obligated to support.

6. **Does the sliding fee scale application require individuals to document income and family size and to certify by signature that this information is correct?** The policy should require that income and family size be documented and define how that may be done. For example, for income – paycheck stubs or a signed letter from the employer stating hours worked per week or biweekly and pay per hour; for unearned income – proof of child support, social security statements, or unemployment check stubs; or if no household income – a document denying medical assistance. The documentation should be kept on file with the application and the application should be signed by the patient. It's best to keep these records separate from patient records. The policy should identify the circumstances, if any, where self-declaration of income will be permitted.

7. **Does the health center provide discounts by type of service?** Although it complicates its administration, it is possible to offer different discounts for different services. Similarly, some centers pay for services provided by referred care providers or secure agreements to have referred care providers see health center patients at a discount. Centers may also help patients establish eligibility for other reimbursement or indigent care programs such as Medicaid or pharmacy assistance programs. It's good if all the arrangements designed to remove financial barriers for indigent patients are included in the policy being approved.

8. **What criteria are defined in the policy for referring patients to other reimbursement programs?** The policy should include criteria for identifying patients who may be eligible for other reimbursement programs, particularly Medicaid, and to refer them so their eligibility may be determined. It is prudent to require these patients to document that they were rejected prior to approving their sliding fee application.

Adopt a Sliding Fee Discount Program

9. **Do sliding fee discount procedures make use of the health center's automated practice management system?** When possible, the health center's automated practice management system should support the sliding fee discount program by having it set the sliding fee class; flag expired accounts; generate mailing lists for patients whose eligibility is about to expire so applications can be mailed; and track the charges, collections and visits by sliding fee class in order to be able to evaluate the collections experience.

10. **Are there provisions in the policy to encourage and enforce patient compliance with the policy requirements such as income documentation and fee collection?** Given that overall collections from sliding fee patients are often immaterial compared to total patient service revenue, it is often best to use non-financial techniques to maximize collections and minimize the loss of goodwill of patients and staff. The policy might include focusing staff efforts on properly classifying patients for the sliding fee and other reimbursement programs, designing procedures to collect at the time of service, and forgoing use of mailed statements and collection agencies for the sliding fee population. Another provision to simplify fee collection may be to use a flat fee for all visits for each sliding fee income grouping instead of a fee based on discounting the charges for each particular visit. For example, patients between 101% and 150% of poverty could be charged a flat fee of $25 regardless of the services received. This enables staff to know what the patient is expected to pay prior to their being seen by the clinician.Referrals to a financial counselor and the loss of appointment privileges are other common enforcement provisions.

11. **Are insured patients eligible for the sliding fee program?** Insured patients may have deductible and copayment charges and may also receive services that are not covered by their insurance payer. These charges can represent a barrier to care for those insured patients who are indigent. The sliding fee policy should include insured patients whose income meets the sliding fee guidelines and the sliding fee discounts should be applied to the patient liability portion of their accounts.

3 Adopt a Sliding Fee Discount Program

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2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES POVERTY GUIDELINES
http://aspe.hhs.gov/poverty/11fedreg.shtml

FREQUENTLY ASKED QUESTIONS RELATED TO THE POVERTY GUIDELINES AND POVERTY
http://aspe.hhs.gov/poverty/faq.shtml#differences

ESTABLISHING AND COLLECTING FEES FOR HEALTH CENTER SERVICES
NACHC analysis, July, 2009
http://www.nachc.com/client/documents/Establishing_and_Collecting_Fees.pdf

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- *Links for additional information and resources.*

4 Approve and Monitor Annual Budget

The budget is the health center's financial plan for achieving its health service program and financial goals. It is one of the principal ways the governing board controls what the health centers does and how it will be done.

Goals for the Budget

- Is designed to achieve a breakeven or better financial performance;
- Maintains or increases the organization's service capacity;
- Uses conservative assumptions based upon prior period actual data;
- Makes allowances for uncertainties yet reliably achieves the projected result;
- Is prepared in a timely fashion well in advance of the start of the budget period;
- Is routinely monitored, variances are explained, and projected results achieved;
- Contributes to the improved financial well-being of the health center.

Governing Board's Responsibilities

- Assure that the health center has a realistic plan for achieving the organization's annual and long term programmatic and financial goals;
- Assure that the budget accurately reflects the expected revenues and cost of operations;
- Assure that the health center maintains and to the extent possible increases its service capacity;
- Review and approve the budget;
- Regularly evaluate budget projections and correct as necessary.

Health Center Program Requirements

In order to receive and continue receiving federal financial grant support from the Health Resources and Services Administration's Bureau of Primary Health Care (HRSA/BPHC), health centers are required by law to:

- Develop a budget that reflects the costs of operations, expenses, and revenues, including the Federal grant, necessary to accomplish the service delivery plan, including the number of patients to be served;
- Provide that the governing board has the authority to oversee the operations of the health center including approving the annual health center grant application and budget, and measuring and evaluating the organization's progress toward achieving its annual and long term program and financial goals.

Described in Sections 330(k)(3)(D), Section 330(k)(3)(H), Section 330(k)(3)(I)(i), of the **Public Health Service Act** – the Federal law that authorizes the Health Center Program, and in the **Code of Federal Regulations** that defines operating requirements – 42 CFR Part 51c.304 and 45 CFR Part 74.25.

This series of publications was supported by Grant/Cooperative Agreement No. U30CS16089 from the Health Resources and Services Administration, Bureau of Primary Health Care (HRSA/BPHC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA/BPHC.

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Information for the Governing Board to Review

The board may be involved in approving multiple budgets at different times of the year. The organization's fiscal year may be different from its federal Health Center Program grant budget period. In this case, the board will be approving the health center's total operating budget prior to the start of the center's fiscal year. The Health Center Program grant budget will be approved prior to the grant budget period. There also may be other major programs the organization is conducting with different budget periods requiring separate reviews and approvals. The information suggested below is generic but represents the kind of information the health center governing board finance committee should receive and review prior to approving a budget.

- ❑ **Relevant grant program budget requirements:** The Health Center Program issues guidance that identifies requirements for each specific grant offering. The board or finance committee should have access to this guidance in order to assess whether the proposed budget fulfills requirements and that required forms are completed, including the income analysis, the budget justification, and the financial performance measures forms.

- ❑ **Prior period actual data**: This will typically include the prior year's actual data, and the current budget period's actual year-to-date data annualized. Comparisons to prior period actual data should be presented to support the budget information as well as a final summary budget. The finance committee should have access to whatever detailed actual data as may be needed and requested.

- ❑ **Supporting information for new components to the budget:** Any new budget component such as a new site, new service, or expansion of service should be separately considered and justified.

- ❑ **Personnel costs budget:** Personnel costs typically account for approximately 70% of a health center's cost of operations. A detailed personnel budget by individual showing titles, level of effort or FTE, annual salary, and budgeted salary classified by function along with detail showing the cost of benefits by benefit type is usually provided. Larger organizations will often consolidate this data by position type and by function. Provisions for increases and changes in benefits should be separately identified and considered. This should be sufficiently detailed and explained so as to reveal compliance with the organization's personnel, salary, and benefit policies.

- ❑ **Non-personnel costs budget:** The need for separate budget schedules for costs other than personnel is largely a function of the complexity of the organization. Non-personnel costs include supplies, equipment, service contracts, pharmaceuticals, communications expense, postage, freight, housekeeping, insurance, travel, training and similar items. Organizations with multiple functions or services will often present separate schedules by service type. Less complex organizations may find it adequate to present non-personnel costs in the summary budget.

- ❑ **Revenue budget:** Revenue for health centers is often divided into three main revenue streams: 1) federal grant, 2) patient service revenue; and 3) state, local, and other revenue. The federal revenue for the grant application budget is set at the prior year's "federal target level" without any increases projected. A schedule for state, local, and other revenue should be prepared showing each source and documenting any estimations made about continued funding for sources whose terms are subject to renewal during the budget period being proposed. The patient service revenue budget requires a separate presentation.

4 Approve and Monitor Annual Budget

- **Patient service revenue (PSR) budget:** Patient service revenue is the direct earnings from providing services to patients, such as reimbursement from Medicaid or payments from self-pay patients. The patient service revenue budget accounts for approximately 60% of the average health center's total revenue. It is the largest and most uncertain of the three main revenue streams. *The ability to accurately forecast and realize the PSR target will often makes the difference between financial success and failure. For this reason, this part of the budget process warrants the most attention by the board and management.*

  a) The PSR budget begins with identifying clinical staff and projecting their level of effort – often counted as *hours scheduled to see patients over the course of the year.* This should account for new and terminating staff as well as any volunteer or substitute staff.

  b) Next is an assumption about productivity which can be expressed as *visits per scheduled hour* for each clinician. This leads to visit production for each clinician that can be rolled up by type of clinician and by type of service.

  c) Next is an assumption about *the mix of visits by payer*. The main pay groupings are Medicaid, Medicare, Other Public, Private, and Self Pay.

  d) Last is an assumption about the *amount that will be collected for each visit* within each pay grouping.

  It is often necessary for health centers with multiple types of service to construct separate PSR budgets for each service type such as internal medicine, pediatrics, ob/gyn, dental, and behavioral health. Capitated managed care, ancillary services such as pharmacy, and other service programs will require separate approaches to forecasting the earned revenue.

- **Summary budget:** Detail from all the schedules can be rolled up and presented in summary fashion in the same level of detail as is presented in the audit or monthly financial statements. This summary presentation should include a comparison to the prior period actual data. This is often the presentation made to the full board with a recommendation for approval from the finance committee.

- **Budget narratives:** The detailed schedules and summary budget each require a narrative or footnotes discussing and justifying any new programs, estimates, or assumptions which deviate materially from historical data.

- **Grant budget forms and program narrative**: Final board approval of the budget for the Health Center Program grant should involve a review of the budget forms required in the application guidance document and the budget information presented in the "support requested" section of the application's program narrative.

- **Budget performance data:** The organization's monthly income statement or statement of activity should include a budget performance element. The classic presentation is a six column format including the actual, budget, and variance for the current month plus the actual, budget, and variance for the fiscal year-to-date period. Board members should receive a written explanation for variances in the statements.

Questions for the Board to Ask

1. **How did the health center's actual performance compare to the budget last year?** If actual performance was close to budget in the prior year, it helps support the budget process used. If there were significant variances, corrective actions should be taken in the current budget as may be appropriate.

2. **How did the fiscal-year-end interim financial statement compare to the audited statement?** If there were large differences in the result shown in the interim statement compared to the audited statement due to adjustments made by the auditor, it may undermine the reliability of the interim statement data being used to support the budget. A common example of this is when the auditor in effect decreases patient service revenue because bad debt was underestimated. The reason for any significant financial statement adjustments should be taken into consideration in preparing and reviewing the budget.

3. **Is the Health Center Program grant revenue budgeted at the prior year's target level?** Grant revenue projected in the budget should be the amount awarded in the prior year without any projected increase.

4. **Is the bottom line breakeven or better?** The Health Center Program grant budget by definition must be budgeted to breakeven. The organization's fiscal year budget may be projected to do better than breakeven. The board should resist approving a fiscal year budget that proposes less than breakeven performance.

5. **Is there prior period actual data supporting the budget and its key assumptions?** The absence of prior period experience is a significant disadvantage when budgeting. Similarly, if actual prior period data is not organized or available in the format in which the budget is presented, it will be of no or limited use. These deficiencies increase uncertainty and financial risk. Benchmarking data from elsewhere may help but without prior experience or data, it is important to use conservative assumptions.

6. **Does the Health Center Program grant budget or its assumptions deviate significantly from the prior period actual data?** Any significant deviations of approximately *5% or more* from prior experience should be fully explained and justified in footnotes or budget narratives.

7. **Does the budget maintain or increase the health center's service capacity?** The health center should make every effort to maintain and possibly increase its service capacity measured, for example, by the number of patients served and the services provided.

8. **Does the budget achieve the organization's program goals?** There should be an understanding of the extent to which the budget contributes toward the organization's program goals and objectives such as expanding a service, adding a site, acquiring equipment, and implementing electronic patient records.

4 Approve and Monitor Annual Budget

9. **Does the budget achieve the health center's financial goals?** Health centers are required to set project period goals for five financial measures in their grant application. These include the total cost per patient, medical cost per medical visit, change in net assets as a percent of expense, working capital to monthly expense ratio, and long term debt to equity ratio. These projections and any other financial goals the organization has set for itself should be part of the budget review and approval process.

10. **Are there any changes being proposed in the budget that requires prior approval by the Health Resources Services Administration's Bureau of Primary Health Care (HRSA/BPHC)?** Additions and deletions of sites, services, and service areas are to be approved in advance by HRSA/BPHC by filing a change in scope application. This process requires filing a written request and a budget showing that the change can be accommodated without any addition of Federal funds. Any changes of this nature should not be included in the annual HRSA/BPHC grant application without having received prior approval.

11. **Does the budget include medical malpractice expense or does it rely fully on Federal Tort Claim Act (FTCA)?** The Health Center FTCA Medical Malpractice Program reduces or eliminates health centers' malpractice insurance premiums in order to increase availability of funds to health centers to provide primary health care services covered in centers' approved scope of project. If health center staff provide medical services outside the approved scope of project, the center will need to supplement its FTCA coverage with a separate commercial malpractice policy, commonly known as a "gap" policy. Whether the health center relies totally on FTCA or whether it purchases malpractice insurance should be justified and approved as part of the budget approval process.

12. **Should the budget be constructed to take into account seasonal differences?** This is usually only done when there is significant seasonal variation in the health center's business. This is often the case with migrant health centers and other health centers whose business is affected by tourism. In absence of any significant variation, a seasonal budget is unnecessary.

13. **How should budgets for program expansions and other new ventures be evaluated?** Program expansions and new ventures must be carefully evaluated not just for the financial feasibility of the budget assumptions but also for the effect the expansion may have on the financial condition of the organization. Program expansion requires additional ongoing infrastructure costs, such as increased staff or new equipment for information systems. If the organization's change in net assets, working capital, and long term debt to equity measures are weak or below set goals, the health center may not be in a good position to take on the added risk associated with the proposed new venture. It may be that additional financial support is required to minimize risk and make the venture financially feasible.

4 Approve and Monitor Annual Budget

For More Information

HEALTH CENTER PROGRAM REQUIREMENTS
http://bphc.hrsa.gov/about/requirements/index.html

APPLICATION GUIDANCES ON VARIOUS HRSA/BPHC GRANT PROGRAMS
Scroll down to Primary Health Care and Program Details.
http://www.hrsa.gov/grants/index.html

HOW DO I PREPARE A BUDGET
http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Financing/preparebudget.html

FEDERAL TORT CLAIMS ACT (FTCA) HEALTH CENTER POLICY MANUAL
http://bphc.hrsa.gov/policiesregulations/policies/pdfs/pin201101manual.pdf

SECTION 330 OF THE PUBLIC HEALTH SERVICE ACT
Authorizing Legislation of the Health Center Program
http://bphc.hrsa.gov/policiesregulations/legislation/index.html

HEALTH CENTER PROGRAM REGULATIONS
Federal rules to operate a health center funded under the Health Center Program
http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=321ed7fdd7b481dfb7547bcb3da20b7d&rgn=div5&view=text&node=42:1.0.1.4.26&idno=42

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The *HEATLH CENTER PROGRAM GOVERNANCE REQUIRMENTS* series was written for NACHC by **Leo Fishel, *Healthcare Consulting, Inc.***

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*Health centers must comply with legal and regulatory requirements to receive financial support under the Health Center Program, including requirements related to governance authority and oversight. This series – **Governing Board Responsibilities and How to Do Them** – addresses several of the main governance requirements of the Health Center Program and for each describes board responsibilities and actions to meet and comply with requirements. Each document in the series provides guidance on:*

- *Goals for health centers to achieve related to the requirement*
- *Responsibilities of the governing board to achieve those goals*
- *Information for board members to receive from staff*
- *Questions for boards to review with staff and*
- *Links for additional information and resources.*

5 Review Independent Financial Audit

Health centers must be financially sound in order to achieve the program goals set forth in the grant application and to protect the public interest in the federal funds being invested. An essential step in validating the financial integrity of the grantee organization is the required financial audit.

Goals for the Independent Financial Audit

- Complies with the health center's procurement policy and requirements specified in health center law;
- Is arranged, conducted, and submitted in a timely manner;
- Results in an "unqualified "conclusion with no material findings, questioned costs, reportable conditions, or material weaknesses;
- Findings are addressed in a written, board approved corrective action plan prepared by management;
- There are no repeat findings from the prior fiscal year audit;
- The board is fully informed about the audit and meets with the auditor to discuss the audit report.

Governing Board's Responsibilities

- Select the auditor in keeping with the health center's procurement policy;
- Assure that the audit is conducted and submitted in compliance with federal requirements;
- Assure adequate communication between the auditor and the board;
- Assure that management resolves audit findings as promptly as is feasible.

Health Center Program Requirements

In order to receive and continue receiving federal financial grant support from the Health Resources and Services Administration's Bureau of Primary Health Care (HRSA/BPHC), health centers are required by law to:

- Maintain accounting and internal control systems appropriate to the size and complexity of the organization;
- Use Generally Accepted Accounting Principles (GAAP);
- Separate financial functions appropriate to the organization's size;
- Safeguard assets;
- Maintain financial stability;
- Perform an annual, independent, financial audit in accordance with federal audit requirements, including the submission of a corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the audit report.

Authority described in Section 330(k)(3) (D) and Section 330(q) of the **Public Health Service Act** – the federal law that authorizes the health center program and in the **Code of Federal Regulations** that defines grantee administrative requirements - 45 CFR Parts 74.14, 74.21 and 74.26.

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Information for the Governing Board to Review

The health center governing board finance committee should receive and review as necessary the following prior to arranging and approving the center's independent financial audit:

❑ **Relevant documents identifying compliance requirements** including:
- The health center's policy governing the auditor selection;
- The health center statute and regulations pertaining to the audit -- **Section 330(q) of the Public Health Service Act** requires health centers to submit an independent financial audit in accordance with federal audit requirements;
- The Office of Management and Budget (OMB) **Circular number A-133**, "Audits of States, Local Governments, and non-Profit Organizations," issued pursuant to the Single Audit Act of 1996 to set forth uniform audit requirements for non-federal entities administering federal awards.

❑ **Any written communication between the board and the auditor** including:
- The letter of engagement with the auditor;
- The Statement on Auditing Standards (SAS) 114 letter from the auditor to the board, if one is issued;
- The audit report including the A-133 reporting package, if required;
- The auditor's management letter, if one was issued.

❑ **Health center management's written corrective action plan:** The document prepared in response to any audit findings.

❑ **The verbal presentation of the audit report to the board by the auditor.**

Questions for the Board to Ask

1. **What is the health center's procurement policy governing the selection of an auditor and is this policy being followed?** It is the responsibility of the board to select the independent auditor. Although the health center may have general policies governing the procurement of advisory, consultant, contractor, and similar services, it is helpful to have specific provisions dealing with the selection of an auditor. Congress enacted the Sarbanes–Oxley Act of 2002 to create stronger corporate and auditing accountability requirements. The law prohibits auditing firms from providing non-auditing services, such as consulting, to the same organization. The law also specifies:
   - the need to re-compete the audit at least every three to five years;
   - the selection criteria including price, responsiveness, experience with health centers, staff qualification, and external reviews;
   - the requirement that a letter of engagement be issued; and
   - the rule regarding compliance with the **OMB circular A-110** procurement requirements.

   The board or committee overseeing the audit should be in charge of this procurement process.

5 Review Independent Financial Audit

2. **What should the letter of engagement contain and when should it be signed?** The letter of engagement with the auditor should be executed well in advance of the close of the fiscal year. This helps ensure that the auditor will be available to complete the audit in a timely fashion. Some of the provisions contained in the agreement should address:
   - Objectives and scope of the audit;
   - Compliance with the A-133 requirements;
   - Estimated price and ceiling;
   - Timing of the field work;
   - Schedule for completion; and
   - Exit meeting with the board.

3. **What is the OMB circular number A-133?** This document sets forth standards for obtaining consistency and uniformity among federal agencies for the audit of states, local governments, and non-profit organizations expending federal awards. Organizations expending more than $500,000 of federal funds annually are required to produce annual audits that comply with the circular's requirements. Chief among these is the production of the "reporting package" consisting of:
   - Financial statements and a schedule of federal awards;
   - A summary schedule of prior audit findings;
   - The auditor's reports consisting of an opinion, a report on internal control related to the financial statements, a report on compliance with laws and regulations, and a schedule of findings and questioned costs; and
   - The corrective action plan.

   Health centers spending less than $500,000 of federal funds annually must still produce an annual audit in compliance with the Single Audit Act and the A-133 circular but do not need to produce the reporting package required by the A-133 circular.

4. **What does A-133 circular require of the health center?** The A-133 circular says the entity being audited is responsible to do the following:
   - Identify, in its accounts, all federal awards received and expended and the federal programs under which they were received;
   - Maintain internal control over federal programs;
   - Comply with laws, regulations, and the provisions of contracts or grant agreements related to each of its federal programs; and
   - Prepare appropriate financial statements, including the schedule of expenditures of federal awards;

5. **When and where must the audit be submitted?** The audit must be submitted to the federal clearinghouse and the Bureau of Primary Health Care (BPHC) no later than nine months after the end of the fiscal year or within 30 days of its completion by the auditor whichever is sooner. HRSA/BPHC now requires that audits be submitted electronically using the Electronic Handbook (EHB), as described in the BPHC **Program Assistance Letter 2009-06**. It is possible for a well run health center to complete the audit well in advance of the nine month deadline. Five months is a more reasonable target for most health centers.

6. **What is the consolidated health centers compliance supplement?** This is a document produced by OMB for auditors to use when testing whether the grantee organization complies with the federal requirements for the community health centers, migrant health centers, health care for the homeless, school based health and public housing programs. The supplement identifies requirements related to:
   - Allowed and unallowed activities,
   - Allowable costs and cost principles,
   - Eligibility,
   - Program income,
   - Reporting, and
   - Governance.

   This may help both the board and management better understand what the auditor will be examining. In the governance area the supplement suggests the auditor:
   - Determine whether the bylaws address the required elements of the board and its operation;
   - Review minutes to see if the board approved the budget; and
   - Determine if the board approved any changes made to the board membership, services provided, operating hours, or the center director and if so, whether it did so in accordance with the center's bylaws and policies.

7. **What is the Statement on Auditing Standards (SAS) No. 114?** This is a policy document issued by the Auditing Standards Board of the American Institute of Certified Public Accountants (AICPA) which establishes standards and provides guidance on the auditor's communication with the governing board of the entity being audited.
   - It recommends among other things that the auditor meet with the committee of the board charged with overseeing the audit at least annually without management present.
   - It requires that the auditor communicate to the board:

     - the auditor responsibilities;

     - the planned scope and timing of the audit; and

     - significant findings from the audit.

     Significant findings include qualitative aspects of accounting practices; policies; estimates; disclosures; difficulties encountered during the audit; uncorrected misstatements; disagreements with management; and other matters.
   - Findings are usually communicated in writing and are presented in what is often called the "SAS 114 letter." This letter will provide the board with an indication of whether there were any significant problems with the audit. BPHC requires that the grantee submit the SAS 114 letter along with the audit or provide a statement indicating none was issued.

8. **What is a management letter?** This is a letter written to the management and board of an entity by an auditor at the completion of the audit. It contains recommendations for improved control systems or efficiency and effectiveness of operations that were noticed during the audit. Auditors are not required to produce a management letter. The findings presented typically go beyond matters required to be revealed by the A-133 circular and should be taken as suggestions for performance improvement. HRSA/BPHC requires that the grantee submit any management letter received along with the audit or provide a statement indicating none was issued.

9. **What should be done about the auditor findings presented in the audit report or management letter?** Management must prepare corrective action plans addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the audit report and other recommendations that may be made in the management letter. These plans are to be approved by the governing board. Health centers may include these plans in writing in the audit report or together with the management letter. In so doing this gives the reader a better understanding of the organization rather than leaving open the question of how the organization will respond. HRSA/BPHC requests these board approved corrective action plans be submitted in response to any of the auditor's findings. As noted at the outset, a principal goal of the audit is an unqualified opinion with no findings and particularly no repeat findings from a prior year.

10. **Are there other things not specifically required by law or regulation that may be asked of an auditor?** There are a number of things health centers may ask of their auditors. Health centers are required to submit financial status reports (FSRs) for each of their federal grants each budget period. Auditors may be asked to prepare or review the preparation of these reports or to provide initial guidance so that management can do these reports independently in the future. Similarly, health centers have cost reporting obligations under Medicare and in some cases Medicaid. Auditors may be asked to prepare these reports, to review them or to certify them if that is required by state.

    As noted above, the Sarbanes–Oxley Act of 2002 prohibits auditing firms from providing non-auditing services, such as consulting, to the same organization for which they conduct a financial audit.

    It is helpful for management and external readers for the audit to include statements of activity with detailed income and expenses and in organizations with many departments or funds, to include statements of functional, departmental, or fund's costs.

    HRSA/BPHC now requires grantees to report actual results and projections for three audit measures:

    - Change in net assets as a percent of expense,
    - Working capital to monthly expense, and
    - Long-term debt as a percent of net assets.

11. **Is the audit to be made available to the public?** The A-133 circular stipulates that unless otherwise restricted by law or regulation, the auditee shall make copies of the program-specific audit report available for public inspection. See OMB circular A-133, §___.235 Program-specific audits, paragraph (c) Report submission for program specific audits.

More Information

HEALTH CENTER PROGRAM REQUIREMENTS
http://bphc.hrsa.gov/about/requirements/index.html

OMB CIRCULAR NUMBER A-133 - AUDITS OF STATES, LOCAL GOVERNMENTS, AND NON-PROFIT ORGANIZATIONS
http://www.whitehouse.gov/sites/default/files/omb/assets/a133/a133_revised_2007.pdf

STATEMENT ON AUDITING STANDARDS (SAS) 114
Describes the role of communication, legal considerations, those who are charged with governance, management, matters to be communicated, the communication process, and documentation.
http://www.aicpa.org/Research/Standards/AuditAttest/Pages/SAS.aspx

PROGRAM ASSISTANCE LETTER 2009-06
http://bphc.hrsa.gov/policiesregulations/policies/pal200906.html

SECTION 330 OF THE PUBLIC HEALTH SERVICE ACT
Authorizing Legislation of the Health Center Program.
http://bphc.hrsa.gov/policiesregulations/legislation/index.html

HEALTH CENTER ADMINISTRATIVE REGULATIONS
Title 45, Part 74 - Administrative requirements for health center grantees.
http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=9de47029ddc8d5924737e389e539f183&rgn=div5&view=text&node=45:1.0.1.1.35&idno=45

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6 Monitoring Financial Performance Using Financial Statement Data

A primary responsibility of a health center's governing board is to understand the health center's financial situation and to react accordingly with management. The Health Resources and Services Administration's Bureau of Primary Health Care (HRSA/BPHC) requires that governing boards of grantees of the Health Center Program assure accountability for health center resources and evaluate the organization's annual and long-term financial goals. There are many aspects to overseeing financial performance but this guidance addresses setting and reviewing basic financial goals for the organization using financial statement data. A few good measures can provide a complete picture of the financial well-being of the organization.

Goals for Measuring Financial Performance Using Financial Statement Data

- Presents interim financial statements and audits in a timely manner;
- Provides accurate interim statements using the method and format of the audit;
- Establishes measures that provide a complete description of the organization's financial situation;
- Sets achievable financial targets that represent improvement over prior period baselines;
- Establishes and protects the financial viability of the health center.

Governing Board's Responsibilities

- Assume legal fiduciary responsibility of the health center – assuring financial accountability, effective oversight of the center, and sound financial viability;
- Review and approve the annual audit and monthly financial statements;
- Ensure that there are board members who are willing and able to perform the financial oversight function;
- Approve the selection of the financial measures and their annual and long term goals;
- Regularly review progress and ensure corrective action is taken when necessary.

Health Center Program Requirements

In order to receive and continue receiving financial grant support from HRSA/BPHC, health centers are required by law to:

- Maximize collections and reimbursement for its costs in providing health services, including written policies and procedures reflecting billing, credit, and collections;
- Accurately collect and organize data for program reporting and to support management decision making;
- Provide the governing board the authority to measure and evaluate the organization's progress in meeting its annual and long-term programmatic and financial goals, develop plans for the long-range viability of the organization, monitor organizational assets and performance, and establish general policies for the center.

Authority described in Section 330(k)(3)(D)(F)(G)(L) of the **Public Health Service Act** – the federal law that authorizes the health center program.

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Information for the Governing Board to Review

The finance committee will usually take the lead in establishing financial measures, their goals and reviewing progress. They will be the primary reviewer of the information identified below.

- ❑ **Independent financial audit:** Health center grantees are required to conduct an annual independent financial audit in compliance with OMB circular A-133. The audit must be conducted in accordance with generally accepted accounting principles. The audit validates the organization's financial statement data or makes qualifying statements about its validity. Interim financial statement data are subject to and are often adjusted for the audit. Auditors are required to communicate significant adjustments to the governing board. HRSA/BPHC relies on audit data to evaluate the financial performance of grantees. Similarly, the governing board's final judgments about progress made achieving the annual and long-term financial goals using financial statement data should be based upon the audit, not the interim statements. Any differences in the year-end interim and audit statement data should be reviewed and corrective actions taken as may be necessary.

- ❑ **Interim financial statements:** The financial statements consist of a balance sheet, a statement of activity, and a statement of changes in financial position. The interim financial statements should use the same method and format or account classification used in the audit and statements should be prepared in accordance with generally accepted accounting principles. If the interim statements are not prepared on a full accrual basis as is required for the audit and the accounts are not classified in the same way, the financial performance might not be comparable and may be misleading.

  - The assets and liabilities section of the balance sheet should be classified into current and long term sections so that the HRSA/ BPHC required measures can be calculated. It is helpful if the interim balance sheet includes a comparison column showing the account balances at the end of the prior fiscal year.
  - The interim statement of activity should include budget performance columns. The classic six column presentation has actual, budget and variance columns for both the current and year-to-date amounts.
  - A statement of net cash flow may be substituted for a statement of changes in financial position. Additional detail and schedules supporting the financial statements may be appropriate but the accuracy of the basic statements and their comparability to the audit data are needed for a proper review of performance.

- ❑ **Grant application:** The required and any supplemental financial performance measures are contained in the grant application. The current grant application process requires the identification of annual and project period goals, contributing and restricting factors, and one or more actions to improve financial performance for each measure. The project periods can be as long as five years, which corresponds to the typical period for setting long-term financial goals. The governing board should evaluate progress for each of these financial statement measures on a monthly and annual basis along with any other measures it chooses to review.

- **Trend or other report that includes the required and any supplemental financial statement measures:** The financial statement measures should be presented in a monthly trend report that ideally shows the performance of each measure each month in the fiscal year. Reports of this type are often one page and include other operating data being tracked by the health center.

- **Financial statement and trend report comments:** The chief financial officer should produce a brief written summary each month to accompany the interim statements and trend report highlighting and explaining any significant findings. This should include comments about the financial measures.

Required and Supplemental Financial Measures

There are currently five financial measures required by HRSA/BPHC. Two are based upon calendar year Uniform Data System (UDS) reporting data that Health Center Program grantees routinely collect. They are total cost per patient and medical cost per medical visit. These two measures are based on operating data, patients, and visits. There are three financial measures based solely upon audit or financial statement data. They are change in net assets as a percent of expense, working capital to monthly expense ratio, and long-term debt as a percent of net assets. These measures were chosen in order to describe the three principal dimensions of a health center's financial situation: the current period change, the current financial condition, and the long-term financial condition. Taken together these measures provide a reasonably complete picture of the organization's financial well being and are the principal measures used by HRSA/BPHC to evaluate financial performance. Health centers may choose to track additional measures for internal monitoring. Additional measures will provide more detail but will not change the basic result the required financial statement measures describe. Each of the required measures and a few possible supplemental measures are briefly discussed below.

HRSA/BPHC Required Financial Performance Measures

- **Total Cost per Patient:** This is a measure of the dollar value of services provided. It is determined by dividing the total accrued costs before donations and after allocation of overhead by the total number of patients.

- **Medical Cost per Medical Visit:** This is a measure of medical cost efficiency. It is determined by dividing total accrued medical staff salaries and benefits and other direct medical costs such as dues, supplies, depreciation of equipment, etc., plus allocation of overhead costs by the total number of non-nursing medical encounters.

- **Change in Net Assets as a Percent of Expense:** This is a measure of current performance and is the most significant of the three financial statement measures. This measures the current year's financial performance or the amount by which the organization increased or decreased in value during the audit period.

  This measure adds up all the income earned and all the expense incurred during the audit period plus any other transactions that affected the change in value of the organization during the period. The difference is the change in net assets. Just knowing the amount of change does not tell you whether it is significant, but by dividing it by the total expense, the measure compares the change to the size of the organization. In accounting, any change over 5% is considered material or significant.

The Health Center Program grant application requires budgets to be presented at breakeven. Minimally organizations should achieve breakeven or better performance. Organizations in a weak financial condition can survive so long as their operations are profitable. Health centers with weak current and long-term financial conditions need to have better than breakeven performance in order to retain earnings and improve their financial health.

- ❑ **Working Capital to Monthly Expense Ratio:** This measures the organization's current financial condition and is the second most important financial statement measure.

  Working capital is calculated by subtracting current assets from current liabilities. Current assets are those assets the organization owns that can be realized in cash in a year's time. Current liabilities are those debts the organization owes that must be paid in a year's time. The difference between current assets and current liabilities is working capital. Working capital is the cushion the organization has to deal with business disruptions. Disruptions can include losing clinicians, reimbursement problems, and unforeseen expenses. Just knowing the value of working capital does not tell you whether the current financial condition is good or bad. Dividing working capital by the average monthly expense compares working capital to the size of the organization. It tells you how many months of working capital you have.

  Working capital amounting to three months of operations would be considered good for protecting normal operations. However, if a health center is saving for future development, a much larger amount may be appropriate. Working capital amounting to less than one month of operating expense is considered weak and in need of improvement. If working capital is negative, the organization's current financial condition is in trouble. Minimally health centers should strive to have working capital equal between one and three months of average monthly expense. If working capital exceeds three months of operating expense, there should be a capital development plan or other planned use for those resources.

- ❑ **Long-Term Debt to Equity Ratio:** This is measuring the organization's long-term financial condition.

  Long-term debt are those debts that are payable after one year's time. Equity, or net assets, is the difference between what the organization owns and what is owes.

  The less long-term debt the organization has the better its financial condition. Minimally an organization should have long-term debt amounting to less than half of net assets. However, an organization with nominal net assets will distort the ratio. If this is the case, an alternate measure may be used to evaluate the long-term debt load. One suggested alternate measure described below is the long-term debt to fixed assets ratio.

HRSA/BPHC Supplemental Financial Statement Measures

- ❑ **Months of Cash:** This is a measure of current financial condition. Cash is part of current assets. Ideally, cash should amount to one month or more of expense to protect against business disruptions.

- ❑ **Days in Accounts Receivable:** This is a measure of current financial condition. Patient accounts receivable are typically the largest item in current assets for health centers. There are different ways to calculate this measure but preferably, it is done by dividing net accounts receivable (accounts receivable less allowances), by average daily net charges (charges less adjustments). The ideal number of days in accounts receivable will depend upon payer mix but can amount to 40 days or less. If it exceeds 120 days, it should be a cause for concern.

- ❑ **Days in Accounts Payable:** This is another measure of current financial condition. There are different ways to calculate this measure but the typical calculation subtracts depreciation from non-personnel expense and divides by 365. Organizations that are in good shape will pay bills at least twice monthly so that accumulated payables will not amount to more than 15 days of payables. Most invoices are due either upon receipt or within 30 days. If the days in payables exceed 45 days, it should be another cause for concern.

- ❑ **Long-Term Debt to Fixed Assets Ratio:** This is measuring the organization's long-term financial condition by dividing long-term debt by net fixed assets. Net fixed assets are those assets such as land and the depreciated value of buildings and equipment that the organization would ordinarily borrow against when taking out a long-term loan. If long-term debt exceeds 60% of net fixed assets, the debt load might be considered heavy.

Questions for the Board to Ask

1. **Is the financial capability of the board adequate?** The board needs one or more members who have the professional training and experience in either accounting or financial management or both and who are willing to take the time to lead the board's financial oversight responsibility. The absence of this capability and commitment will jeopardize the board's ability to fulfill its fiduciary obligation.

2. **Does the board establish the financial measures, set the goals, and regularly monitor performance?** The board must approve the grant application, which includes the required and supplemental financial measures, their annual and project period goals, the contributing and restricting factors affecting those measures and proposed actions to be taken to improve the measure. The progress for each of these required financial statement measures must be evaluated on monthly and annual basis along with any other financial measures it chooses to establish.

3. **Are appropriate corrective actions taken if goals are not achieved?** The board must have management take appropriate corrective action if goals are not achieved. These actions can range in severity from resetting the goal to preparing a financial recovery plan.

4. **Are supplemental measures needed?** The required financial statement measures do a good job of describing the current year performance, the current financial condition, and the long-term financial condition of the organization. However, it is appropriate and often necessary for the other measures to be established and monitored. A few are described in the preceding section.

5. **Are the interim statements acceptable?** As noted earlier in this document, the statements consist of a balance sheet, a statement of activity, and a statement of changes in financial position. Indicators of acceptable interim financial statements include:

   - The statements are presented in the same manner as presented in the audit and are prepared in accordance with generally accepted accounting principles and on a full accrual basis as is required for the audit.

   - On the balance sheet, the assets and liabilities section is classified into current and long term sections and includes a comparison column showing the account balances at the end of the prior fiscal year.

Monitoring Financial Performance Using Financial Statement Data

- On the interim statement of activity, budget performance is demonstrated using the classic six column presentation for actual, budget and variance columns for both the current and year-to-date amounts.
- A statement of net cash flow may be substituted for a statement of changes in financial position.
- Accuracy of the statements is demonstrated by a minimal number and value of adjustments the auditor makes to the interim statements. The auditor is required to communicate significant adjustments to the governing board.

6. **What is the health center's financial situation?** The board should have a well-found sense of the financial situation of the organization based on the reports received from staff. Reports that present current data compared to prior period, the budget, the strategic plan, and industry benchmarks provide context for board member oversight. It can be characterized as simply as good, okay or bad. A good situation requires regular surveillance but less attention. A bad situation requires significantly more time and attention.

7. **How do the measures relate to grantee organizations that have corporate activity unrelated to the health center that is outside the scope of federal project?** BPHC will evaluate the required financial statement measures for all the corporate activity included in the audit. This will include activity outside the scope of project. The financial well being of the grantee organization has a bearing upon its ability to be a reliable steward of the federal funds. Similarly, the board has an obligation to govern the whole corporation, not just the health center. In these situations, the board should consider developing comparable supplemental financial performance measures specific to the health center operation.

8. **How do the measures relate to public entity grantees?** BPHC does not require public entity grantees to use the financial statement measures. Nevertheless, the co-applicant boards of public entity grantees must still evaluate the performance of the health center and should develop supplemental financial performance measures specific to the health center operation. Public centers are still required to respond to the two UDS based financial measures: total cost per patient and medical cost per medical visit.

9. **Are there other financial data that the board should review besides the established measures?** The finance committee should review a lot more information than just the financial measures. This should include among other things source data reports that substantiate the numbers presented in the financial statements. The reports for the finance committee might include the following: an income statement and balance sheet with budget performance elements; a one page summary of statement highlights; a one page trend report with financial measures; finance committee minutes; a statement of net cash flow; an updated projection of net cash flow if there are cash problems; an accounts receivable aging report; an accounts receivable reconciliation between the general ledger and the subsidiary ledger or billing system; a grants receivable aging report; an accounts payable aging report; individual provider productivity reports; and an old and new business progress report.

For More Information

HEALTH CENTER PROGRAM REQUIREMENTS
http://bphc.hrsa.gov/about/requirements/index.html

CLINICAL AND FINANCIAL PERFORMANCE MEASURES
http://www.bphc.hrsa.gov/policiesregulations/performancemeasures/index.html

FINANCIAL MANAGEMENT RESOURCES
http://www.mscginc.com/mscg/Resources/documentspublic.cfm

FINANCIAL MANAGEMENT TECHNICAL ASSISTANCE TOPICS
http://bphc.hrsa.gov/technicalassistance/tatopics/financialmanagement/index.html

BPHC NEW START WEB GUIDE
Financial Management and Control Policies
http://bphc.hrsa.gov/technicalassistance/newstarts/managementfinanced.html

NATIONAL ASSOCIATION OF
Community Health Centers

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For more information about the series, contact Betsy Vieth at NACHC, 301-347-0400, bvieth@nachc.com.

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- *Goals for health centers to achieve related to the requirement*
- *Responsibilities of the governing board to achieve those goals*
- *Information for board members to receive from staff*
- *Questions for boards to review with staff and*
- *Links for additional information and resources.*

7 Establish a Quality Assurance/Quality Improvement (QA/QI) Program

Quality of service is central to the mission, goals, and policies of all grantees of the Health Center Program and the health center's approach to assuring and improving quality should be expressed in a Quality Assurance/Quality Improvement (QA/QI) plan. The governing board has the responsibility to review and approve the QA/QI plan each year and to make sure the plan is being implemented effectively.

Goals for the QA/QI Plan

- Accurately reflects the organization's mission and goals;
- Assures and improves the quality of the organization's clinical and management services;
- Communicates improvements in clinical and management services to staff, board, patients, and others;
- Complies with Health Center Program requirements.

Governing Board's Responsibilities

- Review and approve the QA/QI plan annually;
- Provide for QA/QI orientation and training for board members and ensure that there are board members with expertise in patient safety and quality improvement;
- Ensure that there is a board committee assigned to oversee the QA/QI function;
- Assure that the CEO hire qualified clinical staff, including a Clinical Director (in most cases a physician but if that's not possible, another health care provider) who has responsibility for clinical and administrative quality on a daily basis, is adequately supported, and that other staff and committees responsible for QA/QI are identified and functioning;
- Assure that the record keeping and reporting systems are capable of providing the information needed to properly assess the quality of service and that the confidentiality of patient records is maintained;

Health Center Program Requirements

In order to receive and continue receiving federal financial grant support from the Health Resources and Services Administration's Bureau of Primary Health Care (HRSA/BPHC), health centers are required by law to:

- Have an ongoing QA/QI program that includes clinical and management services, maintains the confidentiality of patient records, is a primary responsibility of the Clinical Director, and includes periodic assessments of the use and quality of services. The clinical assessments are required to be conducted by licensed physicians and other health professionals; be based upon the systematic evaluation of patient records; and to identify, document, and implement needed service improvements.
- Provide that the governing board has the authority to oversee the operations of the health center including measuring and evaluating the organization's progress in meeting its annual and long-term program and financial goals, developing long range strategic plans, conducting ongoing review of the organization's mission and bylaws, evaluating patient satisfaction, and monitoring organizational assets and performance;
- Provide that the governing board establish the general policies for the health center.

Described in Sections 330(k)(3)(C), Section 330(k)(3)(H) of the **Public Health Service Act** – the Federal law that authorizes the Health Center Program, and in the **Code of Federal Regulations** that defines operating requirements – 42 CFR Part 51c.303 and 51c.304.

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- Receive and act on periodic reports about quality assessments, quality improvements, patient satisfaction, adverse incidents, accreditation findings, and other external reports concerning program quality and performance, such as the FTCA application that requires the date when the board approved the QA/QI plan.

Information for the Governing Board to Review

The committee designated by the board to oversee the QA/QI program will usually take the lead to review the information suggested below.

- ❑ **Annual QA/QI plan:** The ongoing nature of this requirement means that the approach to QA/QI should be updated periodically, which usually means a new QA/QI plan is developed by management and approved by the board each year. The plan will include among other things, the scheduled QA/QI activities and the goals for the BPHC core and other performance measures.

- ❑ **Staff QA/QI program reports:** The nature and frequency of QA/QI reports by staff made to the designated committee(s) and full board will vary but some board reporting is essential. Typically this will include monthly reporting to the designated committee. Committee minutes are shared with the board with significant findings noted verbally at the full board meeting. Similarly, the clinical director's report to the full board, which may be monthly or less frequently should include significant QA/QI activities and results.

- ❑ **Accreditation/ certification reports**: The results of surveys by accrediting bodies such as the Accreditation Association of Ambulatory Health Care (AAAHC) or The Joint Commission (TJC), or recognition from the National Committee for Quality Assurance (NCQA) though their Patient-Centered Medical Home program.

- ❑ **External program and financial audit reports:** Funding sources will often conduct on-site or other program and financial performance reviews. These reports should be reviewed by the designated committees and shared with the full board as appropriate. The auditor must present the required annual financial audit report to the full board for their approval. The board should review and approve management's responses to audit findings and assure responses are incorporated into upcoming QA/QI activities as appropriate.

- ❑ **Patient satisfaction surveys:** Patient satisfaction surveys are a program requirement and an important component of a QA/QI program. These surveys should be conducted annually if not more frequently and reported to the designated committee and board.

- ❑ **Adverse incident reports:** The QA/QI program should include arrangements for identifying documenting and reporting adverse incidents affecting patient satisfaction, staff satisfaction, safety, possible professional and general liability insurance claims, and the quality of clinical and management services. These reports and management's responses should be regularly reported to the designated committee and board.

- ❑ **HRSA/BPHC required clinical and financial measures and the health center's performance:** The results of the HRSA/BPHC performance measures are minimally reported annually. Other internally designated measures may be assessed and reported more frequently. Some may be incorporated into regular monthly reports reviewed by the board and some may be included in other QA/QI reports.

7 Establish a Quality Assurance/Quality Improvement (QA/QI) Program

Questions for the Board to Ask

1. **What is quality?** This is a philosophical question about which much has been written. The Institute of Medicine in a recent publication offered a six part definition of what health care quality means. It said care should be safe, effective, patient-centered, timely, efficient, and equitable. It would be good to consider these criteria when reviewing QA/QI plan activities and goals.

2. **What are the QA/QI activities and goals?** These should be designed to advance the organization's mission, program goals, and concept of quality. Areas where improvement is most needed can often be identified by comparing current performance with national data, previous self-performance, and/or other benchmarks. Health centers are required to include management as well as clinical quality activities in their QA/QI programs. Goals should represent achievable improvements over current performance documented by baseline data from a prior period. The goals are expressed as the target result for a specific performance measure, such as the percent of children with their second birthday in the measurement year with appropriate immunizations.

3. **Who is leading the QA/QI program?** Health centers are required to have a clinical/ medical director who assumes responsibility for the quality of health services. Larger and more complex centers may have a QA/QI coordinator in addition to a clinical/medical director to manage the QA/QI program. The board should know who on staff is leading the effort and be assured that they have the training and competence needed to successfully conduct the QA/QI program.

4. **Are the health center personnel appropriately trained and competent?** Most of what the health center does is dependent upon the capability of its personnel. Failure to achieve performance improvement goals can often be traced to deficiencies in the number and capability of clinical and other personnel. The QA/QI program should include the peer review, privileging and reappointment of its clinical staff and be linked to the organization's staffing plan, personnel management policies, and in particular, its staff appraisal and development program.

5. **Is the Board QA/QI capability adequate?** Boards need orientation and training in the QA/QI function as well as one or more members who have expertise in this area.

6. **Is performance being improved? Why or why not?** Reports to the board should reveal the extent to which performance goals are achieved. If goals are not achieved, the reasons should be identified and corrective actions taken if appropriate. This might involve more reporting, revisions to policy and procedures, staffing changes, and other actions.

7. **Are the organization's patient record and reporting systems sufficient to support the QA/QI function?** The QA/QI program is greatly dependent upon the capability and efficiency of the patient record, practice management, and other reporting systems. Deficiencies in these systems will hamper the ability of the organization to assess quality and improve performance.

8. **Is the confidentiality of patients, staff, and others adequately protected?** The confidentiality of patient records must be maintained. Similarly, health centers are required to protect staff and others in order to encourage their reporting of adverse incidents or other matters affecting the quality of service.

9. **Are more resources needed to improve performance?** The need for additional resources to support staffing, systems, services, facilities, and other areas that may be required to achieve improvements in performance should be identified.

10. **Does the QA/QI program comply with HRSA/BPHC requirements?** Management should make clear that the QA/QI program complies with the HRSA/BPHC requirements as detailed on the first page of this document.

7 Establish a Quality Assurance/Quality Improvement (QA/QI) Program

For More Information

HEALTH CENTER PROGRAM REQUIREMENTS
http://bphc.hrsa.gov/about/requirements/index.html
See #8.

CLINICAL AND FINANCIAL PERFORMANCE MEASURES
http://bphc.hrsa.gov/policiesregulations/performancemeasures/index.html

QUALITY IMPROVEMENT PLANNING LEARNING SERIES
http://bphc.hrsa.gov/policiesregulations/quality/index.html

HEALTH CENTER PATIENT SATISFACTION SURVEY
http://bphc.hrsa.gov/policiesregulations/performancemeasures/patientsurvey/satisfactionsurvey.html

CREDENTIALING & PRIVILEGING OF HEALTH CENTER PRACTITIONERS
http://bphc.hrsa.gov/policiesregulations/policies/pin200116.html

FTCA RISK MANAGEMENT WEBINARS
http://bphc.hrsa.gov/ftca/riskmanagement/webinars/webinars.html

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8 Select Services Provided and Hours of Operation

Health Center Program grantees must provide services as required in health center legislation, as well as additional health services that may enable a person to get care at the health center, such as transportation or translation services. Services must be available at times and locations that are accessible and meet the needs of the community served by the health center. The governing board has authority to oversee the selection of services to be provided and the hours of operations.

Goals for Health Center Services and Hours of Operation

- Assures access to all required primary, preventive, and enabling services and facilitates access to related health and social services based upon the needs of the community and people served by the health center;
- Maximizes services offered by the health center by collaborating with other service providers and organizations in the community;
- Creates a system that provides access to a full range of care including hospital, specialty, diagnostic, and therapeutic services;
- Provides services during times that best serve the needs of the target and patient populations;
- Provides ready access for patients during hours when the center is closed;
- Complies with health center program requirements specified in law.

Governing Board's Responsibilities

- Establish and approve the scope of the federal grant project including clinical staffing, number of sites, services, target population, and service area;
- Establish and approve the services to be provided and the method used to provide those services – either directly by staff or referral to another provider in the community;

Health Center Program Requirements

In order to receive and continue receiving federal financial grant support from the Health Resources and Services Administration's Bureau of Primary Health Care (HRSA/BPHC), health centers are required by law to:

- Provide all required primary, preventive, and enabling health services as well as additional health services as may be appropriate and necessary, either directly or through written referral arrangements;
- Provide professional coverage during hours when the center is closed;
- Have admitting privileges for health center physicians at one or more referral hospitals or an arrangement that ensures continuity of care;
- If admitting privileges and other arrangements are not possible, the health center must establish arrangements for hospitalization, discharge planning, and patient tracking;
- Provide that the governing board has the authority to oversee the operations of the health center including, among other things, the selection of services to be provided and the hours of operations;
- Provide that the governing board establish the general policies for the health center.

Described in Section 330(a), Section 330(k)(3)(A), Section 330(k)(3)(L), and Section 330(k)(3)(H) of the **Public Health Service Act** – the federal law that authorizes the Health Center Program, and in the **Code of Federal Regulations** that defines operating requirements – 42 CFR Part 51c.304.

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- Review and approve written referral agreements and other formal arrangements with other service providers or organizations and ensure that this includes an arrangement for hospital care;
- Approve requests to HRSA/BPHC to change the approved scope of the grant project and prior to submitting the grant application to HRSA/BPHC, review and approve any changes in the scope of work in the application;
- Review and approve the hours of operation of each service site and the arrangements for after-hours coverage.
- Assure the health center complies with HRSA/BPHC program requirements by documenting the board approvals in the board meetings minutes.

Information for the Governing Board to Review

The committee designated by the board to oversee the clinical program will usually take the lead in reviewing the services, methods of service delivery, service agreements, hours of operation, and the after hours coverage policy. This committee will also be the primary reviewer of the information identified below. The budget implications for the decisions to be made about these matters will involve the consideration of the board's finance committee.

- **BPHC grant application:** The grant application contains the elements comprising the scope of project -- clinical staffing, sites, services, target population, service area, and the hours of operation for each site. Since the board must formally approve each submission of the grant application and document its approval in the minutes of the board meeting, the board is in effect also approving all of the elements in the scope of project.

- **Needs assessment, mission statement, and strategic plan:** The health center's scope of project and hours of operation should be based on the center's mission, its strategic plan, and the needs of the target and patient populations. For the board to make sound approval decisions, board members must understand these documents.

- **Form 5A and service agreements:** Form 5 A specifies the scope of services approved by HRSA/BPHC. It shows the method of service delivery for each required and additional clinical and non-clinical service. Services may be provided in three ways: 1) directly, 2) by paying a referred care provider, or 3) by an unpaid formal referral arrangement or some combination of these. One or more delivery methods must be in place for each required service.

  Each service that is provided by a referred care provider must be accompanied by a written agreement to be included in the approved scope of project and approved by the board. The agreements should provide for:
  - Written documentation of services rendered to each patient by the referred care provider;
  - Evidence that the provider has appropriate licensing, privileging, and quality assurance;
  - The reimbursement arrangement where applicable; and
  - The availability of services on a sliding fee scale.

  Informal referral arrangements, which are not supported with a formal agreement, are not part of the approved scope of project.

Select Services Provided and Hours of Operation

- **Form 5B documents:** Form 5B documents and describes each of the service sites in the approved scope of project including some characteristics of the hours of operation, whether the site is full or part time, year round or seasonal, the hours open per week, and the months of operation. A detailed schedule of the hours of operation for each site is an essential planning and budgeting assumption that the board should approve as part of the budgeting and grant approval process.

- **Change in scope policy:** The governing board should be familiar with the current HRSA/BPHC policy regarding the definition of the scope of project and making changes to the scope of project. This policy is presented in Policy Information Notice (PIN) 2008-01, *Defining Scope of Project and Policy for Requesting Changes* and PIN 2009-02, *Specialty Services and Health Centers' Scope of Project.* Beginning in 2008, grantees were required to formally document each element of their scope of project and receive HRSA/BPHC approval. Changes may now only be made by filing a change in scope (CIS) request and receiving HRSA/BPHC approval. If a change is made without HRSA/BPHC approval, the element falls outside the scope of project and is not eligible for benefits of the Health Center Program such as cost-based reimbursement from Medicare and Medicaid and malpractice coverage under the Federal Tort Claims Act (FTCA).

- **Change in scope requests:** All additions or deletions to the approved scope of service must be approved by the governing board and documented in the board meeting minutes. Any addition or deletion of services that are either provided directly or by paying a referred care provider must also be formally requested in writing and approved by HRSA/BPHC.

- **After-hours coverage policy:** Health centers are required to provide professional coverage during hours when the center is closed. The coverage arrangements should be included in a written policy, approved by the board, and documented in the minutes. Coverage should be provided by health center clinicians but when that is not possible, agreements with others may be made. The coverage should include telephone access to the covering clinician and an arrangement for the patient to be seen at a suitable location as may be necessary.

Questions for the Board to Ask

1. **Are the service arrangements and hours of operation fulfilling the needs of the target and patient populations?** Decisions about the scope of project including the service arrangements and hours of operation must be in line with the current needs of the target and patient populations. Management and the governing board should have a good sense of the extent to which the needs are being satisfied and the priorities for improvement. These priorities should be reflected in the organization's strategic and operating plans.

2. **Does the board formally approve the scope of services and hours of operation?** The governing board must approve the scope of project including the services offered and the hours of operation. This approval is to be documented in the minutes. Approval of the grant application in effect is an approval of the scope of project. However, each element of the scope of project warrants separate consideration by the board in the appropriate committee venues. As noted, the committee designated by the board to oversee the clinical program will usually take the lead in reviewing the services, methods of service delivery, service agreements, hours of operation and the after hours coverage policy. It would be appropriate for the board approve each of these items separately in its deliberations.

Select Services Provided and Hours of Operation

3. **Are arrangements in place for all required services and any additional services needed?** The scope of project policy requires that one or more of the three delivery methods be used for each required clinical and non-clinical service. Health centers receiving homeless grant funds are required to provide or arrange for substance abuse services for their homeless patients. Additional clinical and non-clinical services should be provided to the extent they are needed to facilitate access to basic health services. The required and additional service arrangements are specified on Form 5A.

4. **Are there appropriate written agreements for all referred care arrangements?** As noted above, each service that is provided by a referred care provider must be accompanied by a written agreement for it to be included in the approved scope of project. The agreements should provide for written documentation of services rendered to each patient from the referred care provider, evidence of appropriate licensing, privileging, and quality assurance, the reimbursement arrangement where applicable and the availability of a sliding fee scale. These agreements should be approved by the governing board. Informal referral arrangements that are not supported with an agreement are not part of the approved scope of project.

5. **Are arrangements for lab, x-ray, and pharmacy services sufficient?** The provision of effective primary care requires the support of basic ancillary lab, x-ray, and pharmacy services. Arrangements for these services must be made available in sufficient quantity and include the elimination of financial barriers for indigent patients if care is to be accessible and effective.

6. **Does the health center participate in the 340B federal drug-pricing program?** The 340B program provides access to federal drug prices for FQHC patients. These prices are mostly well below market rates. Health centers are expected to arrange an in-house or community-based 340B program or demonstrate why it is not feasible to do so.

7. **Are there appropriate arrangements for hospital care?** Health center physicians are required to have admitting privileges at one or more referral hospitals or to have an arrangement in place that ensures continuity of care. In cases where health center physicians cannot participate, a formal arrangement must be made for hospitalization, discharge planning, and patient tracking. However, in extreme cases where the provision of physician services in the hospital by the health center is not feasible and the available hospitals refuse reasonable arrangements, exceptions may be made.

8. **Does the health center collaborate effectively with other service providers and organizations in the community?** Health centers should maximize the use of suitable health, social, and other service resources in the community through its referral arrangements and other cooperative agreements. Centers are encouraged to form or join integrated service delivery systems to improve access to hospital and other services for their patients.

9. **Are all of the center's services available to all residents of the service area?** Health centers are required to make all the services offered available to all residents of the service area to the extent they are able.

10. **Does the center offer any early morning, evening or weekend hours?** Health centers should offer extended hours if needed by the target population.

11. **Are appropriate arrangements made for after-hours coverage?** Health centers are required to provide professional coverage during hours when the center is closed. Coverage should be provided by health center clinicians, but if that is not possible, agreements with others may be made. The coverage should include telephone access to the covering clinician and an arrangement for the patient to be seen at a suitable location as may be necessary. The coverage arrangements should be included in a written policy, be approved by the board and documented in the minutes.

For More Information

HEALTH CENTER PROGRAM REQUIREMENTS
See "Services" section.
http://bphc.hrsa.gov/about/requirements/index.html

HEALTH CENTER PROGRAM REQUIRED SERVICES
See section(b) Definitions of (1) required primary and (2) additional health services.
http://bphc.hrsa.gov/policiesregulations/legislation/index.html

BPHC FORMS 5A (SERVICES PROVIDED) AND 5B (SERVICE SITES)
Scroll down to 5A and 5B.
http://www.hrsa.gov/grants/apply/assistance/NAP/forms.html

DEFINING SCOPE OF PROJECT AND POLICY FOR REQUESTING CHANGES
http://bphc.hrsa.gov/policiesregulations/policies/pin200801.html

SPECIALTY SERVICES & HEALTH CENTERS' SCOPE OF PROJECT
http://bphc.hrsa.gov/policiesregulations/policies/pin200902purpose.html

SITES, SCOPE OF PROJECT, & CAPITAL PROJECTS
http://bphc.hrsa.gov/policiesregulations/policies/pal201107.html

BPHC NEW START WEB GUIDE
See Tables 2 and 3 for checklists for decisions about referral arrangements.
http://bphc.hrsa.gov/technicalassistance/newstarts/servicesa.html

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The *HEATLH CENTER PROGRAM GOVERNANCE REQUIRMENTS* series was written for NACHC by **Leo Fishel, *Healthcare Consulting, Inc.***

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*Health centers must comply with legal and regulatory requirements to receive financial support under the Health Center Program, including requirements related to governance authority and oversight. This series – **Governing Board Responsibilities and How to Do Them** – addresses several of the main governance requirements of the Health Center Program and for each describes board responsibilities and actions to meet and comply with requirements. Each document in the series provides guidance on:*

- *Goals for health centers to achieve related to the requirement*
- *Responsibilities of the governing board to achieve those goals*
- *Information for board members to receive from staff*
- *Questions for boards to review with staff and*
- *Links for additional information and resources.*

9 Engage in Long-Term Strategic Planning

One of the most important responsibilities of the governing board is to set the course for the organization. Developing goals and objectives to guide the organization's decisions and actions concerning the allocation of human and financial resources over the next 3-5 years is strategic planning.

Goals for the Strategic Plan

- Defines performance goals to achieve the health center's mission and vision;
- Responds to the health care needs of the target and patient populations;
- Assures the financial well-being of the health center;
- Guides strategic and operational decision-making and action;
- Improves the value of the organization to its patients and the community;
- Reflects current conditions within the health center and its marketplace.

Governing Board's Responsibilities

- Take a leadership role to develop the planning process by, for example, forming a strategic planning committee with management to develop the process;
- Participate in making decisions about the plan and formally approve the plan;
- Assure that the plan is used to guide strategic and operational decisions;
- Evaluate the organization's progress in meeting the plan's goals and objectives;
- Ensure that the plan is updated as time and changing conditions warrant.

Health Center Program Requirements

In order to receive and continue receiving financial grant support or designation as an FQHC look-alike under the Health Center Program, health centers are required by law to:

- Assure that the governing board has the authority to oversee the operations of the health center including, among other things, measuring and evaluating the organization's progress in meeting its annual and long-term programmatic and financial goals;
- Developing plans for the long-range viability of the organization by engaging in strategic planning, ongoing review of the health center's mission and bylaws, evaluating patient satisfaction, and monitoring organizational assets and performance.

Described in Section 330(k)(3)(H) of the **Public Health Service Act** – the Federal law that authorizes the Health Center Program, and in the **Code of Federal Regulations** that defines operating requirements – 42 CFR Part 51c.304.

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Information for Governing Board Review

The committee designated by the board to oversee planning will take the lead in this area and should be reviewing the information identified below as part of the planning effort.

- ❑ **Mission statement, needs assessment, and strategic plan:** Board members should review these documents to monitor progress and to periodically reassess whether to update them to fit current community conditions and needs.

- ❑ **Capital plan:** A capital plan identifies the capital needs corresponding to the organization's strategic plan. This might include working capital needed to simply improve the health center's current financial condition or major fundraising goals corresponding to a site or program development agenda. This plan should be revised together with any revisions to the strategic plan.

- ❑ **Health Center Program grant application:** An essential part of the strategic plan is defining the scope of federal project including the clinical staffing, sites, services, target population, and service area and setting a course for their further development over the near and long term. The scope of project is defined by activities in the Notice of Grant Award (NGA), which is based on the approved grant application that contains a clear delineation of each of the elements comprising the scope of project and is a good reference for those on the governing board who are overseeing the planning function.

- ❑ **Patient and employee satisfaction surveys and board evaluations:** The board is required to review patient satisfaction and to evaluate its own performance as part of its oversight function. These findings along with similar feedback from the staff can help evaluate performance and identify opportunities for improvement, which can be included in revised strategic plans.

- ❑ **Clinical and financial performance measures:** The health center's clinical and financial performance measures are found in the center's most recent grant application, as are annual and project period (usually 3-5 years) goals, factors that might impact on performance, and one or more actions intended to improve performance. Action steps, goals, and measures to assess performance are a significant part of the organization's strategic plan.

- ❑ **Organizational assessments and external reports:** Health centers periodically conduct organizational assessments to determine what improvements in operations are needed, basing goals and objectives of the strategic plan on findings from the assessment. Similarly, health centers can use findings and recommendations from financial audits, accreditation bodies such as the Joint Commission, and program assessments from funding organizations to set goals and priorities.

Questions for the Board to Ask

1. **Does the health center have a board approved strategic plan?** The strategic plan should serve the basic purposes noted above under "Goals." It must be approved by the board and the approval documented in the board meeting minutes.

2. **Does the plan reflect the needs of the target and patient populations?** The plan must address the needs of the target and patient populations and these needs must be reassessed periodically as plans are reconsidered and revised.

3. **Is there a process for ensuring that the plan is current?** The plan must be adapted to current internal and external conditions. There should be a process in place to update plans as time and circumstances warrant.

4. **Are the goals and objectives of the strategic plan tied to the performance of the leadership staff?** The organization's leadership should be directed to execute the strategic plan and their performance appraisals should be linked to the achievement of those goals.

5. **Does the strategic plan guide the decision-making of the board and management?** The plan should guide the strategic and operational decisions made by the board and management. This includes decisions regarding the scope of project including the clinical staffing, sites, services, target population, and service area and the further development of each of these. It should also provide the framework for other planning activities such as the capital plan, the annual operating plan, a business plan, or feasibility study for a specific development project or venture.

6. **How does the board measure progress meeting its long term strategic clinical and financial goals?** Measuring the health center's clinical and financial performance measures provides one way of measuring the health center's performance over the short and long term. Other goals included in the strategic plan should each be expressed in a way that can be measured objectively.

7. **Who should be involved in strategic planning?** The strategic planning process can be accomplished successfully in many ways. The best approaches will include, to some extent, all those who are involved with the organization including management, patients, staff at all levels, board representatives, community representatives, health service collaborators, payers, funding source representatives, and others. Management must do most of the work developing the plan while the board's responsibility is to oversee the process and make the significant decisions about the plan.

For More Information

HEALTH CENTER PROGRAM REQUIREMENTS
See # 17.
http://bphc.hrsa.gov/about/requirements/index.html

THE BOARD'S ROLE IN STRATEGIC AND CAPITAL PLANNING
NACHC Information Bulletin #14 (Governance Series)
http://www.nachc.com/client/documents/publications-resources/gov_14_06.pdf

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