FEBRUARY 2021

NATIONAL ASSOCIATION OF Community Health Centers®

COVID-19 and Health Center Boards

FOCUS AREA: UNDERSTANDING THE IMPACT OF COVID-19 ON THE HEALTH CENTER

Pandemic-Related Budgeting Considerations for Health Center Boards

BACKGROUND

Since March 2020, health centers across the country have responded quickly to the extraordinary challenges caused by the COVID-19 pandemic. As the virus continues to rage across the country, and as vaccines are increasingly becoming available, it is important for health center boards to understand the short- and medium-term picture of financial health which is represented in the health center budgeting process. This article summarizes key pandemic-related considerations for health centers boards in the budgeting process. Additionally, this resource contains a list of discussion questions for boards at the end of the document.

Items to Consider

The board is responsible for reviewing and approving the annual organizational operating budget, which is the health center's financial plan for achieving its health service program and financial goals. Health centers also submit an annual grant application that includes a budget, called a "total budget," to the Health Resources and Services Administration (HRSA) that reflects the revenues and costs needed to support the health center's proposed or HRSA-approved scope of project.[1]

Various pandemic-related budgeting considerations regarding revenue, expenses, and the overall bottom line are outlined below.

Revenue

Below are items that boards should stay mindful of regarding revenue (primarily patient service and grant income):

- Patient Visits: The onset of COVID-19 initially caused health center visit volume to plummet. Health centers are gradually returning to pre-pandemic levels, but some challenges remain in certain practice areas, including:
  - Medical—Medical services shifted rapidly to telehealth in April 2020. As health centers have better understood the COVID-19 virus, and the protections and protocols necessary, in-person services have increased. For the center's next budget (or reforecast of the current budget), it may be prudent to continue to budget less than 100% of pre-COVID medical visit volume.
  - Dental—Dental is the area hardest hit by COVID-19. Because of the risk of disease spread through saliva in the air and the corresponding high demands on personal protective equipment (PPE), many health centers initially shut down or reduced dental services. The center's next budget (or reforecast) should consider what level of dental services are realistic during the budget period.
  - Behavioral/mental health—Behavioral health is the one area where many health centers have actually seen an increase in services due—in large part—to virtual visits. Both providers and patients have found the

1 For more about the board's role regarding budgeting and financial oversight, see Chapter 4: Financial Oversight in NACHC's Governance Guide for Health Center Boards available at **https://www.healthcenterinfo.org/details/?id=2302**. For details about HRSA Health Center Program Requirements, please see the Health Center Program Compliance Manual available at **https://bphc.hrsa.gov/programrequirements/compliancemanual/index.html**.

telehealth platform to be very useful for behavioral health. Given this, it may be appropriate to project increased behavioral health volume in next year's budget (or reforecast).

- School based—Since many schools are closed, school-based health centers are also closed. While zero visits should be projected at closed sites, the budget (or reforecast) should also consider if the patients will go to another health center site.

- Understanding telehealth: Telehealth refers to health center providers serving patients over the phone or via video.[2] During the pandemic, telehealth reimbursement expanded as authorized under a public health emergency; future reimbursement arrangements are unclear. Board members should ask the following questions about telehealth in the budgeting process:
  - What is our telehealth strategy for the budget period?
  - What percentage of our visits are telehealth and in-person, and how does that percentage change in the budget period?
  - Expanded telehealth reimbursement was authorized under a public health emergency. How long are we guaranteed telehealth reimbursement? What if telehealth reimbursements are not made permanent change? What would a transition back to the old model look like?
  - We get paid only $92.03 per visit from Medicare for telehealth. Is this sustainable?
  - What advocacy actions can the board take related to telehealth?
- Special accounting for COVID-19-specific revenue:[3] Many health centers have received COVID-19-specific revenue at various phases in the pandemic, which are associated with different rules that impact a center's budget. For example:
  - Payroll Protection Program (PPP)—Many—though not all—health centers received PPP funding to help them cover employee salaries while their revenue was reduced from decreased visits. The health centers have already received the cash from this program, and program funds needed to be spent by the end of 2020. However, since PPP was structured as a loan, the health center may not have yet recorded the revenue. In 2021, the federal government will forgive the loan, and the health center will record revenue. Health center boards should be aware of two impacts of PPP accounting:
    1. The revenue recorded in 2021 will make health center financials look better than they are (that is, they will show revenue that does not generate cash), and
    2. Remember that staff should not project additional PPP revenue/cash in next year's budget (note at the time of the writing of this article in February 2021, a second round of PPP was announced. Because of changes to eligibility, fewer health centers are eligible than in the first round. The board should ensure that they have an understanding of the health center's round 2 eligibility).
  - Cares Act Funding—Health centers who receive 330 grant funding from HRSA got three special rounds of funding. This funding was awarded in March to May 2020, and all needs to be spent by April 2021. However, health centers do not record revenue for these grants until they spend money on grant items. Typically, the health center draws down the cash at the same time. Health center boards should be aware of at least two impacts of Cares Act Funding:
    1. There may be additional cash to draw down (and the board should ask the CFO how much remains), and
    2. Remember that staff should not project additional Cares Act revenue/cash in next year's budget.

2 For more on telehealth, please see "Current and Future Strategic and Oversight Considerations Related to Telehealth for Health Center Boards" available on the Health Center Resource Clearinghouse (**https://www.healthcenterinfo.org/**) in February 2021.

3 See COVID-19 Frequently Asked Questions for additional information on funding and appropriate use available at **https://bphc.hrsa.gov/emergency-response/coronavirus-frequently-asked-questions?field_faq_category_tid=285&combine=/**

Expenses

Below are expense-related items (i.e., the cost of operations) for consideration:

- Staff: In the early days of the pandemic, the priority was keeping staff safe, which meant keeping most, if not all, of them out of the health center. Many health centers adapted to remote and work-from-home solutions. As our understanding of COVID-19 has evolved and health centers have developed patient and staff safety protocols, health centers need more of their clinical and non-clinical staff to be available in centers. However, many centers are finding it difficult to keep their positions full. Given this, the budget should include a higher than usual vacancy factor. Additionally, some staff are reporting burnout and requesting higher wages for working in a COVID-19 environment. Budgets should anticipate higher wages. There are several questions to ask about staff during the budgeting process:
  - Can we find enough staff?
  - Do we need to pay more?
- Other COVID-related operating expenses: With the threat of COVID-19, health centers will continue to need personal protective equipment (PPE), and this should be included as a line item in the budget. Many health centers reported higher contracted costs for additional services. In addition, there are still shortages of various items and so if the health center is paying more for certain items, the higher cost should be included in the budget.
- Telehealth cost: While it may seem that telehealth is a cheaper way of delivering care, that is not always the case. Telehealth may actually require more staff time. If the board and CEO decide to continue to provide telehealth services in the next budget period (and beyond), the budget should specifically identify telehealth expenditures (which may include equipment for patients).
- Capital: The budget may include expenses for protective screens, shielding, and other minor modifications to health center facilities in response to pandemic safety protocols. The health center may also have to budget spending for dental equipment, reconfiguring walls or health center space, adding greater filtration capabilities to the HVAC (heating, ventilation, and air conditioning) system, setting up outdoor clinical and pharmacy services, adding additional vaccine storage, and other expensive items. These high-cost items will not be included in expenses since the health center will account for their expense over time through depreciation, but the center will need cash or financing to pay for these items.

Bottom Line

Below are items that boards can be aware of related to the center's bottom line (i.e., overall profitability):

- Economics of testing and vaccinations: Health centers play a vital role in the health of our communities. While health centers are actively engaged in ongoing testing efforts, and are ramping up for vaccinations, it is important to understand the financial model of both services:
  - Testing—Health centers are dependent on performing a billable visit, that is a face-to-face encounter between a patient and a billable provider, to be able to bill their Medicaid and Medicare Prospective Payment System (PPS) rates.[4] Note that community health center "testing," is typically only collection of a specimen, which is then sent to a lab to perform the test. So, the service that the health center performs may not be billable at all, or if it is, only at a low level of reimbursement. Health center expenses associated with testing are significant—PPE, staff time, etc. Some health centers have reported that staff are unwilling to do testing, and that they have to hire outside, contract workers. While health centers have received grant funding to perform testing, that funding is limited, and may run out at some point. In considering testing, health centers need to

4 A Prospective Payment System (PPS) is a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, diagnosis-related groups). Source: **www.CMS.gov**.

determine how much they can afford to do, either in the health center or out in the community.

- Vaccination—Like testing, vaccination does not generally result in a billable visit, and has limited reimbursement. Medicare has instructed FQHCs to report COVID-19 vaccinations on the Medicare cost report, as they have previously reported influenza and pneumococcal vaccines. Centers for Medicare & Medicaid Services (CMS) has announced that for other providers, Medicare will pay $28.39 for administering a single dose vaccine, and $46.33 for two-dose vaccine administration. Other payors, including State Medicaid agencies, may follow this reimbursement structure. This amount is far below health center's PPS rates, and their cost per visit. Thus, while the vaccine itself may be free, the health center should still perform a detailed financial analysis of vaccination. While no federal grant funding has been announced for HRSA grant funding for COVID-19 vaccination at the time of writing this article, health centers should monitor if future funding is available.

Despite these considerations, many boards are reporting that they view ensuring the center participates in COVID-19 testing and vaccination as central to the center's mission. Many boards and senior staff leaders are considering together how to offset some of the expenses (e.g., foundation funding, etc.).

- Profitability and growth for the next 18 months: Many health center boards are accustomed to seeing years of profitability and growth. This profitability and growth will probably not be the norm in the current health center budget year, and probably will not be in the next budget year. Boards members should be prepared to adjust their expectations accordingly.
- Run scenarios: In preparing budgets, it is often useful to develop several scenarios, to provide a "what if" analysis for certain key events/conditions. In the COVID-19 era, the budgeting process should include various scenarios, possibly including a "best case," "middle case," and a "worst-case scenario." The worst-case scenario should show health center financial projections using a variety of the budgeting factors listed above but with the assumption these factors could get worse. The worst-case scenario should consider provider vacancies, health center site shutdowns, changes to telehealth reimbursement, and other key factors so that the health center is ready to act should any of these issues come to pass.
- Cash: Cash is an important measure of a health center's financial health. The budget should include a calculation of budgeted days cash on hand, which is a measure of how much cash a health center has to meet its expenses.[5]

Discussion Questions

Below are questions that board members or Finance Committee members may wish to ask at board or committee meetings regarding pandemic-related budgeting items.

Revenue

- What changes are anticipated to various forms of visits and how will that impact projected revenue and cash flow? What assumptions about visit volume are included in the budget?
- What is our telehealth strategy for the budget period?
  - What percentage of our visits are telehealth and in-person, and how does that percentage change in the budget period?
  - Expanded telehealth reimbursement was authorized under a public health emergency. For how long are we guaranteed telehealth reimbursement? What if things change? Can we switch back to the old model?
  - Does telehealth reimbursement cover the center's costs? Is the reimbursement rate sustainable?
- Have we appropriately accounted for PPP funds?
- What remaining Cares Act Funding is available to draw down?

5 Generally, centers will want to have 45 to 60 days cash on hand as a minimum. Boards will want to ensure they are continuing to review the Cash Flow Statement on a routine basis. For more information, see the online module by the National Association of Community Health Centers on "Understanding the Importance of Cash Flow" available at **https://conferences.nachc.org/nachc/articles/2128/view**.

Expenses

- Have we budgeted enough for staffing? Has the budget factored in additional staffing to administer vaccines, and other cost factors?
- Does the budget adequately reflect COVID-related operating expenses (e.g., PPE)? Are estimates for COVID-19 related supplies accurate?
- Does the budget reflect costs anticipated related to Telehealth (e.g., equipment for patients)?
- What capital expenses are anticipated?

Bottom Line

- What is the center's strategy regarding COVID-19 testing and vaccinations? Do we anticipate additional funding to help cover costs?
- What is the center's realistic outlook regarding profitability and growth for the short-to-mid-term?
- Have we considered a "best case," "middle case," and "worst case" scenario?
- What is our projected days cash on hand? What is the "best case," "middle case," and "worst case" scenario?

Acknowledgements and Additional Information

This article was made possible through a generous grant from The Pfizer Foundation.

The Pfizer Foundation

This article was written on behalf of NACHC by Curt Degenfelder, Curt Degenfelder Consulting, Inc. The following individuals provided input on the content: Gervean Williams, Director, Health Center Finance, NACHC; M. Scott Alarcón, Health Center Board Member and Governance Consultant; Steven Sera, Health Center Board Chair; Gina Capra, Senior Vice President, Training and Technical Assistance, NACHC; Emily Heard, Director Health Center Governance, NACHC.

For additional resources from NACHC related to COVID-19, please visit **https://www.healthcenterinfo.org/priority-topics/covid-19/** and **http://www.nachc.org/coronavirus/**. Please contact Emily Heard, Director of Health Center Governance at NACHC, with questions (trainings@nachc.com).