

PURPOSE OF CHANGE IN SCOPE FINANCIAL IMPACT ANALYSIS

All change in scope requests must demonstrate that they can be accomplished and sustained without additional section 330 Health Center Program grant funds.

Therefore, when submitting a change in scope request to add or replace a site or add a service (including providing a service directly as opposed to via referral for the first time), a grantee must provide:

- Evidence that adequate revenue will be generated and/or made available via another funding source to cover all expenses as well as an appropriate share of overhead costs incurred by the health center in administering the new site or service. In general, budget assumptions must also be reasonable and achievable.
- A break-even (worst case) scenario or the potential for generating additional revenue¹ as documented in the budget presentation.

Similarly, a change in scope request to delete a site or service must also demonstrate at minimum, a break-even budget scenario given the potential for a decrease in revenue resulting from the change.

In all cases, if the Financial Impact Analysis budget indicates that additional section 330 Federal grant funds will be necessary to fully implement the proposed change in scope, it will not be approved.

¹ Health centers are also reminded that additional revenue (program income) obtained through the addition of a new site and/or service must be invested in activities that further the objectives of the approved health center project, consistent with and not specifically prohibited by statute or regulations.

GUIDELINES FOR COMPLETION OF THE FINANCIAL IMPACT ANALYSIS

- The Financial Impact Analysis must itemize **revenues AND expenses** of the health center grantee's total operating budget inclusive of all types of Health Center Program funding that the specific grantee receives (e.g. 330(e) and/or 330(h) funds). Use the budget presentation to clearly explain each line-item within each cost element. **NOTE:** It is important to ensure that the budget presentation contains detailed calculations explaining how each line-item expense is derived (e.g., number of visits, cost per unit).
- Do not include funds from pending supplemental grants (Federal or non-Federal) or any other unapproved changes in scope (e.g. a separate change in scope that the grantee has just submitted to add a new service) other than the proposed change in scope associated with this Financial Impact Analysis.

The Financial Impact Analysis must be presented as a line-item budget with THREE COLUMNS (see Sample Financial Impact Analysis) that clearly show the impact of the proposed change in scope as follows:

COLUMN 1: Change in Scope 12 Month Budget	COLUMN 2: Health Center Current Total Annual Budget	COLUMN 3: Revised 12 Month Health Center Total Annual Budget (CIS Budget + Current Budget)
<p>In this column, the grantee will provide a 12 month budget that <u>specifically outlines/isolates the projected impact of the change in scope request</u> on any and all applicable revenue and expense line items. For example if the addition of a new site is being proposed, this column will isolate out any projected increases/decreases (positive or negative budget entries)-<u>including if applicable, no change i.e. \$0.00</u>-in staffing, equipment, etc. as well as any anticipated impact on revenue associated ONLY with the new site and not the entire scope of project.</p> <ul style="list-style-type: none"> • It is important to distinguish one-time or start-up costs from continuing costs in this column. • The Change in Scope Budget projections should represent a full year at full capacity. • While only a one year budget presentation is required, grantees may present multi-year budgets if they wish. 	<p>In this column, the grantee will provide the <u>current total 12 month budget</u> (revenue and expenses) for its <u>entire section 330 (H80) approved grant program scope of project.</u></p> <ul style="list-style-type: none"> • The grantee should utilize the line item budget presentation included in the most recent BPHC funding application (New Access Point-for Newly Funded grantees, Services Area Competition, Budget Period Progress Report) as the baseline for this column’s budget presentation. • If the grantee has any APPROVED supplemental grants (Federal or non-Federal) or any other APPROVED and VERIFIED changes in scope (e.g. a new service that was approved and verified as implemented in the scope of project last month) that have impacted the budget since the submission of the last NAP/SAC/BPR application, these may be reflected in this column. 	<p>In this column, the grantee will show a <u>revised total health center 12 month budget, which integrates the proposed Change in Scope request</u> (e.g. shows what the total revised project budget would look like with the new proposed site incorporated).</p>

REVENUE AND EXPENSE LINE ITEM DEFINITIONS FOR PREPARATION OF FINANCIAL IMPACT ANALYSIS

REVENUE: The two major classifications of revenues are as follows:

Program Income: includes fees, premiums, third party reimbursements, and payments generated from the projected delivery of services. Program income is generally divided into Fee for Service and Capitated Managed Care.

Projected Fee For Service Income

(Medicaid and Medicare): Show income from Medicaid and Medicare *regardless of whether there is another intermediary involved*. For example, if the health center has a Blue Cross fee-for-service managed Medicaid contract. If CHIP is paid through Medicaid, it must be included. In addition, if the health center receives Medicaid reimbursement via a Primary Care Case Management (PCCM) model, this income must be included as Medicaid: Other Fee for Service revenue.

(Other Public): Includes CHIP **not** paid through Medicaid as well as any other state or local programs that pay for visits (e.g., Title X family planning visits, CDC's Breast and Cervical Cancer Early Detection Program, Title I and II Ryan White visits).

Projected Capitated Managed Care Income

This applies only to capitated programs. Visits provided under a fee-for-service managed care contract are included in the fee-for-service income projections.

FQHC Cost Settlement and Wrap Adjustments: This is the *total* amount of payments made to the health center to cover the difference between the PMPM amount paid for Medicaid or Medicare managed care visits and the health center's PPS/FQHC rate.

Other Income: includes all state, local, the section 330 (H80) grant as well as other Federal grants or contracts (e.g., Ryan White, HUD, Head Start), and local or private support that is not generated from charges for services delivered but that still clearly support the approved section 330 scope of project. It also includes grants for construction, equipment, or other activities that support the project, where the revenue is not generated from services provided or visit charges. It can

also include income generated from fundraising and contributions. In-kind donations may be included but should be on their own line item indicating this.

- ***All time-limited or special one-time funds listed under Other Income should be clearly identified as such in the Financial Impact Analysis and the sustainability of the proposed change in scope once this funding ends must be discussed in the appropriate section of the checklist.***
- ***If these categories do not describe all possible categories of Revenue (Program Income or Other Income, e.g., laboratory, imaging, pharmacy, other professional services), health centers may add lines for additional revenue sources. Explanations for such additions must be noted within the Financial Impact Analysis attachment.***

EXPENSES: Include the following major categories in the Expenses section of the Financial Impact Analysis:

Personnel Costs: Personnel costs must be explained by listed in total by the major personnel categories (e.g. Administrative, Medical Staff, etc.). Grantees may find it helpful to utilize the optional Staffing worksheet provided in the second tab of the Sample Financial Impact Analysis. **Reminder regarding salary limitations:** *Per the Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011, HRSA funds may not be used to pay the salary of an individual at a rate in excess of \$179,700 (the Executive Level II salary of the Federal Executive Pay Scale). Reasonableness and allowability regulations continue to remain in effect.*

Fringe Benefits: List the components of the fringe benefit rate (e.g., health insurance, taxes, unemployment insurance, life insurance, retirement plan, tuition reimbursement). The fringe benefits must be directly proportional to the portion of personnel costs allocated for the project.

Travel: List travel costs categorized by local and long distance travel. For local travel, the mileage rate, number of miles, reason for travel, and staff members/patients/board members completing the travel must be outlined. The budget must also reflect travel expenses associated with participating in proposed meetings, trainings, or workshops.

Equipment: Identify the cost per item and justify the need for each piece of equipment to carry out the proposed project. Extensive justification and a detailed status of current equipment must be provided when requesting funds for

the purchase of computers and furniture that meet the definition of equipment (a unit cost of \$5,000 or more and a useful life of one or more years).

Supplies: List the items necessary for implementing the proposed project, separating items into three categories: office supplies (e.g., paper, pencils), medical supplies (e.g., syringes, blood tubes, gloves), and educational supplies (e.g., brochures, videos).

Contractual: Provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. List both patient care (e.g., laboratory) and non-patient care (e.g., janitorial) contracts. Each grantee is responsible for ensuring that it has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring contracts.

Other: Include all costs that do not fit into any other category and provide an explanation of each cost (e.g., audit, legal counsel). In some cases, rent, utilities, organizational membership fees, and insurance fall under this category if they are not included in an approved indirect cost rate. This category can also include the cost of access accommodations, including sign language interpreters, plain language materials, health-related print materials in alternate formats (e.g., Braille, large print), and cultural/linguistic competence modifications (e.g., use of cultural brokers, translation, or interpretation services at meetings, clinical encounters, and conferences).

Indirect Costs: Costs incurred for common or joint objectives that cannot be readily identified but are necessary to organizational operation (e.g., facility operation and maintenance, depreciation, administrative salaries). Indirect costs may only be claimed if the grantee provides documentation of an approved indirect cost rate. If an organization does not have an approved indirect cost rate, one may be obtained through the HHS Division of Cost Allocation (DCA). Visit <http://rates.psc.gov/> to learn more about rate agreements, including the process for applying for them. **Note: If your organization claims indirect costs in your budget, you must upload a copy of your most recent indirect cost rate agreement.**

If these categories do not describe all possible categories of Expenses, health centers may add additional expense line items.