BEYOND THE ROUNDS

July 24, 2026

Don't Let Your Biennial Evaluation Become a Survey Liability

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On this week's Rural Rounds, we discussed some questions around who needs to participate in a Rural Health Clinic's (RHC's) Program Evaluation and some of the requirements. When CMS updated 42 CFR § 491.11 in 2019 to shift the RHC Program Evaluation from an annual to a biennial cycle, many clinic managers breathed a sigh of relief. However, doubling the timeframe between evaluations makes it easy to push this critical task to the back burner- until a surveyor arrives at your door.

Program Evaluation deficiencies remain among the most common survey citations for Rural Health Clinics. A compliant biennial evaluation isn't just a box-checking exercise; it is a full-system checkup on your clinic's clinical quality, operational compliance, and financial health.

Under federal regulations, your evaluation must directly answer three fundamental questions:

1. **Service Utilization:** Were the services rendered appropriately according to community needs?
2. **Policy Adherence:** Were established healthcare and operational policies followed?
3. **Corrective Action:** What operational or clinical changes are required based on the findings?

1. Utilization Review

The first core component evaluates clinic volume and sevice patterns over the trailing 24-month period. You report should synthesize high-level operational data to paint a clear picture of clinic activity.

Don't just list raw-numbers - include 2-3 sentences explaining significant trends

Key Metrics to Detail:

- **Total Patient Encounters:** Broken down by year and provider type (Physician, NP, PA, LCSW, etc)
- **Top Diagnosis & CPT Codes**: Identify your top 10-20 billed services to demonstrate the scope of care provided
- **Community Census Alignment**: Pull recent census and demographic data for your service area (e.g., aging populations, poverty rates, or growing pediatric groups) and evaluate whether your current clinical services align with community needs.
- **Mid-Level Staffing Threshold:** Verify and document that non-physician providers (NPs/PAs) cover at least 50% of the total hours the RHC is opening and operating.
- **Demographics & Payer Mix:** Document shifts in Medicare, Medicaid, Medicare Advantage, commercial, and uninsured patient volume to show alignment with community needs

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2. Medical Record Review

The goal here is not just to catch missing signatures - it 's to pull and review a representative sample of charts that reflects the overall quality and consistency of care across your clinic.

Per the CMS State Operations Manual (Appendix G), your total audited samples must be at least 5% of active patient records, or 50 records, whichever is less. But you do not need to pull all 50 charts during your evaluation month. Most compliant RHCs conduct monthly or quarterly peer reviews throughout the two-year cycle and simply roll those aggregated findings into your program evaluation report.

Audit Selection Criteria

- **Active vs Closed:** The sample must include both current active patients and closed/inactive records.
- **Provider Representation:** Include records from every practicing physician, NP, and PA proportionally
- **High-Risk Categories:** Include charts with controlled substance prescriptions, pediatric visits, and chronic disease management

What Reviewers Are Verifying

- Documentation is clear and legible.
- Patient history is clearly documented
- The exam was pertinent to the chief complaint and documentation is complete
- Medication reconciliation was performed with current medications along with dosages documented.
- Diagnostic testing was appropriate and the results clearly documented
- Follow-ups or referrals, if applicable, are appropriate and documented.
- The diagnosis/es are supported by documentation
- The treatment plan is consistent with assessment and diagnosis

3. Policy & Environmental Review

A compliant evaluation isn't just an exercise in verifying that your policy binder has recent dates - it is a critical assessment of policy adherence. Surveyors don't just ask, "Do you have a policy for this?" They ask, "Are you actually doing what your policy says?"

Policy Review & Operational Reality

Review all clinical guidelines, standing orders, and administrative policies to ensure they reflect current standards and your clinic's day-to-day practices. Pay special attention to:

- **Patient Care Policies**: Ensure biennial updates signed by the Medical Director and NP/PA match real-world workflows
- **Adherence Audits:** Verify that staff are actively following protocols (e.g. if a policy states you will obtain signed consent to treats annually, verify they are being done annually).
- **Emergency Preparedness:** Review of the biennial hazard vulnerability assessment (HVA), staff training records, and executed emergency exercise logs and after-action plans.
- **Infection Control:** Audits of hand hygiene compliance, personal protective equipment (PPE) usage, and equipment sterilization/disinfection logs.

Physical Plant & Safety

The most effective way to evaluate your physical plant and clinical operations is by conducting a formal annual mock survey. Walk your facility with a surveyor's mindset to assess compliance against core Condition for Certification standards.

During your walk-through, document every potential deficiency immediately - whether its an expired mutli-does vial, uncalibrated scale, or a blocked emergency exit. For every finding, log the specific corrective action taken to rectify the issue and bring the clinic back into full compliance before finalizing your report

In your program evaluation report, review the results of your mock survey and the corrective action taken. Additionally, note and review any preventative maintanence or repairs done on all equipment.

4. Advisory Group Review

The Biennial Program Evaluation cannot be conducted in a vacuum by a single manager. CMS requires review from a designated advisory group, though how that review takes place offers some operational flexibility.

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Meeting Requirements & Best Practices

A formal, in-person meeting of the advisory group is not explicitly required by CMS regulations to complete the Program Evaluation. However, hosting a formal meeting is highly recommended. It remains the single best way to maintain compliance, foster clinical collaboration, and conduct a thorough checkup on the overall health of your RHC program.

Clarifying the Outside Member's Role

CMS regulations require and outside member (a non-employee representative such as a local pharmacist, public health official, or consultant) to participate in your advisory group. However their obligation is specific.:

- **Required:** Reviewing and signing off on your Patient Care Policies biennially (or annually if required by state law).
- **Not Required**: The outside member is not required to sign the Program Evaluation report or committee meeting minutes.

Required Program Evaluation Sign-Offs

While the outside member focuses on policy approval, official sign-off on the final Biennial Program Evaluation report rests internally:

- RHC Medical Director (Physician)
- Mid-Level Provider (NP or PA)

While additional reviewers are not legally required by CMS, it is often highly advisable to involve clinic owners, practice administrators, billing managers, and other staff providers in the evaluation process. Broadening input ensures operational bottlenecks and financial considerations are addressed alongside clinical quality.

5. Closing the Loop: The Action Plan

An evaluation report that simply identifies problems without proposing solutions is incomplete. Surveyors expect to see a clear thread connecting your data analysis to concrete, measurable operational improvements.

Translating Data & Audit Findings into Actionable Plans

When your evaluation identifies potential deficiencies, gaps, or shifts, your report must explicitly document corrective action steps your leadership team will take:

- **Chart Audit Deficiencies:** If chart reviews reveal systemic documentation issues - such as missing provider signature or incomplete problem lists - document the corrective steps
- **Mock Survey & Safety Deficiencies:** If your annual physical plant walk through turns up environmental or operational gaps - such as expired medication or uncalibrated equipment - detail the immediate remediation steps taken to bring the facility back into full compliance
- **Policy Gaps & Non-Compliance:** If staff are not adhering to written protocols or if clinical guidelines have become outdated, document policy revisions, staff re-education plans, and workflow updates.
- **Service Gaps:** If community census data reveals unmet health needs (e.g., a surge in a pediatric visits or spike in chronic disease management), outline plans to close those gaps.
- **Payer Mix & Revenue Shifts:** If shifts in your payer mix negatively impact clinic revenue, document your financial strategy - such as reviewing existing commercial contracts or renegotiating reimbursement rate.

Buidling a Compliant CAP

For every clinical, physical, or operational deficiency noted during your evaluation, establish a simple Corrective Action Plan (CAP) containing three key elements:

1. The Root Cause
2. The Assigned Owner
3. The Target Date & Re-audit Schedule

Final Thought: Stay Survey Ready

Don't wait for your 24-month deadline to approach before gathering data. Keep a running "Program Evaluation File" where you drop monthly chart audits, meeting minutes, and maintenance logs. When evaluation time comes, assembling your final report will take hours instead of weeks - keeing your clinic compliant and your sanity intact.

Need additional resources email us at info@empowerruralhs.com

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