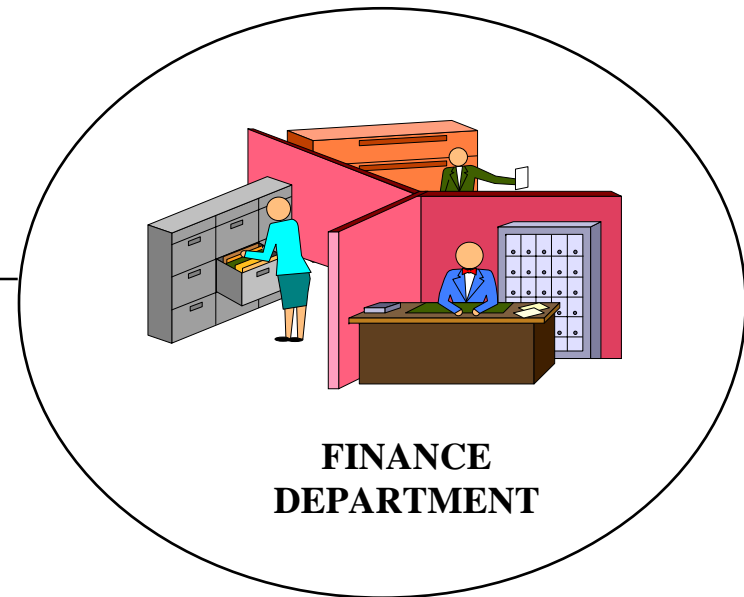


2005 HRSA Primary Health Care  
All Grantee Meeting  
Washington, D.C.

# Financial Management for Community Health Centers



# Financial Management for Community Health Centers

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## GOALS

- To provide an understanding of the responsibilities, functions and organizational structure of an efficiently operated finance department.
- To identify the key elements of an effective financial management system.
- To highlight the financial reports needed to assist in managing the finance department and the operations of the CHC.
- To discuss management indicators and other tools to be used to monitor the financial performance of the CHC.

# Financial Management for Community Health Centers

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## ROLE OF THE CHIEF FINANCIAL OFFICER

### Core Requirements:

- Maintenance of the Books and Records of the CHC and Ensuring Compliance with all Applicable Laws and Regulations
- Stewardship of Assets
- Provide Information, Insight and Guidance as a Key Member of the Management Team in the Strategic Planning Process
- Provide Financial Information to the Board in Conjunction With the Management Team

# Financial Management for Community Health Centers

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## ROLE OF THE CHIEF FINANCIAL OFFICER

### Core Requirements (con't):

- Monitor and Control Billing to Third Parties and Collection Efforts of Receivables
- Liaison to External Parties in Regard to Financial Information
- Develop and Monitor Budgets (Including Regulatory, Internal Management, and Capital)
- Manage Cash Flow

# Financial Management for Community Health Centers

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## CORE COMPETENCIES OF THE CHIEF FINANCIAL OFFICER

- Bookkeeping / Accounting Skills
- Preparation of Financial Statements
- Billing and Collections
- Healthcare Operational Expertise
- Grants Management
- Treasury Management (including financing)
- Interpersonal, Negotiation, and Supervisory Skills
- Knowledge of Information Management

# Financial Management for Community Health Centers

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## RESPONSIBILITIES OF THE FINANCE DEPARTMENT

- Safeguarding of Assets
- Accurate and Timely Preparation of Financial Reports
- Efficient Management of Cash Flow
- Contain Costs / Maximize Revenue
- Interact With Outside Auditors
- Comply With Regulatory Requirements

# Financial Management for Community Health Centers

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## COMPLIANCE WITH REGULATORY REQUIREMENTS

### Types of Requirements:

- Generally Accepted Accounting Principles
- Federal Grant Regulations
- Medicare Regulations
- Medicaid Regulations (State specific)
- IRS Regulations

# Financial Management for Community Health Centers

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## COMPLIANCE WITH REGULATORY REQUIREMENTS

### Federal Grant Regulations:

- OMB Circular A-110 (Administrative Requirements)
- OMB Circular A-122 (Cost Principles)
- OMB Circular A-133 (Audit Requirements)

# Financial Management for Community Health Centers

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## COMPLIANCE WITH REGULATORY REQUIREMENTS

### Federal Grant Regulations (continued):

- Program Expectations (BPIN 98-23)
- 45 CFR, Part 74
- PHS Grants Policy Statement
- RPGM 91-6: Financial Status Reports
- RPGM 91-7: Excess Program Income
- RPGM 96-17: Prevention, Problem Identification & Resolution (PPIR)

Information can be downloaded from the internet at the following website: [www.bphc.hrsa.dhhs.gov/](http://www.bphc.hrsa.dhhs.gov/)

# Financial Management for Community Health Centers

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## OTHER APPLICABLE REGULATIONS/INFORMATION

- Scope of Project (BPIN 2002-07)
- Objective Performance Review (OPR) Performance Review Protocols
- Grant Opportunities
  - New Access Points
  - Expanded Medical Capacity
  - Service Expansion
- NACHC Issue Briefs

# Financial Management for Community Health Centers

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## HIPAA

- Electronic Transaction/Code Set Standards
  - Extensions to 10/15/03
  - Begin testing by 4/16/03
- Privacy Standards
  - Policies in place by 4/14/03
- Security Standards
  - Final regulations published 2/03
  - Must be compliant by 4/05

# Financial Management for Community Health Centers

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## ELEMENTS OF AN EFFECTIVE FINANCE DEPARTMENT

- Well-Defined Organizational Structure
- Complete Accounting Policies and Procedures Manual
- Strong Financial Management Systems:
  - Tailored to Your Operations
- Timely and Accurate Financial Reporting
- Continual Reassessment / Re-evaluation
- Compliance With Regulatory Requirements

# Financial Management for Community Health Centers

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## ASSESSMENT OF FINANCE DEPARTMENT'S ORGANIZATIONAL STRUCTURE

1. Review / Revise Job Descriptions
2. Review / Revise Organizational Chart
3. Assess Each Position's Responsibilities and Job Qualifications and:
4. Train and Cross-Train Staff
5. Emphasize Communication
6. Supervise and Promote Teamwork
7. Maintain Routine and Structured Evaluation Process

# Financial Management for Community Health Centers

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## PURPOSE OF ACCOUNTING POLICY AND PROCEDURES MANUAL

- Detailed Explanation of How to Process Transactions
  - Guidance to Staff
- Strong Internal Controls
  - Safeguard Assets
  - Segregation of Duties
  - Accurate Financial Reporting
- Ensure Compliance With Regulatory Requirements

# Financial Management for Community Health Centers

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## SECTIONS OF ACCOUNTING POLICIES AND PROCEDURES MANUAL

- I. Introduction
- II. Preparation of Financial Reports
- III. Chart of Accounts
- IV. Cash Disbursements
- V. Cash Receipts
- VI. Journal Entries
- VII. Maintenance of Accounting Records (See Exhibit 1)
- VIII. Requisitioning, Purchasing and Receiving
- IX. Accounts Payable (See Exhibit 2)
- X. Payroll
- XI. Accounts Receivable
- XII. Fixed Assets
- XIII. Billing
- XIV. Statistical Data Collection

# Financial Management for Community Health Centers

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## REPORT DEVELOPMENT

- Prepare External Reporting List and Timeline
- Prepare an Internal Report List With Timeframes and Users
- Develop Reports (i.e., format) to Satisfy the Needs of the End User
- Determine the Requirements of Each System to Generate the Information Necessary for the Reports
- Customize Each System Based on the Needs Developed Above

# Financial Management for Community Health Centers

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## EXTERNAL REPORTING REQUIREMENTS

- Bureau of Primary Health Care
  - Uniform Data System (UDS)
  - Financial Status Report (FSR)
  - Prevention, Problem Identification and Resolution (PPIR)
  - Objective Performance Review (OPR)
  - Audit Under OMB Circular A-133
  - Form PSC-272

# Financial Management for Community Health Centers

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## EXTERNAL REPORTING REQUIREMENTS

- State / Local Funding Agencies
  - Monthly / Quarterly Expenditure Reporting
  - Audit Reports Under Specific Requirements
- Medicaid / Medicare Cost Reports
- Tax Returns
  - Internal Revenue Service
  - State / Local Tax Authorities

# Financial Management for Community Health Centers

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## INTERNAL REPORTING REQUIREMENTS

- Financial Statements (Profit / Loss)
- Cash Flow Projections
- Patient Volume
  - Provider Productivity
- Other Reports (as requested)
- Varying Degrees of Reporting Based on User
  - Board of Directors vs. Finance Committee
  - Executive Director vs. Program Directors
  - Finance Director

# Financial Management for Community Health Centers

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## INTERNAL REPORTING REQUIREMENTS

### Health Center Management

#### Daily / Weekly:

- Encounters by Individual Provider Versus Standard
- Visits by Payor and Payor Mix
- Cash Position Worksheet
- Encounters - Appointments Kept versus Missed

# Financial Management for Community Health Centers

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## INTERNAL REPORTING REQUIREMENTS

### Health Center Management

#### Monthly:

- Revenue and Expense Statements by Department / Program
- New Users by Payor
- Days in Accounts Receivable by Payor Source
- User Trends-Medicaid to Selfpay
- Managed Care Actuarial Mix and Utilization
- Contract Revenue and Receivable Analysis
- Patient Revenue Per Visit by Payor Source

# Financial Management for Community Health Centers

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## INTERNAL REPORTING REQUIREMENTS

### Board of Directors

#### Monthly Financial Statements, Including:

- Balance Sheet
  - Current Year vs. Prior Year
- Statement of Operations
  - Current Year vs. Budget
  - Current Year vs. Prior Year
- Report of Patient Visits
  - By Payor Source (with payor mix) vs. Budget and Prior Year
  - By Provider Type vs. Budget and Prior Year

# Financial Management for Community Health Centers

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## INTERNAL REPORTING REQUIREMENTS

### Finance Committee

#### Monthly Financial Statements for Board and:

- Cash Flow Projections (Weekly vs. Monthly)
- Medicaid Managed Care Analysis
  - Members and Capitation Analysis
  - Utilization
- Key Financial Indicators

# Financial Management for Community Health Centers

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## TIPS ON ANALYZING THE BALANCE SHEETS

- Current Ratio = current assets divided by current liabilities.  
*Want this ratio to be at least 1:1 and do not want to decrease over time. [BPHC expectation: between 1:1 and 2:1]*

$$\$628,000/\$700,500 = 0.90:1$$

- Unrestricted Net Assets, Available for Operations = total unrestricted net assets less net investment in fixed assets\*.  
(\* Fixed assets, net of accumulated depreciation reduced by outstanding debt used to purchase fixed assets)

*Want this measure to be positive and not to decrease over time.*

$$\$102,500 - \$107,500 = <\$5,000>$$

# Financial Management for Community Health Centers

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## TIPS ON ANALYZING THE BALANCE SHEETS

- Days in Reserve = unrestricted net assets available for operations divided by average daily expense ([total expenses less bad debt and depreciation] divided by 365 days)

*Goal is 60 to 90 days of operating expenses.*

$$\langle \$5,000 \rangle / (\$1,957,000 / 182.5) = \langle 0.47 \rangle \text{ days}$$

- Days in Accounts Receivable = net patient accounts receivable, divided by average daily patient revenue ([Patient revenue, net of adjustments and bad debt, excluding managed care capitation] divided by 365 days)

*Increase in ratio indicates potential billing problem and could hurt cash flow. [BPHC expectation: , 120 days]*

$$(\$372,000 / (\$900,000 - \$230,370) / 182.5) = 101.38 \text{ days}$$

# Financial Management for Community Health Centers

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## TIPS ON ANALYZING THE BALANCE SHEET

- Days in Accounts Payable = Trade accounts payable and accrued expenses divided by average daily trade expenses ([Total expenses less salaries and wages, donated services, bad debt and depreciation] divided by 365 days)

*An increase indicates that you are paying your vendors slower, indicating a cash flow problem. [BPHC Expectation: <120 days]*

$$\$325,500/((\$2,004,500 - \$1,216,475 - \$47,500)/182.5) = 80.22 \text{ days}$$

- DHHS Refundable Advance

*Indicates that you have drawn down more grant funds than earned, equivalent to a loan; should not be greater than 10% of grant.*

$$\$125,000/\$1,200,000 = 10.42\%$$

# Financial Management for Community Health Centers

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## TIPS ON ANALYZING THE STATEMENT OF OPERATIONS

### Trends and Relationships:

- Analyze changes in patient revenue as compared to changes in patient volume (i.e., visits), prior year vs. current year and current year vs. budget.
- Any Unusual Trends Should Be Researched:
  - ⇒ Change in Reimbursement Rates
  - ⇒ Shifts in Payor Mix

# Financial Management for Community Health Centers

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## TIPS ON ANALYZING THE STATEMENT OF OPERATIONS

- Analyze changes in expenses as compared to changes in patient volume (i.e., visits).
- Any Unusual Trends Should Be Researched:
  1. Analyze by Department
  2. Review Costs Per Visit
    - ⇒ By Department
    - ⇒ By Ancillary Cost (e.g., Lab, X-ray)
  3. Review Provider Productivity

# Financial Management for Community Health Centers

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## TIPS ON ANALYZING THE STATEMENT OF OPERATIONS

- Analyze Changes in Patient Volume (visits) as Compared to:
  - ⇒ Users (identify patient utilization trends)
  - ⇒ Providers (identify provider productivity trends)

# Financial Management for Community Health Centers

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## TIPS ON ANALYZING THE STATEMENT OF OPERATIONS

### Managed Care Measures:

- Analyze Trends in Member Utilization
- Analyze Trends in Managed Care Revenue Per Visit
- Analyze Trends in Capitated Revenue Per Member Per Month (PMPM)

# Financial Management for Community Health Centers

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## SETTING A FEE SCHEDULE

- Historically, it has not been uncommon for provider charge structures to not have been based on the cost of each service provided, but rather on environmental conditions and the targeted patient population.
- Section 330 statute requires that CHCs have a “schedule of fees or payments for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation” AND have “a corresponding schedule of discounts to be applied to the payment of such fees or payments, which discounts are adjusted on the basis of the patient’s ability to pay.”

# Financial Management for Community Health Centers

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## HOW TO EVALUATE YOUR FEE SCHEDULE

Consider the following information regarding ABC Health Center -

	Visits	Charges	Adjustments	Net Revenue
Medicaid	10,000	\$ 1,000,000	\$ (250,000)	\$ 1,250,000
Self-pay	5,000	250,000	150,000	100,000
Totals	15,000	\$ 1,250,000	\$ (100,000)	\$ 1,350,000

Other Relevant Information:

- Total Health Care Costs = \$1,875,000
- Total CHC Grant = \$500,000

*What issues are currently confronting this health center?*

# Financial Management for Community Health Centers

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## HOW TO EVALUATE YOUR FEE SCHEDULE

Now consider the following information after implementation of a cost-based charge structure -

	Visits	Charges	Adjustments	Net Revenue
Medicaid	<b>10,000</b>	<b>\$ 1,250,000</b>	<b>\$ 0</b>	<b>\$ 1,250,000</b>
Self-pay	<b>5,000</b>	<b>625,000</b>	<b>525,000</b>	<b>100,000</b>
Totals	<b>15,000</b>	<b>\$ 1,875,000</b>	<b>\$ 525,000</b>	<b>\$ 1,350,000</b>

Other Relevant Information:

- Total Health Care Costs = \$1,875,000
- Total CHC Grant = \$500,000

*Is the health center still encountering the same issues?*

# Financial Management for Community Health Centers

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## **ESTABLISHING A SCHEDULE OF DISCOUNTS**

- Section 330 regulations require that the schedule of discounts conform with the following guidelines:
  - CHCs must charge patients above 200% of the Federal poverty level guidelines the full fee for services provided
  - CHCs may collect nominal fees from patients at or below 100% of the poverty level guidelines
  - Discounts must be applied to charges to ensure access for patients with annual incomes between 100% and 200% of the poverty level guidelines
- Section 330 statute further requires that “a health center has made and will continue to make every reasonable effort to secure from patients payment for services in accordance with such schedules.”

# Financial Management for Community Health Centers

## ESTABLISHING A SCHEDULE OF DISCOUNTS

Example of sliding fee scale discount methodology -

Poverty Level	% Discount	Sample Charge	Discount	Net Fee to be Collected
< 100%	75%	\$ 100.00	\$ 75.00	\$ 25.00
101% – 150%	50%	\$ 100.00	\$ 50.00	\$ 50.00
151% - 200%	25%	\$ 100.00	\$ 25.00	\$ 75.00
> 200%	0%	\$ 100.00	\$ 0.00	\$ 100.00

- **CHCs have flexibility in establishing their own specific nominal fee for patients under 100% of poverty**
- **CHCs have flexibility in establishing the number of sliding fee categories between 100% and 200% of poverty as well as the level of discounts offered**

## **FORMS OF PATIENT SERVICES REVENUE**

Each type of patient revenue can have different reimbursement schemes. These include:

- Fee-For-Service
- All-Inclusive Rate
- Prospective Payment System
- Capitation

## **MAXIMIZING FFS REIMBURSEMENT**

To generate more revenue, a health center can:

- Provide more procedures
- Properly code encounter forms to ensure all services provided are billed
- Utilize a comprehensive encounter form to ensure all billable procedures are included

# Financial Management for Community Health Centers

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## OVERVIEW OF COST-BASED REIMBURSEMENT

Allowable Costs		\$1,000,000
Billable Visits		(÷) <u>10,000</u>
All-Inclusive Rate		= <u>\$100</u> per visit
Medicaid Visits		<u>7,500</u>
Medicaid Revenue	(7,500 x \$100)	<u>\$750,000</u>

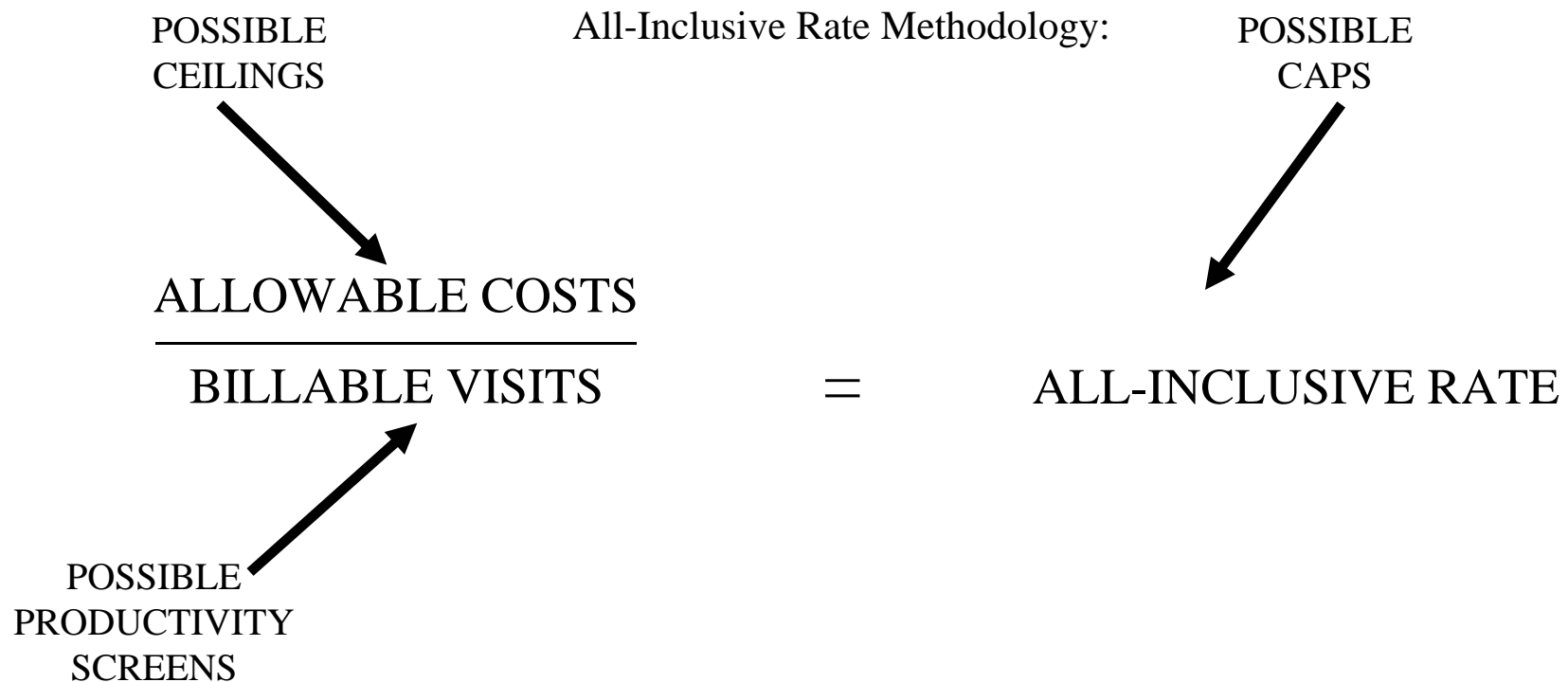
**OR**

$$\frac{\text{Medicaid Visits}}{\text{Total Visits}} = 75\% \times \$1,000,000$$

# Financial Management for Community Health Centers

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## MAXIMIZING COST-BASED REIMBURSEMENT



## **COST-BASED REIMBURSEMENT SYSTEMS**

- Interim Rates
- Desk Review
- Final Settlement (rate reconciliations)
- Field Audits
- Retrospective Versus Prospective (by provider type)

## **MAXIMIZING COST-BASED REIMBURSEMENT**

### FQHC Medicare

- Interim Payment Rate - Prospective Rate Based on Submitted Cost Report Based on Prior Year Costs and Visit Information
  - Opportunity to Adjust After Desk Review
- Final Reconciliation - Receive Difference Between Interim Payments for Year and Actual Cost Based Rate
  - May Appeal Rate If Appropriate
- Regulations
  - FQHC
  - HIM-15

# Financial Management for Community Health Centers

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## **MAXIMIZING COST-BASED REIMBURSEMENT**

### FQHC Medicare (cont'd)

- Part B billing for non-covered services
- 100% Reimbursement for Pneumococcal and Influenza Vaccines and Administration
- Medicare Bad Debt Recovery
- Coinsurance Reimbursement and Sliding Fee Scale Applicability
- No Patient Deductible

## **MAXIMIZING COST-BASED REIMBURSEMENT**

### Medicaid

- Each state has implemented the Prospective Payment System differently
- Each State's Filing Requirements Differ
- Regulations:
  - State Specific
  - If Medicaid Regulations are Silent, Then Medicare Regulations Apply

# Financial Management for Community Health Centers

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## PROSPECTIVE PAYMENT SYSTEM (PPS)

- Base Medicaid rate (2001) based on average of 1999 and 2000 cost per visit.
- Future Medicaid rates (2002+) based on 2001 rate adjusted for MEI and changes in scope of services.
- “Wraparound” protection for Medicaid managed care contracts.
- Alternative Payment Methodologies.

# Financial Management for Community Health Centers

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## PPS STRATEGIES

- Ensure that base year cost reports were prepared accurately
  - Allocation of costs
  - Billable visits
- Monitor “wraparound” payments
- Monitor rate appeal opportunities for change in scope of services

# Financial Management for Community Health Centers

## PPS CHANGE IN SCOPE OF SERVICES

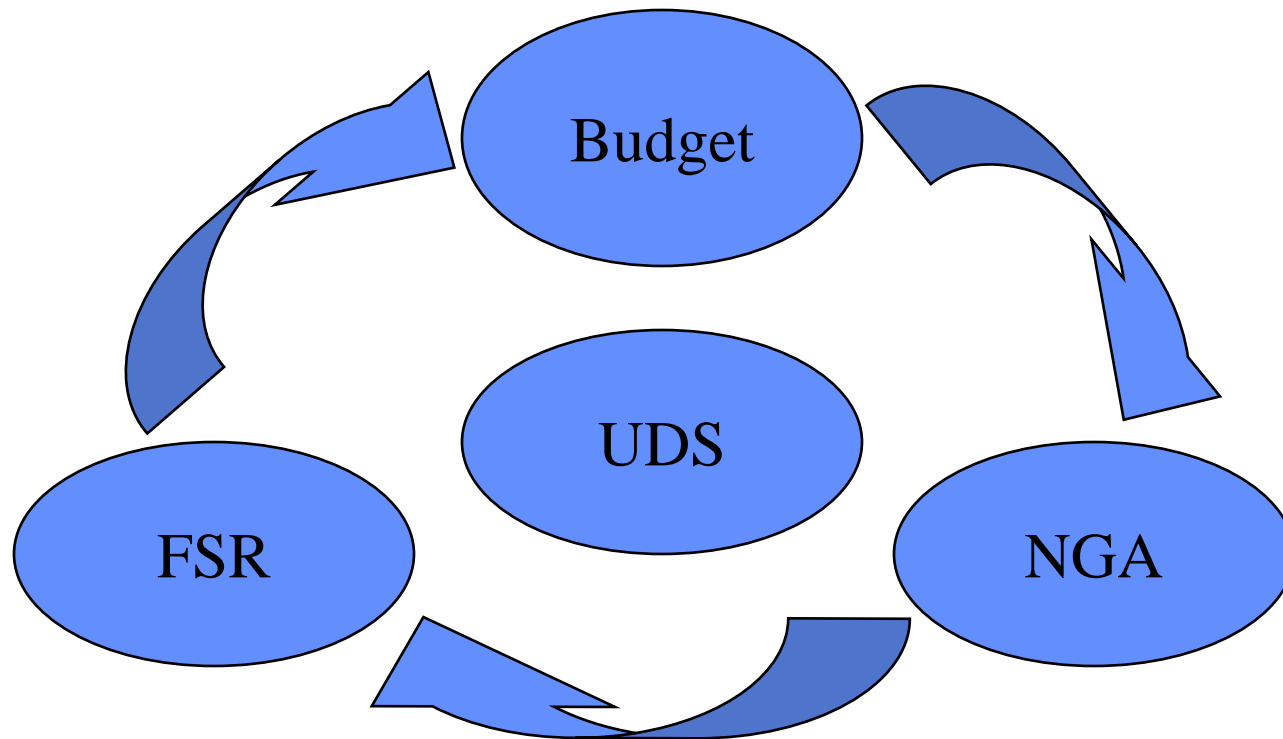
### Cost Per Visit Analysis:

	<b>1999</b>	<b>2000</b>	<b>Avg.</b>	<b>Trended</b>	<b>2003</b>
<b>Medical</b>	50.00	55.00	52.50	57.75	60.00
<b>Ancillaries</b>	10.00	10.00	10.00	11.00	20.00
<b>Enabling</b>	15.00	15.00	15.00	16.50	15.00
<b>Administration</b>	15.00	15.00	15.00	16.50	15.00
<b>Capital</b>	10.00	15.00	12.50	13.75	25.00
<b>TOTAL</b>	<b>\$100.00</b>	<b>\$110.00</b>	<b>\$105.00</b>	<b>\$115.50</b>	<b>\$135.00</b>

# Financial Management for Community Health Centers

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## DHHS GRANT REVENUE CYCLE



# Financial Management for Community Health Centers

## GRANTEE PERFORMANCE MEASURES

Measure	Minimal Expectation
Medical User Growth Rate	No % Decline
Medical Encounter Growth Rate	No % Decline
Changes in Self-Pay Charges	No % Decline
Use of BPHC Receipts for Uncompensated Care	Not less than 50 <sup>th</sup> %: Urban > 109.2%; Rural > 65.9%
Medicaid User Growth Rate	No % Decline
Medical Team Provider Productivity	Not less than 20 <sup>th</sup> % = 3,732
Medical Care Services Cost per Medical Encounter	Not more than CMS Cap: Urban = \$106.58; Rural = \$91.64
Percent of Self-Pay Charges Collected	Not less than 20 <sup>th</sup> % = 13.7%

Note: Above represent 2003 measures projected to 2004; trends compare 2004 to the average of 2003 & 2002

# Financial Management for Community Health Centers

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## OPR PERFORMANCE REVIEWS

Office of Performance Review (OPR) to perform performance reviews

- Evaluate how the CHC measures performance
- What impacts performance
- Strategies the CHC undertakes to improve performance

# Financial Management for Community Health Centers

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## OTHER HELPFUL TIPS

- Prepare a projected FSR on an interim basis.
- Project potential final settlements for cost reports and Medicaid managed care wraparound calculations on an interim basis.
- Evaluate your health center's performance on an interim basis, as compared to BPHC standards (i.e., projected UDS).

# Financial Management for Community Health Centers

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## SUMMARY

Constantly Reassess the Needs of Your Health Center:

- Re-evaluate Reporting Requirements and Accounting Department Structure
- Stay Abreast of Changes in Applicable Regulatory Requirements
- Modify Systems and Procedures Manual
- Secure Financial Viability of the Health Center into the Future