# Assess, Conquer, and Elevate (ACE) Your Finances

*Understanding your  Core FQHC Financial Management, Revenue Cycle, Business Performance*

**North Carolina Community Health Center Association**
Primary Care Conference

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Primary Care Development Corporation

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CONSULTING & TRAINING AT PCDC

# 30+ years helping practices optimize their care models and strengthen their financial health.

## CARE MODEL

- Quality Improvement
- Value-Based Payment
- Integrated Care
- Care Coordination
- Medical Home Operations


## BUSINESS PRACTICES

- Revenue Cycle Management
- Policy & Workflow Development
- KPI Analysis
- Financial Fundamentals
- Financial Modeling

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# Learning Objectives

1. Understand the importance of collaboration and communication in the health center space related to financial and revenue cycle management.
2. Name funding sources that impact health center operations.
3. Define key accounting and revenue cycle concepts and identify Key Performance Indicators (KPIs) essential to financial and revenue cycle management.

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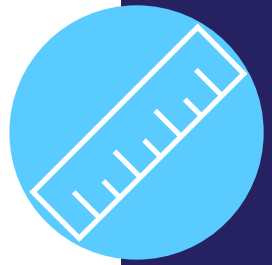
# Why is it Important for ALL Leaders to have a Foundation in Finance **and** Revenue Cycle?

- Foster dialogue, collaboration, and understanding with a common language.
- Answer critical operational and strategic questions that drive business decisions:
  - Can we afford to hire additional staff OR add a new service line?
- Help the organization meet benchmarks or assess the performance of your department.
- Assist with health center compliance responsibilities.

**No margin no mission**

**Every decision has a financial impact**



**Measure performance**

**Compliance and stewardship of federal funds**

# FQHC Foundations

# Federally Qualified Health Center Background

- Established in **1964** as part of Lyndon B. Johnson's War on Poverty; two initial sites in Massachusetts and Mississippi
- In **1975**, the program was formalized/expanded through **Section 330** of the Public Health Service Act
- FQHC "Look Alikes" were established in 1990 to expand access when no additional funds were available for FQHCs
- The program has been expanded and renewed – in bipartisan efforts – throughout the last fifty years, most recently in-line with Affordable Care Act in 2010
- There are currently approximately 1,400 FQHCs and FQHC-Lookalikes across United States and U.S. Territories

Source: HRSA

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# What is a Health Center?

- **Community-based and patient-directed organizations**
- Provide **affordable**, **accessible**, **high-quality** primary health care services
  - Primarily engaged in providing primary care and qualified preventive health services
- **Integrate** access to health services, including:
  - pharmacy,
  - mental health,
  - substance use disorder,
  - and oral health.
- Coordinated Care Management

Source: HRSA

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# Benefits of FQHC Status

- Access to an **enhanced fee-for-service** (Prospective Payment System, “PPS”) for Medicaid and Medicare beneficiaries
- Participation in **340B Federal Drug Pricing Program** (discounted drug purchasing)
- Access to free vaccines for underinsured and uninsured children
- Access to support for recruiting/retaining providers through National Health Service Corps
- Employees covered as federal employees under Federal Tort Claims Act (FTCA); reduces the need to purchase expensive malpractice insurance
- Receives **“330 Grants”** to support subsidy to operations for providing care to under/uninsured populations
- Access to other Health Resources and Service Administration grants and technical assistance

Source: Health Center Solutions

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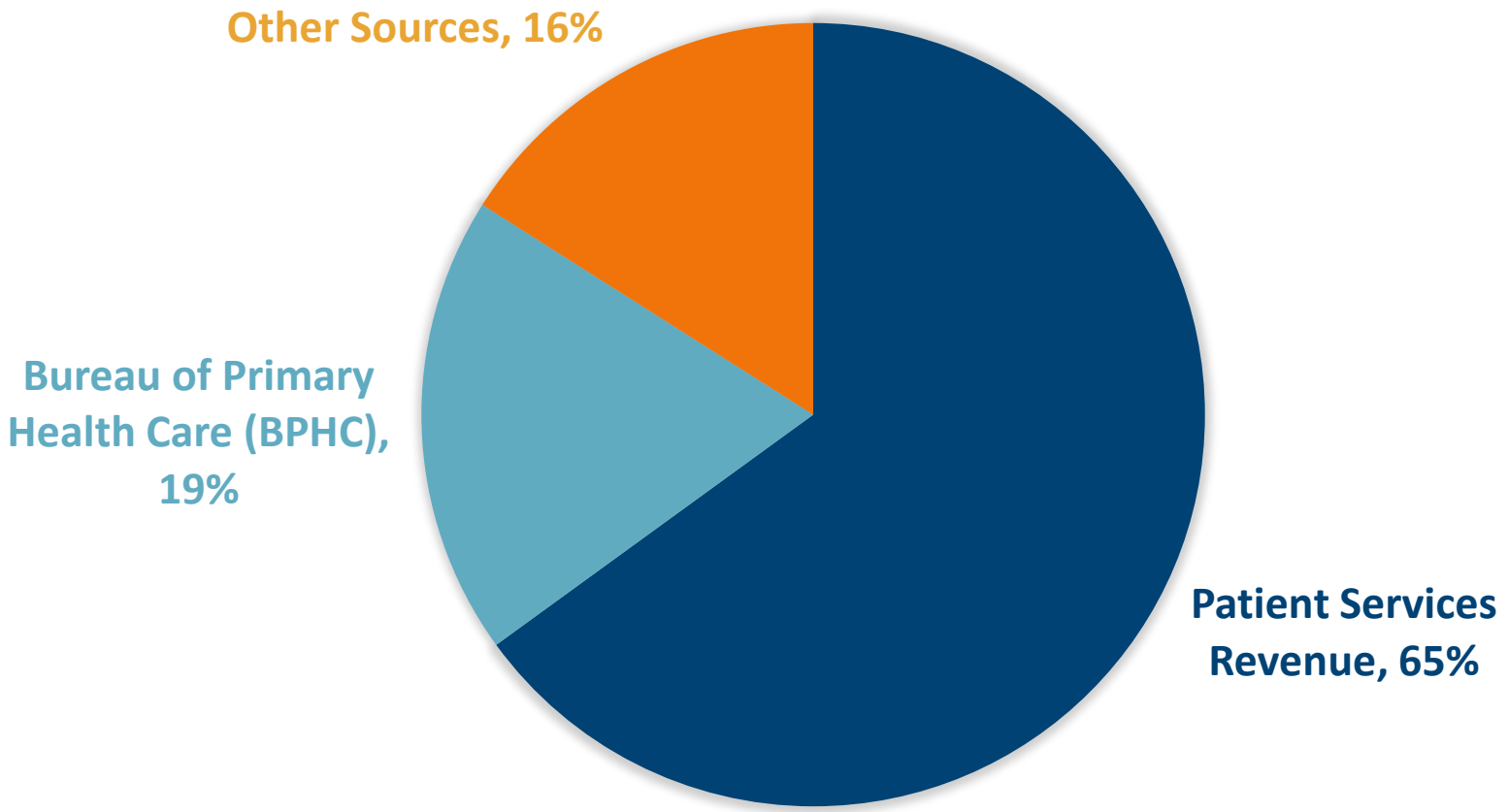
# Health Center Funding




Source: HRSA Health Center Funding

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# Patient Services Revenue

340B

| PPS Rate | Negotiated FFS Rate | Value-Based (VBP) Alternative Payment (APM) | Sliding Fee Scale** |
|---|---|---|---|
| Medicare | Commercial* / Private Insurance | Medicare Shared Savings Program (MSSP) | Under / Uninsured |
| Medicaid | | Medicaid/ Commercial | |

*Commercial insurance not required to pay PPS rates; most services are not "bundled"

**HRSA requires FQHCs to have documented and consistently applied sliding fee scale for those patients unable to cover cost of treatment

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# Federal Funding

## Section 330 of the Public Health Services Act

"330 Grant"

## Other Federal Grants for Specific Populations

- Migrant Seasonal Agricultural Worker
- People Experiencing Homelessness
- Residents of Public Housing
- People with Limited English proficiency

Source: HRSA Funding

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# Other Funding Sources

## Other Contract Revenue

- State Contracts
- Local Contracts

## Philanthropy

- Private Donations
- Fundraising / Grants

## Other

- Interest Revenue
- Other Miscellaneous

Source: HRSA Funding

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# Chapter 15: Financial Management and Accounting Systems

- “The health center must maintain effective control over, and accountability for, all funds, property, and other assets to adequately safeguard all such assets and ensure that they are used solely for authorized purposes.”
- Written policies and procedures to ensure adequate use of federal funds – should be reviewed annually and updated based on new statutes or requirements.
- Utilize financial management and control systems – need to be compliant with Generally Accepted Accounting Principles (GAAP).
- If receiving over $750k in federal awards, must have an annual audit.
- Must ensure financial management system can specifically identify federal awards.
- Ensure non-grant funds are used as permitted under section 330.

Source: HRSA

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# Finance Foundations

# Accounting Terms

**Asset:** Provides economic value or future benefit

- "Things that we own"
- Cash is one type of asset in accounting

**Liability:** A financial obligation to another entity

- Sometimes referred to as debt.
- "Things that we owe"

**Net Assets:** Accumulated surplus of funds

- It is the Assets minus the Liabilities
- Restricted vs. Unrestricted

**Revenue:** Increase of assets by providing a good or service.

- Not to be confused with profit
- Also called income

**Expense:** The use of assets from producing or delivering goods or services.

- Also called costs

**Change in Net Assets (profit/loss):** The subtraction of total expenses from total revenues

Source: Small Practice Management Essentials

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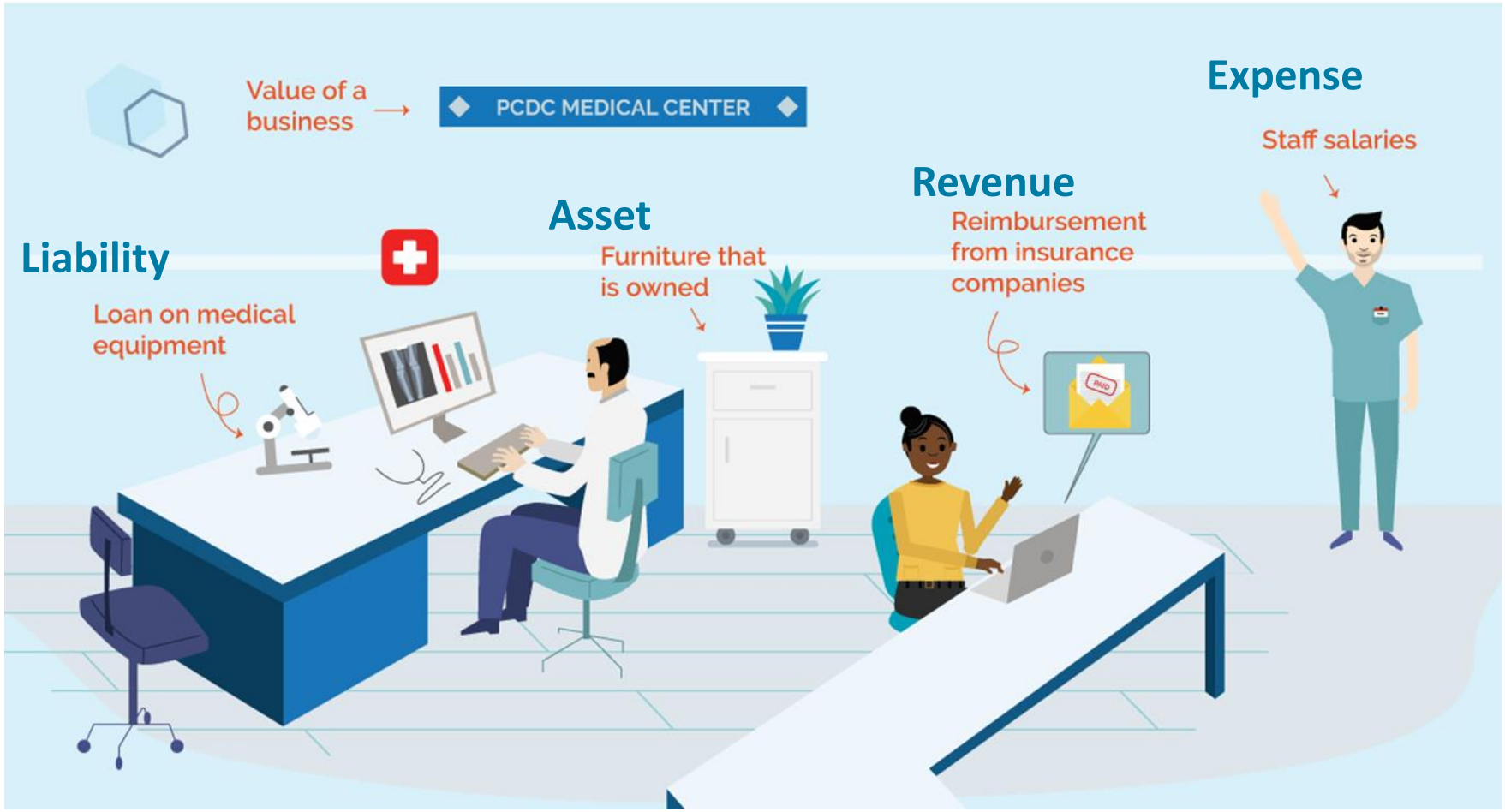
# Understanding Accounting Transactions




Source: Small Practice Management Essentials

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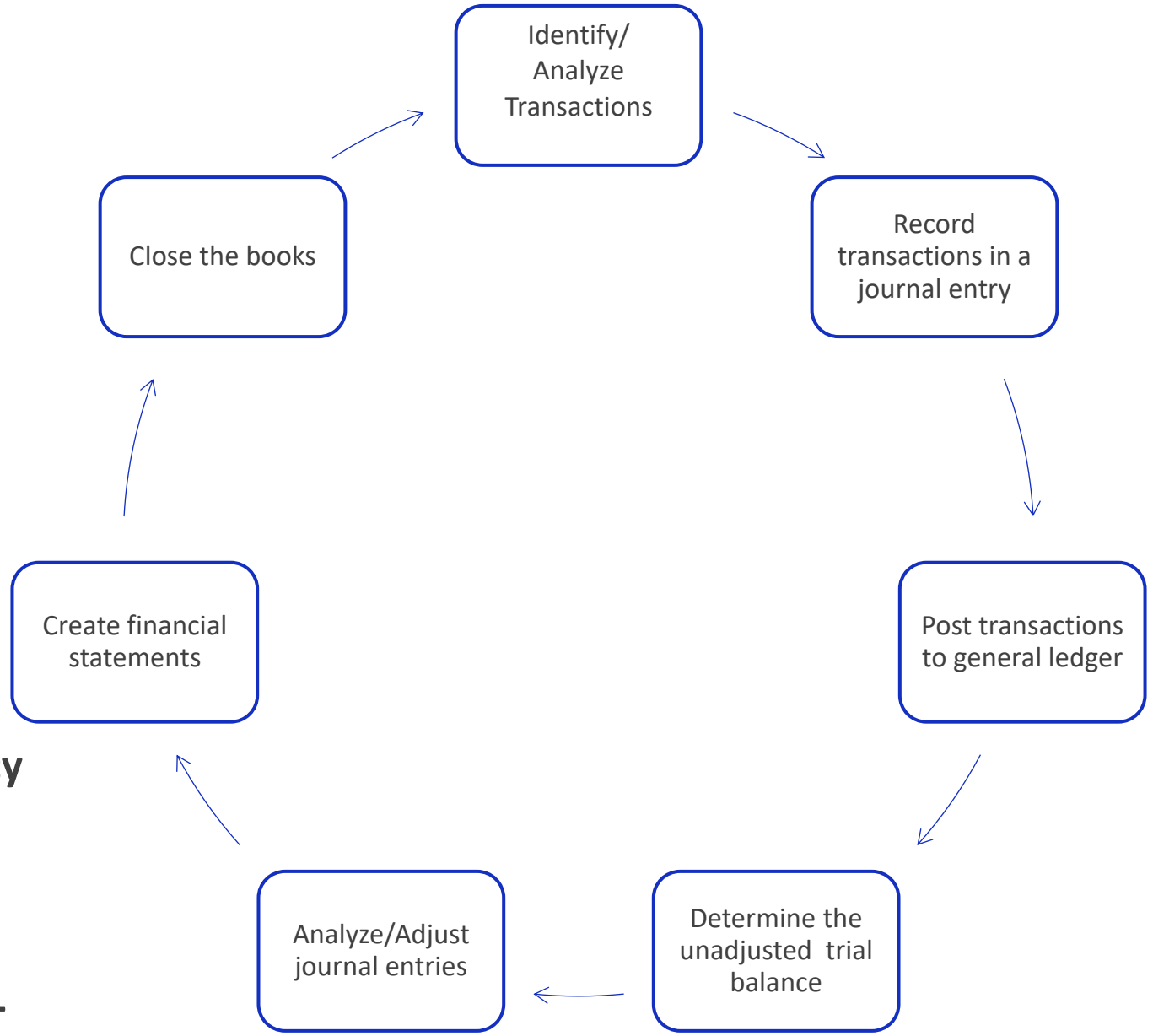
# Accounting Cycle

- Accounting is the **language of business.**
- The process of analyzing, recording, and producing **financial statements**
  - Follow a set of standards referred to as Generally Accepted Accounting Principles (GAAP)
- Enables accurate and complete financial information to **increase transparency** and **reliability**
- Reduces the **risk of fraud**
- Identifies financial trends to inform **decision-making**




Source: Business News Daily

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# Accounting Principles

**Accrual Basis Accounting**

- The recognition of revenue and expenses **when generated or incurred**
- Recognize **accounts receivable and accounts payable**, i.e., provides a more accurate picture of financial health.
- Follows **Generally Accepted Accounting Principles** (GAAP) set by the Financial **Accounting Standards Board (FASB)**
- More useful for budgeting and forecasting

**Cash-Basis accounting**

- Transactions are recorded **when cash is received or paid**

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# Understanding Costs

### Fixed vs. Variable

**Fixed expenses** such as rent and salaries **remain constant** regardless of the volume of output (# of patients seen), **variable expenses** such as supplies **increase** or **decrease** in proportion to the volume of output.

### Direct vs. Indirect

**Direct costs** can be attributed to a **specific service**, such as patient service revenue; **indirect costs** include **administrative** and **overhead costs**.

### Incremental Costs

Additional costs that arise while expanding a service such as **staff time** and resources to **expand working hours**.

### Opportunity Costs

Lost opportunity to generate revenue or profits from not providing a service.

Source: Principal Principles

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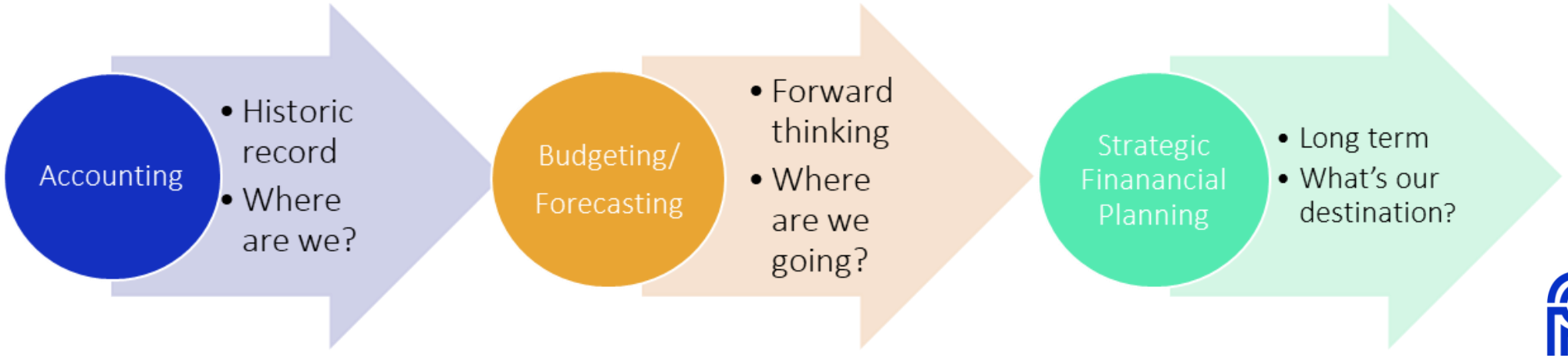
# Financial Reporting and Analysis

# Financial Reporting, Planning and Analysis

- **Accounting and financial reporting** tell the financial story of the organization in the current state.
- **Budgeting and forecasting** focus on projecting where the organization is headed in the coming year.
- **Strategic financial planning** is concerned with where we would like to go and evaluates the future financial impact of our decisions.

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# Reporting Requirements

## External Reporting

- Audited financial statements
- Medicare and Medicaid cost report
- IRS Form 990 tax return
- Federal Financial Report (FFR)
- Uniform Data System (UDS)
- Benefit plan audit and form 5500 filing

## Internal Reporting

- Monthly financial statements
  - Balance sheet
  - Statement of operations
  - Statement of cash flows
- Monthly board package
- Operating information (productivity by site/provider)

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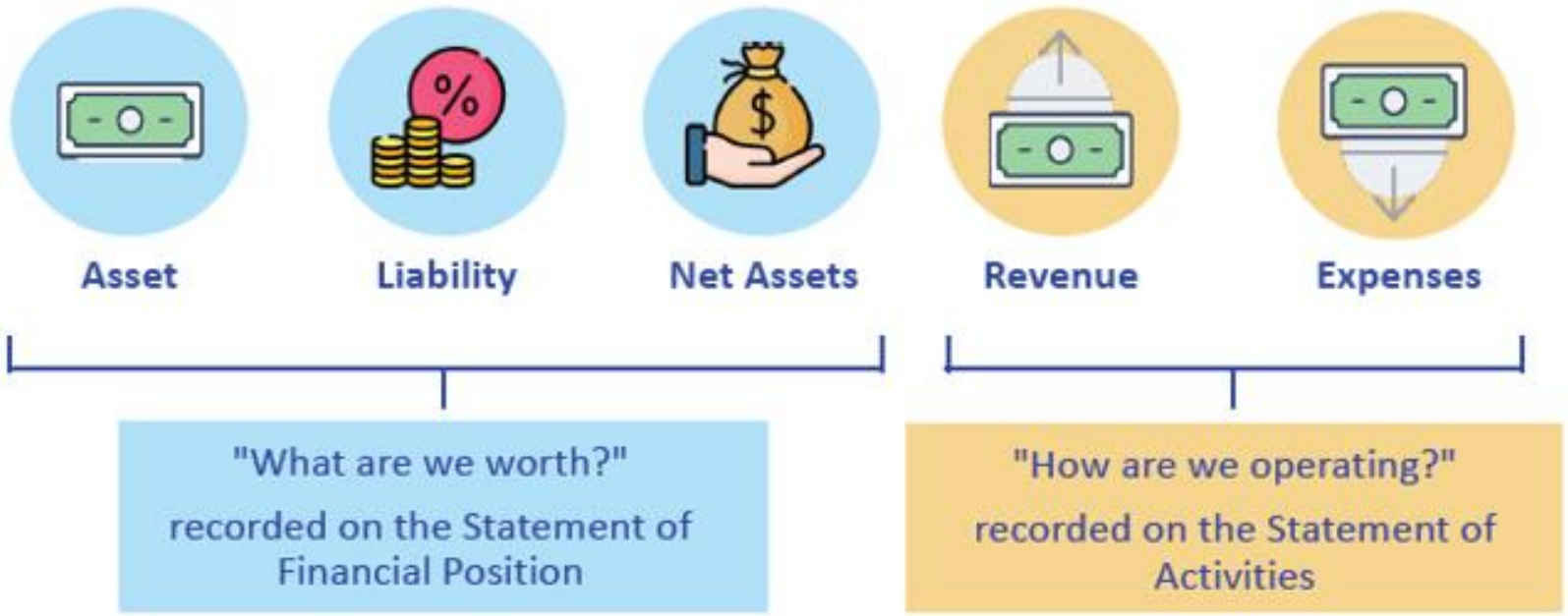
# Introduction to Financial Statements




All transactions will be recorded into one of these five accounts.

## Chart of Accounts

Source: Primary Care Development Corporation. “Small Practice Management Essentials: Course 10 – Basics of Expense and Revenue Tracking.” Apr. 2022. https://pcdc.course.tc/catalog/small-practice-management-essentials

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# Financial Statements

## Statement of Financial Position
(Balance Sheet)

- **Snapshot** of the value of the organization at a given point in time.
- **How much are we worth?**
- Assets = Liabilities + Net Assets

## Statement of Activities
(Income Statement)

- **Lists all revenues and expenses** for a given period of time.
- **How are we operating?**
- Revenues – Expenses = Change in Net Assets

## Statement of Cash Flows
(Cash Flow Statement)

- Lists **sources** and **uses** of cash from **operating**, **investing** and **financing** activities.
- **Do we have enough cash to meet our expenses?**

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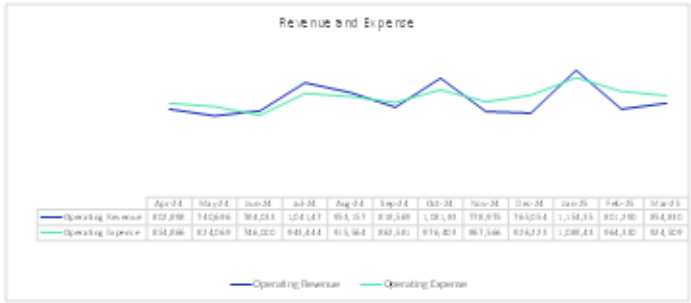
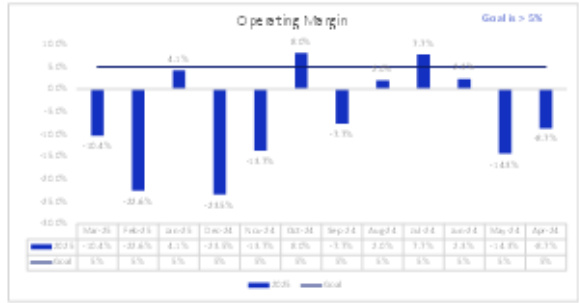
# Accounting Key Performance Indicators

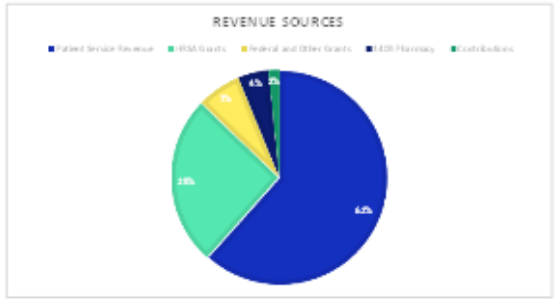
| Ratio | Formula | Description |
|---|---|---|
| Operating Margin | $\frac{Change\ in\ Operating\ Net\ Assets}{Total\ Operating\ Revenue}$ | Assesses an organization's ability to generate a profit from **operations**, indicating the strength of the business model |
| Bottom Line Margin | $\frac{Change\ in\ Net\ Assets}{Total\ Operating\ Revenue}$ | Shows the extent to which the performance is dependent on **non-operating revenue** sources like fundraising, grants or investment returns. |
| Days Cash on Hand | $\frac{(Operating\ Cash)}{(\frac{Operating\ Expenses - Noncash\ Expenses}{365})}$ | Measures **liquidity** and ability to **pay for immediate expenses** |
| Current Ratio | $\frac{Current\ Assets}{Current\ Liabilities}$ | Ability to pay **current obligations** |
| Debt to Equity Ratio | $\frac{Long - Term\ Debt}{Unrestricted\ Net\ Assets}$ | Assess an organization's **financial leverage**. How much debt does an organization take on to fund operations? |

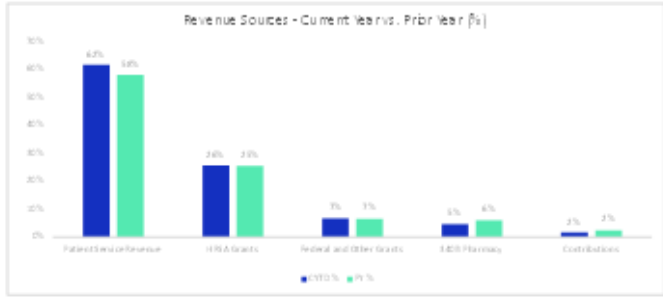
# Sample Health Center

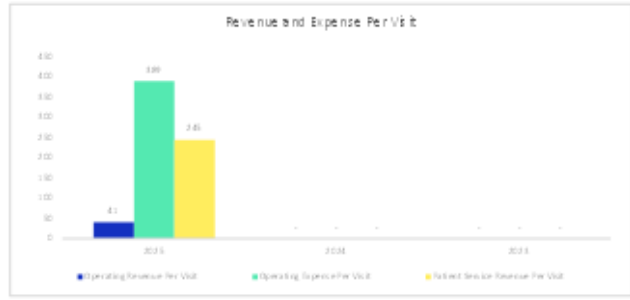


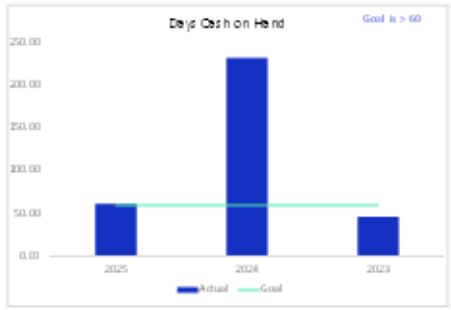



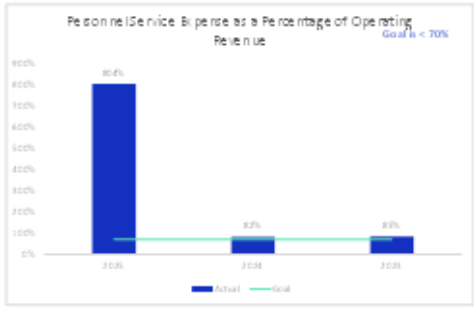


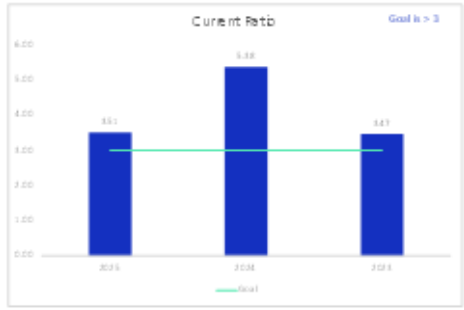


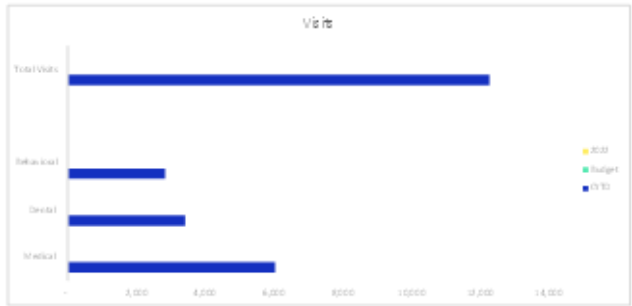



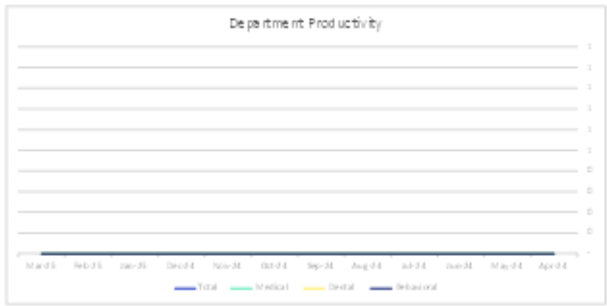









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# How is Accounting Information Used?

- For internal stakeholders:
  - Leadership team to analyze performance and sustainability, benchmark against peers, prepare budgets, and make strategic decisions.
  - Frontline staff to provide context for programmatic changes, and insight into how their role impacts the organization.
  - To ensure the board has proper oversight.
- For external stakeholders:
  - Health Resources and Services Administration (HRSA) for UDS reporting
  - Internal Revenue Service (IRS)
  - Bank for loan applications
  - Grant applications

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# Revenue Cycle Management (RCM)

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# Defining the Revenue Cycle

- The revenue cycle includes all activities that lead to payment for rendered services.
- In healthcare, Revenue Cycle Management (RCM) is the financial process health centers use to manage the administrative and clinical functions associated with claims processing, payment, and revenue generation.
- Having well-defined revenue cycle management processes improves accuracy in capturing revenue, resulting in improved financial health outcomes.

Source: Delvecchio, A., & Lee, K. (n.d.). *Revenue Cycle Management (RCM)*. Tech Target.
https://www.techtarget.com/searchhealthit/definition/revenue-cycle-management-RCM

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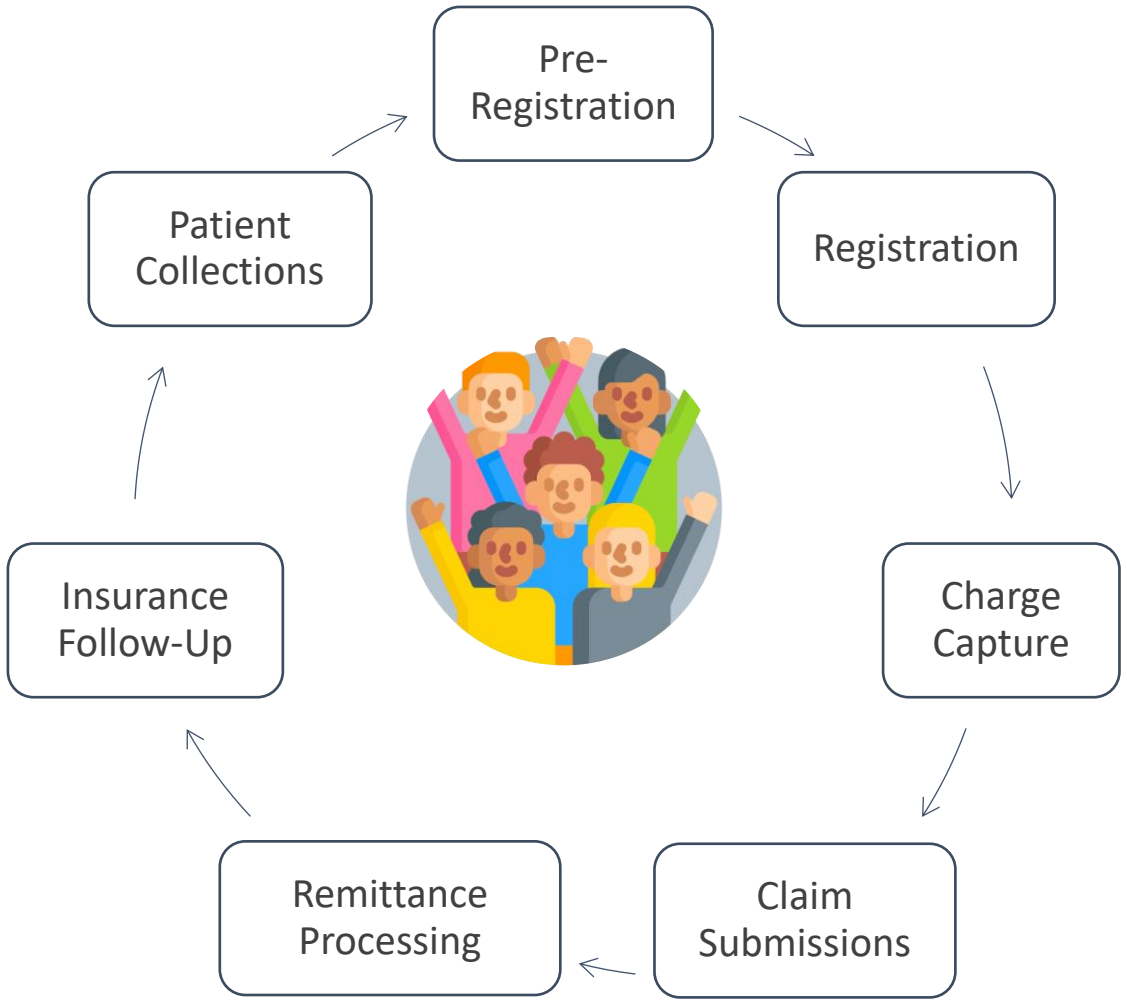
# Critical Components and a Team Approach




- Front Office
- Clinical Operations
- Providers
- Coders
- Billers
- Clinical Documentation Improvement
- Health Information Management
- Credentialing
- Compliance

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# Pre-Registration

- Pre-registration is when your health center collects patient information before the patient's visit.
- **At this time, your team could collect the following:**

- Name,
- Date of birth,
- Insurance information, and
- Information relative to your health center's sliding scale.

Source: (2023, April 21). *Revenue Cycle of a Healthcare Practice – Seven Steps*. LBMC Physician Business Solutions. https://www.lbmc.com/blog/revenue-cycle-healthcare-practice/

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# Insurance Verification

- Once pre-registration is complete, your health center team should begin the insurance eligibility verification process, which is the process of verifying a patient's insurance coverage and benefits, often done prior to the encounter.
- It is essential to check the coverage and benefits extended under your patient's insurance plan each time they visit your office.
- **Proactively verifying insurance prompts your team to:**

  - Ask for updated coverage information,
  - Identify co-payments and deductibles,
  - Conduct financial screenings as needed, and
  - Inform patients of the cost in the absence of coverage.

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# Registration

- Registration solidifies the process of ensuring that your patient's information is correct.
- During registration, your health center team should **verify** and **confirm** the information collected during pre-registration.
- **Registration is also the time when your health center staff could:**
  - Collect payment,
  - Ensure that financial policies are reviewed, and
  - Assign insurance benefits.
- This could also be the time when your team screens for sliding fee eligibility.

Source: (2023, April 21). *Revenue Cycle of a Healthcare Practice – Seven Steps*. LBMC Physician Business Solutions. https://www.lbmc.com/blog/revenue-cycle-healthcare-practice/

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# Charge Capture

- Charge capture is the process of rendering medical services into billable charges.
- Often, this process is automated, and information in the electronic medical record (EMR) flows into the practice management (PM) platform based on how providers document rendered services.
- The further a clinician gets from seeing a patient, the greater the risk of error and lost revenue.
- **Charges should be captured at the point of care to:**

  - Support revenue and quality metrics,
  - Improve accuracy and timeliness of billing, and
  - Improve continuity of care.

Source: (2023, April 21). *Revenue Cycle of a Healthcare Practice – Seven Steps*. LBMC Physician Business Solutions. https://www.lbmc.com/blog/revenue-cycle-healthcare-practice/

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# Claim Submission

- Claim submission involves sending information to the insurance carrier after charges are entered.
- Before submitting a claim, your health center billing team should verify:


- Charges
- CPT or HCPCS Codes
- Diagnosis Codes
- Date of Service
- Modifiers
- Place of Service
- Provider Information
- National Drug Codes (NDC)
- Revenue Codes
- Units

Source: (2023, April 21). *Revenue Cycle of a Healthcare Practice – Seven Steps*. LBMC Physician Business Solutions. https://www.lbmc.com/blog/revenue-cycle-healthcare-practice/

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# Claim Remittance

- Once your claims have gone out, you will receive remittances back.
- The electronic remittance advice (ERA), will show you what you were paid for the services your health center provided.
- During this process, it is essential to remember not to “post and go”.
- **Prior to posting payments, your health center billing team should review the:**

  - Allowed amount
  - Paid amount
  - Patient responsibility amount
  - Contractual adjustments

Source: (2023, April 21). *Revenue Cycle of a Healthcare Practice – Seven Steps*. LBMC Physician Business Solutions. https://www.lbmc.com/blog/revenue-cycle-healthcare-practice/

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# Insurance Follow Up

- Revenue for most health centers is stuck in the insurance follow-up stage, and a significant amount of money may be waiting to be collected.
- Insurance follow-up involves reviewing what has not been paid by patients and contracted payers.
- To do this, review aging accounts receivables reports because they show outstanding revenue for both patients and payers categorized by age.
- To create a plan for follow-up, consider prioritizing outstanding receivables by date of service and dollar amount.
- Defining a clear follow-up structure and ensuring that your billing team sticks to it can help increase cash flow and reduce the number of days in outstanding receivables.

Source: (2023, April 21). *Revenue Cycle of a Healthcare Practice – Seven Steps*. LBMC Physician Business Solutions. https://www.lbmc.com/blog/revenue-cycle-healthcare-practice/

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# Patient Collections

- The best time to collect money from a patient is when they are in your office.
- All front desk staff should be trained on the importance of collecting from patients at the time of service.
- To make collection easier, standard policies should be in place to:
  - Identify how co-pays and deductibles should be collected,
  - Outline sliding fee screening processes, and
  - Inform how outstanding balances are handled.
- To increase staff comfort, consider:
  - Scripting.
  - Roleplaying and practicing during staff meetings.


Source: (2023, April 21). *Revenue Cycle of a Healthcare Practice – Seven Steps*. LBMC Physician Business Solutions. https://www.lbmc.com/blog/revenue-cycle-healthcare-practice/

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# Revenue Cycle Key Performance Indicators

| Ratio | Formula | Description |
|---|---|---|
| Net Collections Rate | $\frac{Collections\ -Refunds}{Gross\ Charges\ -Contractual\ Adjustments}\ x\ 100$ | Identifies how effective your organization is at collecting **reimbursement** for **rendered services** |
| Time of Service (TOS) Collection Rate | $\frac{Collections\ on\ DOS}{Patient\ Balances\ Owed\ at\ DOS}\ x\ 100$ | Provides insight into collections at the **time of service** or when a patient is in the health center |
| Denial Rate | $\frac{Total\ Dollar\ Amount\ of\ Claims\ Denied}{Total\ Dollar\ Amount\ of\ Claims\ Submitted}\ x\ 100$ | Identifies the **percentage** of **denied claims** out of all **claim submissions**<br>*Can also use claim count. |
| Days in Accounts Receivable | $\frac{Total\ Accounts\ Receivable}{Average\ Daily\ Gross\ Charges}$ | Identifies how much **time** a bill spends in Accounts Receivable (DAR) |
| AR > 120 Days | $\frac{AR > 120\ Days}{Total\ Accounts\ Receivable}x\ 100$ | Identifies **significantly aged AR** |

# The Most Critical Component

- The most important component of the revenue cycle is the **team**.
- To foster a greater sense of team and break down silos:
  - Create shared goals
  - Clarify and define roles
  - Identify opportunities to improve communication
- Facilitate and foster experiences that build trust
- Create measurable processes and outcomes
  - Key Performance Indicators

Source: Hourani, E. (2020, August 7). *Prioritize Revenue Cycle Team Building*. Impact Advisors. https://www.impact-advisors.com/article/prioritize-revenue-cycle-team-building/

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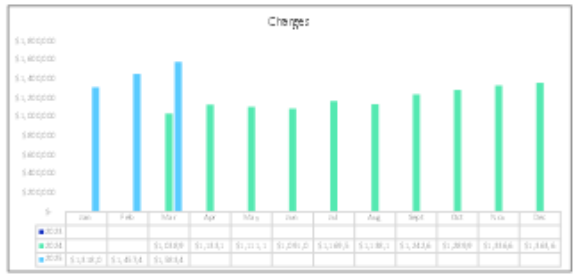
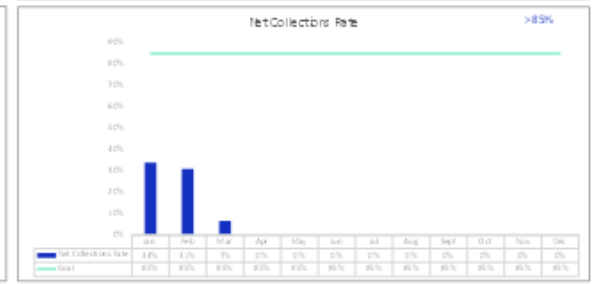
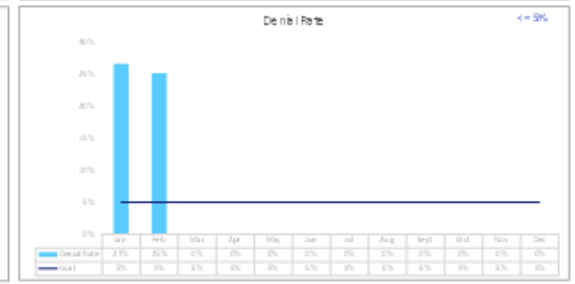
## Sample Health Center



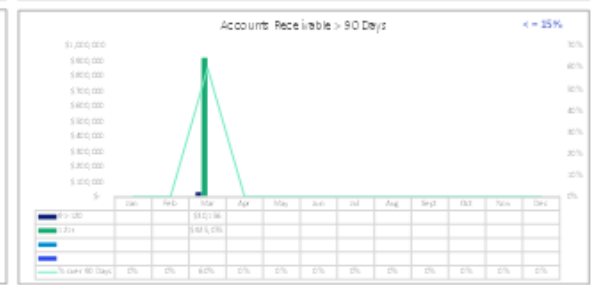


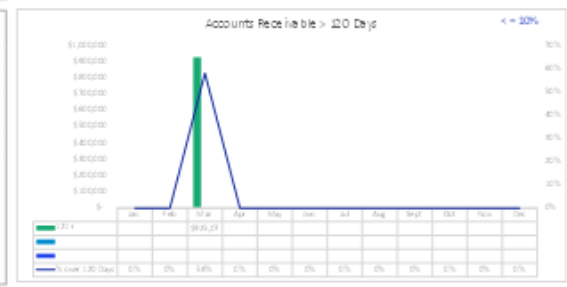




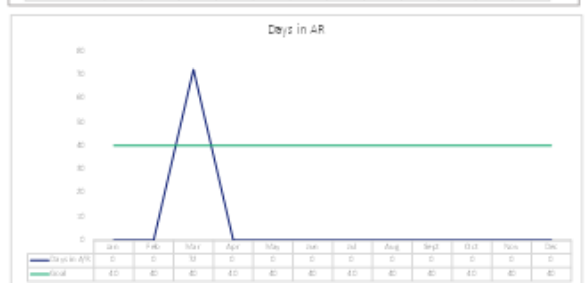



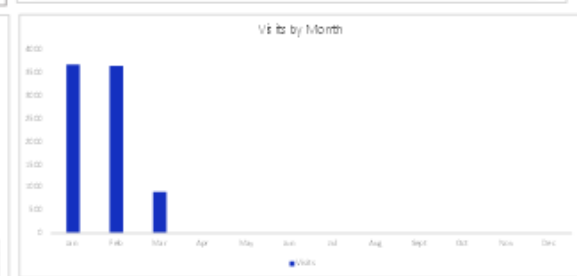






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# Additional KPIs to Track

## Front Desk Efficiency

- Statements in Returned Mail
- Claims on Hold (Registration Errors)

## Provider and Billing Team Scorecards

- Charge Lag
- Days to Bill
- Volume of Claims Submissions per Day

## Additional A/R Tracking

- Credit Balance Report Review

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# How is Revenue Cycle Information Used?

**Analyzing revenue cycle metrics:**

- Provides meaningful and actionable data
- Identifies opportunities for improvement and informs the development of action plans for correction

- Identifies trends
- Aids in the recognition of risks
- Increases depth of understanding of your patient population

- Drives workflow + policy evaluation and optimization
- Creates a pathway for sustainability

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# Best Practices

Recommendations for success and sustainability.


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# Recommendations

Ensure strong internal controls and accounting processes to ensure accurate reporting and compliance.

Review existing policies and workflows, identify opportunities for improvement, and ensure standardization across processes.

Leverage available data to identify successes as well as opportunities for improvement, ensure that you  have mechanisms in place to review trends.

Don’t manage to one metric, look for a balance of metrics without being overwhelming.

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# Recommendations

Use your PM/EMR systems to the highest degree of functionality.

Maximize communication and teamwork, seek input from team members and stakeholders.

Regularly conduct mini audits to ensure financial and revenue cycle accuracy.

Get to know your payors.

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# Resources

- NACHC 2025 Documentation and Coding Webinar Series
- National Council for Mental Wellbeing – Financing the Future of Integrated Care
  - Medication for Opioid Use Disorder
  - Screening
  - Care Coordination
  - Metabolic Monitoring
  - Treatment for Tobacco Use Disorder
  - Health Related Social Needs

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