Building High-Performing Health Centers: Lessons from Site Visits to Support Financial and Operational Improvement

Community Health Care Association of New York State

Catherine Gilpin, Partner, April 21, 2025

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Introductions – Meet the Forvis Mazars Team

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Agenda

1 Current Financial Condition of Federally Qualified Health Centers

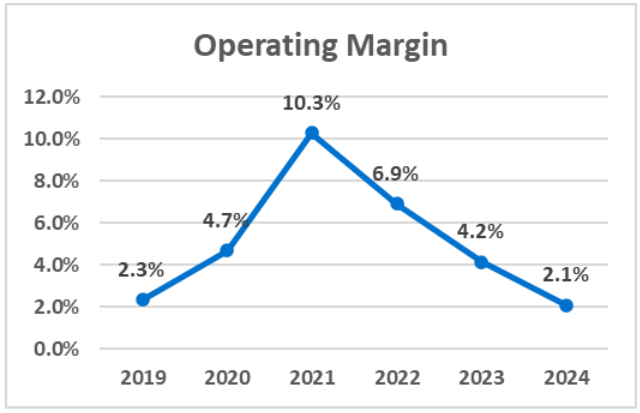
2 Lessons Learned from Health Center Site Visits

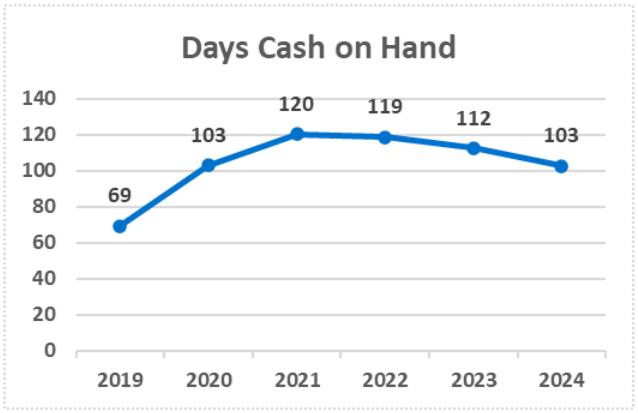
3 Planning for Long-Term Sustainability

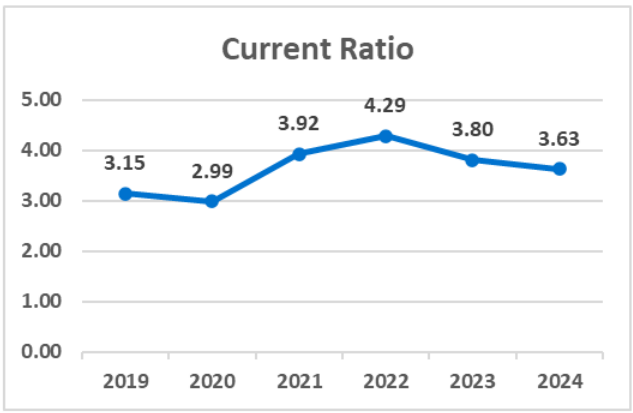
1

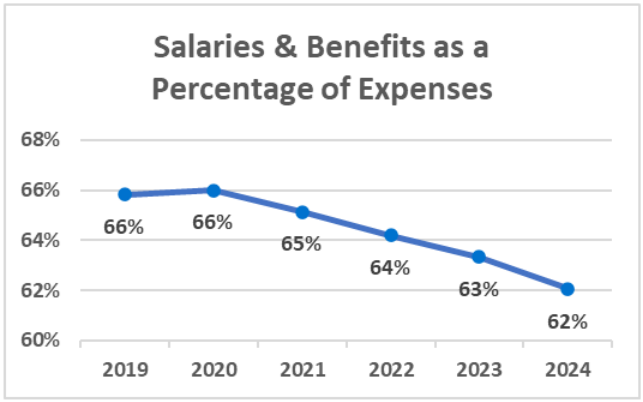
Current Financial Condition

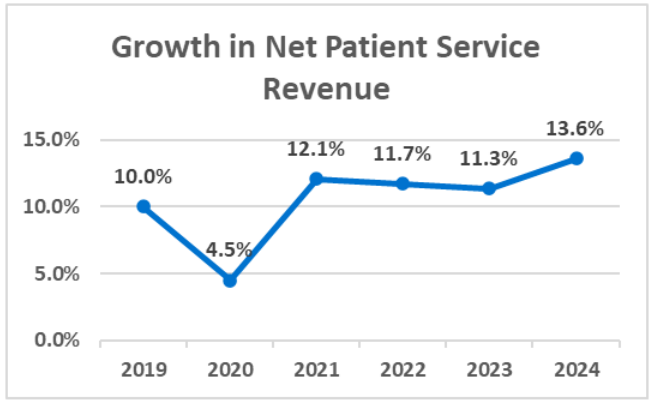
National FQHCs at the Median 2019–2024 (33% of audits for 2024)

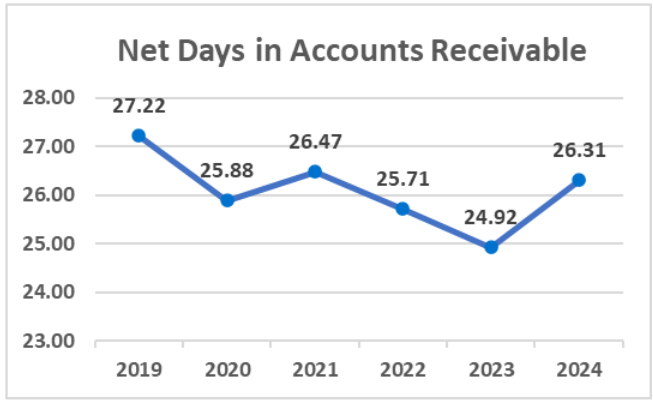


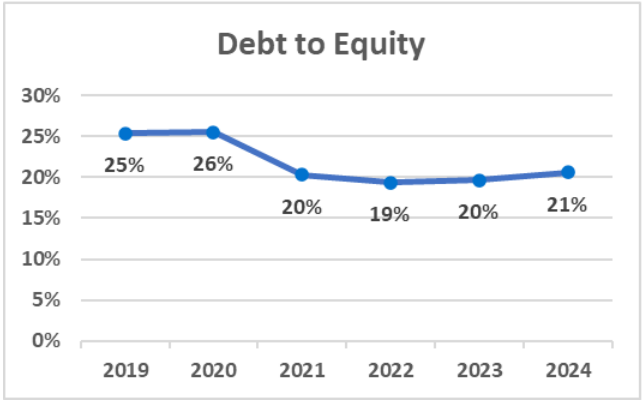


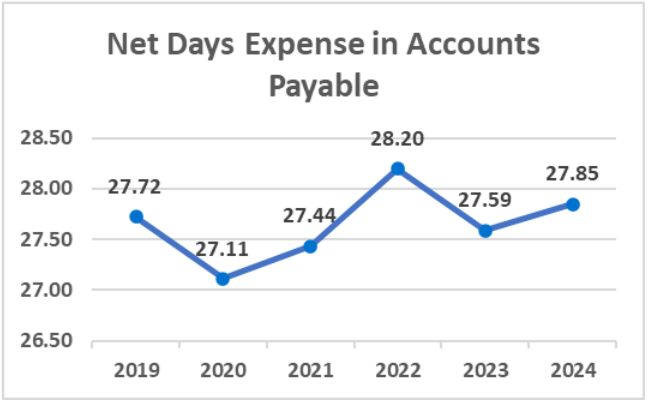


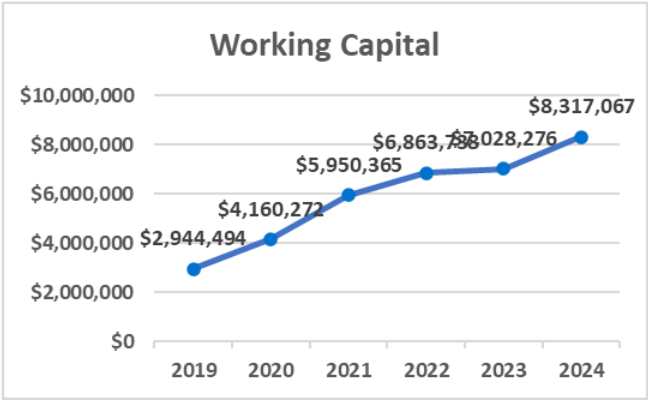












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National FQHCs

Overall Financial Condition

2024 National Financial Update as of 4/11/2025									
Source: Audited Financial Statements	National Median								
Key Financial Metrics	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2024 FQHCs 25th Percentile**	**2024 FQHCs Average**	**2024 FQHCs 75th Percentile**
Operating Margin	2.3%	4.7%	10.3%	6.9%	4.2%	2.1%	-3.3%	2.1%	7.5%
Days Cash on Hand	69	103	120	119	112	103	51	146	183
Current Ratio	3.15	2.99	3.92	4.29	3.80	3.63	2.06	5.19	6.02
Salaries & Benefits as a Percentage of Expenses	66%	66%	65%	64%	63%	62%	56%	61%	68%
Growth in Net Patient Service Revenue	10.0%	4.5%	12.1%	11.7%	11.3%	13.6%	5.4%	14.7%	22.8%
Net Days in Accounts Receivable	27.22	25.88	26.47	25.71	24.92	26.31	18.77	35.94	38.00
Debt to Equity	25%	26%	20%	19%	20%	21%	8%	34%	41%
Net Days Expense in Accounts Payable	27.72	27.11	27.44	28.20	27.59	27.85	16.81	34.47	42.74
Working Capital	$2,944,494	$4,160,272	$5,950,365	$6,863,738	$7,028,276	$8,317,067	$2,839,155	$14,570,916	$15,939,008

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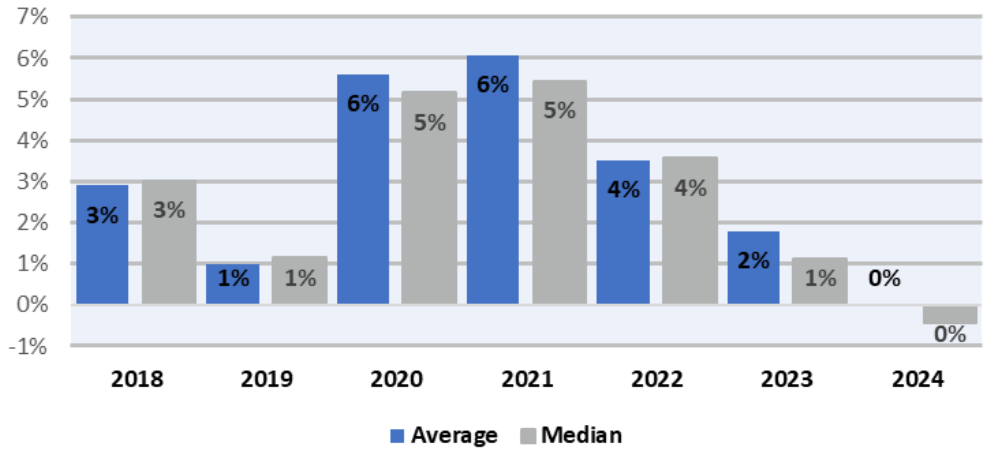
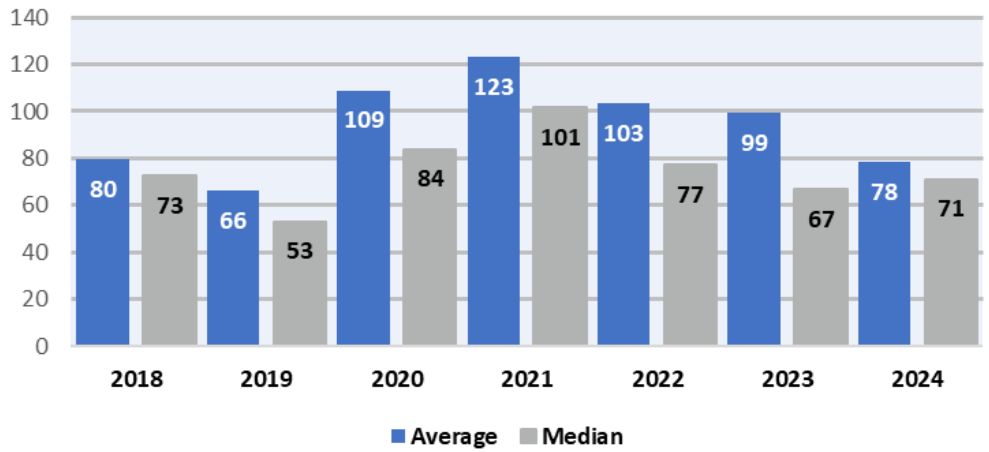
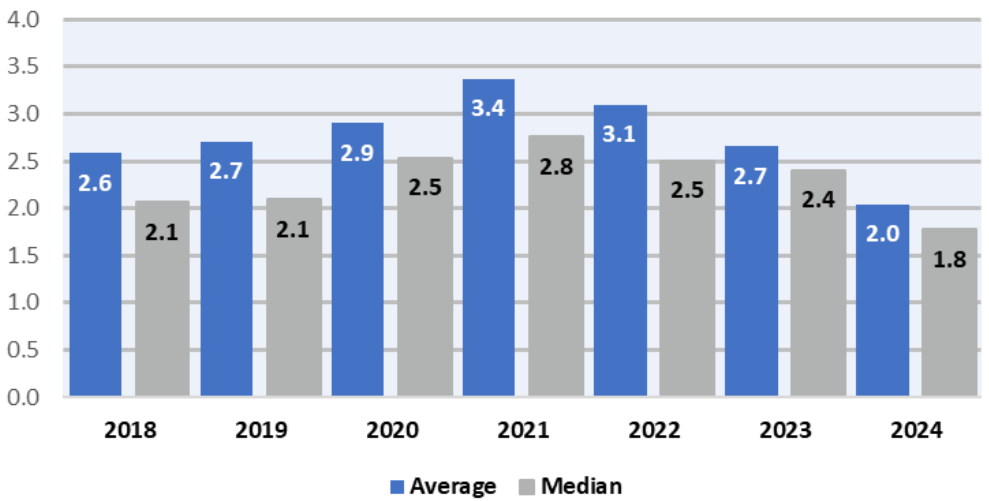
Operating Income to Revenue Ratio - New York Average & Median



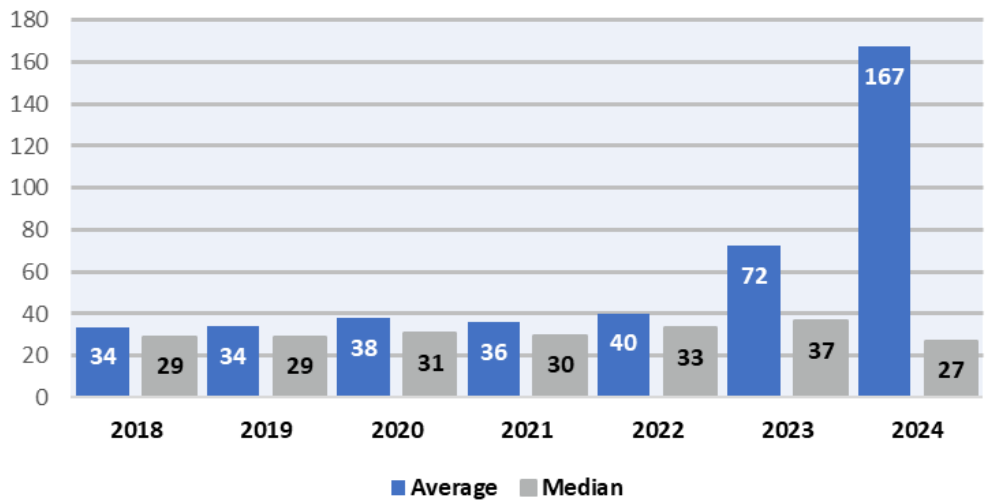
Days Cash on Hand - New York Average & Median



Current Ratio - New York Average & Median



Net Days in A/R - New York Average & Median



Your Health Center

By the Numbers

- **Productivity in 2023 – How does my health center compare to 2023 UDS National averages**
  - **Physicians** –2,725 nationally
  - **Mid-Levels** –2,466 nationally
  - **Dentists** –2,307 nationally
  - **Dental Hygienists** –1,079 nationally
  - **Other LMHPs** –1,030 nationally

- **Productivity Potential Consideration**
  - # of actual days available to see patients = 260 days per year *minus* CME days *minus* PTO *minus* Holidays
  - Available schedule time per day = Total hours *minus* admin time *minus* breaks
  - Available scheduled slots per day = Available schedule time per day / visit time allotted (15, 20…minutes, account for new visits)
  - # actual days available to see patients * Available scheduled slots per day

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Your Health Center

By the Numbers

- **Collections as a % of Charges – How does your health center compare to national averages?**
  - Medicaid – 85% Nationally
  - Medicare –61.5% Nationally
  - Commercial –58% Nationally
  - Self-Pay –21% Nationally

- **Coding and Proper Documentation of Patient Visits**
  - Reduce denials
  - Get paid properly
  - Preparation for value-based care

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Lessons Learned and Common Findings from Health Center Site Visits

Engagement Scope

Assessment of Potential Opportunities

Revenue Cycle

Detailed Findings

Revenue Cycle Improvements (continued)

- CMO (or medical director) run a monthly provider meeting that includes the CEO. Recommend a formal agenda that includes business performance (visit metrics, open encounters, denial trends) in addition to workflow and process discussions. As information is received from managed care organizations on Clinical Quality measures, include this information in the meeting. This will allow information to cascade through the organization and not be the focus during Huddle.
  - Maintain 5 double book slots per provider per day with leadership periodically verifying scheduling templates and these slots announced at daily huddle
- Analyze administrative time of providers – recommend 45 minutes daily in total
- Maintain automated telephone/text appointment reminders. Explore the cost of adding an additional automated reminder 24-hours prior to the appointment.
- Periodically review schedules to verify follow-up visits are being scheduled, as requested by the providers
- Consider focusing one provider on walk-in/same day visits daily to reduce no-show opportunities. If that focus is not implemented, create a culture where walk-in patients are worked into the schedule by the front desk and have the front desk person call the scheduled patient who has not arrived to ask if they will be coming.

Detailed Findings

Revenue Cycle

- Medicare billing, including billing for Medicare Part B items and also billing for Medicare Advantage claims and related wrap around payments need some attention at Health Centers
- Commercial insurance contracts are not reviewed regularly at most health centers. Taking a deep dive on all contracts prioritizing the top few is potentially a big opportunity to increase revenues depending on the existing. Additionally, language should be included in the contracts as possible to allow for the lesser of sliding fee charge or co-pay from contract
- Fee schedule review should be conducted annually but every two years at a minimum. Health Centers should utilize G-codes, a cost comparison to remain compliant, and utilize local prevailing rates
- Cross training of employees on payment posting, follow-up on outstanding claims, charge review, billing, etc. will help provide a more seamless process and what is expected from others
  - Cross training within various departments should be considered as appropriate
  - Improves communication between departments, which is an issue for some
- Consideration of centralized scheduling and policies for proper provider scheduling to reduce downtime

Detailed Findings

Revenue Cycle Improvements (continued)

- Denials process appears to require some training. Claims processing and credentialing are also areas of need for improvement.
- Having an internal certified coder is a missing component at some health centers
- Focused training on Practice Management System to help with automation of processes.
  - Build system to allow for more clarity on code selection and documentation for providers
- Open schedule to primarily serve walk-in patients will improve access and productivity, reduce no shows and cancellations
- Scheduling and Registration workflow opportunities including daily reconciliation and deposit of cash collected at front desk
- Opportunity to reset expectations and culture for success and sustainability
- Ensure justification for CMO's, CDO, CBHO, etc. – if not seeing patients

Payer Mix

Detailed Findings

Commercial Insurance Contracts

- Health Centers should review commercial contracts for amounts paid for all Current Procedural Terminology (CPT) codes and review payment rates.
  - For example, what is the HC getting paid for a 99213? We have seen this payment rate as low as $32 but many times below $50 on average for HCs. This is very low for a mid-level visit
    - Based on prevailing rates for many areas, it would not be uncommon for commercial insurance payors to pay $80 or more for this type of patient visit.
  - The HC needs to compare commercial contracts with what is actually being paid
  - Determine the number of patients with commercial insurance and measure the impact of updating payment rates to current market rates to potentially result in a substantial increase in patient service revenue depending on existing reimbursement rates.
  - Important to note is that the impact is measured by visits per patient which accentuates the amount of potential reimbursement from any commercial insurance rate increases.

Detailed Findings

Medicare

- Many health centers are increasing their marketing efforts to increase their Medicare patient base. This typically increases operating margins as the Medicare PPS rate is high and many Medicare patients are on multiple prescription medications, so pharmacy margins typically increase as well. FQHCs are exempted from Medicare deductibles which can be very helpful to Medicare patients that are struggling financially.
  - It is important to periodically review Medicare billing to help ensure that all services are billed appropriately. Some procedures and services are allowed to be billed to Part B outside the typical face to face visit in the FQHC that is billed to Part A
- **Medicare Advantage**: Many patients are choosing to purchase a commercial product in lieu of traditional Medicare – this is referred to as Medicare Advantage (Medicare Part C). In these cases, it is important to remember that you can be eligible to receive your full PPS rate, even when the MA plan does not pay the PPS rate. Health centers not billing for these wraps represents lost revenues for the health center.
- Make certain the Medicare cost report is completed accurately

Detailed Findings

Medicaid

- Compare the most current PPS rate for medical with total cost per visit based on the Medicare cost report to determine if your health center is covering costs.
- Also Identify the UDS report medical accrued cost per medical visits from Table 8A including facility and non-clinical support services allocated to the costs. Compare to the most current Medicaid PPS rate. Many health centers only receive the MEI adjustment which typically is not in step with increasing costs.
- Health Centers should always monitor cost per visit and compare that to Medicaid rates to help determine if rates are appropriate and commensurate with the cost of providing services.
  - As appropriate, consider a scope change request to the state if costs of providing care exceed Medicaid PPS rates. Working with the Primary Care Association to update the costs versus reimbursement is typically helpful for negotiations with your State to avoid conflicting messages.

Detailed Findings

Self-Pay

- Some health centers have significant self-pay revenues which are a substantial source of income which may deserve more attention if demand is not in-line with the collections and 330 grant.
  - Many health centers have seen an increase in self-pay patients as a result of economic factors as well as the sunsetting of COVID-19 Medicaid recipient redeterminations
  - A focused review of the patients' insurance status would be beneficial to ascertain whether there are additional opportunities for identifying insurance programs for these patients as appropriate
- Bad-debt and sliding fee discounts should be monitored and measured on a regular basis
  - If not performing already, management should implement quarterly self-audits mimicking the sliding fee testing that is conducted during the annual compliance audit. If any exceptions arise, then training should be completed to help ensure the sliding fee program is compliant and to help ensure clean audits
  - If not in place already, management should examine sliding fee policies and consider whether simplifying the process would be beneficial. Many health center management teams have implemented set fee amounts per sliding fee discount category to help make compliance efforts easier

Strategic Financial Planning

Detailed Findings

Strategic Financial Planning

- Every decision made at the health center has a financial consequence. For all strategic decisions, the following should be completed:
  - What is the decision's effect on the health center's operations? Does this new location or new service, etc. add or detract from the current operating margin?
  - What will be the effect on the balance sheet? (cash reserves, etc.)
- A forecasted set of financial statements should be prepared for all material strategic decisions that are being considered by the leadership team
  - Appropriate time should be allocated for the CFO to be able to provide strategic financial planning for the CEO and Board of Directors

340B Pharmacy Program

Assessments and Observations

340 B Pharmacy Program

- Many health centers are considering in-house pharmacy to optimize this program
- Health centers that monitor capture rate and are operating at or near 65% seem to have the most success.
- It is also important to have a good tracking system to determine:
  - Number of scripts per day with the in-house pharmacy
  - Gross Receipts
  - All costs associated with the pharmacy to include staffing, operations, cost of pharmaceuticals and facility costs
  - Net Pharmacy revenue
- Management should work with all of its operating personnel to discuss ways to help increase the capture rate. All forward-facing patient personnel can encourage the use of the internal pharmacy. Ultimately, it is the patient's decision what pharmacy to use, but the patient should be **fully informed** of the internal pharmacy option
  - Staying compliant is the responsibility of the health center even with a consultant doing a majority of the work. Many health centers rely completely on these consultants for compliance, audits and for tracking revenues which is ultimately the responsibility of the health center.

Compensation

Detailed Findings

Compensation Package – Common Inclusions

- Cost of Living increases to wages and salaries
  - Merit increases and incentive program bonuses, as appropriate – *Some considerations for this are Visits, Patient Satisfaction, Quality Metrics, Annual Review Scores, Contract specific, Overall financial performance of organization, and some health centers are steering toward Relative Value Units (RVUs) due to the complexity of patients which may be combined with the number of visits
  - Perform market assessment – Is provider paid at 75th percentile but performing at 25th? – Ensure alignment between pay and performance.
- License Reimbursement
  - CME days and dollars for providers – typically 3-5 days depending on licensing requirements and $1,500 to $7,500 in some health centers nationally

Detailed Findings

Compensation Package and Related Information (continued)

- Culture of the organization can play a major part in retaining and attracting employees:
  - Cross-training between department roles as possible and appropriate can increase staff knowledge, confidence, and abilities for more substantial roles within the organization. It also provides a mechanism for reducing interruptions in the process when staff leave helping improve transitions
  - Introducing non-supervisory coaches or mentors that have held a specific role or are familiar with the organization to help new staff and others not in a position to understand the impact they have on the organization has been useful in other organizations
  - Company-wide events, virtual company-wide updates from the c-suite, and the ability to volunteer (see Employee Appreciation above) as part of the compensation package is successful at some health centers
- Well-defined roles within the organization are essential for efficiency and can improve employee morale

Detailed Findings

Compensation Package and Related Information

- Attracting and retaining knowledgeable, efficient and invested staff is a challenge for most health centers
  - Additional holidays and floating holidays are popular among health center employees
  - Quickly vesting for new employees into 401K, 403B and other benefits
- Providing 1-on-1 meetings for employees to better understand the opportunities
- Employee appreciation and involvement
  - Salary enhancements for providers and others based on years of service – dependent on organization financial condition
  - Base productivity awards on data reporting
- Performing exit interviews for information on reasons for departure and potential future solutions
- Team incentives for:
  - Meeting productivity goals
  - Positive patient experience surveys

Detailed Findings

Compensation Package – Common Inclusions

- Benefits:
  - Group Life Insurance, Short & Long-term disability
  - Medical, Dental & Vision Insurance – Employee, Spouse, Family
- Paid time off:
  - Paid Time Off ranging from 15 days up to one year of service to as many as 30 days after ten years
  - Paid holidays from around 8 days to as many as 13 days, including floating holidays
  - Paid Jury Duty
  - Bereavement Leave – typically 3-5 days depending on relationship
  - Health Savings Plans and Flexible Spending Accounts as appropriate
  - Retirement and investment plans – some health centers have an immediate vesting plan and employer matching amounts and/or automatic employer contributions with matching to a degree above that point
  - Employee Assistance Plans
  - Wellness Program

Dashboard Reporting

Detailed Findings

Dashboard Reporting

- Having Key Performance Indicators (KPIs) should be on the Board, CEO, and C-suite dashboards
- Revenue Cycle Managers should also have a set of KPIs to review regularly to identify issues with charges, coding, timeliness, denials and others as appropriate
  - Leading vs. lagging indicators
- It is also important to consider these metrics with trending (month to month, quarter to quarter and/or year to year), comparisons to other FQHCs and with specific targets for contemplation

Financial & Grants Management

Financial Department

- Opportunity to report by site and service to allow for better reporting and analysis of financial activity
- Health Centers should prepare financial statements monthly and in a timely manner and provide to C-suite and Board of Directors in time to review
- Finance team should reconcile all accounts monthly and ensure financials on a monthly basis are as accurate as annual financial statements
- Opportunities for automation
- Opportunities to improve understandability of the financials
  - KPI's – Analyze KPI's to determine if those included need to be revised and include up to date benchmarking information
  - Presentation of information
  - Narrative not provided with financial statements
  - Staffing
    - Ensure you have someone to complete critical tasks such as entering bills, cutting checks, financial reporting, etc. Create standard operating procedure documents as it relates to the operations of the finance department.
    - Assess staffing – Do we have CFO, Controller, Accountants, and Clerks? Is CFO operating at appropriate level?

Grants Management

- Review policies and procedures related to grants management and be sure to incorporate any updates
  - October 2024 updates?
- Check the OIG vendor exclusion list (sam.gov and LEIE database) before making purchases with federal funds. Current vendors and contractors should be checked at least every 6 months.
- Ensure you have a system of internal control that supports time and effort reporting. Best practice is to incorporate time and effort reporting into your payroll system so that employees are responsible for allocating their time and effort on their timesheet.
- Evaluate all awards letters/contracts/agreements in accordance with ASC 958-605.
  - Revenue for restricted grants can only be used for the restricted purpose and recognized when the expense has been incurred or requirement has been met.
  - Conditional grants should not be recorded in the financial statements until the condition is met. If cash is received in advance, it is recorded as deferred revenue until the condition is met then can be recognized as revenue.
  - Record all expenses related to grants directly in the general ledger with a grant specific code.

Document! Document! Document!

3

Planning for Long-Term Sustainability

What Can Be Done to Prepare for Your Future?

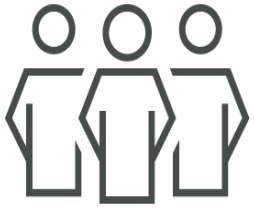
- Be Proactive - Financial difficulties should not “sneak up” on any health center
- Obtain data showing financial results from each operating location & each department as a whole (medical, dental, pharmacy, etc.)
  - What operational changes could be made to limit negative financial outcomes?
  - Are revenue opportunities being missed? Look at metrics to help determine
  - Look at staffing & productivity models to help increase efficiencies
  - Communicate, communicate, communicate – everyone has to be on the same page

Challenges & Opportunities Ahead

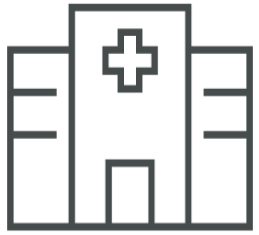
Financial Challenges Facing CHCs of Tomorrow

Eroding Margins

Regulatory Compliance



Staffing & Productivity



Competition

Payment Reform

Inflation | Payor Mix Erosion | Grant Dependency | Revenue Cycle Opportunities

Aging Population | 340B Reform | Federal Scrutiny | Recruitment

Productivity | Provider Contracting Strategies | Upstream Competition | Consolidation

Partnership Strategies | Value Based Reimbursement | Alternative Payment Models

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Medicare Strategy

Planning for the Aging Population

- Medicare will become a much more significant payer to CHCs as the population ages – what is your strategy to capitalize on this opportunity?

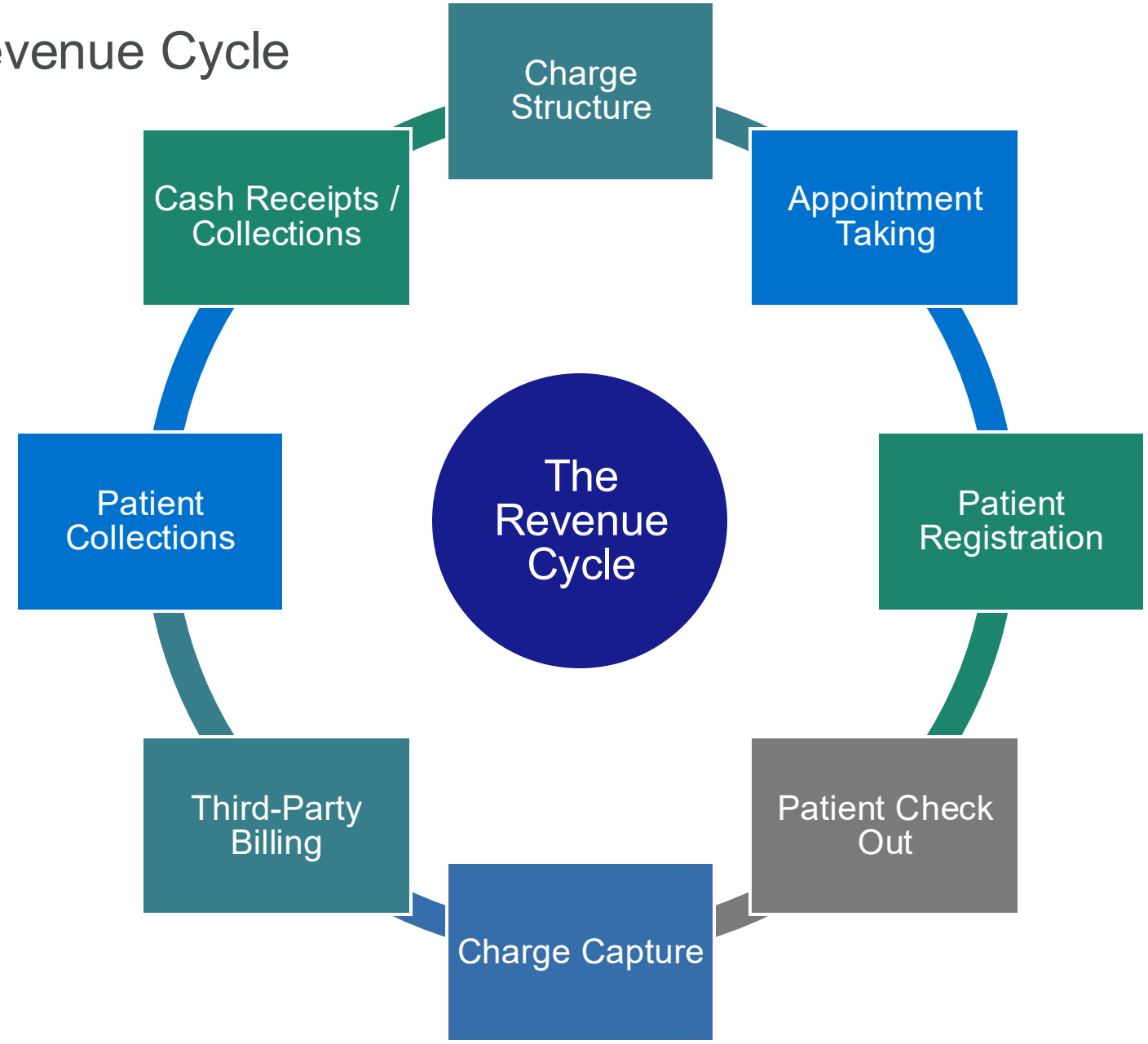
Fee Schedule & G Codes

- Important to remember to update your fee schedule & G codes at least annually remembering compliance issues in setting your charges

Consider Needs of Aging Patients

- Consideration should be made for a separate clinic or at least a separate waiting area for Medicare patients

Optimizing the Revenue Cycle



Infrastructure Considerations

Grants Management

- HRSA still stressing grants management (CHC's still lacking)
- Budget acts & changes / funding
- Program Income Flexibility / Restrictions
- Site visits & the Health Center Compliance Manual
- HHS OIG COVID & UIP Audits
- HRSA DFI Audits

Information Technology

- Consider adding a Chief Information Officer
  - Data Analysts – IT and Finance
- Access to data vs. Access to **useable** data
- Software for compliance vs. manual systems
  - Time and Effort
  - Practice Management Systems
- Integration of Systems
- Dashboards and Monitoring

Revenue Cycle

- Getting paid for every visit would fix a lot of financial issues
  - Operational Optimization of the Revenue Cycle
- Preparing for Value Based Reimbursement Contracts

Contact

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