National Association of Community Health Centers

FOM/IT Conference

Budgeting in the Time of COVID

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Survival Mode

- Clinics closed/reduced services
- Emergency government funding, in descending order of $ received (estimated):
  - Paycheck Protection Program
  - CARES Act (H8D)
  - CHC testing (H8E)
  - Rural area payment
  - Medicare relief funds first round
  - Other COVID programs
  - H8C
  - Medicare relief funds second round
- Cash protection activities
- Switch to telehealth

Where Are We Today?

- Health center operations are stabilized, and may be gradually picking up
- External environment is very unclear – course of the virus, potential State actions, potential new Federal funding
- Health center projections done pre-COVID are not useful
- CFO/Finance Departments have been incredibly busy since mid-March, and may be nearing burnout

CFO's Role – Short Term

- Paying bills, making payroll
- Drawing down, spending and recording grant funds
- Managing cash
- Monitoring revenue cycle to make sure everything continues to be paid at the right rate
- Explaining financial situation to management team
- Explaining financial situation to the Board

The CFO/Finance Department can play a key role in reopening, in identifying the key drivers of bottom line/cash. Doing so will help the leadership/operational/clinical groups develop plans and monitoring

Using A Budget to Align Finance & Operations

Considerations in Medical Projections

- How many can you accommodate?
  - Waiting room capacity (any way to modify?)
  - Maintaining social distance and providing masks
  - Maximum cycle time (patient present in clinic)
  - Maximum number of people in the clinic
- Costs
  - Mask (N95 and other) and face shield, goggles
  - Other PPE
  - Security
  - Staff for screening
- Schedule/cycle time
- Facility modifications

Considerations in Dental Projections

- Which patients?
  - Tested patients
  - Patients with deferred treatment who are at risk of dental infection
- Limits in Dental Procedures (check against CDT count?)
- Ventilation options

Considerations in Behavioral Health Projections

- Telehealth model may be working better operationally than face to face model
  - Lower no-show rate
  - Higher productivity

- What are the % telephonic vs. video (also enables screen sharing of tools)
  - Patient choice
  - Patient technological capability
  - Provider preference

- What portion of the current model is sustainable/desirable in the medium & long term?

Considerations in Pharmacy Projections

- Has volume been impacted?

- Patient access
  - Separate entrance
  - Curbside
  - Parking lot

Testing

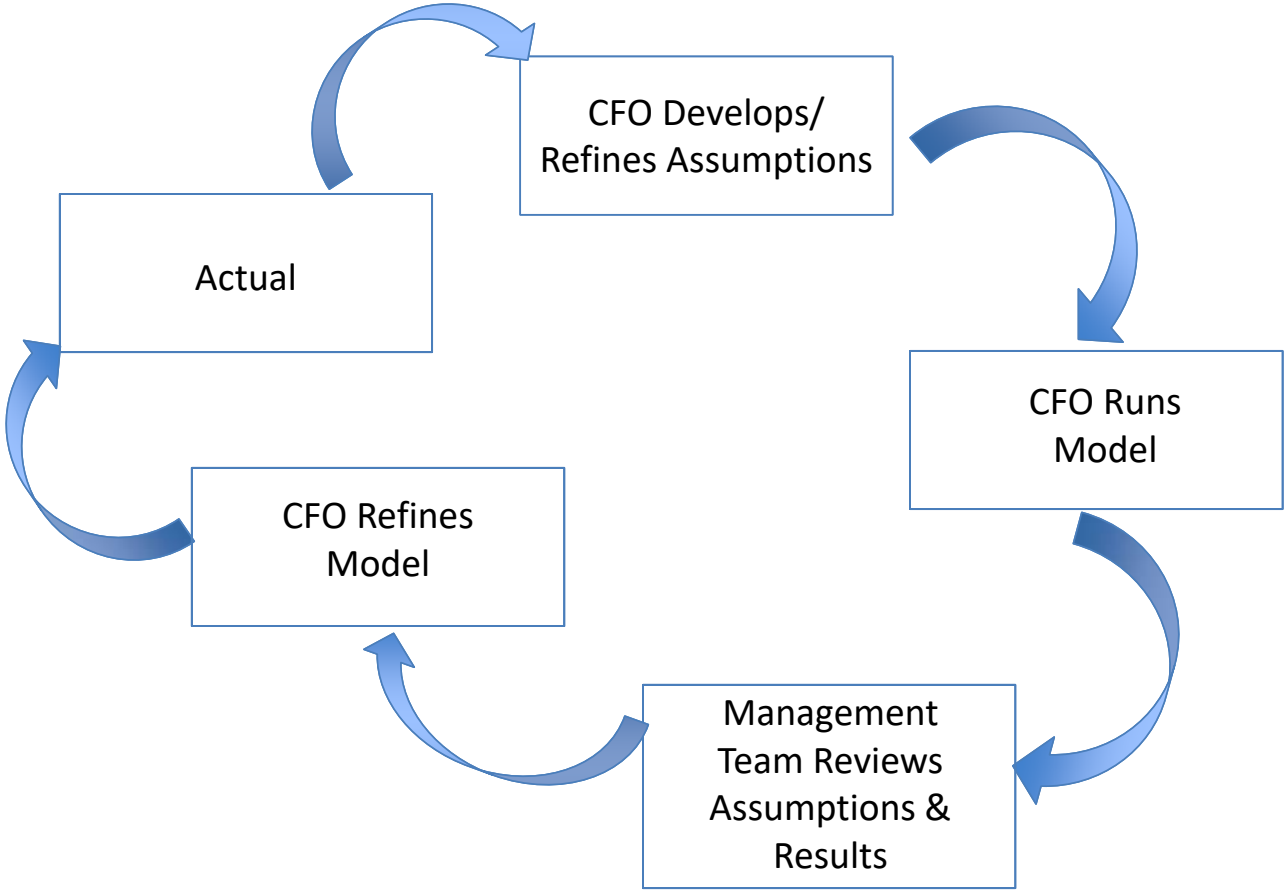
- What are the economics?
  - Grant reimbursement (state grant for specimen collection)
  - Billable visit with provider screening
  - Costs of staff and PPE
  - Current and future grant funding available. How much can the H8E cover?

- What is our long-term role in testing? Does it make or lose money? Did we receive fixed funding to support a certain number of tests, after that we will lose money on it?
  - May have sufficient funding for services in the health center
  - Probably require additional funding sources for community testing

Current Planning

- Health center should prepare a 3-month budget
- This budget should assume that “the perfect is the enemy of the good”
- CFO develops initial set of assumptions
  - Visits by service by month
  - Payor mix (visits)
  - Staffing
  - Additional expenses
  - Reimbursement
  - Capex and other balance sheet items
  - If low on cash, potentially develop weekly financials

Continuous Budgeting/Planning



Planning

- Value of this approach
  - Project bottom line
  - Project cash
  - Get everyone on the same page. It may be hard to develop assumptions in a vacuum. By reviewing the CFO's assumptions, and the results, it might help clarify the thinking of the rest of the management team
  - Shows value of staggered staffing

How 3 Month Financial Projections May Differ From Our Normal Budgeting Process

- Assumptions
  - Greater uncertainty in this period
  - Shorter period makes planning more knowable
  - Even in shorter period, may be variation, i.e. August 1st operations may not look like September 30th operations
  - Time for budgeting process is shorter, so granularity of budget assumptions may be less (e.g. net revenue per visit by service by payor, rather than net revenue per visit by service by payor by site)

How 3 Month Financial Projections May Differ From Our Normal Budgeting Process

- Model
  - Model can be simpler in some areas, but may require new varies (e.g. % of visits that are telehealth)
  - Simpler model is easier to populate with new numbers as model is updated
  - Simpler model might be easiest

How 3 Month Financial Projections May Differ From Our Normal Budgeting Process

- More emphasis on cash, as appropriate
  - Need to budget balance sheet
  - Cash = prior month's cash – change in other assets + change in liabilities + change in net assets
  - Related to days cash on hand
  - Grant receivable/spending period
  - Precision of timing is much more important/impactful, e.g. either balloon payment on mortgage is due this quarter, or it's not
  - Except for self-pay, days in receivable shouldn't be increasing, i.e payors should be paying their bills on time (and it could be argued that they are getting funded for/collecting full premiums

Projecting Revenue at Lower Volume

Aug-20	FTEs	Visits/Day Normal	Visits/Day COVID	% of Normal	Working Days	Projected Visits	Televisits Goal
MD/DO	8	16.8	12.8	76%	22	2,253	45%
MidLevel	9	12.6	9.6	76%	22	1,901	50%
BHC	7	8.75	7	80%	22	1,078	60%
Dentists	1.6	15.4	11.7	76%	22	412	0%
Hygienists	2	8.4	6.4	76%	22	282	0%
						5,926	2,611

Projecting Revenue at Lower Volume

	Historical Collection Rate	Telehealth Collection Rate	Telehealth %	Weighted Average	Allowance For Reconciliation	Collection Rate
Medicaid	90%	80%	44.1%	85.6%	-7.0%	78.6%
Medicare	80%	65%	44.1%	73.4%		73.4%
Private	78%	70%	44.1%	74.5%		74.5%
Self-Pay	50%	NA	44.1%			50.0%
	Payer Mix	**Collection Rate**	**Average Reimbursement**	**Number of Estimated Encounters**	**Estimated Revenue**	**Estimated Revenue Collected**
Medicaid	56%	78.6%	$174.00	3,319	$577,429	$453,860
Medicare	15%	73.4%	$128.00	889	$113,779	$83,514
Private	4%	74.5%	$64.50	237	$15,289	$11,390
Self-Pay	25%	50.0%	$15.00	1,482	$22,223	$11,111
				5,926	**$728,720**	**$559,875**

The Cost Side of Telehealth: Does It Cost More or Less Than In-Person?

- Registration
  - May require a second (first) phone call
  - Still need to capture information for billing

- Medical Assistant work
  - Screening (SBIRT, PHQ9, PRAPARE)
  - Longitudinal home monitoring (glucometer, BP cuff)
  - Check on status of routine tests
  - MA makes sure that patient is on the line for the provider

- Provider time – about the same as in-person

- Facilities
  - Requires less facility space, generally
  - If provider cannot be distant, requires HIPAA compliant space in which to conduct service (exam room)?

Cash

Current Cash	+	Remaining Federal Funds To Be Drawn	-	Burn Rate	-	Required Capex	=	Ending Cash

HRSA preferred range: 45 – 60 days
Needed for effective operations: At least 30 days

Cash Burn Rate

Pre-COVID Annual Revenue		$ 8,000,000					
Pre-COVID Annual Expense		$ 8,000,000					
	Beginning Cash	Undrawn Federal Funds*	Revenue	Expenses	Net Income	Federal Drawdown	Cash Burn
July - Sep 2020	$ 1,000,000	$ 900,000	$ 1,200,000	$ 1,800,000	$(600,000)	$ 400,000	$(200,000)
Sep - Dec 2020	$ 800,000	500,000	1,300,000	1,850,000	$(550,000)	$ 400,000	$(150,000)
Jan -March 2021	$ 650,000	100,000	1,600,000	1,900,000	$(300,000)	$ 100,000	$(200,000)
Apr - June 2021	$ 450,000	-					
* Excludes base grant, which is included in revenue							

Looking at the Revenue Model

Patient Service Revenue from 2019 UDS Table 9D	$ 91,518,045	59.9%
Grant & Other Revenue from 2019 UDS Table 9E	$ 61,259,408	40.1%
Total	$ 152,777,453	

- What was your 2019 ratio?
- What is it now? Is that sustainable? Note that the new grant revenue is already booked
- Revenue to cash
  - Pre-COVID A/R collected?
  - Drawdown of federal grant
  - Collection of current billings

Medium to Long-Term Financial Concerns

- Are capital expenditures to the facility worth it?
  - Do we make renovations with a 25-year depreciable life for conditions that may only exist for the next 12 months?
  - Will those renovations change the facility in a way that impedes patient care in the future?
  - Capex requires cash
  - Cost/benefit of limiting number of patients vs. renovation

The Board

- Board is probably not familiar with grant accounting
- You may be asking the Board to approve next fiscal year's budget, which is highly uncertain
- CFO's responsibility is to put the activities, and financials, in context for the Board
- Need to recalibrate Board's thinking on profitability and growth

Presenting to Board Finance Committee

Community Health Center								
Grant/COVID Funding Schedule								
Name of Funding Source	Date Awarded	Grant/Spending Period	Amount	Cash Drawn Down/Received as of 6/30/20	Remaining to Be Drawn Down as of 6/30/20	Spent as of 6/30/20	Remaining to Be Spent as of 6/30/20	Notes
Payroll Protection Program	5/6/2020	05/06/2020-10/21/2020	2,576,707	2,576,707	-	1,704,866	871,841	Use for allowable payroll for 24 weeks
HRSA H8C	3/19/2020	03/15/2020-03/14/2021	58,228		58,228	58,228	-	Used for Covid testing and related items
HRSA H8D	4/30/2020	04/01/2020-03/31/2021	674,030		674,030		674,030	Used for Covid testing and related items
HRSA H8E	5/4/2020	05/01/2020-04/30/2021	231,499		231,499		231,499	Used for Covid testing and related items
Cares Act Provider Relief Fund	4/17/2020		54,838	54,838	0	54,838	0	Used to makeup lost revenue March - June
Cares Act Provider Relief Fund	6/15/2020		457,977	457,977	(0)	457,977	-	Used to makeup lost revenue March - June
					-		-	
Covid 19 -Funds			4,053,279	3,089,522	963,757	2,275,908	1,777,371	

Medium Term:
Thinking About the State

- State has decreased revenues and increased expenses
- Status of federal help is unclear, a “bailout” is unlikely
- State must submit a balanced budget (under GAAS)
- Healthcare is one of the State’s biggest expense line items. State’s levers for reducing healthcare spending:
  - Cut Medicaid eligibility
  - Cut Medicaid services
  - Cut various health programs
  - Cut reimbursement rates to providers (but not FQHCs!!)
- Next FY budget starting may be worse

Medium Term:
Thinking About the State

- Higher unemployment/unemployment insurance reduced or expires = more uninsured at lower income levels = more Medicaid eligible.
  - Can/will the State enroll them? Is there a backlog from furloughs?
  - Should the CHC step up in enrollment assistance?
  - Are these current commercially insured patients shifting to Medicaid? What's the differential in reimbursement? Changes in rules (maybe no deductible?)
  - What about formerly commercially insured non-health center patients? Will their current provider accept them as Medicaid patients? If not, will they come to the health center?

What Will The Next 12 Months Look Like?

- When do we reach “herd immunity”?
  - When will we have a vaccine?
  - When will the vaccine become available in sufficient quantities?
  - Will people be vaccinated
    - Anti-vaxxers
    - COVID deniers
    - Skeptical/wait and see crowd
- Big effort around flu vaccination
- Will we still have outdoor services (and during winter)?
- How much in-person school will we have had?

Budgeting: Preparing for the Hard Choices

What if the budget shows a deficit?

- It's not the CFO's job to change the budget numbers until it shows breakeven/profit
- Up front, i.e. before budget period starts:
  - Are there new things that the health center can delay/not do
  - Hiring freeze
  - Determine how much the health center can afford to lose (days cash on hand is a huge driver here)
- In the budget period (for example, 4 months in) hard choices:
  - Cutting staff
  - Closing sites
  - Reducing employee benefits

Provider Capacity – Per Session

- When doing an annual budget, keep in mind that you are projecting *average* visit productivity over the course of the year

"We can get back to full productivity in fiscal year 9/1/20 – 8/31/21"

Aug-20	FTEs	Visits/Day Normal	Visits/Day COVID	% of Normal	Working Days	Projected Visits
MD/DO	8	16.8	12.8	76%	20	2,048
MidLevel	9	12.6	9.6	76%	20	1,728
BHC	7	8.75	7	80%	20	980
Dentists	1.6	15.4	11.7	76%	20	374
Hygienists	2	8.4	6.4	76%	20	256
		6,995		77%		5,386
FY 9/1/20 - 8/31/21						
Sep-20	**Oct-20**	**Nov-20**	**Dec-20**	**Jan-21**	**Feb-21**	
79%	82%	85%	88%	91%	94%	% of Normal
5,526	5,736	5,946	6,156	6,365	6,575	Visits
Mar-21	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	
97%	100%	100%	100%	100%	100%	
6,785	6,995	6,995	6,995	6,995	6,995	
Total Projected Visits		78,064				
Total Projected Visits @ 100%		83,940				

Ongoing Economics of Testing

- It appears that there will be an ongoing need for testing. If the CHC receives a fixed amount of funding for testing, funding per test declines over time
- What are the direct costs of testing?
- Opportunity costs of testing:
  - Provider time (if it doesn't result in billable visit)
  - Nurse time
  - MA time
- Potential fee-for-service payments:
  - Medicaid - $13 for specimen collection (need SPA approved by CMS)
  - HRSA uninsured program run
- Same questions for contact tracing

Ongoing Economics of Telehealth

- Consensus seems to be that more telehealth is here to stay
- Word on the street is that health centers have been able to increase their % of telehealth visits that are video
  - More likely to be paid in the future (than telephone)
  - What is the cost of a video visit vs. telephone? (vs in-person)
  - What capital investment is required to move to video?
- Medicare still pays $92.03
- Need to track very carefully Medicaid payment policies for telehealth (including dual-remote)

Ongoing Economics of Vaccination

- Costs:
  - Vaccine
  - Supplies
  - Staff time
  - Space
  - Opportunity cost of utilizing resources

- Reimbursement?

- What if the vaccine requires multiple doses?

COVID Funding Reconciliation

- PPP cash received vs. revenue recognized based on date of loan forgiveness. Also don't project PPP revenue into future years

- Supplemental HRSA funding awarded vs. drawn down. Also recognize when funding runs out.

Financial Risks

- Second wave causes shutdown/reduced revenue
- Health center staff is infected/exposed necessitating shutdown
- Changes to telehealth
  - Payors stop paying for telephone and only agree to pay for video
  - Payors stop paying for dual-remote, requiring provider to be onsite
  - Medicaid pays at fee schedule rather than FQHC rate
  - Medicare continues to pay only $92.03
  - Extra HIPAA requirements that are difficult/impossible to meet
- Retroactive clarifications of Federal COVID funding
- Work at home becomes untenable for some staff and health center needs to provide safe workspace

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