Revenue Cycle Management for FQHCs: *Two W's - Workforce & Workflow*

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Meet the Presenters

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14 Question Quiz

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- How many open encounters currently exist (visit complete but not billed)?
- How many visits were done by payer type last week? Did all those claims go out clean?
- Have we been paid, appropriately, for visits billed? Is the cash in the bank on those?
- What is the current days in AR by financial class (gross and net)?
- What is the current amount of credit balances by financial class?
- What are the top 5 denial reasons in volume and dollars?
- When was the last review/update of payor contracts?
- When was the last review/update of fees?
- How do the Medicare G code charges compare to the PPS rate?
- Is the health center enrolled in the 340B Rx program?
- Does the health center submit bad debt on the annual Medicare Cost Report?
- Are you enrolled in any risk-based revenue programs (capitation, incentive, shared savings arrangements)?
- Are you billing Medicare to receive optimal reimbursement for services performed? (Part A, B, D)
- Do we take advantage of available grants and donations?

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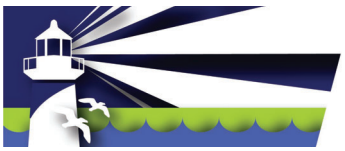
Agenda

1 Workforce

- In Office vs Remote vs Hybrid
- Outsource vs In House

2 Workflow

- Front end
- Middle
- Back end



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Workforce

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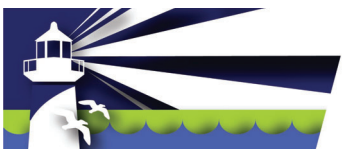
In Office vs Remote vs Hybrid

Opportunities	In Office	Remote	Hybrid
Personnel interaction	X		X
Tools (Printer, Internet)	X		X
Flexible schedule		X	X
Training	X	X	X
Location/Weather/Commute		X	X
Distractions			



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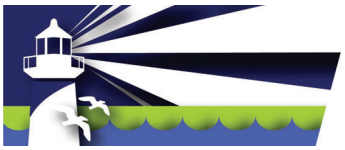
In Office vs Remote vs Hybrid

Challenges	In Office	Remote	Hybrid
Personnel interaction		X	X
Tools (Printer, Internet)		X	X
Flexible schedule	X		X
Training	X	X	X
Location/Weather/Commute	X		X
Distractions	X	X	X



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In Office vs Remote vs Hybrid

	Practical Advice
Personnel interaction	Weekly team building activity scheduled same time each week
Tools (Printer, Internet)	Evaluate and invest in tools
Flexible schedule	Identify work that is flexible vs rigid in terms of completion to allow flex work schedules
Training	Assess attendee and topic for one-to-one vs group Ask yourself what would work best Segmented sessions
Location/Weather/Commute	Work anywhere No lost time due to commute or weather
Distractions	Complete time study Support/encourage breaks during workday Consider flex schedule

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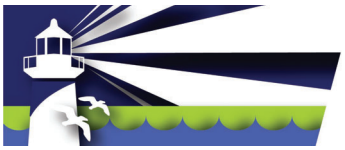
In Office vs Remote vs Hybrid

- Considerations
  - Hourly/salary, C-suite
  - Trust
  - Productivity
    - Time vs another measure of job, mechanism to track time ie. Logged in to system
  - Connect to KPI's
  - Incentive bonus?
    - Accuracy, quality vs quantity?



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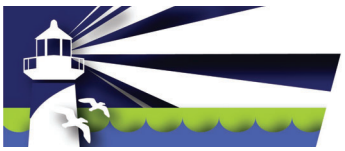
Outsource vs In House

- Why choose one over the other
  - Staff limitation
  - Space limitation
- What questions to ask internally
  - Have all efforts been exhausted with internal staff?
- What questions to ask a potential vendor
  - See Vendor Interview Questions handout



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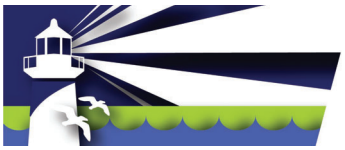
Outsource vs In House

- Considerations:
  - Staffing
    - Community jobs
    - Experience
  - Vendor Selection
    - Related/Unrelated to Practice Management System
    - FQHC experience/expertise
  - Responsibilities
    - Full function
    - Select function



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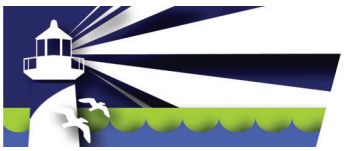
Outsource vs In House

- Considerations
  - Communication
  - Cost
  - Organization knowledge
  - Legal/Term
  - Issue resolution



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Workflow

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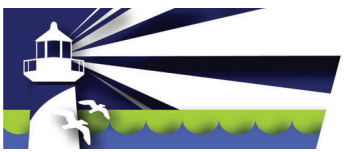
Workflow – Front End

- Scheduling
  - Who
  - Visit times
- Registration
  - Demographics
  - Point of Service Collection
  - Paperwork
- Insurance Verification
  - Payors
  - Automated or Manual
  - When



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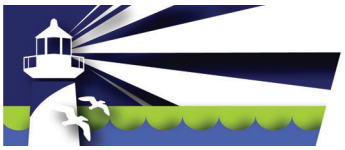
Workflow – Middle

- Coding
  - Certified Coder
  - Provider
- Charge Entry
  - Lag time
  - Impact
- Claim Submission
  - Frequency
  - Electronic vs Manual



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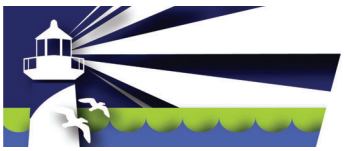
Workflow – Back End

- Payment Posting
  - Automated / Manual
  - Paper check / Electronic Funds Transfer (EFT)
- Denials & Adjustments
  - Contractual
  - Controllable
- Accounts Receivable & Write-offs
  - Patient
  - Insurance



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Closing Thoughts

- Policies and operating procedures
- Job descriptions
- Continued training and education
- Modify systems or implement technology
- Create accountability
- Monitor performance & measure impact

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Questions?

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Agenda

1. Fee Schedule
2. Sliding Fee Discount Program
3. Medicare & Medicare Advantage Wrap Around
4. Medicaid

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Fee Schedule

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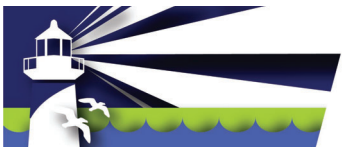
Introduction

- Fee Schedule (Charge Master)
  - Important financial tool within the Health Center
  - Device for billing & collecting services rendered
  - Indicator of a Health Center's compliance with policies & regulations
  - Improper fee schedule could result in the Health Center not receiving full reimbursement



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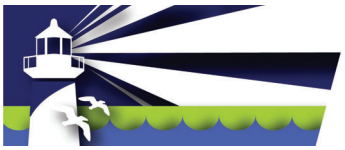
Considerations

- Fees or payments must be designed to cover the health center's reasonable costs in providing the service
- Fees or payments must be consistent with locally prevailing rates or charges for the service
- Must be a corresponding schedule of discounts applied to the fees or payments for uninsured & underinsured persons whose incomes are at or below 200% of the current federal poverty income guidelines, which discounts must be adjusted based on each patient's ability to pay
- Single fee schedule for all payors
- Impact of any fee updates on Sliding Fee Discount Program or other self pay patients



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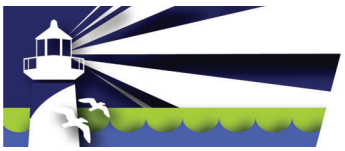
Charge Thresholds

- Minimum charge threshold
  - Enables Health Center to determine the point in which a procedure is considered below the minimum amount
- Maximum charge threshold
  - Enables Health Center to determine the point in which a procedure is considered above the maximum amount



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Benchmarks & Analytical Components

- Medicare Physician Fee Schedule (MPFS) to ensure no fees are below allowable amount
- Considers costs of services
- Establish & use minimum charge threshold to ensure fees are reasonable compared to market
- Establish & use maximum charge threshold to ensure that fees are not priced too high
- Comparison against national & state average charge levels to understand competitiveness, market dynamics, & relative value of services
- Understand use & utilization of procedures & modifiers
- Validation of reimbursement through contracts & EOBs

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Fee Schedule Philosophy

- Asking others…
  - Raises legal concerns
  - Does not take into consideration the uniqueness of the Health Center
  - No assurance of appropriate methodology originally utilized

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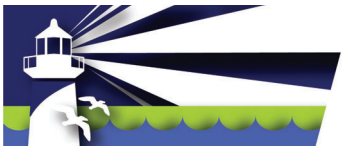
Analytical Spreadsheet

- Building the spreadsheet

Data Fields	
Procedure Code (CPT/HCPC)	Gross Charges (calculated)
Modifier	Non-facility RVU
Description	Medicare Allowed Amount
Charge (Unit)	Private Payor Allowed Amount
Frequency (Total Payor)	Local Prevailing Rate



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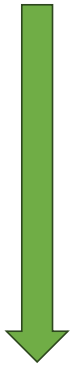
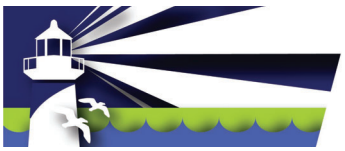
Analyzing the Data



- Identify codes with a charge below the Medicare allowed amount
- Identify codes with a charge below the minimum charge threshold
- Identify codes with a charge below private payor allowed amount

- Identify codes with a charge above the maximum charge threshold
- Identify cost per service exceeds charge per service
  - Utilizing cost data
  - Determine cost per RVU



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Sliding Fee Discount Program

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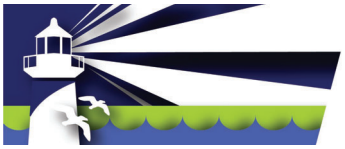
Sliding Fee Discount Program

- Current Federal Poverty Levels (FPL)
- Up to 200% FPL
- Minimum 3 categories
- Discount based on gradation of income
- Nominal category must pay less than 101% FPL category
- Nominal fee is optional for ≤ 100% FPL



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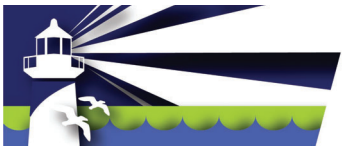
Sliding Fee Discount Program

- Flat rate or % of charge (except nominal), or hybrid
- Service areas / subcategories
- Signage in patient common area
- Assess all patients



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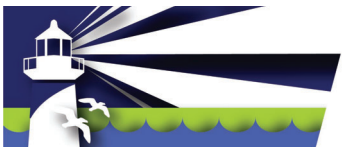
Sliding Fee Discount Program

- Board approved policy
  - Waiver
  - Payment Plan
  - Prompt Pay
- Utilization Analysis



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Medicare

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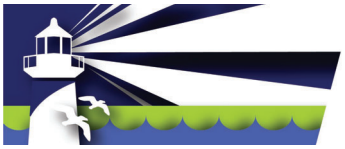
Environment Issues

- The Medicare program, while small as a percentage of overall health center patient related revenues, is an important third-party payer of services
  - Generally, the second-best third-party payer after state Medicaid
  - 12.26% of aggregate health center revenues per Table 9D of 2019 UDS Report Data (9.71% - traditional Medicare + 2.54% Medicare managed care)
  - Increase over previous years



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Medicare Program – The Puzzle Pieces

- The Medicare program includes the following components:
  - Part A – Institutional provider reimbursement
  - Part B – Outpatient and physician professional services reimbursement
  - Part C – Medicare Advantage (Medicare managed care)
  - Part D – Medicare prescription drug coverage
- The Medicare program is administered by regional Medicare Administrative Contractors (MACs)

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Part A – UB04

- PPS payment rates increased with a market basket adjustment
  - Base rate from January 1, 2023, through December 31, 2023 = $187.19
  - Base Rate x Geographic Adjustment Factor (GAF)
    - Established = $187.19 x GAF
    - Higher Intensity = + 34.16%
- Medicare payment = 80% of the lesser of the actual G code charge or the PPS rate
- Beneficiary coinsurance = 20% of the lesser of the actual G code charge or the PPS rate
- Medicare payment = 100% of the lesser of the actual G code charge or the PPS rate for defined preventive services

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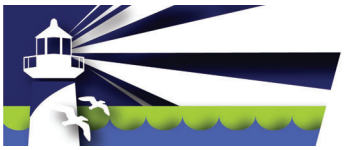
FQHC Services

- FQHC services include:
  - Physicians' services
    - including services and supplies incident to
  - Services of NPs, PAs, CNMs, CP, and CSW
  - Visiting nurse services to patients
  - Certain care management services
  - Certain virtual communication services
  - Certain preventive services



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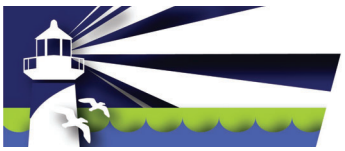
PPS Background Basics

- Five G codes, each with their own qualifying visit CPT codes
  - G0466 – FQHC visit, new patient
  - G0467 – FQHC visit, established patient
  - G0468 – FQHC visit, IPPE or Annual Wellness Visit
  - G0469 – FQHC visit, mental health, new patient
  - G0470 – FQHC visit, mental health, established patient
- Reporting of same day visits



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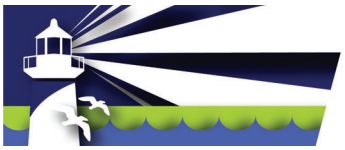
Medicare Part B – 1500 Form

- Medicare covered services outside of FQHC-core visit services
  - Durable Medical Equipment (DME)
  - Ambulance
  - Prosthetic devices
  - Laboratory
  - Technical component of diagnostic tests such as radiology and EKG
  - Technical component of many preventive services (such as pap smears & prostate cancer screenings)
  - FFS Reimbursement based on applicable Medicare fee schedules without regard to the health center's cost of providing such services (Medicare payment based on the lesser of actual charge or the Medicare fee schedule)



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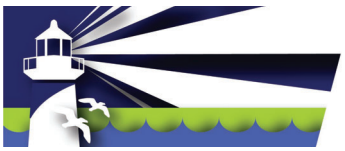
What is DSMT?

- Diabetes Self Management Training
- "Educational and training services furnished…to an individual with diabetes by a certified provider…in an outpatient setting by an individual or entity who meets the quality standards…, but only if the physician who is managing the individual's diabetic condition certifies that such services are needed under a comprehensive plan of care related to the individual's diabetic condition to ensure therapy compliance or to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) to participate in the management of the individual's condition."



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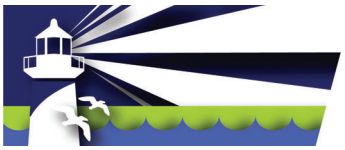
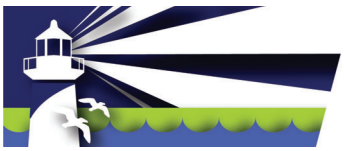
Diabetes Self Management Training (DSMT)

- Certified FQHCs may bill for DSMT services & are reimbursed on a per visit basis
  - Additional program requirements must be met:
    - Instructions in self-monitoring blood glucose
    - Education about diet & exercise
    - Insulin plan treatment developed
    - Motivation to use skills



Care Management Services

- Transitional Care Management (TCM)
- Chronic Care Management (CCM)
- General Behavioral Health Integration (BHI)
- Psychiatric Collaborative Care Model (CoCM)
- Principle Care Management
- Chronic Pain Management



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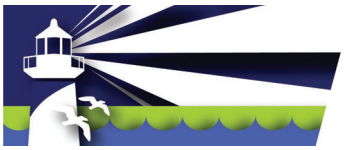
Enrolling as “non” FQHC Provider Type

- May evaluate benefits of enrolling:
  - Clinic/Group Practice
    - CMS-855B
  - Durable Medical Equipment (DMEPOS) Provider
    - CMS-855S
  - Diabetes Prevention Program (MDPP)
    - CMS-20134
  - Opioid Treatment Provider (OTP)
    - CMS-855B
  - Be aware of commingling implications



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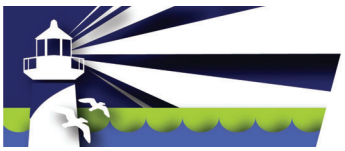
Medicare Part D

- Beneficiary enrolled in Traditional Medicare would elect/enroll in separate plan
- Part D covers prescription/pharmacy
- Not every Part D plan is the same
- Example: Shingrix



Medicare Advantage Wrap Around

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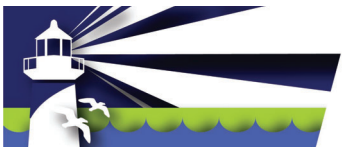
Medicare Wrap Around

- Section 237 of the Medicare Modernization Act (MMA) requires CMS to provide supplemental payments to FQHCs that contract with MA organizations to cover the difference, if any, between the payment received by the FQHC for treating MA enrollees and the payment to which the FQHC would be entitled to receive under the cost-based all-inclusive payment rate as set forth in 42 CFR, Part 405, Subpart X



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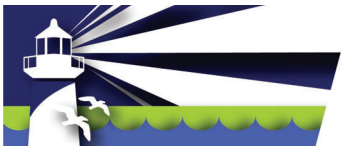
Medicare Wrap Around

- Medicare Advantage Contractor (MAC) requires specific information/data to be submitted
- Wrap rate is determined by MAC
- When the MA contract rate is lower than the applicable PPS rate that would otherwise have been paid by traditional Medicare, the MAC will pay the difference as a supplemental wrap around payment
- When the MA contract rate is higher than the applicable PPS rate, the MAC will not make any supplemental payment



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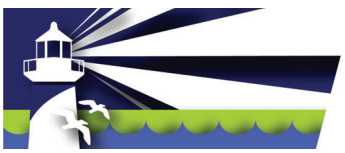
EXAMPLE OF RATE CALCULATION FOR MA CONTRACTS

Example of Per-Visit Payment Rate Calculation for Providers Contracting with an MA Plan
Fee-for-service (FFS) Rate Conversion

MA Number _____
MA Plan Name _____

CPT Code	Proc Desc	Units	Plan Rate	Weighted Rate	Copay / Deductible	Total
99201	INITIAL OFFICE VISIT, FOCUSED	2	$ 36.32	$ 72.64	$ -	$ 73
99202	INITIAL OFFICE VISIT, EXPANDED	62	$ 64.67	$ 4,009.54	$ -	$ 4,010
99203	INITIAL OFFICE VISIT, DETAILED	30	$ 96.17	$ 2,885.10	$ -	$ 2,885
99204	INITIAL OV, COMPREHENSIVE, MOD. COMPL	21	$ 136.35	$ 2,863.35	$ -	$ 2,863
99205	INITIAL OV, COMPREHENSIVE, HIGH COMPL	3	$ 173.01	$ 519.03	$ -	$ 519
99211	ESTABLISHED OV, MINIMAL	38	$ 21.16	$ 804.08	$ -	$ 804
99212	ESTABLISHED OFFICE VISIT, FOCUSED	411	$ 38.15	$ 15,679.65	$ -	$ 15,680
99213	ESTABLISHED OFFICE VISIT, EXPANDED	1,866	$ 52.25	$ 97,498.50	$ -	$ 97,499
99214	ESTABLISHED OFFICE VISIT, DETAILED	781	$ 82.04	$ 64,073.24	$ -	$ 64,073
99215	ESTABLISHED OV, COMPREHENSIVE	58	$ 119.70	$ 6,942.60	$ -	$ 6,943
99387	PREV. MED. NEW PT. 65 AND OVER	7	$ 150.87	$ 1,056.09	$ -	$ 1,056
99397	PREV. MED. ESTABLISHED OVER 65	191	$ 118.28	$ 22,591.48	$ -	$ 22,591
	Totals:	3,470				$ 218,995
	Average Rate:					**$ 63.11**



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Medicare Advantage (MA) Plans in the PPS Environment

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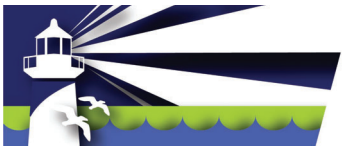
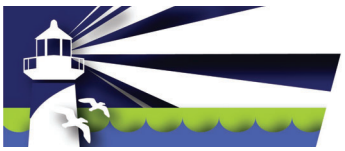
- We are not seeing PS&R form 778 payments of significance
- Money on the table
- Why?
  - Confusion on how to get enrolled
  - Confusion on setting up the payment



Medicare Advantage (MA) Plans in the PPS Environment

FORV/S

- Written contracts with a MA organization are paid by the MA plan at the rate specified within their contract.
- If the MA contract rate is less than the Medicare PPS rate, Medicare will pay the difference. This is called a supplemental wrap around payment.
- Supplemental payments are calculated by determining the difference between the FQHC all-inclusive cost-based per visit rate and the average per visit rate received from the MA payment, less the co-pay the FQHC charges the MA enrollees.
- Claims will return to provider with reason code 37098 when the FQHC PPS supplemental rate is not present for the MA plan.



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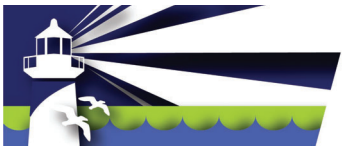
MA Plans in the PPS Environment, Cont.

- For FQHCs under contract (directly or indirectly) with MA organizations
  - CMS has indicated that the supplemental "wrap-around" payment will be based on the applicable PPS rate without comparison to the FQHC's charge
- Important to successfully navigate the process of establishing appropriate "wrap-around" rate(s)
  - Oftentimes health centers do not navigate this process effectively & leave money on the table



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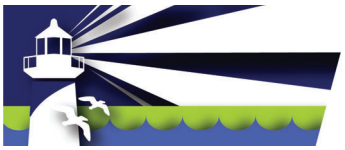
Medicaid

FORV/S

Medicaid PPS

- Federal law implementing a Prospective Payment System (PPS) for state Medicaid payments to RHCs/FQHCs effective January 1, 2001
  - Medicare, Medicaid, & SCHIP Benefits Improvement and Protection Act (BIPA)
- BIPA legislation required (continued):
  - Permitted establishment of an alternative payment methodology (APM) as long as the APM resulted in Medicaid payment equal to (or greater than) the PPS methodology AND the APM was agreed to by affected organizations



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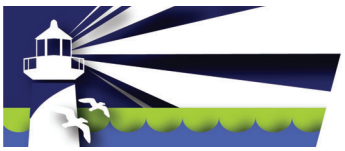
Medicaid FQHC Reimbursement

- Services and operating site must be in scope to be eligible for FQHC reimbursement
- If an FQHC has multiple sites, then each site must be enrolled separately



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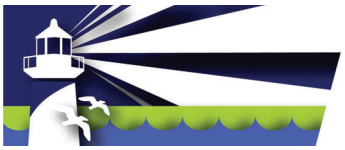
Medicaid

- Payment Methodology
  - PPS
  - Cost Based
- State specific
- Incentive Programs
- Change in Scope



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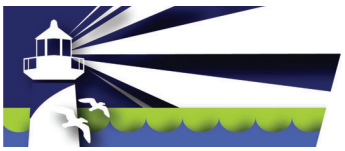
Action Items

- Given the scope and complexity of the "puzzle pieces", consideration of a health center "champion" to shepherd third-party reimbursement processes is important
- Good idea to perform a "self-assessment" of current Medicare & Medicaid FQHC reimbursement issues for your health center
- Health center personnel must understand & manage Medicare & Medicaid FQHC reimbursement & other third-party payer processes proactively to have good outcomes
- Remember – only you look out for you (each health center must consider its individual facts & circumstances to successfully navigate FQHC & other reimbursement issues/opportunities)



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Questions?

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Revenue Cycle Management for FQHCs: *Current Environment & Regulatory Updates*

Scott Gold, CPA, Partner - FORVIS
Nicole Moscatelli, CHFP, Senior Managing Consultant - FORVIS

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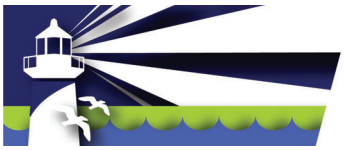
Agenda

1. 2023 Medicare Physician Fee Schedule Updates
2. 2023 Consolidated Appropriations Act
3. 2023 No Surprises Act - Good Faith Estimate - Updates



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2023 Medicare Physician Fee Schedule Updates

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Rate Setting & Conversion Factor

Medicare Physician Fee Schedule – 2023 Final Rule

- Budget neutrality required by law to ensure payment rates for individual services don't result in changes to estimated Medicare spending
- Required statutory update to conversion factor for CY 2023 of 0%
- Expiration of the 3% increase in physician fee schedule (PFS) payments for CY 2022
- $33.06, decrease of $1.55 to the CY2022 rate of $34.61

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Evaluation and Management (E/M) coding & documentation

Medicare Physician Fee Schedule – 2023 Final Rule

- Hospital inpatient, Hospital observation, Emergency department, Nursing facility, Home or residence services, Cognitive impairment assessment
  - New descriptor times (where relevant)
  - Revised interpretive guidelines for levels of medical decision making
  - Choice of medical decision making or time to select code level
  - Eliminated use of history and exam to determine code level; replaced with medically appropriate history and exam
- Creation of Medicare-specific coding for payment of Other E/M prolonged services

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Telehealth Services

Medicare Physician Fee Schedule – 2023 Final Rule

- Make several services that are temporarily available as telehealth services for the PHE available at least through CY 2023
- Extend duration of time that services are temporarily included on the list during the PHE for at least 151 days following the end of the PHE
- Implement provisions in the CAA to ensure a smooth transition after the PHE ends as part of the 151-day extension:
  - Geographic area
  - Any originating site
  - Certain services furnished via audio-only
  - PT, OT, SLP, Audiologists
- Delay the in-person visit requirements for mental health services until 152 days after the PHE ends
- Place of service indicator that would have been used if service was performed in person and use of modifier 95 to inform the service was performed via telehealth through the later of CY2023 or when the PHE ends

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Behavioral Health Services

Medicare Physician Fee Schedule – 2023 Final Rule

- Exception to the direct supervision requirement
- New Behavioral Health Integration (BHI) service for Clinical Psychologists (CP's) & Clinical Social Workers (CSW's) for monthly care integration
- Psychiatric diagnostic evaluation to serve as the initiating visit

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Chronic Pain Management (CPM)

Medicare Physician Fee Schedule – 2023 Final Rule

- New HCPC codes (G3002 and G3003) & valuation for CPM and treatment services
- Facilitate payment for medically necessary services
- Prompt more practitioners to welcome Medicare beneficiaries with chronic pain into their practices
- Help manage patient condition

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2023 Consolidated Appropriations Act

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Consolidated Appropriations Act, 2023 signed into law December 29, 2022

Medicare Physician Fee Schedule – 2023 Final Rule

- Increases applicable Medicare Physician Fee Schedule payments by 2.5%
- Extends some of the pandemic related Medicare telehealth flexibilities for two years through December 31, 2024, including
  - Waivers to the geographic & originating site restrictions
  - Eligibilities for federally qualified health centers & rural health clinics
  - Allowing telehealth to be provided through audio only telecommunications
  - Delaying the in person visit requirement before a patient receives tele mental health services
- Expands FQHC service definition to include services provided by a marriage & family therapist, or by a mental health counselor
- "Intensive Outpatient Services" added as a benefit
- Effective January 1, 2024

What does this mean for a FQHC?

- Chronic Pain Management & Behavioral Health Services
  - Add to general care management HCPCS code G0511
  - Payment would continue to be average of the national non-facility PFS payment rates
  - (CPT codes 99484, 99487, 99490, and 99491) and PCM codes (CPT codes 99424 and 99425)
- Telehealth
  - Extends certain flexibilities in place during the PHE for 151 days after the PHE ends
  - Allow payment for RHCs and FQHCs for furnishing telehealth services as distant site practitioners (though note that mental health visits can be furnished virtually on a permanent basis) under the payment methodology established for the PHE
  - Allow telehealth services to be furnished in any geographic area and
  - in any originating site setting, including the beneficiary's home, and
  - allowing certain services to be furnished via audio-only telecommunications systems.
  - Delay in-person requirement for mental health visits until 152 days after the end of the PHE

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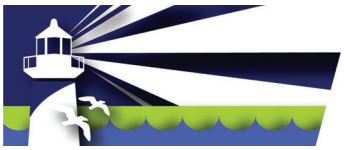
What does this mean for a FQHC?

- Conforming technical changes to the in-person requirements for mental health visits
  - We finalized conforming regulatory text changes in accordance with section 304 of the CAA, 2022 to amend paragraph (b)(3) of 42 CFR 405.2463, "What constitutes a visit," and paragraph (d) of 42 CFR 2469, "FQHC supplemental payments," to include the delay of the in-person requirements for mental health visits furnished by RHCs and FQHCs through telecommunication technology under Medicare until the 152nd day after the COVID-19 PHE ends.



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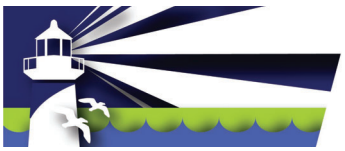
CY2023 MPFS Updates

- January 1, 2023 through December 31, 2023
  - FQHC PPS base payment rate is $187.19

HCPCS Code	Description	CY 2023 Payment Rate
G0511	Ccm/bhi by rhc/fqhc 20min mo	$77.94
G0512	Cocm by rhc/fqhc 60 min mo	$146.73
G0071	Comm svcs by rhc/fqhc 5 min	$23.72
G2025	Dis site tele svcs rhc/fqhc	$98.27



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No Surprises Act - Good Faith Estimate Updates

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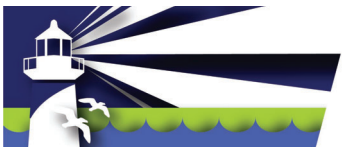
No Surprises Act

- Provides patients with protection from surprise medical bills under certain circumstances.
- Mandates transparency regarding healthcare costs and holds patients liable for in-network cost sharing amounts only.
- Allows healthcare providers & insurers to negotiate reimbursement separately while keeping the patient out of the process.
- Includes a provision for independent resolution if necessary.



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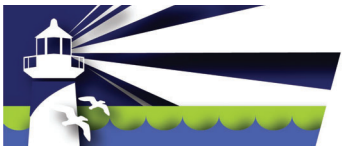
No Surprises Act

- July 1, 2021 “Requirements Related to Surprise Billing, Part I” interim final rule issued
- September 30, 2021, “Requirements Related to Surprise Billing Part II” second interim final rule issued - specifically named Federally Qualified Health Centers as included in the facilities required to comply with the Good Faith Estimate.
- November 17, 2021, “Prescription Drug and Health Care Spending” a third interim final rule issued
- Effective January 1, 2022
- Source: Overview of rules & fact sheets | CMS



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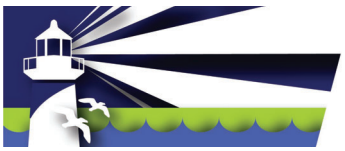
Good Faith Estimate

- FAQ Timeline
  - December 1, 2021
  - April 5, 2022
  - December 2, 2022
  - December 27, 2022



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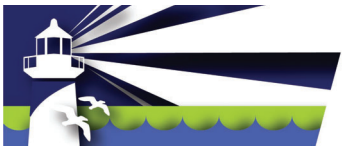
Good Faith Estimate

- 4th set of FAQs December 27, 2022
  - FQHC's are not exempt, but clarity is (indicated) to be provided for:
    - Slide Scale Patients
    - Services provided for free
    - Eligibility for the Patient-Provider Dispute Resolution (PPDR) process



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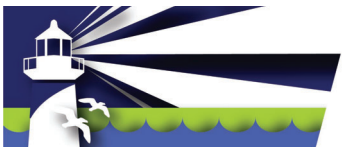
Good Faith Estimate

- What
  - Any service scheduled 3 or more days in advance
  - Upon patient request
  - Include primary and other related services that are provided by the health center (i.e., surgery is primary, include labs or tests, anesthesia, prescriptions)
  - Required for every visit
  - Single GFE for recurring appointments
    - Include timeframes, frequency, and total number of recurring items or services
    - Can cover maximum of 12 months
  - CHC staff must ask patient if they would like a claim to be submitted to insurance



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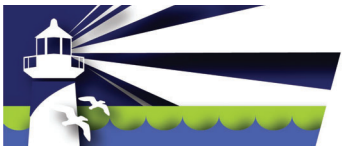
Good Faith Estimate

Timeframes for providing a GFE

If an uninsured or self-pay patient		Is a GFE required, and when?
Schedules an appointment:	Less than 3 business days in advance	No
	Between 3 to 9 business days in advance	Yes, within 1 business day of scheduling
	10 or more business days in advance	Yes, within 3 business days of scheduling
Requests a GFE, or otherwise asks about the cost of a service, but does not schedule appointment		Yes, within 3 business days of the request
Schedule the same service on a recurrent basis (e.g., multiple physical therapy appointments)		A single GFE can be issued for recurring services, up to a max of 12 months.



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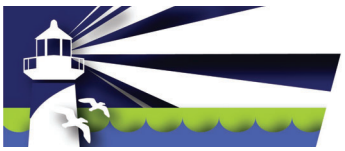
Good Faith Estimate

- Who
  - Uninsured patients
  - Insured patients that do not plan to use their insurance
  - Insured patients but insurance does not provide coverage for service



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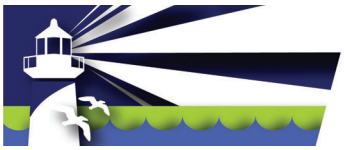
Good Faith Estimate

- Data to include
  - Written form
  - Patient name, date of birth, date/time/location of appointment
  - Standard disclaimer language
  - Charge information
  - Exact dollar amount patient will pay
  - Diagnosis codes and plain English meaning



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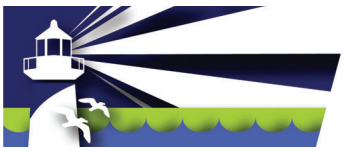
Good Faith Estimate

- *Data to include - Diagnosis Code Update
  - April 5, 2022
  - Q1: Must a GFE include a diagnosis code, even if the provider or facility does not know the patient's diagnosis at the time of scheduling, such as for initial screening visits and checkups, or in instances when there is not a relevant diagnosis code? A1:
  - No. A provider or facility is required to provide a diagnosis code only where one is required for the calculation of the GFE. For example, in situations in which a provider or facility has not determined a diagnosis, such as for initial screening visits or evaluation and management visits; or if there is not a relevant diagnosis code for an item or service, such as for certain dental screenings or procedures, providers and facilities are not required to include diagnosis codes on a GFE. However, the provider or facility must include the expected charges and service codes for the items and services to be furnished during that visit, even when no diagnosis code is available.



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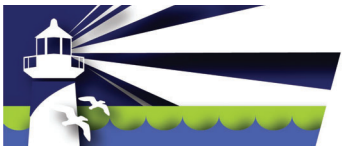
Good Faith Estimate

- Record Keeping
  - Written form (paper or email) even if discussed verbally
    - HIPAA Compliant
  - No formal rules how to document patient received/accepted GFE
  - Include in patient medical record
  - Available for at least 6 years



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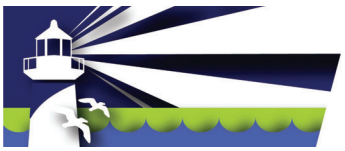
Good Faith Estimate

- Other Information
  - Bureau Primary Health Care (BPHC) reviewers will not be reviewing GFEs during Operational Site Visits (OSVs)
  - CMS will not enforce requirements to include data from outside providers until 2023 (as of 1.1.23 delayed)
  - Primary enforcement when actual costs are >$400 above GFE
    - Individual pays small administrative fee to file
  - No update on comments submitted to CMS (by December 6, 2021)



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Good Faith Estimate

- Notice informing patients of availability of GFE
  - Written in clear and understandable format
  - Prominently displayed
    - in-office
    - where questions can arise about cost of services
    - website

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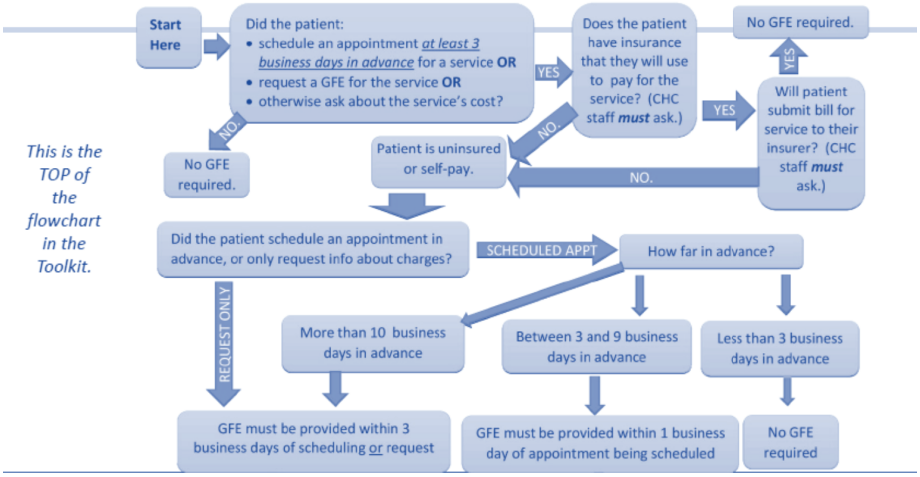
GFE Flowchart



Source: [illegible] Toolkit

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Good Faith Estimate – 2023 Updates

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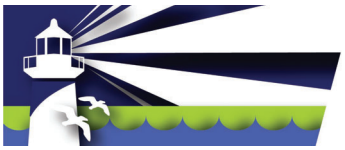
- Beginning in 2023, a list of items and services and their associated costs, that can be reasonably expected to be given to you by another provider or facility involved in your care (a co-provider or co-facility). For example, a doctor probably expects that along with an individual's knee replacement surgery, the patient will also be given anesthesia. Both of these items and services should be included in your good faith estimate, and starting in 2023, the anesthesia items and services will have to be included.

DELAYED



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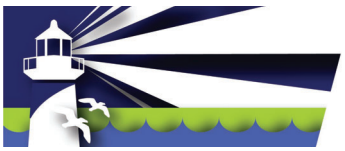
Good Faith Estimate

- Delay Cost Estimate from Co-Provider/Co-Facility
  - HHS exercising enforcement discretion
  - Allow time for providers and facilities to develop mechanisms for convening providers and facilities to request and co-providers and co-facilities to provide, complete and accurate pricing information for the convening provider or facility to incorporate into the GFE for uninsured (or self-pay) individuals
  - Providers and facilities market-wide to adopt a standards-based application programming interface (API)



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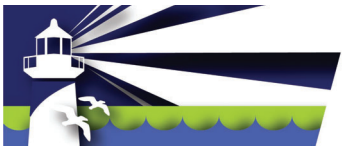
Good Faith Estimate

- Sliding Fee Discount - New Patients
  - Include the itemized list of items or services and other requirements under 45 CFR 149.610
  - Information about patient family size/income is unknown
    - at a minimum list the undiscounted price for each item or service included in the GFE
  - Encouraged but not required
    - include information about the provider's or facility's sliding fee schedule and any other financial protections it offers
  - Demonstrate the expected charges associated with each scheduled or requested item or service as a schedule according to income and family size, with an expected charge per item or service displayed at each income tier
  - Sliding fee discount providers and facilities have flexibility to determine how best to demonstrate the expected charges associated with each listed item or service, and to determine what additional information to include (if any)



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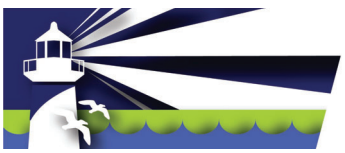
Good Faith Estimate – **CMS Sample Format**

Sample Schedule of Expected Charges[2]

	100% FPL and Under	101 - 135% FPL	136 - 150% FPL	151 - 200% FPL	Above 200% FPL
New Patient Visit (with Exam)	$10	$20	$30	$40	$200
Routine Lab Work	$5	$7	$10	$13	$25
Expected Total Cost	$15	$27	$40	$53	$225
Family Size	Income range	Income range	Income range	Income range	Income range
1	$0 - $13,590	$13,591 - $18,347	$18,348 - $20,385	$20,386 - $27,180	$27,181 and above
2	$0 - $18,310	$18,311 - $24,719	$24,720 - $27,465	$27,466 - $36,620	$36,621 and above
3	$0 - $23,030	$23,031 - $31,091	$31,092 - $34,545	$34,546 - $46,060	$46,061 and above
4	$0 - $27,750	$27,751 - $37,463	$37,464 - $41,625	$41,626 - $55,500	$55,501 and above
5	$0 - $32,470	$32,471 - $43,835	$43,836 - $48,705	$48,706 - $64,940	$64,941 and above
6	$0 - $37,190	$37,191 - $50,207	$50,208 - $55,785	$55,786 - $74,380	$74,381 and above
7	$0 - $41,910	$41,911 - $56,579	$56,580 - $62,865	$62,866 - $83,820	$83,821 and above
8	$0 - $46,630	$46,631 - $62,951	$62,952 - $69,945	$69,946 - $93,260	$93,261 and above



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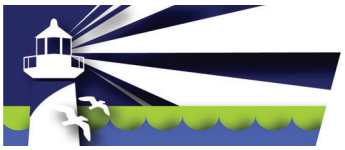
Good Faith Estimate

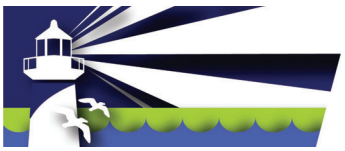
- Sliding Fee Discount – Established Patient's family size and income on file
  - Must provide GFEs in accordance with the requirements of 45 CFR 149.610
  - List the expected charges (reflecting any discounts for the patient) associated with each listed item or service
  - If an established patient informs that their income or family size has changed, the provider or facility may do one of the following:
    - rely on the patient's income and family size information on file to generate the "established patient" GFE or
    - generate a "new patient" GFE that lists the undiscounted price of the items or services
  - For any "established patient" GFE, HHS recommends a disclaimer that this estimate is based on financial information on file with the sliding fee discount provider or facility and actual charges may differ based on changes in the individual's financial circumstances
  - Does not explicitly address patients whose eligibility is due for redetermination



FORV/S

Good Faith Estimate

- PPDR Process for an uninsured or self pay individual with a(n)…
  - New Patient GFE initiate if bill is ≥$400 compared to the undiscounted price on the GFE
  - Existing Patient GFE initiate (as per 45 CFR 149.610 and 149.620) by submitting a notification (initiation notice) to HHS postmarked within 120 calendar days of receiving the initial bill containing charges for the item or service that is substantially in excess of the expected charges in the good faith estimate
  - In both instances the uninsured (or self-pay) individual must submit an administrative fee to the Selected Dispute Resolution (SDR) entity
    - CY2022 Fee $25
    - CY2023 Fee $25



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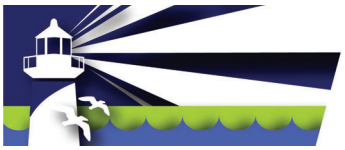
Good Faith Estimate

- Don’t expect to bill uninsured or self-pay patient (free service)
- Can provide patient with complete GFE and include a note which items will be free OR
- Can provide an Abbreviated GFE
- Abbreviated GFE, specifically as a request for cost information is NOT REQUIRED to include:
  - Specific services or items
  - Specific dates of service



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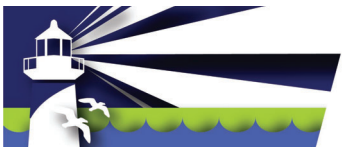
Good Faith Estimate

- Abbreviated GFE
- Designed to reduce burden on providers,
- Ensure patients still have access to the PPDR process
- Providers will be in compliance under the following conditions along with meeting other requirements:
  - They provide uninsured (or self-pay) individuals with an abbreviated GFE;
  - They do not bill uninsured or (self-pay) individuals who receive an abbreviated GFE, provided they meet all other requirements under 45 CFR 149.610 and
  - No items or services included in the abbreviated GFE are expected to be furnished by co-providers or co-facilities in conjunction with the primary items or services



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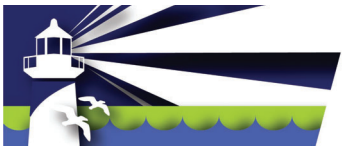
Good Faith Estimate

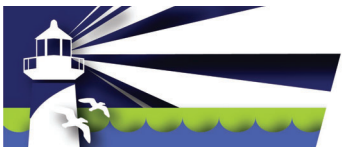
- An abbreviated GFE must include:
  - Patient name and date of birth;
  - Name, National Provider Identifier (NPI), and Taxpayer Identification Number (TIN) of the provider or facility, and the state(s) and office or facility location(s) where the items or services are expected to be furnished by the provider or facility;
  - If scheduled, the date(s) the items or services are scheduled to be furnished;
  - A statement that the provider or facility will not bill the individual for any items or services furnished on the date(s) the scheduled items or services are scheduled to be furnished (if scheduled) or that the provider or facility will not bill the individual for any items or services (if no date(s) of service is scheduled and the GFE is being provided upon request);



FORV/S

Good Faith Estimate

- An abbreviated GFE must include:
  - A disclaimer that informs the uninsured (or self-pay) individual of their right to initiate the PPDR process;
  - A disclaimer that the GFE is not a contract and does not require the uninsured (or self-pay) individual to obtain the items or services from any of the providers or facilities identified in the GFE; and
  - A disclaimer that informs the uninsured (or self-pay) individual that there may be additional items or services the convening provider or convening facility recommends as part of the course of care that must be scheduled or requested separately.
  - HHS encourages including email address and phone number of individual with authority to represent in a billing dispute



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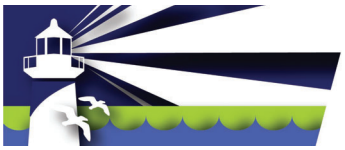
Good Faith Estimate

- Abbreviated GFE
  - For patients who schedule an appointment for the free service/item, the CHC will not charge them for any services/items provided that day
  - For patients who do not schedule an appointment for the free service/item, the CHC will never charge them for any services/items



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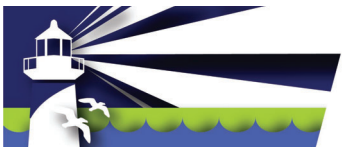
Good Faith Estimate

- Providers or facilities that provide an uninsured (or self-pay) individual an abbreviated GFE upon a request for cost information are not required to list any specific items or services to be furnished or to provide a specific date of service.
- If a provider or facility does not subsequently issue a GFE (including an abbreviated GFE) upon scheduling (because, for example, the individual schedules the item or service fewer than 3 days before the item or service is furnished), the uninsured (or self-pay) individual may be entitled to the PPDR process if any item or service furnished by the provider or facility subsequent to the date of the abbreviated GFE is $400 or more than the amount provided in the GFE issued upon request.
- The abbreviated GFE provided upon request is a commitment to not bill the patient for any items or services provided on any date subsequent to the date of the abbreviated GFE from that provider or facility, until such time as the provider or facility provides a subsequent GFE that reflects the date(s) that the item(s) or service(s) are scheduled to be furnished.
- HHS strongly recommends that only providers and facilities that furnish all items or services free of charge use an abbreviated GFE.



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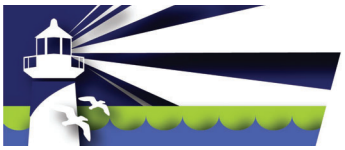
Good Faith Estimate

- Implementation Considerations:
- Steps:
  - Identify affected patients
  - Practice management system support
  - Patient Portal
  - Signage
- Who is involved (within health center)
  - Clinical Operations
  - Patient Access
  - Revenue Cycle



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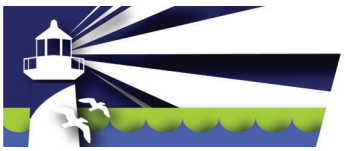
Good Faith Estimate

- Summary
  - Best effort
  - Feedback opportunities to CMS
  - Recent revelations
    - "The government has substantially underestimated the burden associated with implementing the good faith estimates and patient-provider dispute resolution process," AHA wrote. "We urge the agency to revise its estimates based on the actual experience of providers since implementation on Jan. 1, 2022. We also offer recommendations on how to minimize operational inefficiencies without compromising the policy's important goal."
    - Source: AHA weighs in on good faith estimate, patient-provider dispute resolution process burden | AHA News



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340B Pharmacy

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340B Rx Program

- What is it?
- How does it work?
- Where is the revenue potential?

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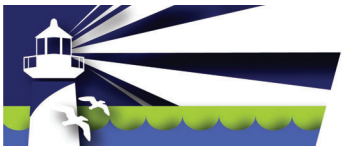
340B Rx Program

- What is it?
  - Ability for pharmaceuticals to be purchased at a significant discount
  - Allows for scarce federal resources to be stretched
  - Eligible health care organizations



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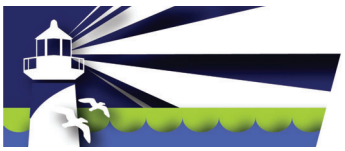
340B Rx Program

- How does it work?
  - Register, enroll, & comply with requirements
  - Be assigned a 340B identification number
  - Identification number is verified to purchase drugs at a significant discount
  - Set charges following health center methodology



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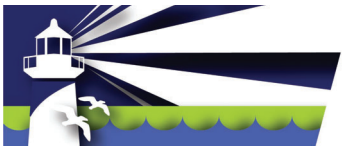
340B Rx Program

- Revenue Potential
  - Difference between payment from payor or patient and the cost to purchase drug
  - Example below $30 revenue pickup
    - Example non-340B Discount
      - Cost of drug $50
      - Charge $200
      - Payment $150
      - $100 Revenue = $150 Payment – $50 Cost
    - Example 340B Discount
      - Cost of drug $20
      - Charge $200
      - Payment $150
      - $130 Revenue = $150 Payment - $20 Cost



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Questions?

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Agenda

1. Five Components of Internal Control
2. Key Controls
3. Segregation of Duties
4. Action Items

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Five Components of Internal Control

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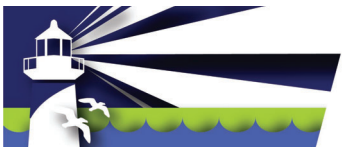
Internal Controls

- Also known as “checks and balances”
- Helps an organization achieve its objectives
- Small or large, all organizations need them…
  - Not just about segregation of duties
- Will be unique to staffing, size and risks of organization
  - No one standard set of controls
  - They don’t have to be complicated
  - Can mean different things to different people…
- Your Organization should have an internal control policy



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Internal Controls

- Why are internal controls important to your Organization?
  - Improved financial reporting
  - Non-compliance with laws
  - Are you prepared if a disaster hits?
  - Decrease dollar amount of losses
  - Decrease duration of schemes that occur

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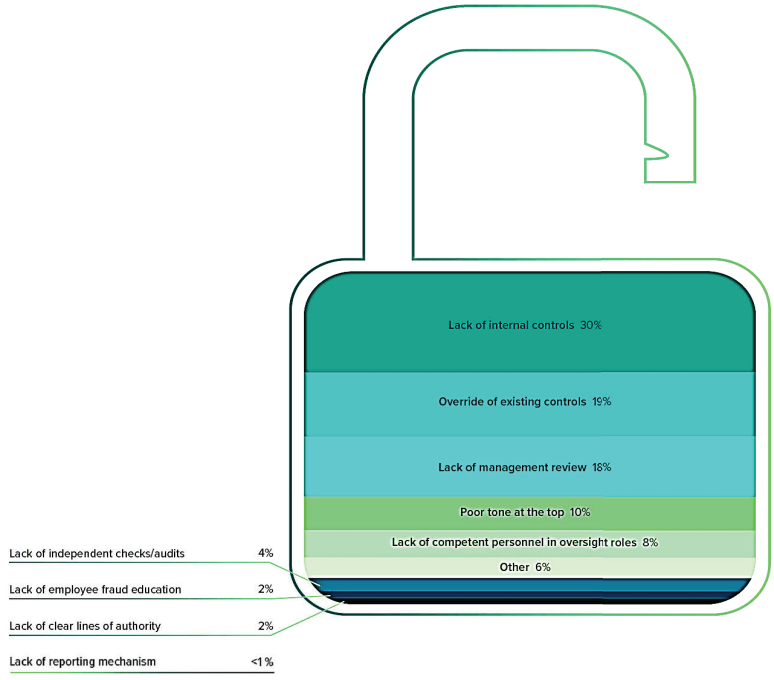
Internal Control Weaknesses

Source: Association of Certified Fraud Examiners-
2018 Global Study on Occupational Fraud and Abuse

FIG. 22 **What are the primary internal control weaknesses that contribute to occupational fraud?**



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Five Components of Internal Control

- Control Environment
- Risk Assessment
- Control Activities
- Information and Communication
- Monitoring Activities

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1. Control Environment

- What is it?
  - Commitment to take ethics and internal controls seriously. Largely influenced by management and the board of directors.
- This is the foundation for internal control
- Demonstrates commitment to ethics and integrity
  - Does your organization take ICs seriously or are they ignored?
- Exercises oversight
- Establishes structure, authority and reporting lines
- Demonstrates commitment to competence
- Enforces accountability

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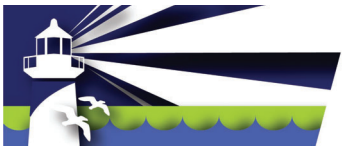
2. Risk Assessment

- What is it?
  - Evaluation and identification of riskiest areas to identify where an organization should implement controls to prevent or detect errors or fraud that could result in material misstatement
- What are the riskiest areas in a health center?
  - Material accounting representations
    - Patient service revenue and accounts receivable
    - Cost report receivable/payable assumptions
    - Billing and collections internal controls
  - Possible diversion or misappropriation of assets
    - Theft of cash – patient collections
    - Theft of checks or EFT's – third-party payer collections



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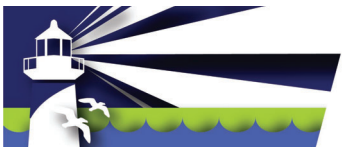
3. Control Activities

- What is it?
  - Policies and procedures that help ensure that management's directives are carried out
- Examples of controls activities in policies includes:
  - Hiring staff with background and skill set necessary to recognize and implement control activities i.e., CPA, industry experience, etc.
  - All journal entries approved by non-preparer
  - Employees having access to cash do not have recording functions in GL or PMS
    - Do your front desk EEs have access to post adjustments in the PMS?
    - Does anyone in finance have access to cash/checks before bank deposits occur?
  - Requirements on monthly reconciliations of all balance sheet accounts
  - Timing requirements for providers to close out encounters
  - What are some others?



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4. Information and Communication

- What is it?
  - IT, Accounting, and Communication Systems and Processes
- Internal Controls - safeguard assets, maintain accounting records, and back up data
  - Daily reconciliations and deposits of collections?
  - Manual or computerized calculations?
    - Revenue estimates
    - Sliding fee adjustments
  - System Access
    - What can vs. what should employees be able to access?
  - Are systems backups done frequently and kept off site?

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5. Monitoring Activities

- What is it?
  - Commitment to take ethics and internal controls seriously. Largely influenced by management and the board of directors.
- How does management monitor its controls?
- How effective is the monitoring?
  - ENRON???
- Does organization change policies that aren't work
- Does the organization follow policies?
  - HRSA Site visit implications – follow policies and regulations
  - Audit implications

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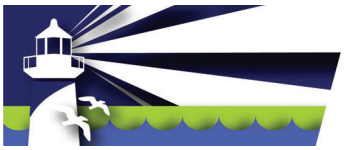
A Few Internal Control Myths

- Myth 1: External audits are the best control
  - Then what is the purpose of the audit?
- Myth 2: Controls hamper operations and cost too much
  - What is at risk?
- Myth 3: Hiring well and trusting each other is a control
- Myth 4: Too few employees – nothing we can do …

- Key Point: Stores do not place armed guards on each aisle to prevent shoplifting. It's about common sense and weighing the risks. Place controls in key areas.



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Key Controls

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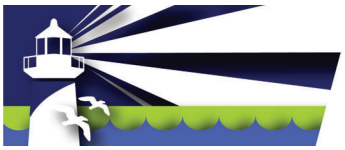
Internal Controls - Example #1

- What procedures does the entity maintain to ensure that patient billings are appropriately prepared, processed and recorded?
  - Client Response: Claims are created 48 hours after the services have been performed. Any charge that is not locked by the provider is not created. The provider is responsible for choosing all codes that are to be billed. Claims are reviewed for any discrepancies from the progress notes. All rejected claims are worked on a daily basis. Statements are sent out once a month for any balances that remain.
  - FORVIS Testing: No key controls identified in client's response.
  - Can you identify controls that are lacking?



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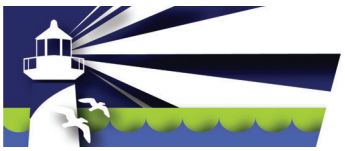
Internal Controls - Example #1

- Gaps in internal controls?
  - The health center is not running a "Patients Checked In but Not Checked Out" report to ensure all encounters are closed and able to be billed.
  - The finance department is not running a "Revenue Cut-off" report to ensure revenue for all encounters posted after month-end are included in the proper month the services were performed.
  - Others?
  - How has Revenue Recognition impact key controls?



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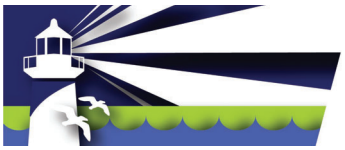
Internal Controls - Example #2

- What procedures does the entity maintain to ensure payments and adjustments are properly applied to patient accounts?
  - Client Response:
    - Front Desk staff receive payments and prepare the daily deposit for the clinics which are reconciled to the Batch Listing and verified by the Site Manager. The bank deposit is prepared by the clinic manager at each site. Facilities personnel pick up locked security bags and make bank deposits each night. The deposit is documented by the certified bank deposit slip and sent to Accounting the next day. Bank deposits are balanced to the general ledger during the bank reconciliation.
    - Front desk personnel can only record patient payments to accounts, they cannot record adjustments.



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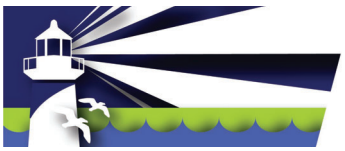
Internal Controls - Example #2

- FORVIS Testing:
  - FORVIS reviewed the daily deposit records for "AA" Clinic for 9/15/2018 (date judgmentally selected by FORVIS). FORVIS reviewed the "Daily Manager Batch Verification Form", noting it contains several verifications to be completed by the site manager/front office supervisor as well as lists the employees who had a batch for the day and the amount of money collected via cash, check, and credit cards for the day. FORVIS selected "Bob" from the listing of employees, noting he collected $85 in cash and $147 in credit card payments. FORVIS agreed collections by "Bob" and in total per the "Daily Manager Batch Verification Form" to the "NextGen Daily Clinic Deposit Report" for 9/15/2018 without exception. FORVIS agreed total cash collections at "AA" clinic on 9/15/2018 of $310 per the "Daily Manager Batch Verification Form" and "NextGen Daily Clinic Deposit Report" to the Bank deposit slip and deposit bag without exception. FORVIS agreed the total credit card receipts at "AA" Clinic on 9/15/2018 of $290 per the "Daily Manager Batch Verification Form" and "NextGen Daily Clinic Deposit Report" to the "Transaction Central settled detail report" without exception.
  - FORVIS also reviewed the September 2018 Bank Reconciliation, noting it was prepared by Staff Accountant and approved by CFO via electronic signature. FORVIS agreed the balance per the bank statement of $1,000,000 on the September bank reconciliation to the ending balance on the September bank statement without exception. FORVIS agreed the reconciled bank balance to the TB Summary for the period ending 9/30/2018 without exception.
  - FORVIS observed a front desk employee attempt to post an adjustment to a patient account. In discussions with the front desk employee, she did not know how to post an adjustment, or even where in NextGen she needed to go in order to do so. As such, while still logged into the Front Desk employee's username, FORVIS had Billing Manager attempt to post the adjustment. FORVIS noted the adjustment was able to be processed. Pdw CFO, he is an admin in NextGen and also has the ability to post adjustments to patient accounts.
  - Can you identify controls that are lacking?



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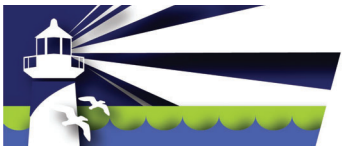
Internal Controls - Example #2

- Controls that are lacking
  - CFO & Front desk can post adjustments to patient accounts
    - Why is this a risk?
      - Front desk pocket payment and post adjustment to account
    - Depending on size – Billing manager and/or CFO should approve all manual adjustments to patient accounts
  - Others?



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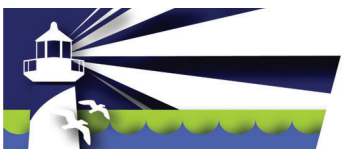
Revenue Cycle - Example Key Controls

- Reconcile payments posted to bank deposit
  - Reconcile daily deposit to amount posted
  - Composition of checks vs. cash vs. credit card
  - Don't allow the same person to do these things:
    - Collect money
    - Post, write-off and adjust accounts in system
    - Prepare deposit
    - Reconcile
    - Take to bank
- Try to insert someone else in this process to prevent complete control over cash and checks received



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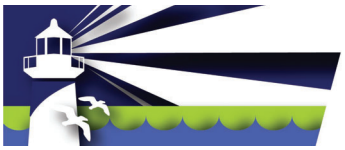
Revenue Cycle - Example Key Controls

- Review of Bank Statements & Cancelled Checks
  - Done right, this is one of the best things you can do
  - Someone outside accounting department
    - CEO or potentially board member (smaller orgs)
    - Member of senior management for medium-sized
  - Get online access to accounts – can do anywhere
  - Review bank statement for ATM, counter withdrawals, wires, ACH and other debits
  - Review cancelled checks for unusual payees, checks to employees (even dollar amounts especially)
  - Many smaller organizations lack this review!!!
  - Even quarterly review of statements would help



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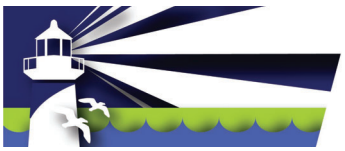
Revenue Cycle - Example Key Controls

- Use of lockbox by each clinic location
  - Good options available – better than 10 years ago
  - Same-day deposit
  - Same-day access to images of checks received



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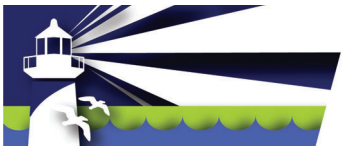
Revenue Cycle - Example Key Controls

- Monthly reconciliations/roll-forwards
  - Patient accounts receivable
  - Grants receivable
  - Contributions receivable
  - Etc. (all balance sheet accounts s/b reconciled)
- Timely and quality review



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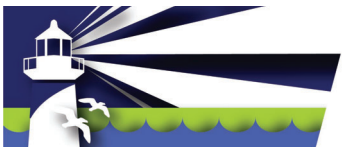
Improving the Control Environment

- Utilize PMS & GL system controls & rights. Review periodically. Update timely as changes occur.
- Develop a formal & clear process for setting up EFTs from third-party payers & conduct follow up audits.
- Do not give cashiers the ability to post adjustments or shut off patient statements. Cashiers should only post payments.
- Give receipts when payments are received. Consider formal System Generated Receipts.



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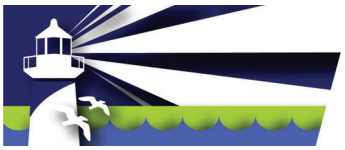
Improving the Control Environment

- Involve different people – non-accounting?
- Receptionist: open mail, prepare cash receipts list & deposit slip, and restrictively endorse checks
- Creative Monitoring Reports from AR System
- Adjustment report by person by payer
- Payments posted by site by day
- Any report for exceptions or additional analysis



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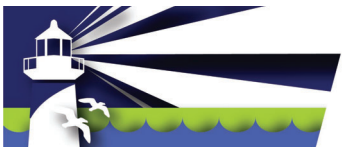
Entity-Level Controls

- Entity-level controls are internal controls that help ensure that management directives pertaining to the entire entity are carried out. They are the second level of a top-down approach to understanding the risks of an organization
- They are typically “high-level” controls but do impact all segments of the organization including the Revenue Cycle



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Entity-Level - Example Key Controls

- Establish HR policies and controls as they impact every phase of the Organization
  - Initial background checks
  - Updated background checks after a few years
  - Credit checks (with consent)
  - Some believe credit checks are better predictor
  - Ethics surveys – how does staff see leadership?
  - Exit interviews

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Entity-Level - Example Key Controls

- Review of monthly budget to actual financial statements
  - Is the reviewer(s) qualified?
    - Executive Management?
    - Board of Directors?
  - Appropriately detailed?

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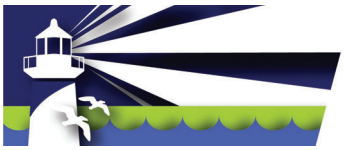
Entity Level- Example Key Controls

- Fraud & cybersecurity awareness training
  - Targeted training for employees & managers
  - Can you solve problems sitting in Finance?
    - No – Organization-wide awareness is critical!
  - Higher levels of controls, lower losses, & shorter duration can be correlated to awareness training for employees
  - Staff should be educated regarding internal controls, why they are in place, and how to report deviations from policy



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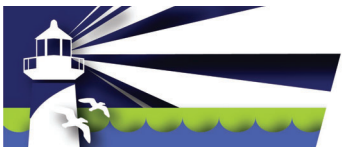
Entity-Level - Example Key Controls

- Required mandatory vacations
  - Someone must fill in for employee on vacation
  - Do not just fill the inbox of the absentee employee
  - Watch for people who come back “to check on things”
  - Job rotation can also be used
  - Amazing how many frauds are identified during absences



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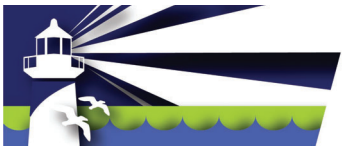
Entity-Level - Example Key Controls

- Establishment of a Fraud/Compliance Hotline
  - Third-party monitored hotline is best practice
  - Tips are #1 way abuse or disregard of internal controls and frauds are brought to management attention
  - Employees are your eyes and ears
  - “Open door” policies not enough
  - Used to report other problems too
  - Make it confidential
  - Encourage employees to report concerns



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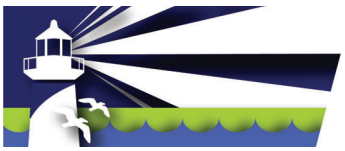
Internal Control Limitations

- Provides only reasonable assurance
- Controls are not a cure-all
- There are no guarantees even with good controls
- Controls are not robotic – large human element
- Human frailty in making business decisions
- Management override and collusion - can often do what they want to do….
  - How can this risk be mitigated?
  - Do CFOs need “Super User” access?



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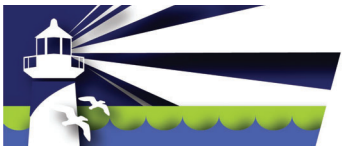
Tips for Smaller CHCs

- After the fact review becomes important
- Board member review/reconcile bank account
- CEO or board treasurer review bank activity online
- Outside firm could do some additional review
- Don’t recommend hiring just to segregate duties



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Segregation of Duties, Fraud & Abuse Policies

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Segregation of Duties

- Why?
  - Strengthens internal controls because…
    - Decreases the risk of fraud
    - Fraud is caught more quickly
    - Catches errors & protects employees
  - It is not for efficiency

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Segregation of Duties

- Access – ability to get to something worth stealing
- Recording – documenting activity, think rights to the general ledger and/or practice management system
- Monitoring – review, reconciliation, follow-up
  - Separate these category of duties
- Custody vs. Authorization vs. Recordkeeping
- Bottom Line: Get more than one pair of eyes

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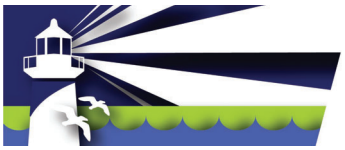
Segregation of Duties

- Generally best practice is to segregate personnel having access to assets from having recording and/or monitoring responsibilities
- Personnel having access to cash/checks should not have the ability to record adjustments to patient accounts



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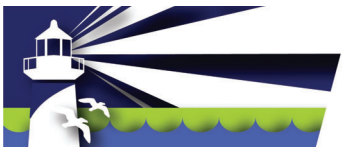
Segregation of Duties

- Think what “can” they do versus normally do
- What system or IT rights does an employee get?
  - We see all too often CHCs grant too many rights for no or poor reasons
- Saying a person “does not know how” is not the same as saying that they cannot do something



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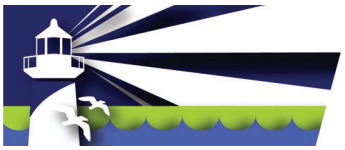
Segregation of Duties

- Great segregation of duties may not be enough
  - Remember that some controls prevent / some detect fraud
    - Management can override controls
    - Collusion between 2 or more employees
  - Awareness is everyone's job…
  - Cost versus benefit factors into decisions
    - Both efficiency & personnel
    - Often someone has a role they do not want
  - Don't forget fidelity (employee dishonesty) insurance
  - Tone at the top



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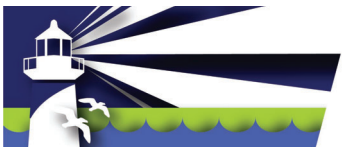
Revenue Cycle - Examples of Conflicts of Duties

- Access examples
  - Receive cash/check or custodian of payments cash/check
  - Provide EFT information to third-party payers
  - Admit and/or discharge patients
- Recording & monitoring examples
  - Record bad debt or contractual adjustments
  - Prepare the billing document
  - Record journal entries
  - Issue patient statements
  - Agreeing cash receipts list to the bank deposit



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What else can you do to influence and strengthen internal controls / reduce risk of theft at organizational level?

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Policies to Have in Place

- Code of Conduct
- Conflict of interest disclosures
- Expense account/reimbursement procedures
- Credit card policies
- Whistleblower policy – require reporting
- Protocol for investigating allegations of wrongdoing
- Consider a third-party hotline

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Set the Appropriate "Tone at the Top"

- Rationalizing can be easy – we all do it
- Grey areas can quickly turn black
- Your gut often tells you right from wrong

- "I knew it was wrong….I knew that what I was doing was misleading. But I didn't think it was illegal. I thought: That's how the game is played. You have a complex set of rules, and the objective is to use the rules to your advantage. And that was the mistake I made."
- – Andrew Fastow, Former Chief Financial Officer of Enron

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Tone at the Top

- It Has to be More than Words on a Page (Even Enron had a 60 page "Code of Ethics")

Foreword

As officers and employees of Enron Corp., its subsidiaries, and its affiliated companies, we are responsible for conducting the business affairs of the companies in accordance with all applicable laws and in a moral and honest manner.

July, 2000

Code of Ethics

ENRON

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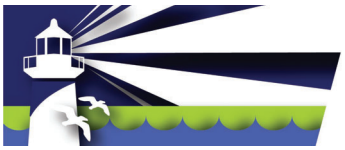
Perform a Risk Assessment

- Consider conducting a formal risk assessment
- Make list of potential risks and rank according to importance
  - A great exercise: Sit with a few others….ask yourself "what would stop/detect if someone tried to_____"
- Implement controls where holes are identified
- Can be done internally or by a third party



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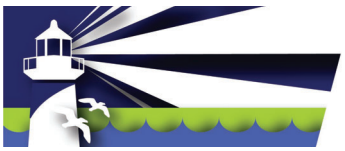
Track Complaints

- Sometimes they are the tip of iceberg
  - Complaints about payments, not providing records, etc.
  - Someone committing fraud may insist on handling
    - Allows scheme to continue
  - Patterns in complaints are seldom recognized until it's too late
  - A lot can be learned by knowing about complaints
- Key Point: What might seem like a bad process or innocent errors can sometimes be an internal control issue!



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Maintain Awareness

Fraud triangle considerations

Perceived pressure facing individual

Perceived opportunity to commit fraud

You can control this!

Person's rationalization or integrity

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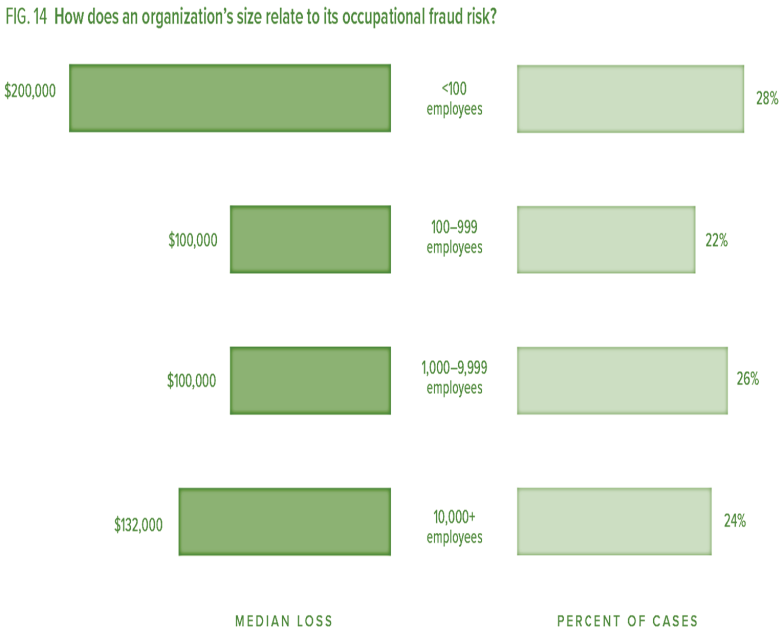
Organization's Size vs. Fraud Risk

Source: Association of Certified Fraud Examiners-
2018 Global Study on Occupational Fraud and Abuse



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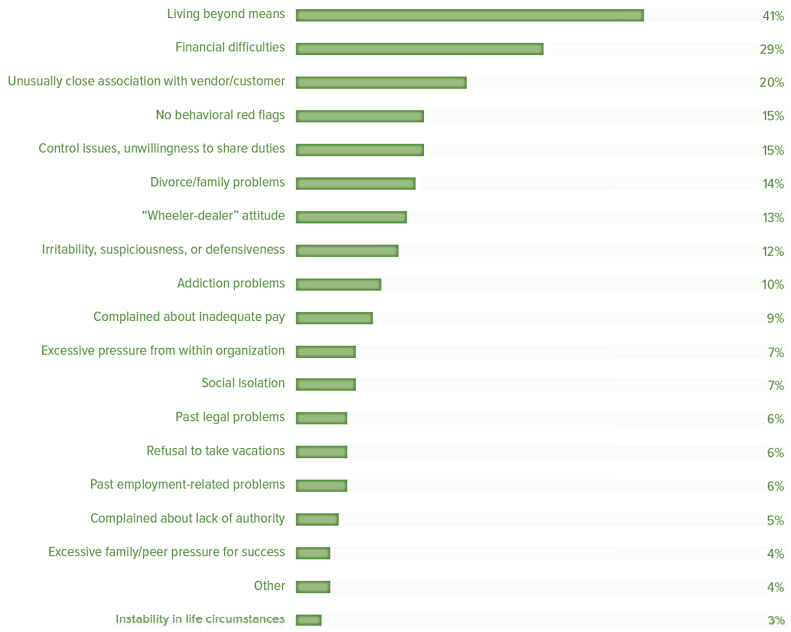
Look for Red Flags

Source: Association of Certified Fraud Examiners-
2018 Global Study on Occupational Fraud and Abuse

FIG. 38 **How often do perpetrators exhibit behavioral red flags?**



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Fraud Schemes

- False non-company accounts when setting up the EFT accounts for insurance payers
- Receiving cash or check & posting adjustments & not payments
- Not recording or altering bank deposits & stealing cash receipts
- Altering credit card receipts
- Granting bogus credits – that could be positive
- Lapping

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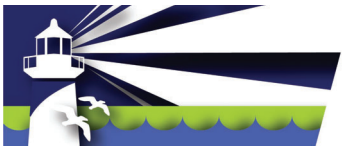
CHC Fraud Example

- There is no lack of fraud in healthcare
  - Community health center employee – senior accountant
  - Embezzled over $130,000
  - Used the CHC debit card for personal items
  - Disguised by altering daily bank account statements
  - Created fictitious/altered journal entries to conceal
  - Pled guilty

- Key Point: Many frauds involve trusted employees. Lack of review and segregation of duties issues often contribute to allowing the fraud to occur undetected for years.



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Action Items

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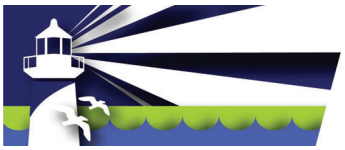
Action Items

- Review and update policies & procedures
- Complete a review of your system access rights on at least an annual basis
- Review your revenue cycle key controls in place and make updates as needed for the new revenue recognition standards
- Consult with your auditor/advisor on treatment where significant judgment is needed



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Thank you!

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