

Financial Findings from California Community Health Centers

As full implementation of the Patient Protection and Affordable Care Act takes hold across the United States, the critical role of community health centers is receiving much attention. An analysis of California's healthcare safety net finds that these providers have experienced robust growth over the past four years, and will continue to play a crucial role in delivering health care to the state's most vulnerable families and individuals for years to come.

California's community health centers experienced strong growth throughout the four-year survey period, as evidenced by the following data:

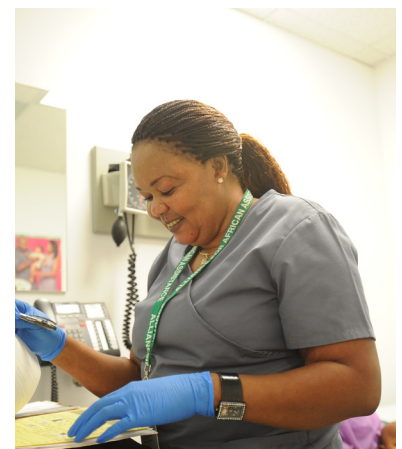
- Community health centers collectively served 4 million patients in 2011, a 26 percent increase from the 3.2 million in 2008;
- Total patient visits grew by 22 percent, with health centers generating an average of 3.1 visits per patient each year;
- Total operating revenue for all health centers increased 9.7 percent annually, from \$2 billion to \$2.7 billion;
- The average revenue per clinic grew 31 percent, from \$13.2 million to \$17.3 million;
- The number of care sites per organization increased from 3.8 to 4.4.

Data show that Federally Qualified Health Centers (FQHCs) and FQHC Look-Alike (LAL) clinics generally outperform other types of community health centers statewide. Patterns also show regional variations in clinic performance, with organizations located in Central and Southern California outperforming those in San Francisco and Northern regions.

These and additional findings are the result of an analysis that tracked, from 2008 to 2011, the financial and operational performance of 158 California community health centers, accounting for roughly 75 percent of all health centers in the state at that time.

This issue brief provides a comprehensive snapshot of the financial strength of California's health center landscape. It's based on a [report](#) entitled *California Community Clinics, A Financial and Operational Profile*. Participants included

In 2011, approximately 43 percent of patient visits were covered by Medi-Cal, which provided 56 percent of all health center revenue.



105 FQHCs, 20 LALs, and 33 non-FQHCs. The analysis was conducted by Capital Link, with funding from Blue Shield of California Foundation and the California HealthCare Foundation. It is a follow-up to Capital Link's 2010 study "California Community Clinics: Financial and Staffing Analysis, FY 2006-2009," and continues the commitment of both foundations to understand the financial health of California's safety net, and identify the critical factors that can positively influence the development of high-performing health centers.

Clinic Finances and Operations

When health centers were clustered by revenue size, those with the largest and the smallest budgets grew at a faster rate than those at the median. Average annual operating revenues for health centers at the median grew 22 percent, while the largest clinics (in the top 25 percent) and the smallest clinics (in the bottom 25 percent) both grew 37 percent.

Across the survey's timeframe, health centers continued to function within relatively tight budget margins, both in operations and in their bottom line, with a substantial portion posting operational losses. Cash reserves, as measured by Days of Unrestricted Cash on Hand (DCOH), remained tight throughout the four-year period:

- For all health centers, the median operating margin¹ was 2 percent;
- Health centers in the top 25 percent generated an average operating margin¹ of 7.1 percent, while those in the bottom 25 percent recorded operating margins of negative 1.6 percent. Notably, the performance of California health centers in any given year was similar to that of their counterparts nationally;
- For bottom-line margins, which included non-operating expenses such as capital expansion, the median was 3.6 percent; clinics in the bottom 25 percent also posted negative bottom-line margins, averaging negative 0.2 percent or lower.
- The median amount in cash reserves across all clinics was 48 DCOH, while the bottom 25 percent of clinics operated with just 22 DCOH or less.

Payer and Patient Mix

Medi-Cal continues to be the single largest payer for California's safety net providers. However, since 2008 as much as 50 percent of patients have been transitioned to managed care programs as a result of enrollment growth and state policy changes. Data show this ongoing shift:

- In 2011, approximately 43 percent of patient visits were covered by Medi-Cal, which provided 56 percent of all health center revenue;
- Among other payers, 18 percent were sliding-scale or free care visits, 7 percent were Medicare, and 22 percent were various other payers.

¹Operating margin measures the percentage of revenue that the health center retains as profit (or loss) as a result of operations. Operating margin is a good indicator of the financial viability of an organization, with a higher operating margin corresponding with stronger performance. Health centers should strive to maintain an operating margin of 1% to 3% or greater.

The median amount in cash reserves across all clinics was 48 days of cash on hand, while the bottom 25 percent of clinics operated with just 22 or less.

Throughout the survey's timeline, 85 percent of patients had annual incomes below 200% of the Federal Poverty Level.

- Medi-Cal managed care continued to grow, with its share of overall health center revenue rising 5 percentage points, from 18 percent to 23 percent, and fee-for-service revenue declining five percentage points, from 38 percent to 33 percent;
- Medi-Cal remains the highest payer for health centers, averaging \$170 per visit for fee-for-service, and \$138 per visit for managed care;
- Health centers in 2011 received an average of \$99 per visit from other payers, \$120 from Medicare, and \$48 per uninsured visit;
- The average reimbursement among all payers rose from \$99 in 2008 to \$117 in 2011, an increase of 18 percent;
- Throughout the survey's timeline, 85 percent of patients had annual incomes below 200% of the Federal Poverty Level.

Medi-Cal Sensitivity Analysis

In recent years, budget pressures have caused the state of California to make a number of cuts to its Medi-Cal program. Given continuing fiscal pressure on government programs at the federal and state level, Capital Link performed a sensitivity analysis to examine the potential impact of future reductions in Medi-Cal payments on community health centers. The analysis shows that reductions to this critical funding source would leave California's safety net providers in a much more vulnerable financial position.

Applying a hypothetical 5 percent reduction in Medi-Cal funding to all health centers in the survey caused the median operating margin to drop to 1 percent. This is a narrow surplus that would threaten the financial stability of at least 50 percent of California health centers.

A hypothetical 10 percent reduction lowers the overall median operating margin even further to 0.1 percent, a financial break-even level. In this scenario, approximately half the health centers in the study would generate losses on operations, resulting in possible closures and the potential for serious disruptions in patient care.

Special Study: Federally Qualified Health Centers and Look-Alike Clinics

This analysis included a focus on FQHCs and LALs, which comprise 79 percent of all health centers included in the data set, and account for 87 percent of total patient utilization in California. The analysis provides FQHCs and LALs with tools to evaluate their performance and to further understand the key factors contributing to these results.

These health centers in particular were analyzed to highlight their respective profiles, and to better understand possible correlations with financial performance. They were grouped by type, location, size, patient mix, payer mix, and service mix.

Finances and Operations

In general, FQHCs and LALs outperformed other health center types, mostly because of their reimbursement structures. Yet, disparities between the largest and smallest FQHCs and LALs still appeared:

- During the study period, the total operating revenues for FQHCs/LALs grew 33 percent, from \$1.6 billion in 2008 to \$2.2 billion in 2011;
- For FQHCs/LALs, Medi-Cal revenue comprised roughly 63 percent of net patient revenue. The shift toward Medi-Cal managed care appeared here also, with managed care revenues rising from 20 percent to 26 percent, and fee-for-service revenue dropping from 43 percent to 38 percent;
- The median margin on operations for FQHCs/LALs averaged 2.4 percent, with the top 25 percent generating margins of 7.1 percent or higher, and the bottom 25 percent generating a negative 0.9 percent margin or worse;
- Bottom line margins for FQHCs/LALs averaged 4 percent, with the top 25 percent earning 8.9 percent or higher, and the lowest 25 percent earning 0.5 percent or lower;
- FQHCs/LALs at the median level operated with 51 DCOH between 2008 and 2011, while the bottom 25 percent had 23 DCOH or less;
- FQHCs/LALs collected their patient receivables within 48 days on average, which is within Capital Link's recommended range of 30-60 days. However, the bottom 25 percent often took 70 days or more to collect, which can contribute to a weaker cash position.

Rural/Urban Disparities

In general, FQHCs/LALs in urban areas outperformed their rural counterparts. There are a number of factors contributing these differences, including provider compensation as a percentage of their budgets, physician retention, and decreases in rural funding. The analysis further showed:

- Over the four-year period, urban clinics generated higher median operating margins than rural clinics, 2 percent versus 1.5 percent. The top 25 percent of urban clinics generated an average operating margin of 8 percent, while their rural peers averaged 5.3 percent. The lowest performing 25 percent in both groups operated with negative margins, with rural clinics generating a negative 3.6 percent margin or lower, substantially below the urban group's negative 1.2 percent margin;
- Rural clinics, on average, spent roughly 2 percent more on salaries than urban clinics, a primary driver of the differentiation in operating margin between the two clinic groups;
- On average, rural clinics operated with 20 fewer DCOH than urban clinics;
- Rural and urban clinics were similar in their proportions of patient revenue from Medi-Cal, but urban clinics earned more revenue from managed care programs;
- Rural clinics had a higher average cost and revenue per patient compared to urban clinics, and also saw patients more frequently, 3.7 visits per patient per year, on average, versus 3.2 visits for urban clinics. Notably, patient revenue covers a lower percentage of costs for rural clinics, 65 percent, than for urban clinics, 67 percent.

Regional Performance Variations

An analysis of FQHCs/LALs by region, based on six regions defined by Blue Shield of California Foundation, showed that FQHCs/LALs in certain geographic areas performed better than others².

Operating margins ranged from a high of 3.7 percent in the Central region to a low of 1.3 percent in the San Francisco region. Revenue growth was also shown to be strongest in the Sacramento, South, and San Francisco regions. Further research is needed to assess the causes of these variations.

Clinic Size

When FQHCs and LALs were analyzed in terms of four key financial measures—DCOH, operating margin, current ratio, and revenue growth—it was evident that **the larger the health center, the better the operating margin.**

While there was significant fluctuation in annual performance among health centers of different revenue sizes over the course of the survey, the smallest organizations showed consistently decreasing margins.

Given that smaller health centers are often located in rural communities, the drop in performance of these organizations may correlate with statewide funding reductions in 2008-09 that significantly affected rural health centers.

Patient Mix

Patient mix—particularly the percentage of patients who earn less than 100 percent of the FPL—is a key factor that influences operating performance and revenue growth. Health centers with at least three-quarters of their patients below 100 percent FPL (which is \$23,550 for a family of four) had deeper cash reserves and higher operating margins than health centers with smaller numbers of such patients. Health centers with larger percentages of patients under 100 percent FPL also had a greater share of their revenue come from sources with a high reimbursement rate, such as Medi-Cal.

Dental

Overall, FQHCs and LALs that provided dental services, about 70 percent of all facilities included in this analysis, had lower operating margins and cash reserves than those that did not. Those with dental services had a median operating margin of 1.7 percent, and 25 DCOH, compared to median operating margins of 3.7 percent and 45 DCOH among those that did not.

Rural health centers that provided dental services did not experience a decline in operating margin, but their DCOH was considerably lower. While urban health centers with dental programs not only experienced a decline in operating margin, but also lower DCOH, current ratios, and revenue growth rates than those that did not offer dental services.

The state of California eliminated most adult dental services from the Denti-Cal program in 2009, and these results may reflect the erosion of coverage for dental care.

²Regions include: Central: Fresno, Kern, Kings, Madera, Merced, San Benito, San Joaquin, San Luis Obispo, Santa Cruz, Tulare, Ventura; Los Angeles: Los Angeles; North: Butte, Glenn, Humboldt, Lake, Lassen, Mendocino, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Trinity, Yuba; Sacramento Valley: El Dorado, Sacramento, Yolo; San Francisco Bay Area: Alameda, Marin, Napa, San Francisco, Santa Clara, Sonoma; and South: Imperial, Orange, Riverside, San Diego

Survey Methodology

Capital Link compiled a four-year financial data set, for 2008-2011, from audited financial statements for 158 California clinic corporations, as well as annual utilization data from the Office of Statewide Health Planning and Development (OSHPD). Capital Link completed this study under the guidance of an advisory group of California community health center leaders.

This approach is unique in that **it is the first time a report of this kind has used only audited data, which contributes to its particular accuracy**. The number of audits per year varied between 156 and 158, the majority of which were collected by Blue Shield of California Foundation as part of its community health center core support initiative. These audits were combined and analyzed with audits from Capital Link's own data base.

OSHPD's annual data on primary-care-clinic utilization was collected for individual facilities, and then aggregated at the parent corporation level. This data was combined with the financial audits to develop the complete sample set for parent clinic organizations. It is important to note that the OSHPD data was based on calendar year data, while the financial audits covered fiscal years. It was determined, in consultation with the advisory group, that this combination of data sources, although imperfect, provides the most accurate analysis currently possible.

About Capital Link

Capital Link is a national, non-profit organization that has worked with hundreds of health centers and Primary Care Associations over the past 15 years to plan capital projects, finance growth and identify ways to improve performance. We provide innovative advisory services and extensive technical assistance with the goal of supporting and expanding community-based health care.

Capital Link was established in the late 1990s as a joint effort of the National Association of Community Health Centers (NACHC), several state-based Primary Care Associations (PCAs), and the Bureau of Primary Health Care. For more information, visit www.caplink.org.

About Blue Shield of California Foundation

Blue Shield of California Foundation's is one of the state's largest and most trusted grant making organizations. Its mission is to improve the lives of all Californians, particularly the underserved, by making health care accessible, effective, and affordable, and by ending domestic violence. Blue Shield of California Foundation is an independent Licensee of the Blue Shield Association.

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