

blue  of california  
foundation

community clinic case studies

# financial health

LFA Group  
2011

Prepared by:



Established in 2000, LFA Group: Learning for Action provides highly customized research, strategy, and evaluation services that enhance the impact and sustainability of social sector organizations across the U.S. and beyond. They engage deeply with organizations as partners, facilitating processes to draw on strengths, while also providing expert guidance. Their high-quality services are accessible to the full spectrum of efforts, from grassroots, community-based organizations to large-scale international initiatives. To learn more, visit: [www.LFAGroup.com](http://www.LFAGroup.com)

## contents

introduction	4
state of financial health in clinics	7
access and quality	12
conclusion: a vision for financial health	16

# introduction

## context

California community clinics are operating in a complex environment. Because of the economic downturn, Medi-Cal payments to clinics were delayed in 2008, 2009, and 2010. Entire programs, such as adult dental and podiatry, were eliminated. A few clinics have closed as a result of financial hardships over the past two years, and many others have cut staff and services.

The Patient Protection and Affordable Care Act of 2010, also known as healthcare reform, has created a climate of excitement and change mixed with tremendous uncertainty about what is to come. If clinics are to thrive, or even just survive, they must operate at higher levels of efficiency while still providing high-quality services to their patients.

Blue Shield of California Foundation (BSCF) believes that clinics functioning at high levels of capacity in several critical areas – engaging in meaningful collaborations, maintaining good financial health, and providing robust professional development – will be poised to meet the future challenges of the field and provide high levels of access and quality care to their patients. These case studies explore that hypothesis and discuss a vision for the future of the clinic field along each dimension of capacity.

## background

In 2007 and 2009, the BSCF commissioned LFA Group: Learning for Action to conduct surveys and a small number of interviews to explore the impact of core support funds on California community clinics. The evaluation findings raised questions about the ways in which several core capacities of community clinics affect access to care and quality of care, and in 2010, BSCF engaged LFA to conduct research on this topic.

This case study on Financial Health is one of three that focus on access to and the quality of care in California community clinics; the other two focus on Collaboration and Professional Development.

**Access to care:** The timely use of personal health services to achieve the best health outcomes.

**Quality of care:** The extent to which care is effective, safe, timely, patient-centered, culturally competent, equitable, and efficient.

## financial health

Financial health allows clinics to maintain stability, run efficiently, and invest in resources (e.g., staff, technology, and medical equipment) that increase access to and the quality of care for patients. While many factors contribute to financial health, the two core elements that were investigated for this case study are payer mix and financial capacity. BSCF believes that clinics can maintain good financial health – particularly in the new healthcare reform environment – by managing their payer mix and demonstrating strong financial skills.

This case study provides concrete examples of how payer mix and financial capacity affect financial health, and, in turn, how financial health affects access to care and the quality of care. It also explores the ways that healthcare reform may affect these factors when it is fully implemented. Finally, additional questions are raised about how community clinics can best anticipate the upcoming changes and plan for success under healthcare reform.

**Financial health** is a measure of a clinic's financial viability. Clinics with good financial health are able to maintain a balanced budget, sustain an adequate reserve fund, and meet debt and expense obligations on time. While many factors contribute to financial health, this case study describes two key components: financial capacity and payer mix.

**Financial capacity** in this case study is based on indicators developed for the 2009 Clinic Core Support Survey. It includes being able to accurately budget and predict revenues and expenses, having staff with knowledge of financial planning and accounting, having financial management and accounting systems in place, and producing and reviewing financial reports on at least a quarterly basis.<sup>1</sup>

**Payer mix** is the percentage of a clinic's annual revenue that is comprised of each revenue source (e.g., Medi-Cal, Medicare, commercial insurance, sliding-scale fee for service).

<sup>1</sup> This definition is based on indicators of financial capacity that were developed for the 2009 Community Clinics survey.

## financial health case study methods

Clinics were selected to participate in this case study based on their responses to LFA's Community Clinic Survey in 2009. Because payer mix and financial capacity are the two core elements of Financial Health described in this case study, clinics were invited to participate in interviews that focused on those topics. LFA selected clinics to participate in the interviews for either topic by choosing samples of clinics that vary in their clinic type, budget size, geographical location, current payer mix, and financial capacity. Clinics were selected separately for the payer mix and financial capacity topics, although two clinics were selected to participate in both case studies. LFA interviewed a total of 17 staff, largely executive directors/ chief executive officers (CEO), and chief financial officers (CFO) from clinics located in the Northern, Sacramento, San Francisco Bay Area, Los Angeles, and Southern regions of California.

This case study was designed according to the principles of the "small sample case study" method. Researchers selected clinics that are "typical" of the population as a whole (California community clinics that meet licensing requirements). The clinics also represented diversity, with respect to the independent variables of interest: the dimensions of financial capacity or payer mix. These clinics are typical of clinics with low and high financial capacity and of those with varying strengths of payer mixes.

Using careful case selection that takes into account both representativeness and variation on the independent variables allows researchers to make inferences about the field these clinics represent, even in the absence of a large random sample. A more complete discussion of the methodology for choosing clinics can be found in the Methodological Appendix.

# state of financial health in clinics

This section describes the current state of financial health in clinics by delving into how clinics optimize their revenue sources, maintain a diverse payer mix, predict and monitor their revenues and expenses, and build their financial health.

## optimization of revenue sources for financial health

An important component of financial health is a clinic's payer mix, which contributes to financial health by affecting total clinic revenue. The amount of revenue clinics receive per patient visit varies widely by payer type. The case study research revealed that there is not a single "ideal" payer mix that applies to all clinics. Rather, researchers heard from clinic staff that the ideal payer mix varies by clinic type, with a particular distinction between Federally Qualified Health Centers (FQHC), FQHC look-alikes, and free clinics. FQHCs and FQHC look-alikes thrive on Medi-Cal patients because of the Prospective Payment System (PPS) reimbursement rate. Rural Health Centers and Indian Health Centers also receive a Medi-Cal PPS rate and depend heavily on that payer source. FQHCs further benefit from the federal 330 grant, which is designed to support clinics by providing a grant for uncompensated indigent care.

Staff from FQHCs report that Medi-Cal is their "bread and butter," and clinics leverage those funds to support visits for patients with other payer types that reimburse at a lower level, such as commercial insurance, as well as for the uninsured. Medicare provides a similar reimbursement rate but excludes a large number of services from reimbursement, including preventive services. (Reimbursement for primary care services will change in 2014 when healthcare reform is implemented.) Clinic staff further note that commercial insurance often does not cover the cost of the standard of care provided by the clinic and that they routinely lose money on visits from commercially insured patients, as well as uninsured patients who pay on the clinic's sliding fee schedule.

In contrast, free clinics depend primarily on government grants, foundation funding, in-kind support, and donations. Staff from free clinics shared that the biggest difference in funding for them is whether funds are restricted or unrestricted. Free clinic staff note that unrestricted funds provide flexibility to help them adapt and meet a variety of patient needs.

---

“When grants become specific, it actually limits our ability to take care of patients.”

*CEO, free clinic*

---

In contrast, restricted funds may help them enhance specific types of care but also tie them to a limited scope of services and extensive reporting requirements. For example, one free clinic shared the example that if they receive a grant for breast cancer screening, they can provide more mammograms to patients, but they struggle to meet other – often more immediate – related service needs for these patients. In contrast, if those funds were unrestricted, they noted that they could hire an OB-GYN provider and meet a wider variety of patient needs, such as pap exams and pregnancy-related services.

### diversity of revenue streams

While some payer sources cover clinics' costs better than others, clinic staff universally agree that a diverse payer mix is critical for maintaining financial health. They explain that diversifying payer sources provides stability and protects their financial health in the case that one funding stream ends or decreases. For example, three clinics reported that while Medi-Cal is their best paying revenue stream, it is important that they also have other revenue streams to support their finances.

This is particularly relevant in the current California economy. Unsigned state budgets have led to withheld payments, and budget balancing efforts have completely eliminated some programs. As one CEO from an FQHC explained: “I think having a strong payer mix is the foundation of a stable facility. You want to get the most money you can per patient visit, and that means Medi-Cal. [However,] having Medi-Cal only hurts when the state can't perform.”



---

“Having a balance of payer mix...keeps everything stable. You're not too dependent and you don't have all of your eggs in one basket.”

*Executive Director, Non-FQHC*

---

The FQHCs and FQHC look-alikes share that they strive to cover approximately 40 percent of their patients through Medi-Cal, and the rest diversified in Medicare, commercial insurance, private pay/sliding-scale fee for service, and/or grant funded.

Free clinics also agree that a diversity of funding sources is critical to their financial health. Since they are dependent on non-patient-based revenue, they need to ensure that they will have consistent revenue streams if any of their grants end. Given that more Californians will be insured after the full implementation of healthcare reform in 2014, there is the chance that private, state, and federal grant dollars that have supported organizations serving the uninsured will decline, and free clinics will be left with shrinking sources of support.

One free clinic CEO described their ideal payer mix, explaining that they would like to cover 20 to 25 percent of their revenue through four to five sources: foundations, in-kind support (e.g., volunteer providers, donated supplies, rent support), state grants, local government grants, and private and patient donations.

## maintaining financial health through financial capacity

Clinics' level of financial capacity influences the type and rigor of financial planning and forecasting they engage in, as well as the extent to which they understand how to adjust their payer mix to improve financial health. This section compares what high and low financial capacity clinics look like in their financial forecasting and budgeting practices.

The interviews revealed that, regardless of budget size, clinics with higher financial capacity are better able to monitor their financial position and make proactive adjustments to their finances than clinics with lower financial capacity. This means that clinics with greater financial capacity and skill have better financial health.

Clinics with higher financial capacity hire staff with the financial knowledge, skills, and sophistication to engage in financial forecasting, predict revenues and expenses, and make adjustments to the clinic's finances proactively. One clinic with high financial capacity explained that they engage annually in a two- to three-month process of updating the operating budget, and on a monthly basis they review financial reports with site managers to determine whether they are working within the budget and how they can improve each site's financial performance. Another clinic with high financial capacity reports that they are "constantly looking out six to 12 months to see what position we are in and think of what we need to do."

The financial staff at that clinic meet weekly to update an annual cash flow model. The clinic's financial staff report that they are "extremely accurate" up to six months out. They also do business modeling for metrics to determine profitability for patient visits by payer type and visit type. These clinics with high financial capacity actively monitor and adjust their finances to maintain their clinics' financial health. They articulated that maintaining financial health ensures that the clinic can run efficiently and provide high-quality care.

---

"If you are monitoring the right things, it will help you see what works with your care and what doesn't."

*CEO, free clinic, medium financial capacity*

---

In contrast to clinics with high financial capacity, staff from the clinics with lower financial capacity recognize that there is a relationship between their payer mix and financial health, but do not actively manage their payer mix as a mechanism for supporting the clinic's financial health. They explain that they see all patients who come into the clinic and report that they do not take any measures to increase the proportion of patients on Medi-Cal or other high-reimbursement funding sources.

Clinics with lower financial capacity also do not engage in forecasting or monitor their expenses regularly. One FQHC look-alike clinic with low financial capacity explained that they have never forecasted or projected revenues and expenses, but they noted that they plan to begin this practice in the upcoming fiscal year. Another clinic with medium financial capacity reported that they contract with an outside financial firm to do their forecasting. They explained that while they tried to build their internal financial capacity for years, they hired "individuals who didn't understand the business and created more problems than results." They found that contracting with the outside firm is a more cost-effective way for them to manage their finances and maintain financial health.

While the clinics with low and medium financial capacity do not have the detailed systems and processes to monitor their financial health, they recognize the importance of financial capacity and reported ways in which they are working to improve this capacity.

# access and quality

This case study explores how financial health affects access to and the quality of care through two core factors: payer mix and financial capacity. This section describes how those two factors contribute to financial health, and, in turn, how increasing a clinic's strength in those two areas can ultimately impact access and quality.

---

“With a strong payer mix, providers are able to expand services and hire appropriate staff, spend more time with patients... More money to go around would pay for a lot more services.”

*Finance Director, Non-FQHC*

---

## payer mix and financial health

Clinics that achieve a strong payer mix for their clinic type by maximizing reimbursements per visit or bring in unrestricted dollars are better able to increase total annual revenues and achieve good financial health. Good financial health allows clinics to invest in expanding access to care and improving quality of care through several mechanisms, including: hiring more staff; expanding clinic hours; purchasing high-quality medical instruments; and implementing up-to-date information technology, such as electronic health records (EHRs) or chronic disease registries. In contrast, clinics with a sub-optimal payer mix bring in less revenue per patient visit and, ultimately, their financial health can suffer.

Clinics shared how they thought the quality of and access to care would change if their payer mix improved or worsened. Staff explained that quality and access can suffer in a few key ways when the payer mix becomes sub-optimal. One commonly mentioned way is that when clinics are financially stressed, there is increased pressure on the system to fit in a

---

“We'd probably have to downsize our clinic and stop seeing new patients if they were coming in at a sliding-fee type... We'd have to limit the amount of patients we see in a month and maybe lose some specialty care.”

CFO, FQHC

---

larger number of patient visits per day, which results in each patient having less time with their provider. Reduced time with the provider can also be perceived by patients as decreased quality.

One finance director of a non-FQHC explained, “There is a relationship that used to happen [between a patient and provider] that doesn't have a chance to form anymore because of the [time] pressure.” He explained that when patients have a very short amount of time with their provider, there is less time for effective communication. Other clinics mentioned that when the payer mix worsens and their total annual revenue decreases, they ultimately have to cut provider hours and patient services.

One clinic noted that patient support services suffer first, such as translation services, insurance eligibility and enrollment support, and behavioral health services. These are services that are particularly relevant and important for the traditional patient population that visits community clinics. Discontinuing these programs would result in reduced access and quality for the neediest populations. Another clinic shared the example that when the Medi-Cal behavioral health and adult dental programs lost funding, their Medi-Cal visits dropped by 15 to 20 percent, and they had to respond by reducing access (i.e., the clinic cut providers and reduced appointments).

## managing financial health through payer mix management

One revealing finding that connected the topics of payer mix and financial capacity was that clinics with high financial capacity manage and adjust their payer mix to ensure that it stays as close to their “optimal” payer mix as possible, with the goal of maintaining good financial health. Clinics with lower financial capacity do not actively manage their payer mix.

---

“The more you understand patient mix [the better your financial stability]. You recognize that you cannot have a ‘come one, come all’ philosophy. If you do, you will deplete the organization’s resources and financial viability.”

*CEO, Non-FQHC, high financial capacity*

---

One clinic with high financial capacity explained that they try to increase their percentage of Medi-Cal and Medicare patients by advertising at social services agencies, on the radio, and at a youth health fair. Another high capacity clinic employs a dedicated staff member who helps patients who come into the clinic without coverage determine if they are eligible for any funding sources and supports them in enrolling in programs. This service increases access for those patients who learn of their program eligibility and can then receive healthcare services with a source of financing.

In addition to actively increasing the number of Medi-Cal and Medicare patients, a few clinics shared that when their payer mix is suffering – and, in turn, their financial health suffers – they waitlist new uninsured patients. A tension exists between clinics’ safety net missions and the practice of waitlisting the uninsured to manage their payer mix. While the waitlist strategy is employed to avoid exceeding a certain level of uncompensated care provided to the uninsured, it obviously reduces access to care for that same population.

### financial capacity and financial health

Clinics’ ability to articulate the ways in which their financial skills affect financial health, as well as how financial health affects access to and the quality of care, varied by their financial capacity.

Clinics with high financial capacity, regardless of budget size or clinic type, provided clearer examples of the relationship between their financial management strengths and their clinics’ financial health than clinics with lower financial capacity. High financial capacity clinics also better articulated how maintaining financial health allows them to improve access and quality. Clinics that engage in financial management practices regularly explain that it allows them to make adjustments to their finances on an ongoing basis, and determine when they need to cut expenses

or when they have the capacity to make investments in additional staff, technology, or equipment. They can use data to assess provider productivity and determine if there is room for increased efficiency.

One free clinic explains that they consider good financial capacity their “prevention,” noting that accurate forecasting allows them to “take advantage of opportunities or recognize when something isn’t an opportunity.” Clinics with high financial capacity explain that monitoring finances and engaging in financial forecasting ultimately increases clinic efficiency and stability, which improves the clinic’s financial health. Improved financial health allows clinics to increase both access and quality by ensuring that they can meet patient needs with adequate staffing levels, up-to-date equipment, and well-trained staff. It also allows clinics to invest in additional patient services, such as mental health and substance abuse services, health education, and translation.

One striking finding was that, regardless of budget size or clinic type, clinics with lower financial capacity described the relationship between financial capacity and access and quality in more theoretical terms than do clinics with higher financial capacity. They did not provide concrete examples of the ways that financial capacity has an impact. Higher capacity clinics, on the other hand, shared rich and specific examples.

---

“Efficient organizations have the capacity to operate stably. One of the most common things I see at community clinics that don’t understand this is...waiting for the Medicare check to come in to pay bill to bill... This instability becomes endemic in provider groups, and they don’t expect to operate efficiently, so they don’t try.”

*CEO, FQHC, high financial capacity*

---

# conclusion: a vision for financial health

## looking ahead to healthcare reform

The federal Patient Protection and Affordable Care Act (ACA) of 2010 is intended to make it easier for Americans to obtain, pay for, and keep healthcare coverage. Once the law is fully implemented (beginning in 2014), estimates are that 94 percent of Californians will be insured through their employers, Medi-Cal, or a new health insurance exchange.<sup>2</sup> Enrollment in Medi-Cal is expected to increase by 1.7 million people (as a result of increasing the income level for Medi-Cal eligibility), while an additional 4 million people are expected to enroll through the exchange.<sup>3</sup>

Increased numbers of covered patients will significantly affect clinics' revenue. When Medi-Cal eligibility changes, clinics will experience a shift in their payer mix as many previously sliding-fee scale patients that become eligible for Medi-Cal will be reimbursable at the PPS rate. Additionally, the ACA allows FQHCs to be paid at the PPS rate for low-income patients enrolled in coverage through the health insurance exchange. These changes will increase revenue for clinics that tend to those patients.<sup>4</sup>

While clinics eligible for PPS rate reimbursement (FQHCs, FQHC look-alikes, Rural Health Centers, and Indian Health Centers) are positioned to benefit from healthcare reform through increased reimbursement, free clinics may experience a different type of change. With more patients receiving coverage through Medi-Cal and the health insurance exchange, free clinics may see a larger proportion of the uninsured population that stand to be the neediest (e.g., patients who are mentally ill, struggle with

---

<sup>2</sup> California HealthCare Foundation, "The Affordable Care Act: What Californians Should Know" (May 2010).

<sup>3</sup> P. Long, and J. Gruber, "Projecting The Impact Of The Affordable Care Act On California," Health Affairs, 30 (1) (2010): 63-70.

<sup>4</sup> The DHCS 1115 Medicaid Waiver will also affect clinics in two key ways over the next five years: 1) Medi-Cal beneficiaries in the aid categories of seniors and people with disabilities will be enrolled in Medi-Cal Managed Care starting June 1, 2011, rather than fee-for-service. Clinics that serve these individuals will be required to meet accessibility and timely access to care standards that are not required for Medi-Cal Fee for Service patients. 2) The Low Income Health Program (LIHP) will create county-based coverage for people below 200 percent of the poverty level who do not qualify for Medi-Cal currently. In each county, a minimum of one FQHC paid at their PPS rate will be required as part of the provider network.



substance abuse, and/or are unable to maneuver the healthcare system). Free clinics will also continue to see undocumented immigrants who will not qualify for Medi-Cal or the health insurance exchange because of their citizenship status.

The safety net will also experience an increased focus on “accountable care” as healthcare reform is implemented, and clinics will eventually need to be prepared to receive reimbursement based on their ability to achieve quality metrics, rather than by quantity of visits. This funding model will create incentives for clinics to maximize high-quality, cost-effective care. This shift to focus on quality of care will mean that clinics need to assess how they can invest in quality and adjust their financial model to adapt to value-based reimbursement.

## financial health in the future

The increase in coverage through the mechanisms that healthcare reform will put in place could contribute to improved access and quality if clinics are adequately prepared. Healthcare reform will create changes in clinics' payer mixes, and clinics will need to ensure that they have strong financial capacity if they are to maintain their financial health in the reformed healthcare environment. It will be critical that clinics focus on providing access to high-quality care when demand for services increases – and when clinics experience competition for patients.

Increased enrollment in Medi-Cal and subsidized individual coverage through the health insurance exchange will create opportunities for previously uninsured patients to seek care. Many patients who previously did not utilize health care because they could not afford to pay out of pocket will now have a source to subsidize and/or finance their visits. Clinics may therefore see their share of Medi-Cal and/or privately insured patients increase, contributing to a more beneficial payer mix. Clinics may also experience the adverse effect of having to restrict the number of new patients because of other types of limitations, such as staff capacity and facility space.

Clinics will also need to ensure that they have adequate financial capacity to manage the changes in reimbursement that they will experience. They will need to strengthen their ability to forecast and plan for the changes in demand for services by determining if and when they have the capacity to increase staffing, update medical equipment, and invest in information

technology that will improve their efficiency and quality of care. Clinics that either currently have high financial capacity, or are able to improve their financial capacity in the next three years, are more likely to succeed within the new healthcare landscape. Those who are not able to maintain adequate financial capacity will likely struggle to meet the increase in demand and will not be able to compete with other clinics that respond to the changes through increased quality and access.

## questions for the field

While the case study interviews provided information about the ways that access and quality are affected by payer mix and financial capacity, as well the role of healthcare reform, they also raise additional questions for the field.

- **What investments can clinics make that will have the greatest impact on the quality of care?** With an increasing number of Medi-Cal patients and patients insured through the health insurance exchange, clinics that are most successful will serve a greater number of patients and bring in more revenue. To remain competitive, clinics are urged to invest in infrastructure, technology, trainings, or other improvements that will increase quality. However, the most effective strategies for increasing the quality of care may vary by clinic and should be explored further in the field.

- **What can the field do to help clinics increase their financial capacity?** While some clinics already have skilled staff and effective financial planning systems in place, those that do not will need to improve staff skills and knowledge, and develop systems before healthcare reform is fully implemented. This creates a need for either targeted development and support or mergers and consolidations with higher performing clinics. Unbiased assessments of clinic viability should be considered at a local/regional level.

**Blue Shield of California Foundation**

50 Beale Street  
San Francisco, CA 94105

[blueshieldcafoundation.org](https://blueshieldcafoundation.org)  
email: [bscf@blueshieldcafoundation.org](mailto:bscf@blueshieldcafoundation.org)