California Community Health Centers

Financial & Operational Performance Analysis, 2013-2016

Prepared by

CAPITAL LINK

Sponsored by

Blue Shield of California Foundation

Introduction

This report, prepared by Capital Link with support from Blue Shield of California Foundation, provides an update to our series of aggregate financial and operational profiles of California health centers. By presenting multi-year statewide results as well as comparative data from health centers nationally, this report offers a framework for identifying the financial strengths, challenges, and benchmarks that support opportunities for performance improvement. Covering the four-year period of 2013 to 2016, this analysis incorporates data from health center financial audits as well as operational and utilization data reported by the Uniform Data System (UDS). This update focuses on the following trends for California Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes (LALs):

- Growth and expansion of the patient population and service provision
- Financial performance as shown by revenue growth and operating margins
- Financial health as measured by liquidity and revenue collections
- Operational measures such as patient utilization and practice mix
- Productivity metrics and quality of care indicators

To access Capital Link's financial and operational profiles for California, visit www.caplink.org/resources/publications.

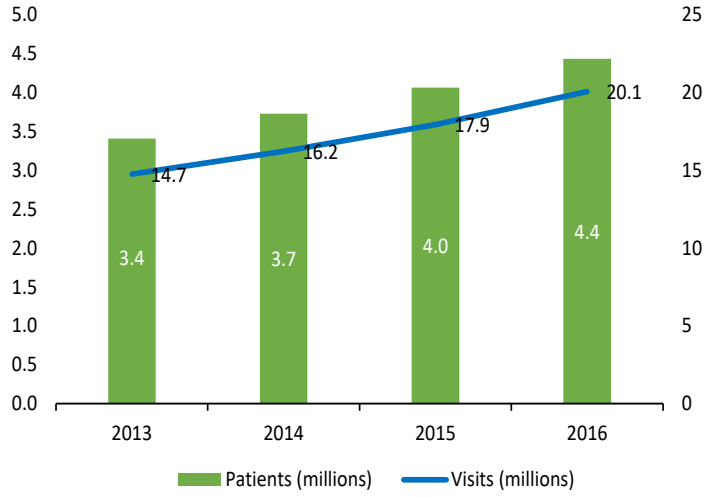
Growth and Expansion

California health centers experienced rapid growth in patients, visits, and sites. Due to the impact of the Affordable Care Act, their payer mix continued to shift towards a higher Medi-Cal enrollment and fewer uninsured patients.

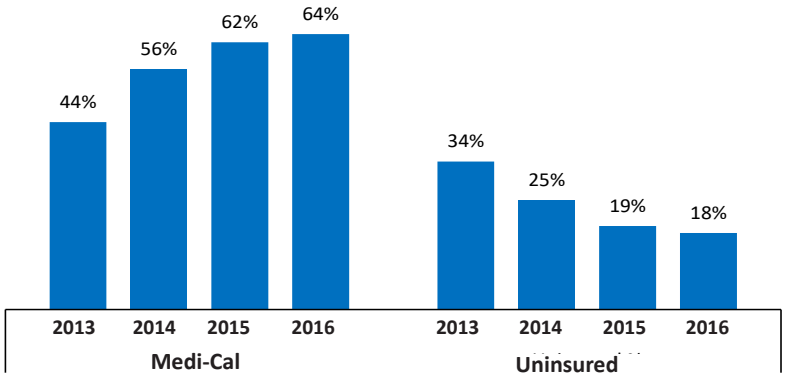
California FQHCs continued to rapidly expand over the review period, providing services to over 4.4 million patients in 2016, an increase of more than 30% from 2013. Annual patient visits increased over 35% to 20 million during the four-year review period. This high level of growth was primarily driven by the statewide insurance expansion initiated by the Affordable Care Act.

The insurance expansion associated with national health care reform dramatically altered the overall patient payer mix of California health centers. Medi-Cal, California's Medicaid program, increased enrollment to cover 64% of FQHC patients in 2016 for the median health center, an increase from 44% in 2013. This expansion directly correlated with the reduction in the median percentage of uninsured FQHC patients from 34% in 2013 to 18% in 2016. Of the remaining patients in 2016, 5% had insurance coverage through Medicare and another 6% were privately insured, median results that were relatively consistent over the previous years of the review period.

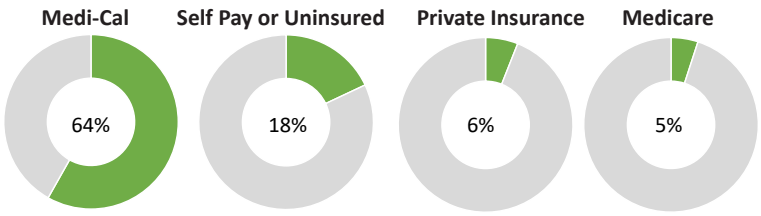
CA Health Centers: Four-Year Patient & Visit Growth Trends (Section 330 Grantees)



CA Health Centers: Medi-Cal & Uninsured Patient Percentage (Median Health Center)



CA Health Centers: Patients by Payer Source (Median Health Center, 2016)*



*Percentages represent median result for each payer source and therefore do not sum to 100%.

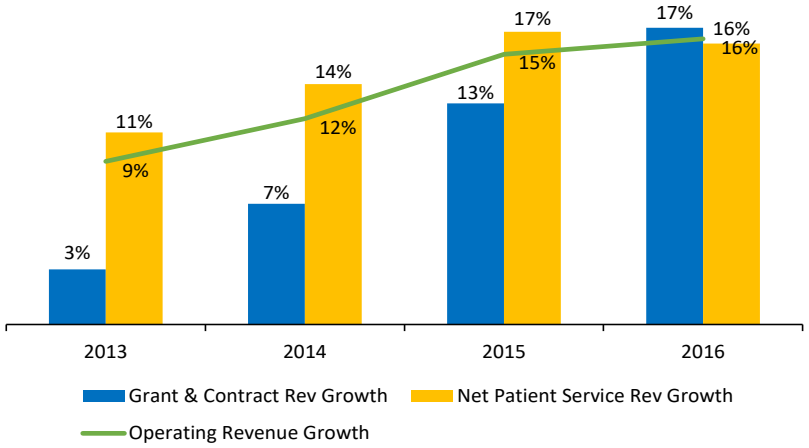
Financial Performance

As a group, California health centers continued to increase revenues, improve operating margins, and boost liquidity. Importantly, the number of clinics that operated below financial breakeven decreased significantly, further demonstrating the overall financial strength of these critical safety net organizations.

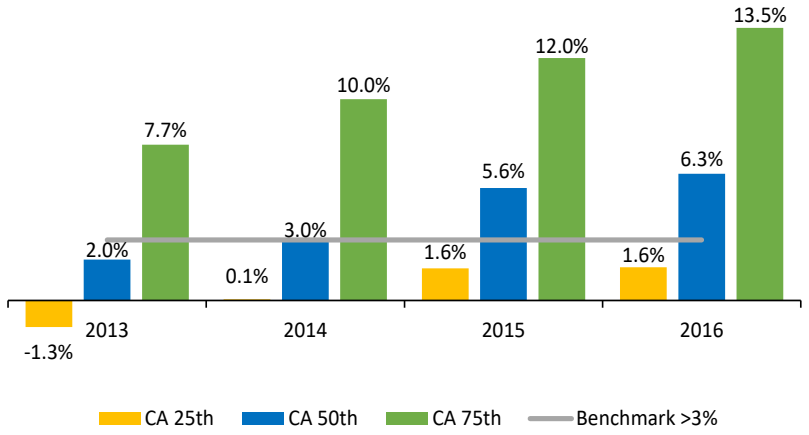
California health centers continued to grow revenues at an increasing rate over the four-year assessment period, reporting an increase to 16% in operating revenues at the median in 2016. The high growth was driven by both patient service revenues, which also grew to 16%, as well as grant and contract revenue, which increased to 17%.

Buoyed by the growth in operating revenues, health centers in California continued to improve their operating performance over the review period. The 2016 operating margin of 6.3%, at the median, was more than double the recommended minimum 3% industry benchmark and represented a significant improvement over the 2.0% result in 2013. Even more importantly, the percentage of clinics operating below a breakeven performance level, or with a negative operating margin, declined from approximately 33% in 2013 (45 of 136 health centers) to 14% in 2016 (21 of 147 health centers). Although this demonstrates improvement, there were still a significant number of health centers in a highly fragile financial position and vulnerable to even temporary disruptions in their funding streams.

CA Health Centers: Revenue Growth by Source (Median)



CA Health Centers: Operating Margin (Percentile)

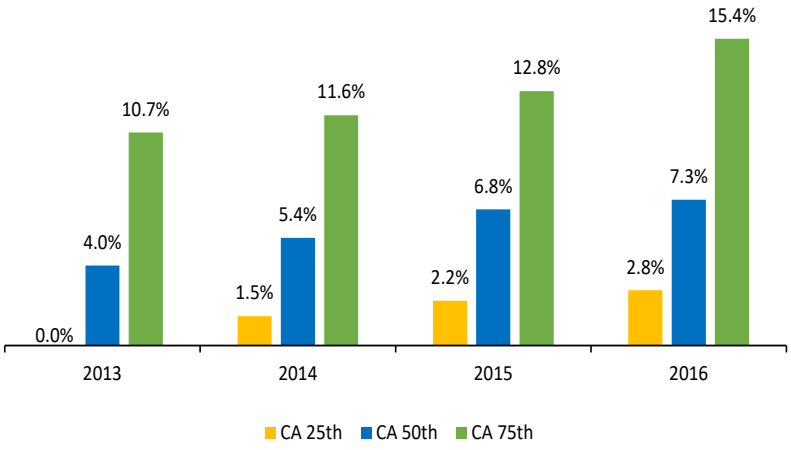


Financial Performance

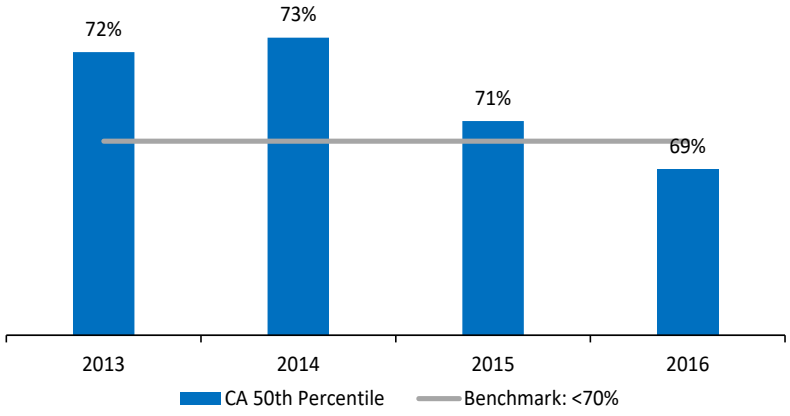
The median bottom line margin, which also included non-operating sources of revenue such as capital grants, was one to two percentage points higher than the operating margin at the median each year of the review period, further driving the improved financial position of California FQHCs.

Personnel-related expenses remained the primary cost driver of the health center operating model, in particular given the generally high demand and short supply of clinical provider staff. Generally speaking, health centers that spend 75% or more of their budget on personnel-related costs are at higher risk of generating operational losses. However, the personnel-related expense as a percentage of operating revenue ratio for California FQHCs declined for the third year in a row, to 69% in 2016, highlighting that revenue growth continued to outpace personnel-related costs. Nevertheless, health centers continue to face intensifying workforce pressures to manage staffing costs with increasing competition for providers as well as for the additional staff required to support team-based care models.

CA Health Centers: Bottom Line Margin (Percentile)



CA Health Centers: Personnel-Related Expense as a Percentage of Operating Revenue (Median)



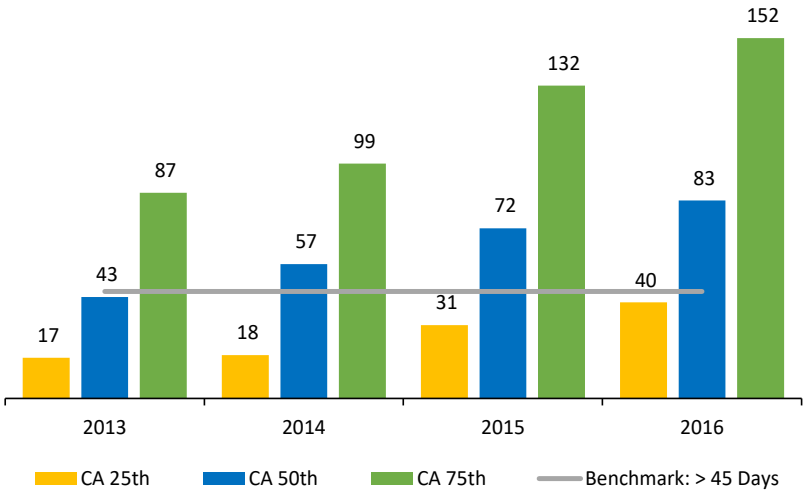
Financial Condition

California health centers further enhanced their liquidity position in 2016, a result of both improved operating performance and financial management systems and processes. Healthy operating reserves continued to support organizational stability as well as high growth in patient care capacity.

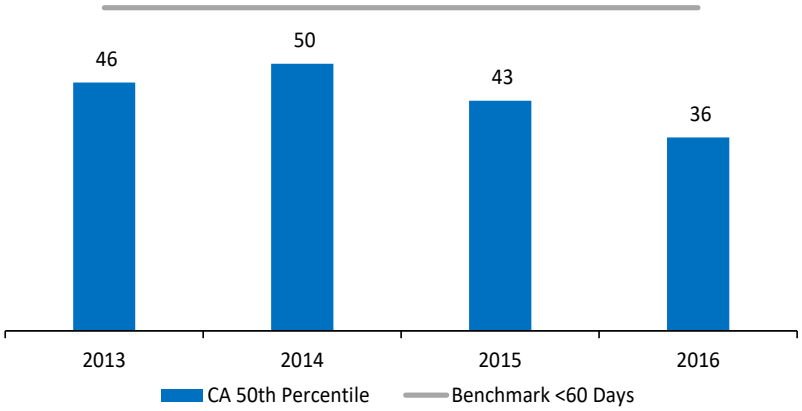
The strong revenue growth and increased performance margins for California FQHCs led to the continued improvement in overall operational liquidity. The 2016 median of days cash on hand increased to 83 days, nearly double the 2013 level and well above the 45 day minimum benchmark. The 25th percentile, representing the sub-group of health centers with the least amount of cash reserves, reached 40 days, which was a significant improvement from the 17 days recorded in 2013 and highlights improved financial sustainability for the vast majority of California FQHCs.

Health center financial operations continued to mature and showed system efficiencies. The patient collections cycle, as measured by days in net patient receivables, was lowered to 36 days at the median, a notable improvement over the 50 days reported for 2014 and a key driver for the improved cash position of most health centers. Further improvements in accounts receivable collections may have been supported by the continued transition to fixed monthly payments for Medi-Cal managed care patients as well as enhancements to revenue cycle management systems across the FQHC community.

CA Health Centers: Days Cash on Hand (Percentile)



CA Health Centers: Days in Net Patient Receivables (Median)



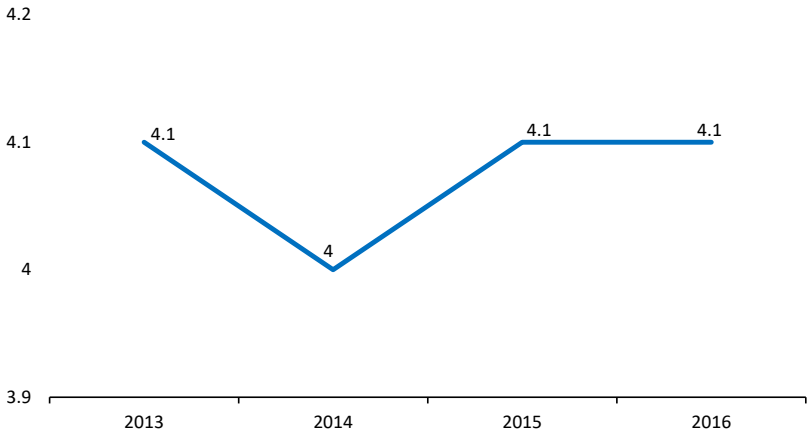
Utilization

Patient utilization, as measured by visits per patient per year, remained steady over the review period. As incentives are aligned more with patient outcomes in a managed care environment, future utilization patterns are likely to be impacted.

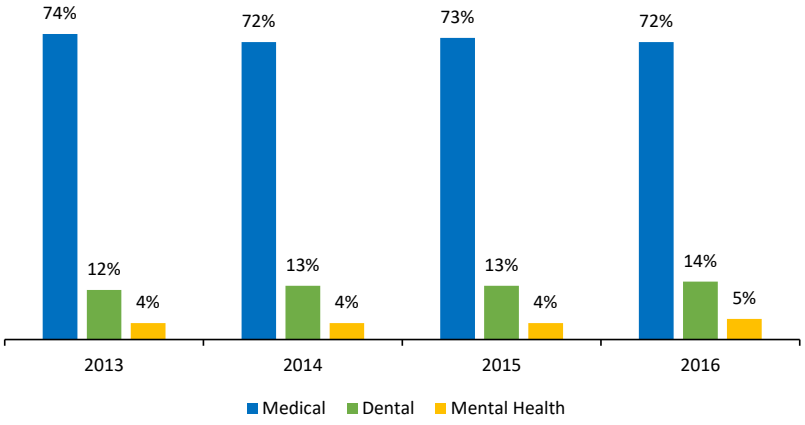
In 2016, annual patient utilization was 4.1 visits per patient at the median, consistent with the median utilization patterns of the previous three years. As payment reform efforts continue to unfold in California, financial incentives will evolve in support of care models that increase access for patients and improve patient outcomes while at the same time effectively managing clinical costs that have been traditionally driven by patient visits.

The health center program mix continued to be mostly centered on primary medical care services, with medical visits representing 72-74% of total patient visits at the median over the review period. However, dental and behavioral health services continued to show the most pronounced growth. The increase in these program areas was a direct result of more integrated and comprehensive patient-care models as well as the reinstatement of adult dental eligibility within the Medi-Cal program.

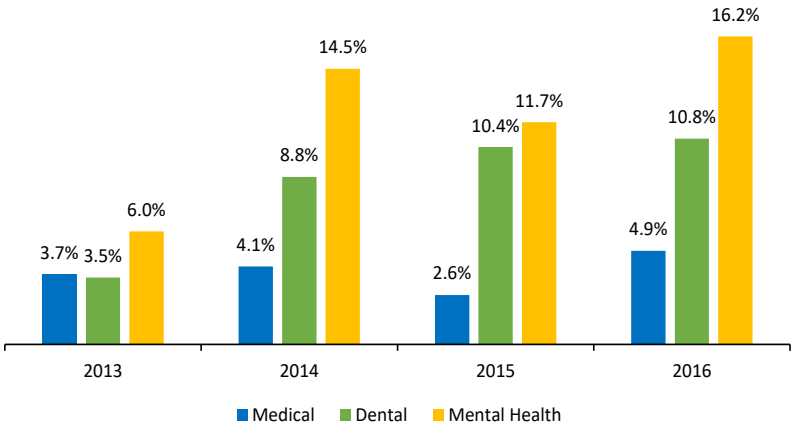
CA Health Centers: Visits per Patient per Year (Median)



CA Health Centers: Patient Visits as a Percentage of Total Visits (Median)



CA Health Centers: Patient Growth by Practice Area (Median)

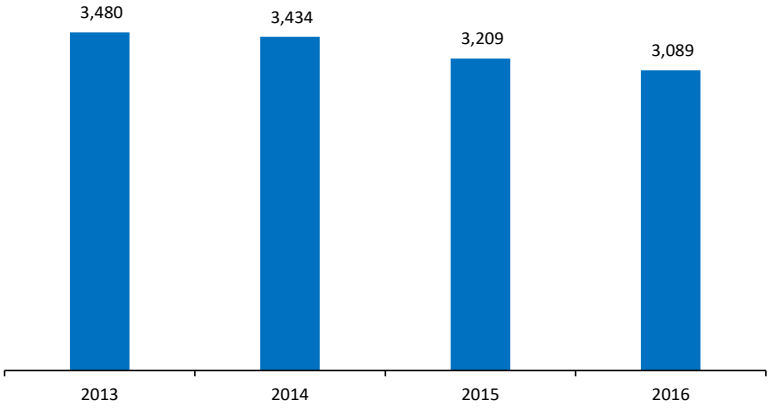


Productivity and Quality of Care

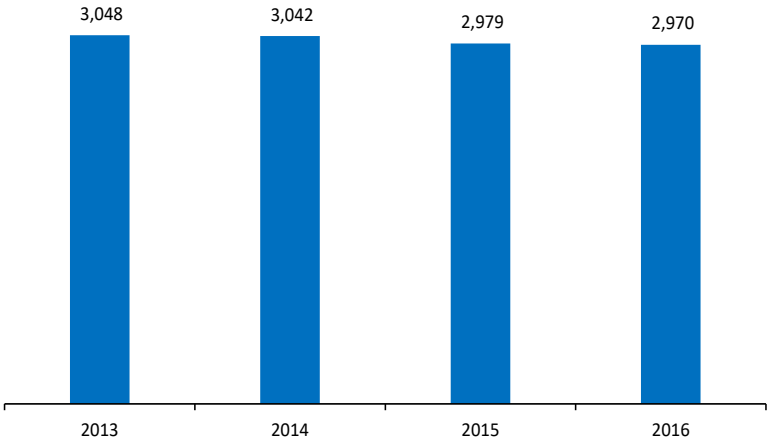
California health centers experienced further declines in productivity in 2016, continuing a multi-year trend. This fall-off coincided with an extended period of transformation of health center operational models, in particular the continued implementation of electronic health records (EHRs) and the transition to team-based care models along with other patient-centered care initiatives.

Overall provider productivity, as measured in office visits, continued a downward trend over the review period. Much of the decrease was generally attributed to changing care models driven by health care reform initiatives, such as the transition to team-based care as well as the continued implementation of electronic health records. Specifically, at the median, physician visits decreased 11% over the review period to 3,089 visits per year, while non-physician provider productivity dropped 3% over the same period to 2,970 visits per year. Dental provider productivity also decreased 4% since 2013 to 2,461 patient visits per year for the median health center.

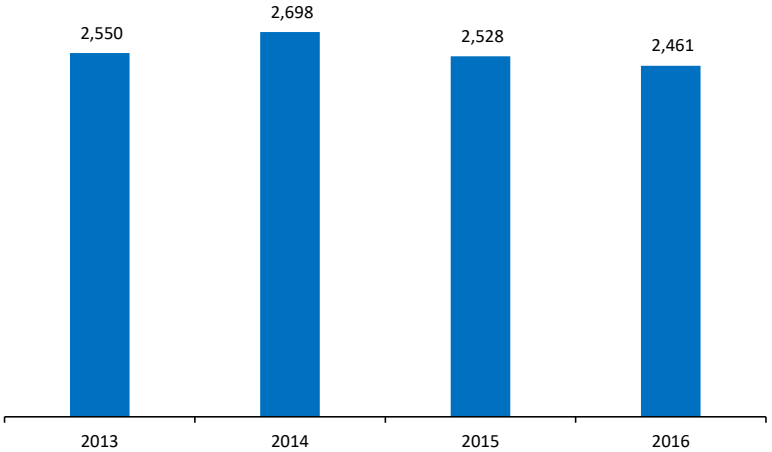
CA Health Centers: Physician Visits per Physician Provider FTE (Median)



CA Health Centers: Non-Physician Provider Visits per Non-Physician Provider FTE (Median)



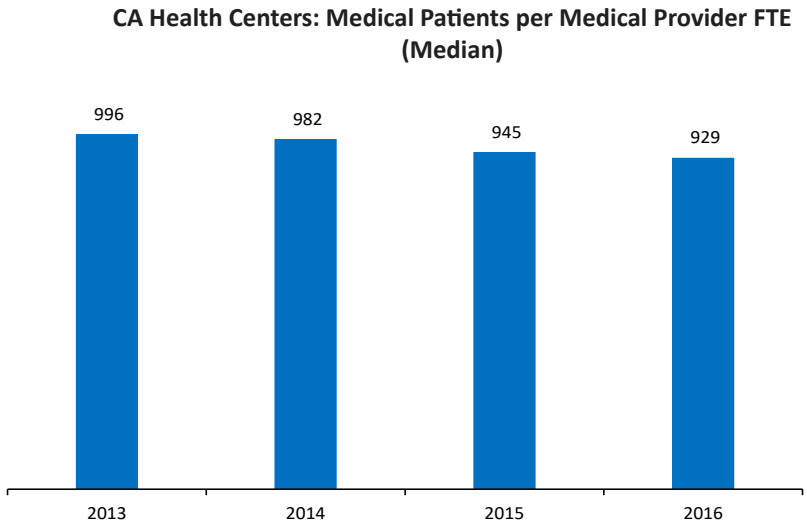
CA Health Centers: Dental Visits per Dental Provider FTE (Median)

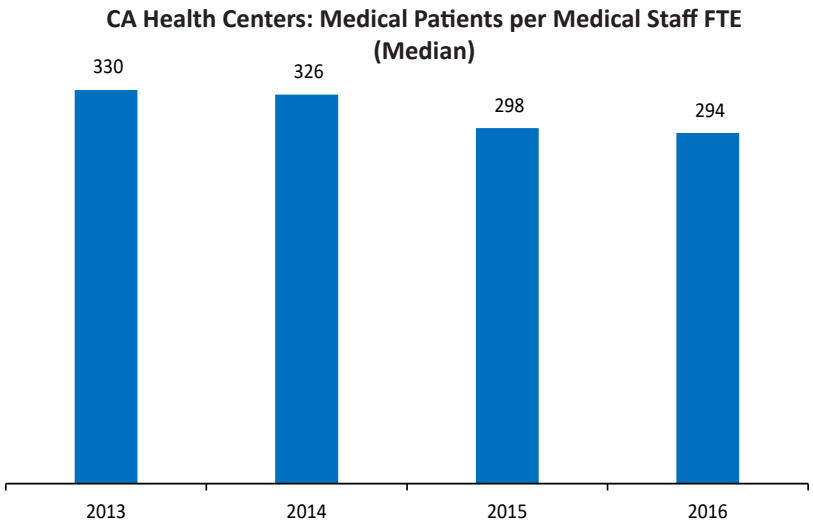


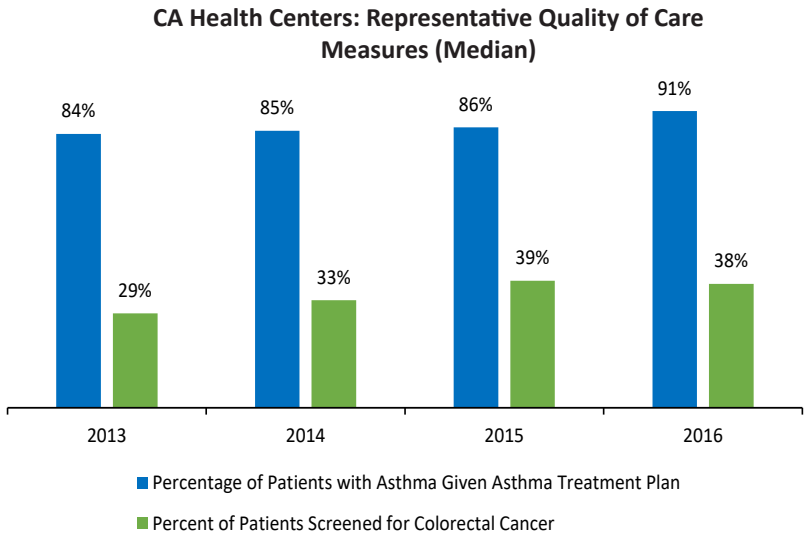
Productivity and Quality of Care

The consolidation of managed care and capitation, in particular for the Medi-Cal program, serves as a platform for further transition towards a value-based reimbursement system where patient panel metrics become increasingly important. However, the data shows that medical patients per medical provider decreased 7% over the period, to 929 patients at the median, while medical patients per total medical staff FTEs dropped 11% from 2013 to 2016, to 294 patients. As team-based care approaches are further implemented over time and financial incentives are aligned accordingly, we can expect to see increasing panel sizes per provider team while still achieving high patient outcomes.

Despite the general decline in productivity, it is notable that California FQHCs continued to show improvement on key quality of care metrics, as reported to HRSA, including asthma treatment and colorectal cancer screenings. Higher quality of care measures may be a result of successful team-based care, but may also impact short-term productivity as health centers transition to new models.







Conclusion

California FQHCs continued to serve an increasing numbers of low and moderate income Californians. Their financial capacity was buoyed by the ACA driven insurance expansion, in particular the Medi-Cal program. Overall, California FQHCs managed their growth successfully with improved financial performance and increased balance sheet liquidity. The 2016 trends demonstrate an industry moving away from the breakeven financial position of the past and towards a future of financial sustainability.

Despite these achievements, health centers remain vulnerable to federal policy changes that may negatively impact the Medi-Cal program and/or their annual operating grants that support their ability to provide comprehensive care to their patients, in particular those without insurance. Health centers are also confronted with changes to their reimbursement models, which are being aligned with value-based care and will require a continued transformation of patient-care models. Though changes ahead will bring further risks and opportunities to health centers, California FQHCs have demonstrated an improvement in financial management capacity that will provide a firm foundation on which to move forward.

	CALIFORNIA DATA SUMMARY	Capital Link Target	2013 CA Median	2014 CA Median	2015 CA Median	2016 CA Median	2016 National Median
# of Financial Audits (FQHC & LALs)			*136*	*148*	*157*	*147*	*883*
FINANCIAL HEALTH							
1	Operating Margin	>1-3%	2.0%	3.0%	5.6%	6.3%	4.4%
2	Bottom Line Margin	>3%	4.0%	5.3%	6.9%	7.3%	5.6%
3	Days Cash on Hand	>30-45 Days	43	57	72	83	67
4	Days in Net Patient Receivables	<60 Days	46	50	43	36	40
5	Personnel-Related Expense as % of Operating Revenue	<70-75%	72.3%	72.7%	70.5%	69.3%	70.5%
# of UDS Reports (FQHCs)			*152*	*169*	*187*	*188*	*1,344*
PRODUCTIVITY & FINANCIAL OPERATIONS							
6	Physician Visits / Physician FTEs		3,480	3,434	3,209	3,089	2,859
7	Mid-Level Visits / Mid-Level FTEs		3,048	3,042	2,979	2,970	2,438
8	Dental Visits / Dental Provider FTEs		2,550	2,698	2,528	2,461	1,827
9	Medical Patients / Medical Provider FTEs		996	982	945	929	876
10	Medical Patients / Total Medical Staff FTEs		330	326	298	294	298
11	Operating Expense per Patient Visit		$181	$190	$203	$219	$218
12	Operating Expense per Patient		$763	$810	$898	$960	$833
STAFFING & UTILIZATION							
13	Medical Support Staff Ratio		2.0	1.9	2.1	2.2	1.9
14	Administrative & Non-Clinical Staff Percentage		39%	37%	37%	37%	37%
15	Patient Visit Growth Rate		4%	4%	5%	9%	7%

METHODOLOGY

Data Sources

The analysis and information contained in this report are based on data from two primary sources covering the 2013-2016 period:

- Audited financial statements of FQHCs (both Section 330s and LALs) as reported by fiscal year
- UDS reports as submitted annually by FQHCs by calendar year to HRSA

Financial audits were gathered directly by Capital Link to create the data set for California health centers. The comparative national health center data set was developed from Capital Link's proprietary database of health center audited financial statements.

Trends reviewing health center financial health and performance were calculated for all California FQHC and LALs (excluding public entity FQHCs) for which financial audits were provided to Capital Link. The number of audits included in the data set varies each year and Capital Link continues to add audits to its database as they become available. The health center data set used for the current analysis is summarized as follows:

Number of Audits

Fiscal Year	FY13	FY14	FY15	FY16
California (FQHCs & LALs)	136	148	157	147

Trends reviewing patient utilization, payer mix, provider productivity, and quality of care for California were calculated from data reported to UDS. The number of FQHCs included in the data set is summarized as follows:

Number of UDS Reports

Calendar Year	2013	2014	2015	2016
California (FQHCs only)	152	169	187	188

ACKNOWLEDGMENT

Capital Link was pleased to prepare ***California Community Health Centers, Financial & Operational Performance Analysis, 2013-2016*** and gratefully acknowledges the support of Blue Shield of California Foundation.

Blue Shield of California Foundation

Blue Shield of California Foundation (BSCF) is one of California's largest and most trusted grantmaking organizations. The foundation's mission is to build lasting solutions to end domestic violence and make California the healthiest state, especially for vulnerable populations. For more information, visit www.blueshieldcafoundation.org.

About Capital Link

Capital Link is a national, non-profit organization that has worked with hundreds of health centers and Primary Care Associations for nearly 20 years to plan capital projects, finance growth, and identify ways to improve performance. We provide innovative consulting services and extensive technical assistance with the goal of supporting and expanding community-based health care. For more information, visit www.caplink.org.