CALIFORNIA

HEALTH CARE ALMANAC

CALIFORNIA HEALTHCARE FOUNDATION

Financial Health of Community Clinics

MARCH 2009

Introduction

Community clinics are a vital part of California's health care safety net — especially for the state's growing populations of uninsured and low-income consumers. These nonprofit primary care centers, which serve the state's neediest people, include: Federally Qualified Health Centers* (FQHCs); nonprofit Rural Health Clinics (RHCs); free clinics; and other licensed safety-net centers such as family planning and school-based clinics.

In a period of economic distress for many Californians, the financial viability of community clinics is particularly important. This snapshot captures key measures of clinics' financial health from 2003 to 2006. It is based on a 2009 report† prepared by Capital Link in collaboration with the California HealthCare Foundation.

KEY FINDINGS INCLUDE:

- Spurred in part by federal grants, California's community clinics have grown significantly in terms of the number of clinics, patient visits, revenues, and expenses. By 2006 there were 762 clinic sites, up from 596 in 2003.
- A growing proportion of California's uninsured and low-income populations are using community clinics. By 2006, over half of Californians with income below the federal poverty level were served at clinics.
- About two-thirds of clinic revenues come from patient services, which increased 43 percent from 2003 to 2006 — faster than other revenue streams.
- Clinics are heavily dependent on Medi-Cal programs, which provide almost 70 percent of revenues from patient services, and the proportion is growing; any change in Medi-Cal reimbursement or eligibility would have a major impact on clinics and patients.
- Larger clinics, in general, perform better financially than smaller ones, although some small clinics also perform well.
- Although one-fourth of clinics have a strong bottom line, most operate at or under breakeven, and these figures are worsening.
- California's fiscal crisis is a threat to clinics due to possible state-funded health program cutbacks as well as to a decrease in the availability of loan capital for nonprofit enterprises with low margins.

*FQHCs include Section 330 health centers, which receive federal grants to help cover the costs of providing care to those who cannot afford to pay, as well as "look-alikes," which do not receive these grants but are eligible for cost-based Medicare and Medi-Cal reimbursement.

†The full report, "California Community Clinics: A Financial Profile," can be downloaded at www.caplink.org/mainnews2.html.

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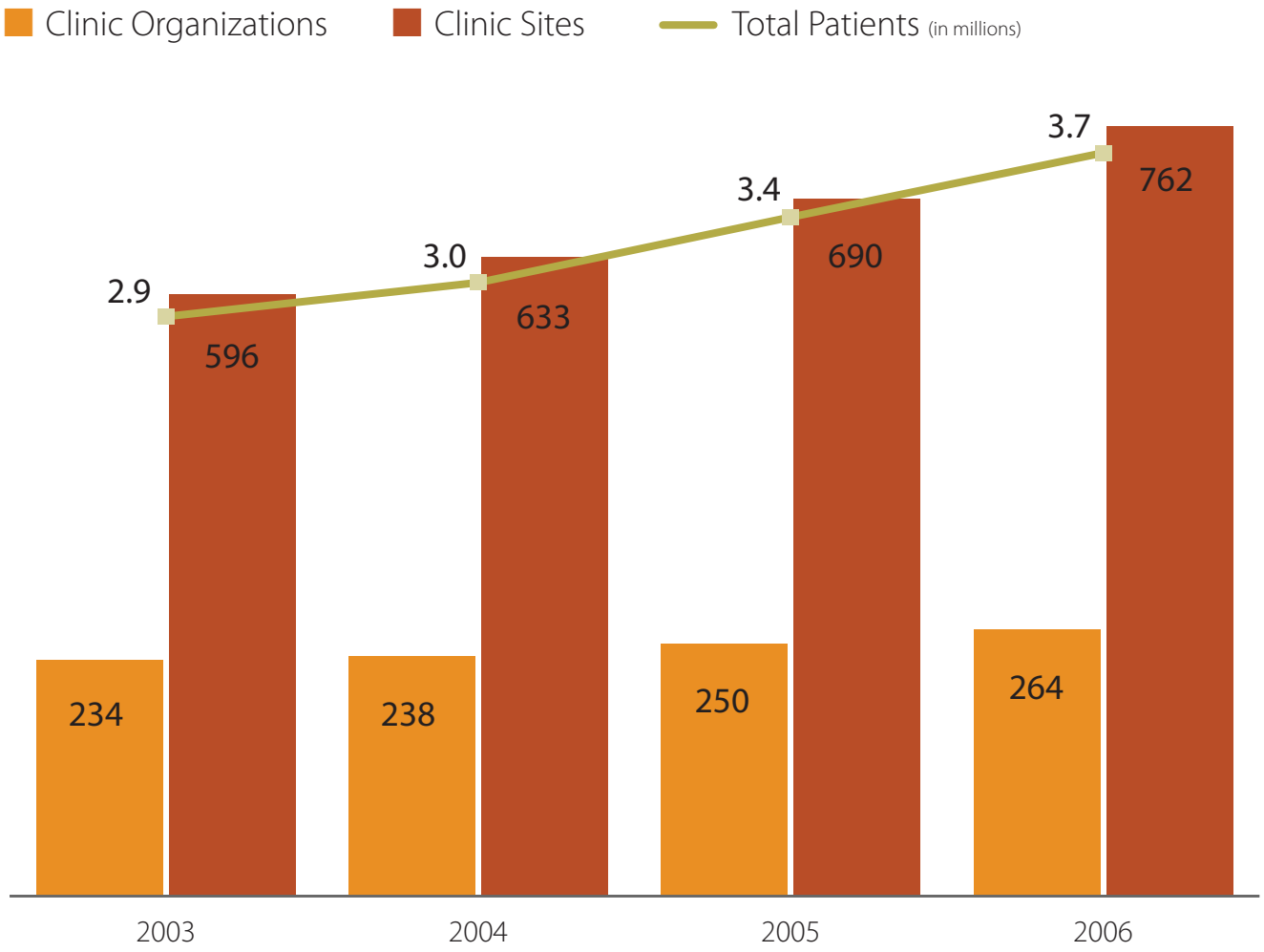
Clinic Organizations, Sites, and Patients, 2003–2006

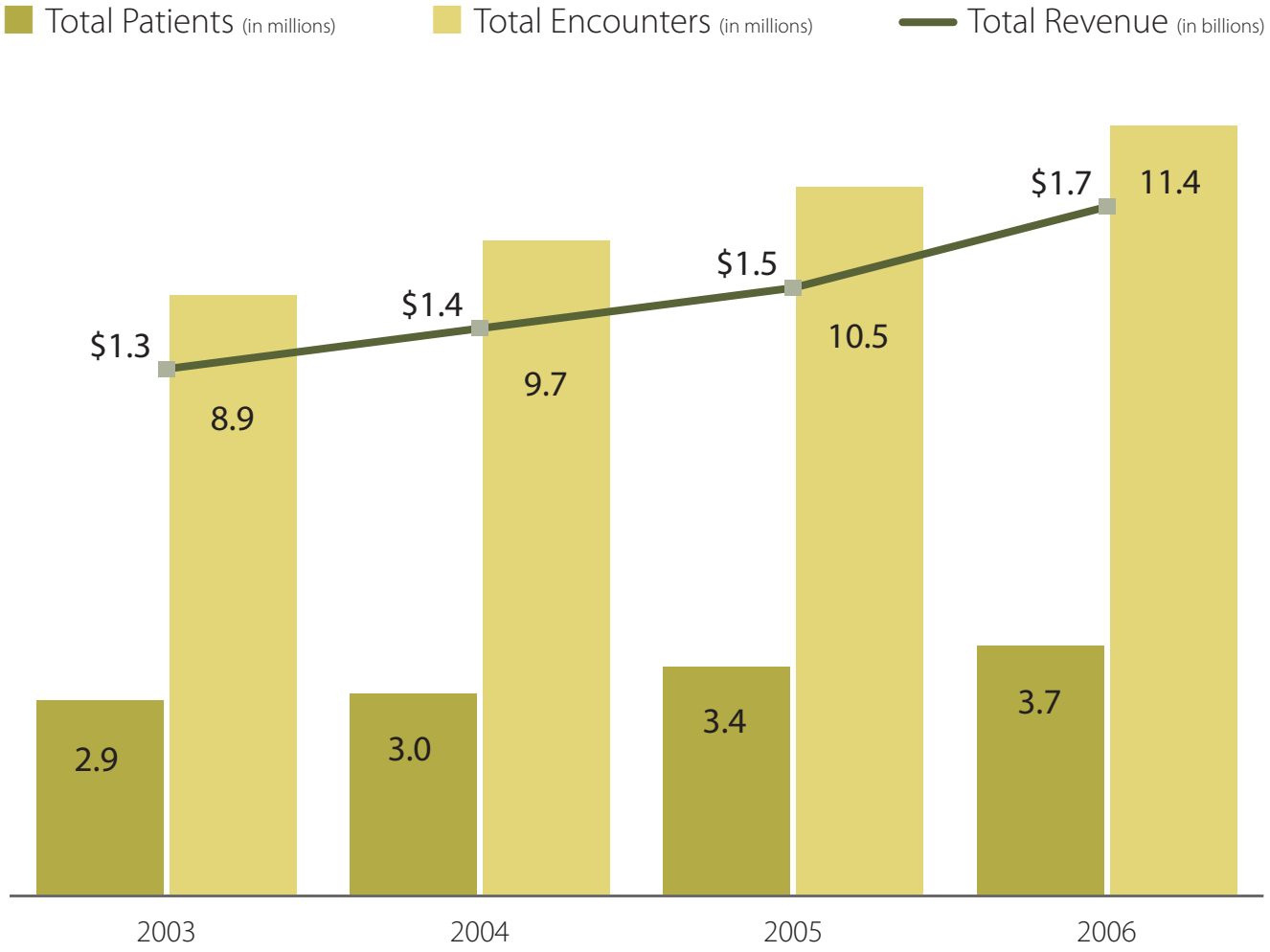


Source: Capital Link, *California Community Clinics — A Financial Profile*, 2009

Clinic organizations increased 13 percent from 2003 to 2006, while the number of sites rose 28 percent — from less than 600 to more than 750. Increased federal funding spurred FQHCs to expand to new sites.

Almost 3.7 million patients were seen in 2006, compared to 2.9 million in 2003.

Patients, Encounters, and Revenue, 2003–2006

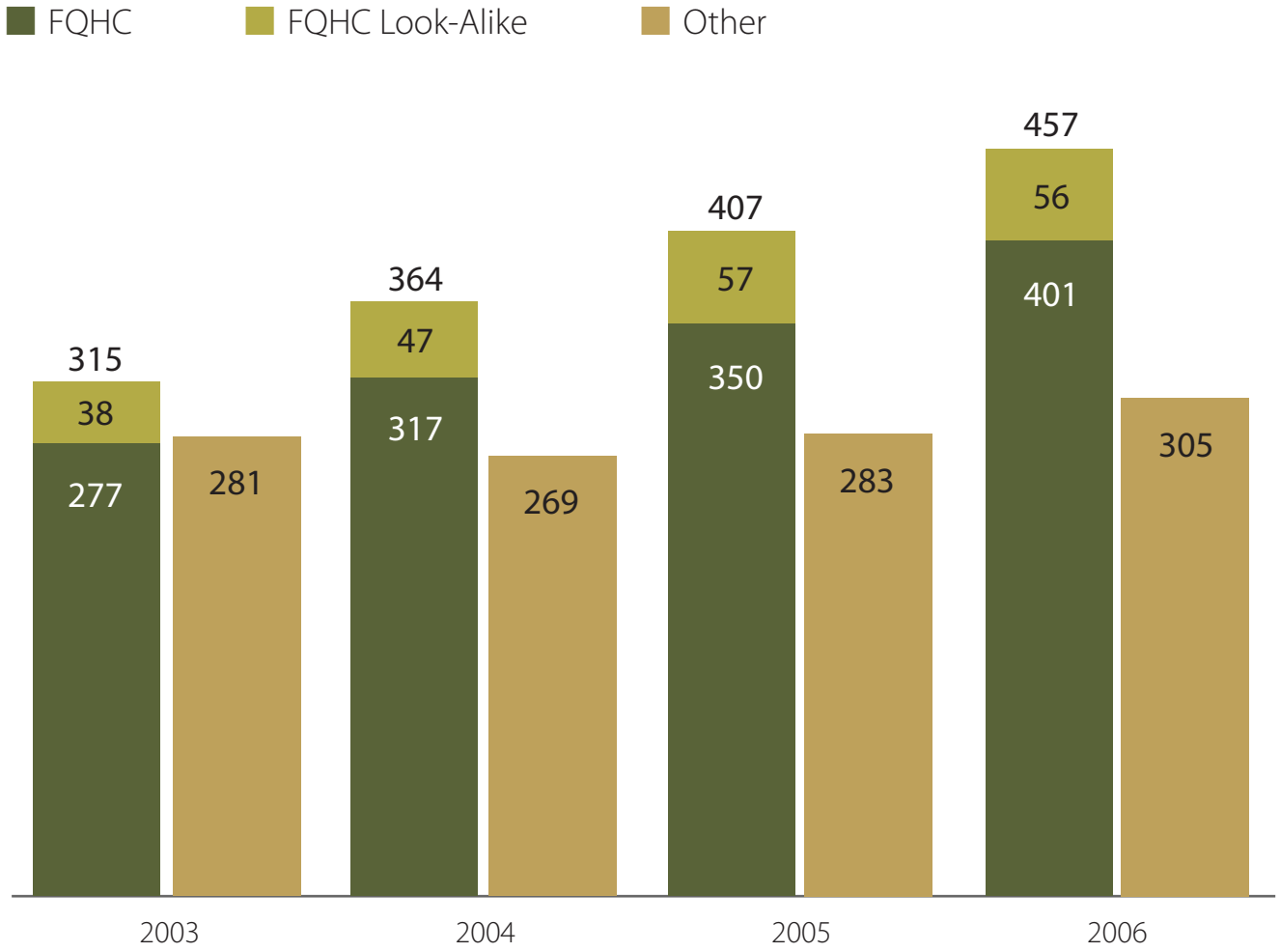


Source: Capital Link, *California Community Clinics — A Financial Profile*, 2009

Patient visits rose from 8.9 million in 2003 to 11.4 million in 2006 — a 28 percent rise.

Total clinic revenue grew 35 percent over that period to over $1.7 billion.

Growth in Community Clinic Sites, by Type, 2003–2006

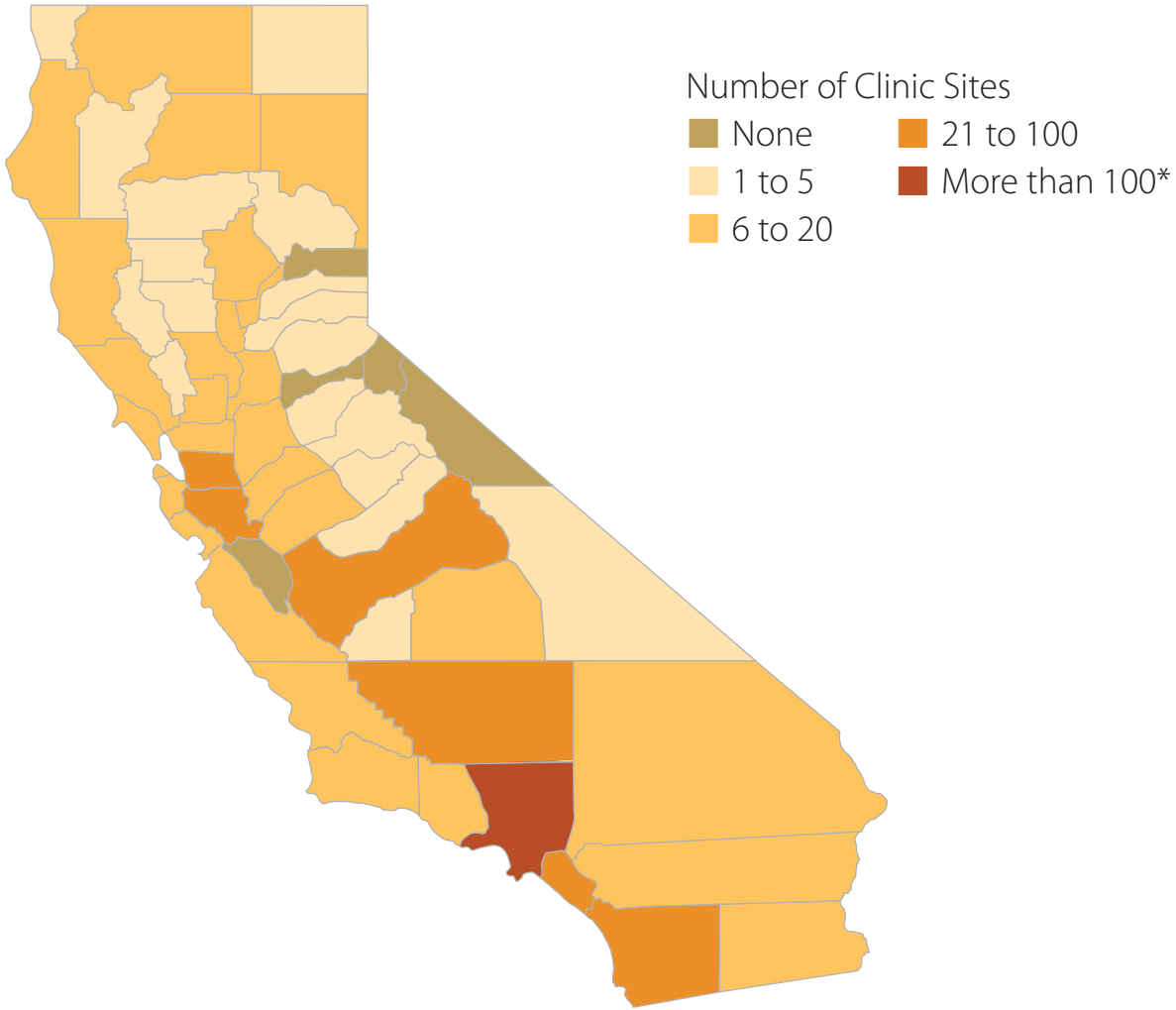


Notes: FQHC "Section 330" clinics receive federal grants to help cover the costs of providing care to those who cannot afford to pay. "Look-alikes" do not receive these grants but are eligible for cost-based Medicare and Medi-Cal reimbursement. "Other" includes nonprofit Rural Health Clinics; free clinics; and other licensed safety-net clinics, including family planning and school-based.

Source: Capital Link, *California Community Clinics — A Financial Profile,* 2009

Federally Qualified Health Centers and FQHC look-alikes represented 86 percent of total clinic site growth from 2003 to 2006.

Geographic Distribution of Community Clinic Sites, 2006

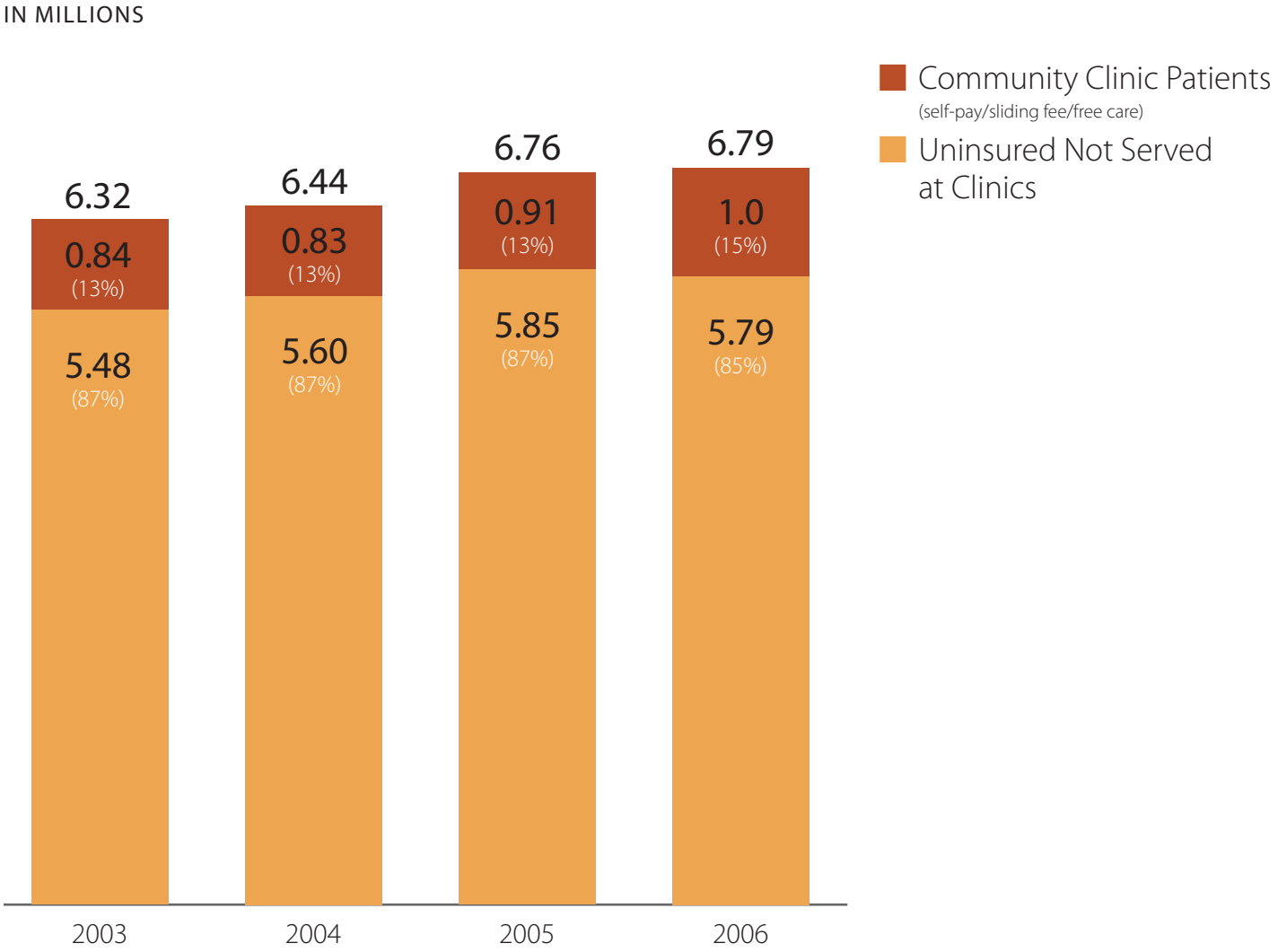


Clinics are located throughout the state, but are more concentrated around dense population centers. Clinics are also somewhat concentrated in rural areas of Northern California.

*Los Angeles County had 172 clinic sites in 2006.

Source: OSHPD, 2006; Capital Link, *California Community Clinics — A Financial Profile,* 2009

Uninsured Californians Served by Clinics, 2003–2006



Source: Capital Link, *California Community Clinics — A Financial Profile*, 2009

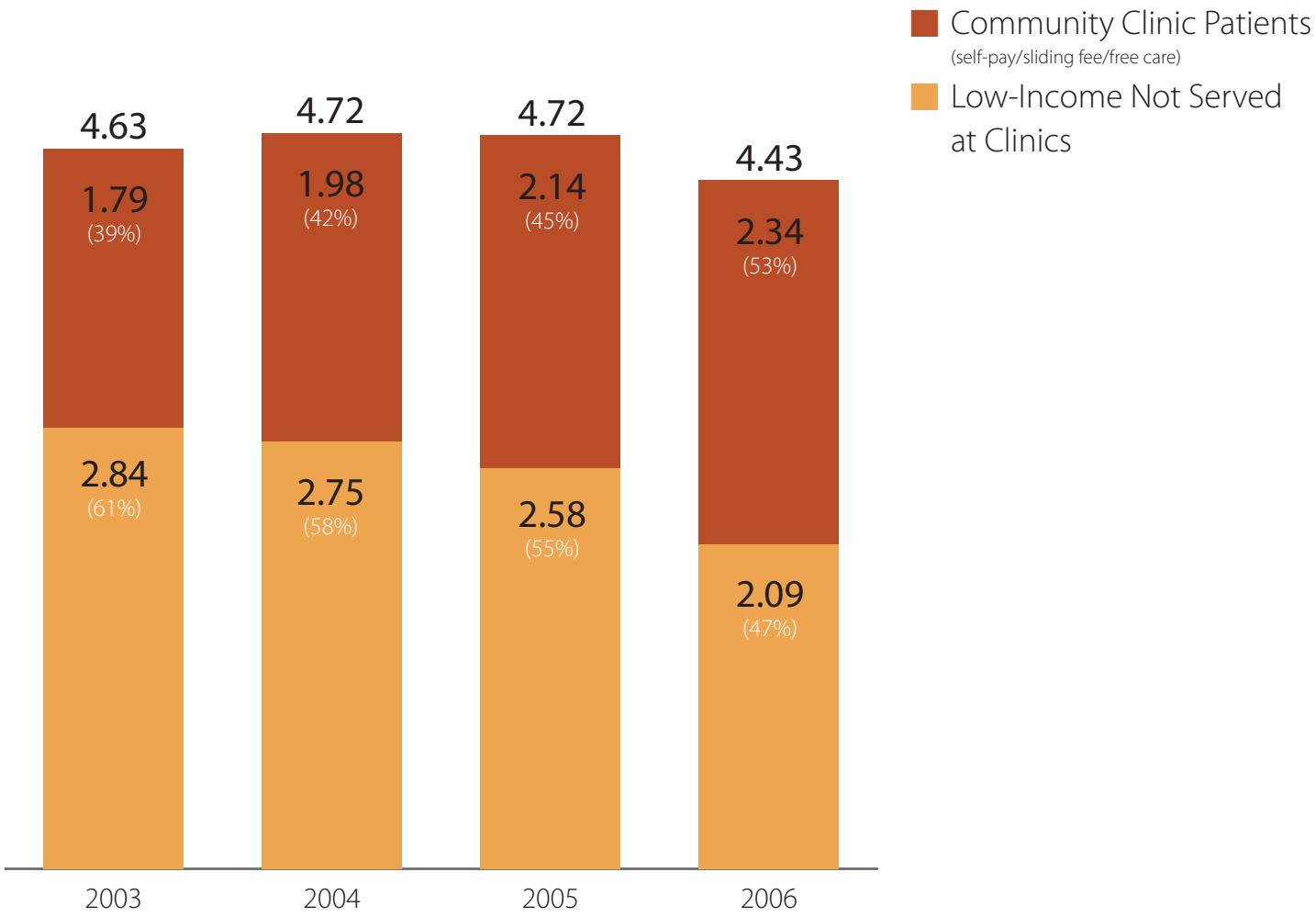
California's uninsured population grew 7 percent from 2003 to 2006.

In 2006, clinics served almost 15 percent of this population, a rise of 18.5 percent over the period.

Nevertheless, 85 percent of uninsured Californians were not served at a clinic.

Low-Income Californians Served by Clinics,
Patients Below 100 Percent of FPL, 2003–2006

IN MILLIONS



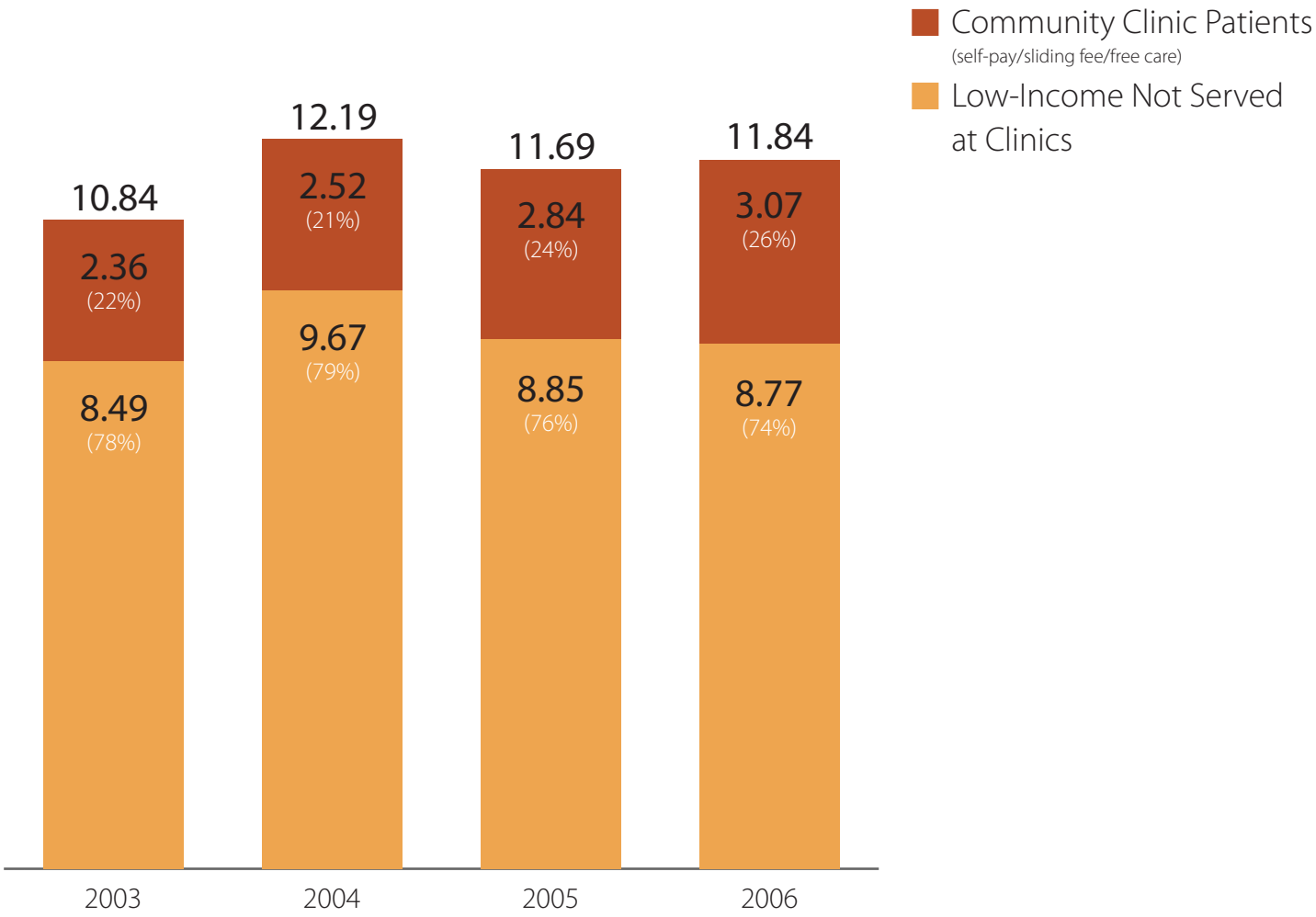
Note: FPL stands for federal poverty level.

Source: Capital Link, *California Community Clinics — A Financial Profile*, 2009

The share of low-income Californians using clinics is growing. In 2006, clinics served 53 percent of those living below 100 percent the federal poverty level, up from 39 percent in 2003.

Low-Income Californians Served by Clinics,
Patients Below 200 Percent of FPL, 2003–2006

IN MILLIONS



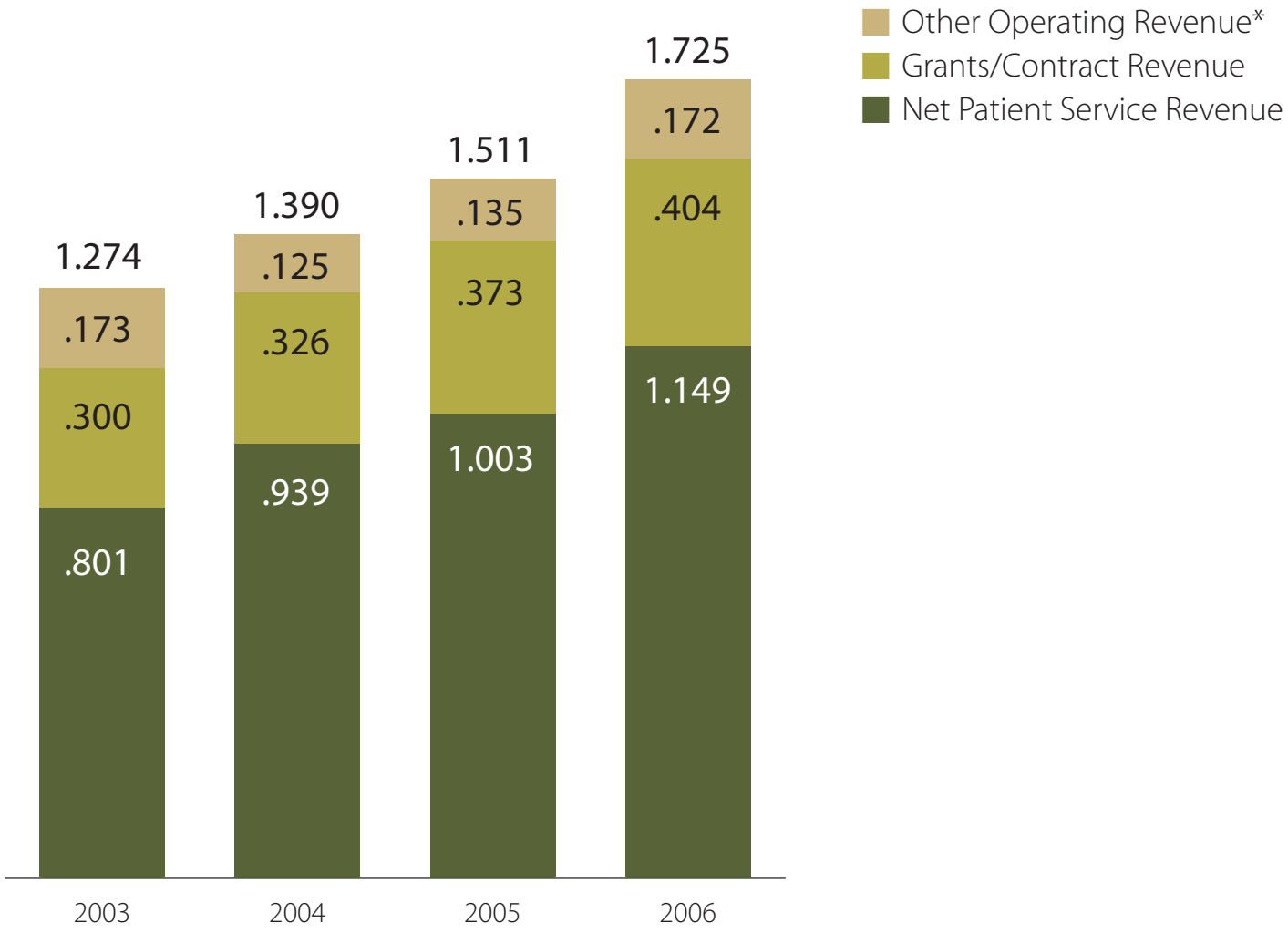
Note: FPL stands for federal poverty level.

Source: Capital Link, *California Community Clinics — A Financial Profile*, 2009

Twenty-six percent of Californians living below 200 percent of the FPL were served by a clinic in 2006.

Clinic Operating Revenue Mix and Annual Growth, 2003–2006

IN BILLIONS



*Includes contributions/fundraising.

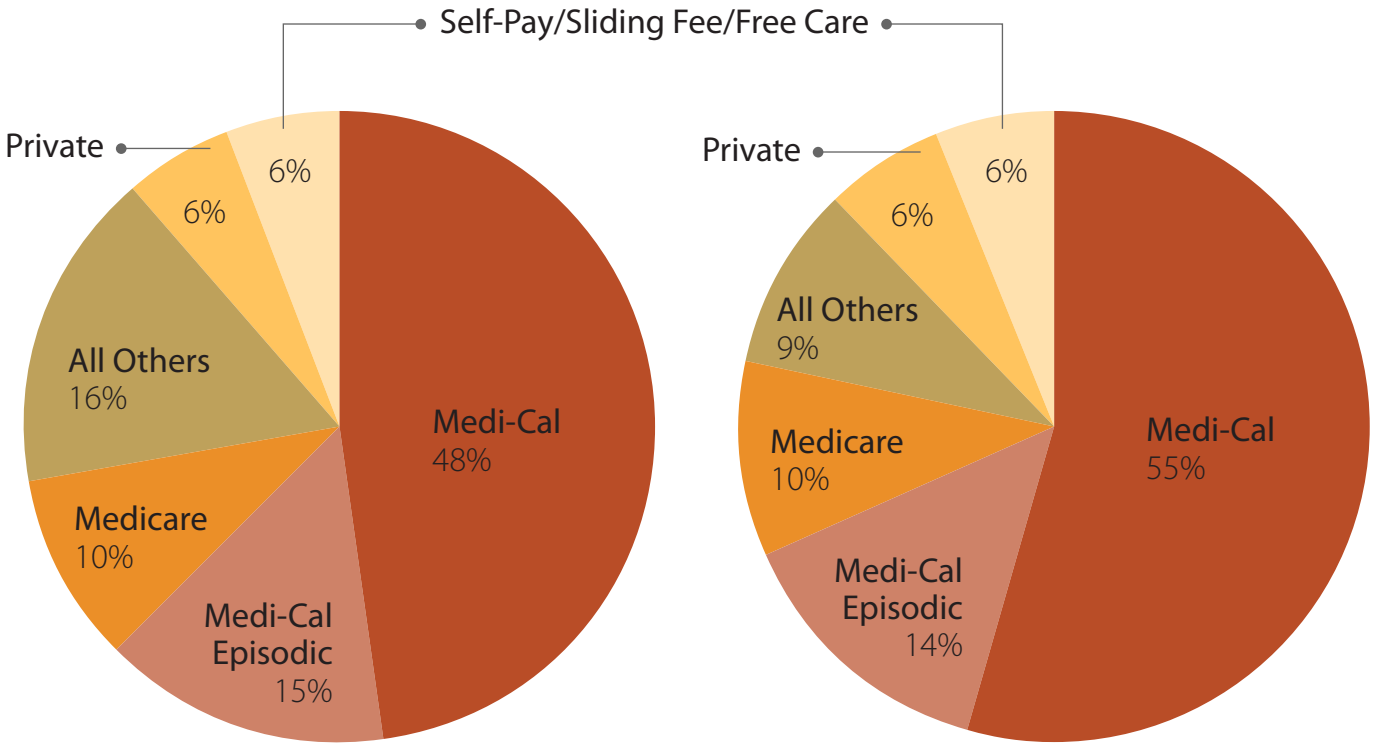
Source: Capital Link, *California Community Clinics — A Financial Profile*, 2009

Operating revenue grew 35 percent from 2003 to 2006, to $1.7 billion.

In 2006, two-thirds of revenue came from patient services, on average, and one-fourth from grants and contracts.

Patient service revenue increased 43 percent from 2003 to 2006, faster than other revenue streams.

Net Patient Revenue, by Payer, 2003 and 2006



Notes: Medicare, Medi-Cal, and All Others include managed care. Medi-Cal Episodic refers to care programs for certain cancers, children's health, and family planning services. Self-Pay/Sliding Fee/Free Care includes uninsured patients.

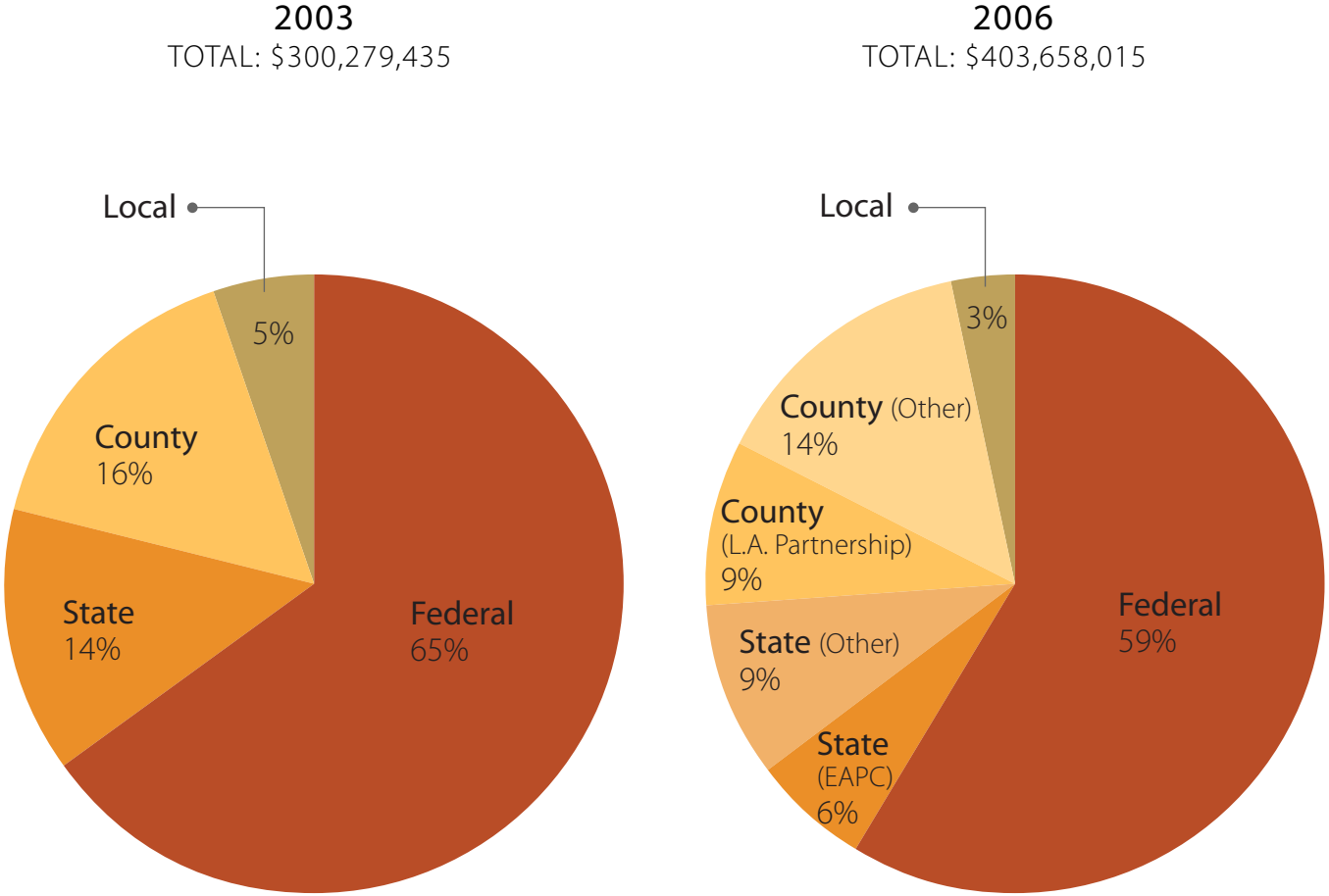
Source: Capital Link, *California Community Clinics — A Financial Profile,* 2009

The Medi-Cal portion of net patient revenue grew from 48 percent in 2003 to 55 percent in 2006.

Altogether, Medi-Cal and Medi-Cal episodic care programs provided 69 percent of patient revenues in 2006 — about $787 million.

Grants and Contracts Revenue, by Payer, 2003 and 2006

Although federal funding increased overall, it decreased as a share of grants and contracts revenue from 2003 to 2006.



Notes: The increase in 2006 county revenue was mainly due to the L.A. Partnership. EAPC refers to the Expanded Access to Primary Care program.

Source: Capital Link, *California Community Clinics — A Financial Profile,* 2009

Clinic Operating Revenue Mix, by Source, 2006

	REVENUE	PERCENT OF TOTAL
Net Patient Service Revenue	**$1,148,793,912**	**66.6%**
Medicare*	$114,607,239	6.6%
Medi-Cal†	$786,724,225	45.6%
Private Insurance	$70,924,055	4.1%
Self-Pay, Sliding Fee, Free Care	$69,161,279	4.0%
All Others	$107,377,114	6.2%
Grants and Contract Revenue	**$403,658,015**	**23.4%**
Federal Funds	$236,880,815	13.7%
State Programs	$62,390,615	3.6%
County and Local Programs	$104,386,585	6.1%
Contributions / Fundraising	**$126,886,386**	**7.4%**
Other Operating Revenue	**$45,323,486**	**2.6%**
TOTAL	**$1,724,661,799**	**100.0%**

*Including fee-for-service and managed care.
†Including fee-for-service, managed care, and episodic care programs.

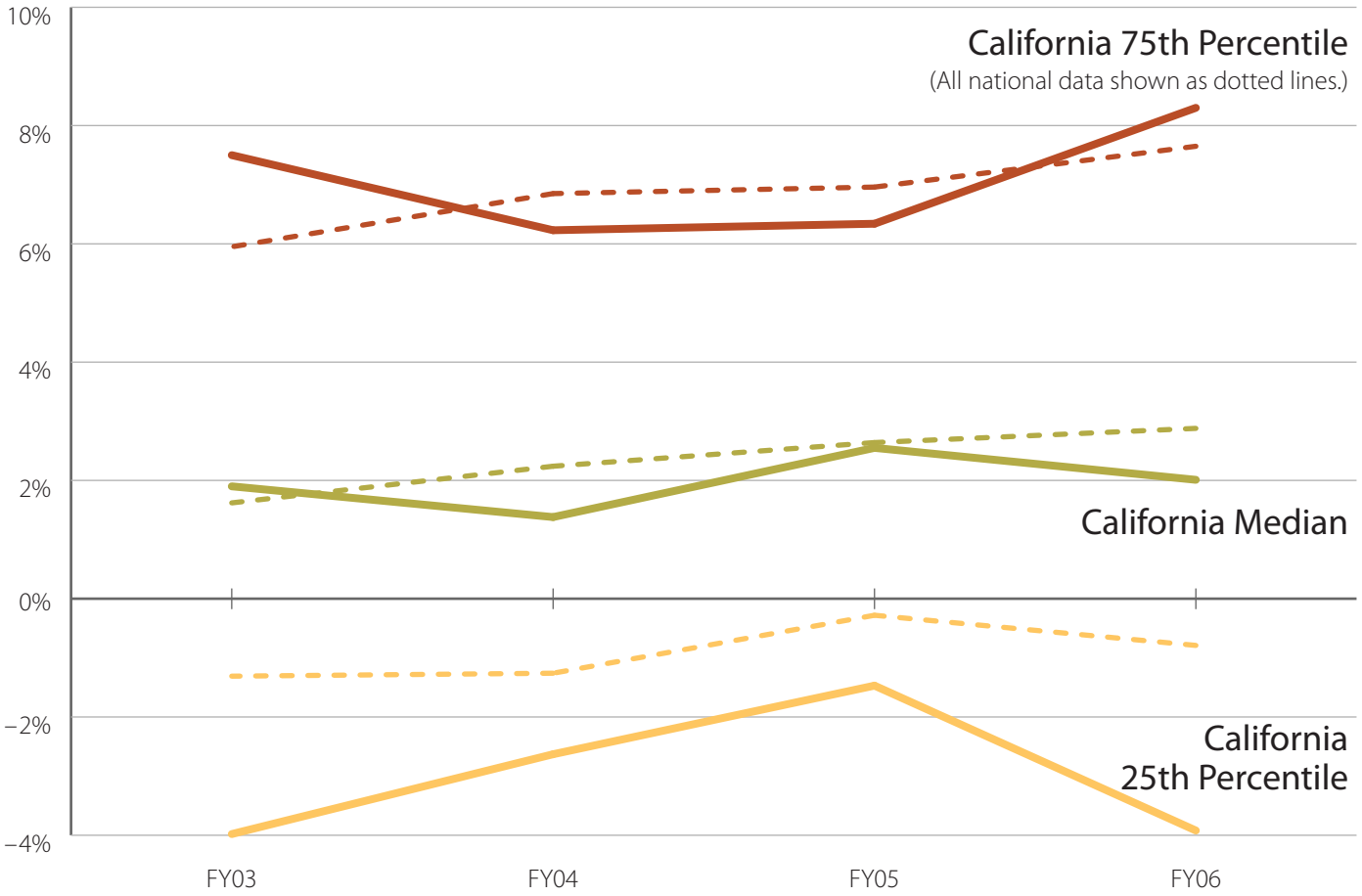
Source: Capital Link, *California Community Clinics — A Financial Profile,* 2009

In 2006, two-thirds of clinic revenue came from patient services, and almost half from Medi-Cal programs.

Grants and contracts provided close to one-fourth of revenue.

Only 8.1 percent of revenue came from private insurance, self-pay, or sliding fee payment.

Clinic Operating Margin, California vs. U.S., 2003–2006

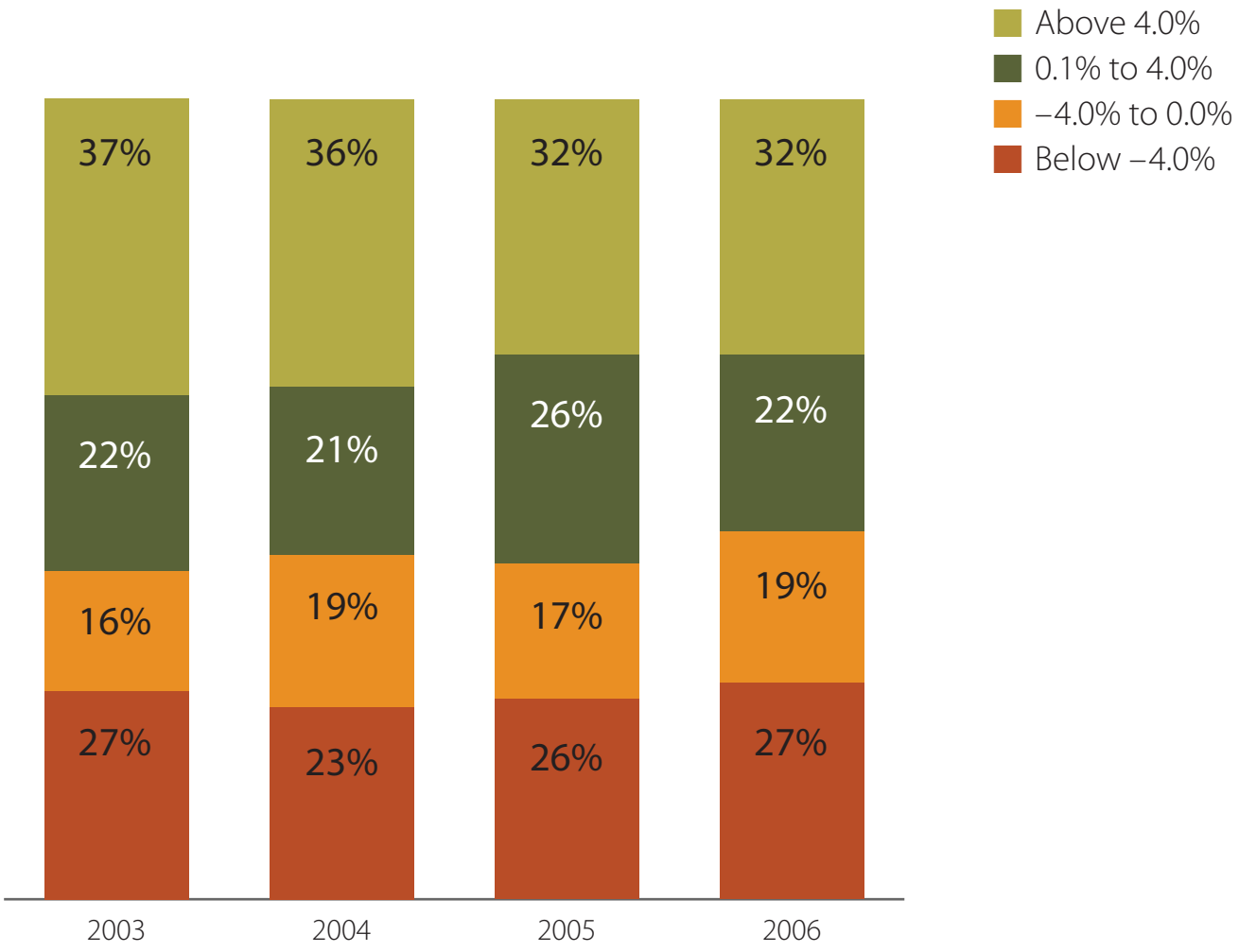


Source: Capital Link, *California Community Clinics — A Financial Profile*, 2009

The financial performance of California community clinics is wide-ranging. About one-fourth are able to generate strong margins in any given year.

However, the bottom fourth of California clinics operate at a minus 2 percent or greater loss — slightly worse than nationally.

Clinic Operating Margin Distribution, 2003–2006



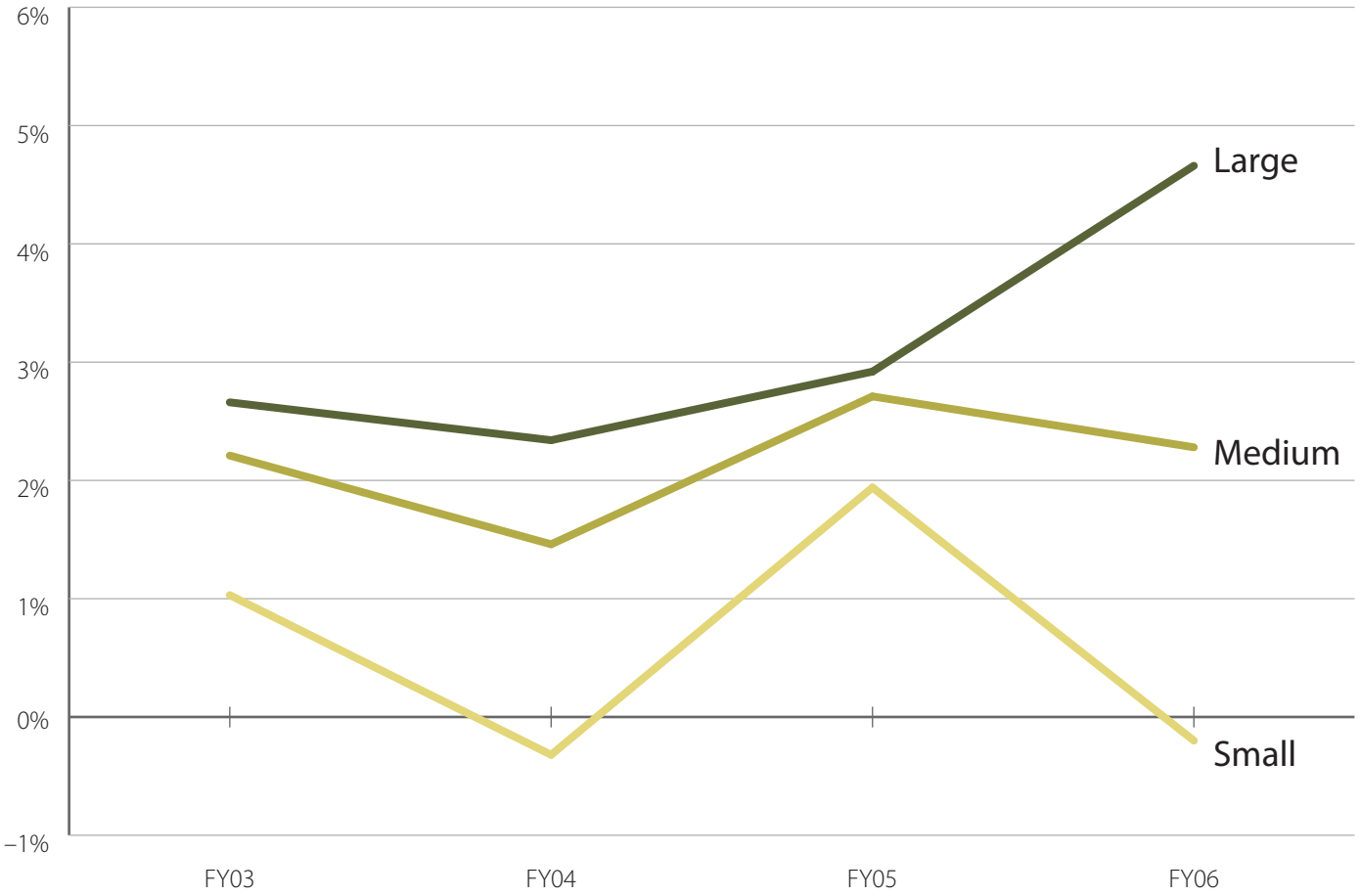
Source: Capital Link, *California Community Clinics — A Financial Profile*, 2009

Operating margins dwindled between 2003 and 2006.

Although 54 percent of clinics operated above breakeven in 2006, 27 percent had margins below minus 4 percent.

Even for clinics above breakeven, many have small margins.

Operating Margin, by Clinic Size, 2003–2006

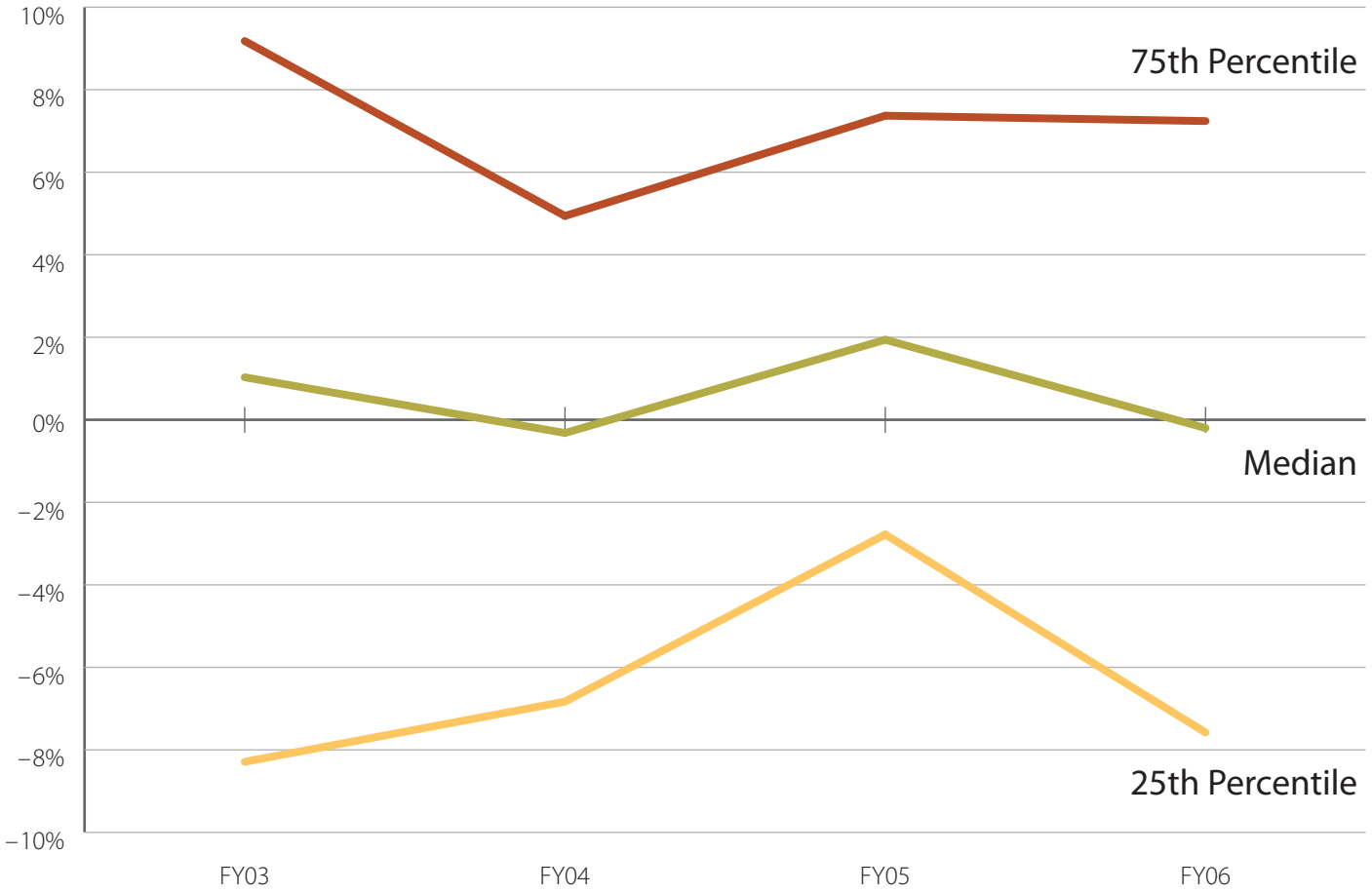


On an operating margin basis, large clinics generally perform better than medium-size ones, which do better, on average, than small ones.

Note: Small clinic is defined by revenue of less than $5 million; medium is $5 to $15 million; large is more than $15 million.

Source: Capital Link, *California Community Clinics — A Financial Profile,* 2009

Operating Margin, by Annual Total Revenue, Small Clinics, 2003–2006

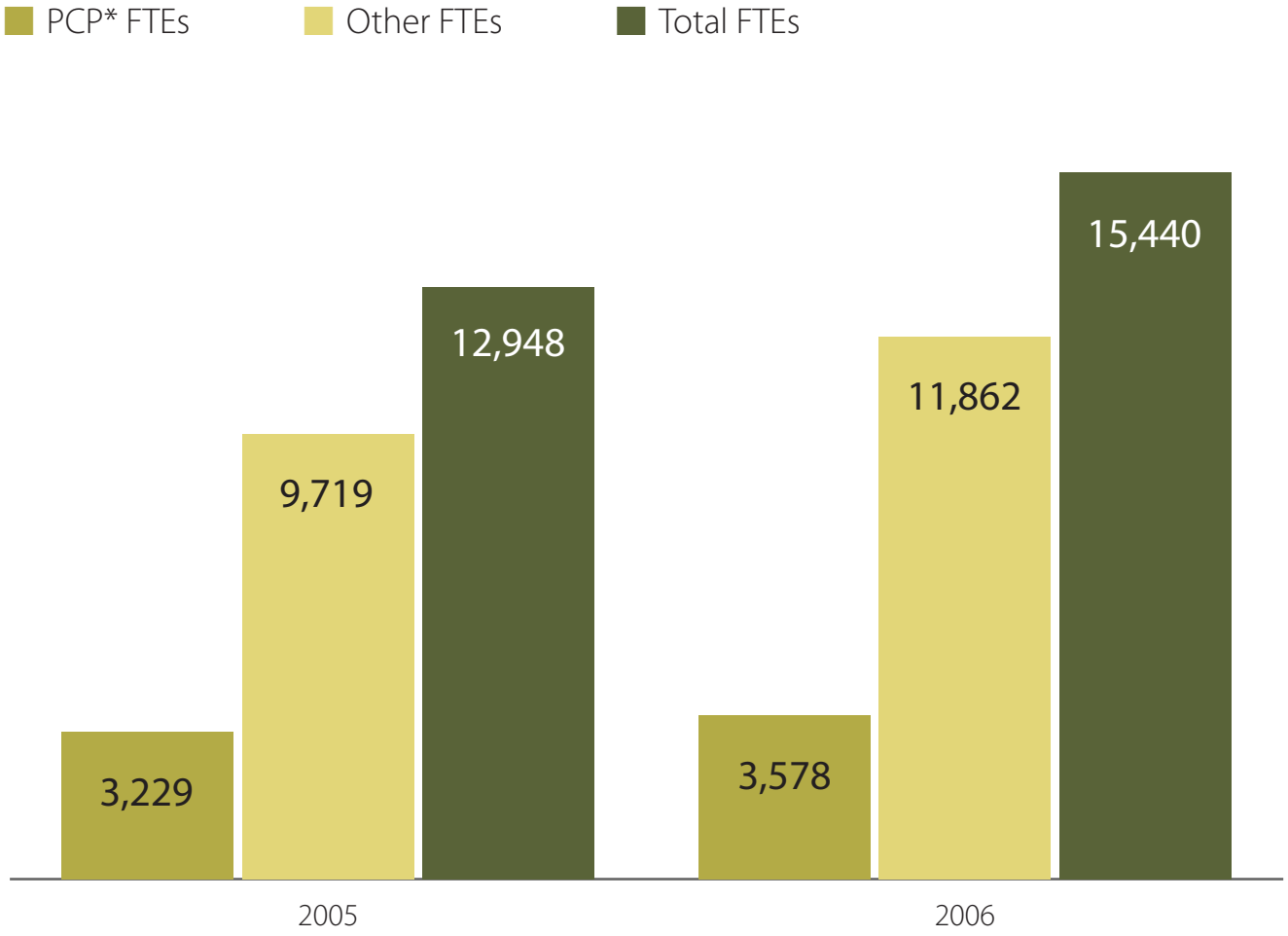


Among small clinics, the top 25 percent generated healthy 2006 operating margins of over 7 percent — down from over 9 percent in 2003.

Note: Small clinic is defined by revenue of less than $5 million.

Source: Capital Link, *California Community Clinics — A Financial Profile,* 2009

Clinic Primary Care Providers and Other Personnel, 2005–2006



Note: OSHPD did not capture complete data on support and total full-time equivalents (FTEs) until 2005.

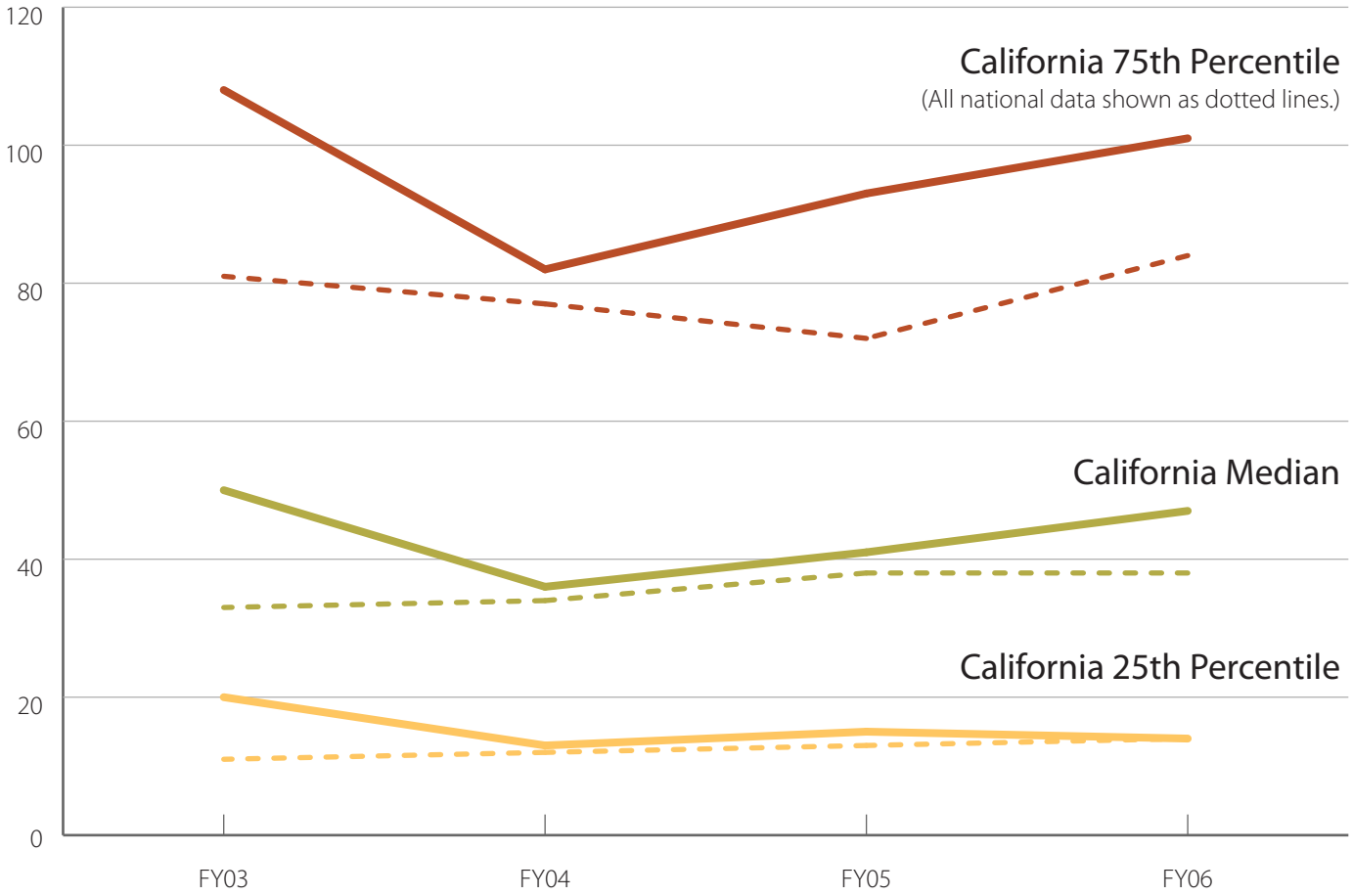
*PCP includes: physicians, physician assistants, family nurse practitioners, certified nurse midwives, visiting nurses, dentists, psychiatrists, clinical psychologists, licensed clinical social workers and other providers billable to Medi-Cal.

Source: Capital Link, *California Community Clinics — A Financial Profile,* 2009

From 2005 to 2006, support personnel grew 22 percent, while primary care providers increased only 11 percent.

This could suggest that clinics have difficulty recruiting and retaining PCPs or that they are offering more support services.

Clinic Days Cash on Hand, California vs. U.S., 2003–2006



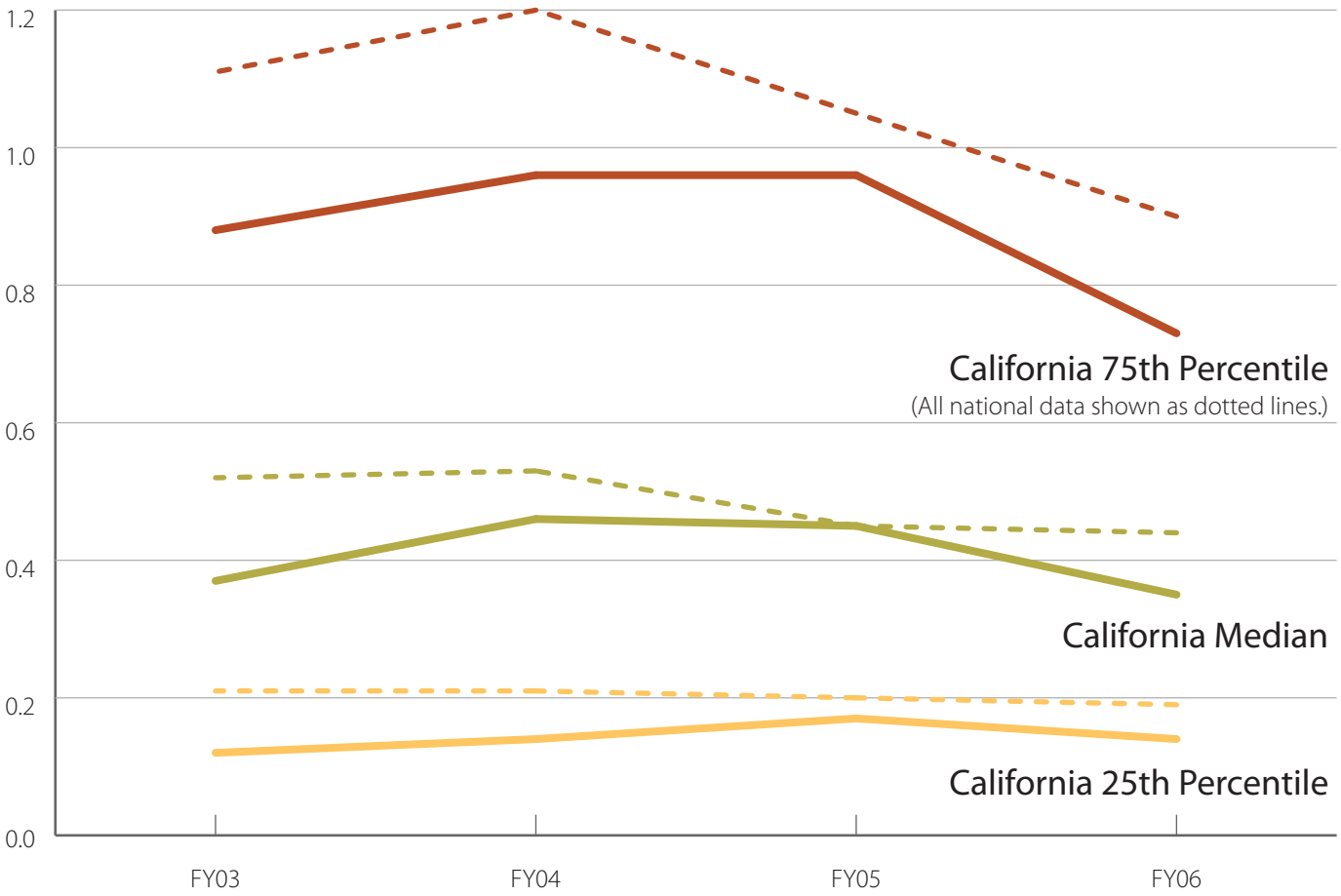
Note: Days cash on hand means the number of days of operating expenses (less depreciation) that can be met with available cash and liquid investments if no additional revenue were received. For efficient operation, it is generally recommended that clinics have at least 30 to 45 days of cash on hand.

Source: Capital Link, *California Community Clinics — A Financial Profile,* 2009

The median California clinic had 47 days cash on hand in 2006 — higher than the national median of 38 days cash.

However the bottom 25 percent had less than 30 days of cash, which makes them vulnerable to any change in revenue flow.

Clinic Leverage, California vs. U.S., 2003–2006



Note: Leverage ratio measures a clinic's total liabilities in relation to its net assets. It is generally recommended that the ratio not exceed 2.5 to 1.

Source: Capital Link, *California Community Clinics — A Financial Profile,* 2009

The majority of clinics operate with very low leverage, which means they have little debt relative to their net assets.

This may indicate that clinics have not invested heavily in buildings and equipment, or that clinics have mainly used grants to fund capital projects.

Data Resources

Authors: Falayi Adu, Jonathan Chapman, Allison Coleman, Amy Harbaugh, Joe McKelvey, and Tony Skapinsky, Capital Link.

The results and analysis in this report are based on two major data sources: California's Office of Statewide Health Planning and Development (OSHPD), and the Internal Revenue Service (IRS) Form 990 data. The national health center financial trend data comes from Capital Link's database of audited financial statements, mostly consisting of data from FQHCs.

All licensed health care clinics in California are required to submit an annual report to OSHPD that includes financial, utilization, and patient demographic information. The reporting period covers one calendar year (January to December). Licensed primary care clinics include:

- Federally Qualified Health Centers (FQHCs), including Section 330 health centers and "look-alikes";
- Nonprofit Rural Health Clinics (RHCs);
- Free clinics; and
- Other licensed safety-net clinics, including family planning and school-based clinics, that provided significant medical or dental services according to criteria developed by the California Primary Care Association.

For more information, download the report at www.caplink.org/mainnews2.html.

Source: Capital Link, *California Community Clinics — A Financial Profile,* 2009

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