CALIFORNIA

HEALTH CARE ALMANAC

California HealthCare Foundation

Financial Health of Community Clinics

SEPTEMBER 2010

Introduction

Community clinics are an integral part of California's primary care and safety-net system, especially for uninsured, underinsured, and low-income people. Between 2005 and 2008, clinics grew in terms of revenue, patients, encounters, and staff. At the same time, numbers of sites increased for Federally Qualified Health Centers (FQHCs), while the number of sites decreased for other types of community clinics.* This report captures key measures of clinics' financial health from 2005 to 2008.†

KEY FINDINGS INCLUDE:

- The low-income and uninsured patients seen at California clinics are growing at a faster pace than similar populations in the state as a whole.
- Clinic operating revenue grew 22 percent, with almost two-thirds coming from patient services.
- Community clinics rely heavily on Medi-Cal and Medicare, which accounted for 89 percent of net patient service revenue in 2008. Therefore state budget reductions have a significant impact on clinic financial stability.
- The California clinic system continues to vary widely in terms of financial strength. While one-fourth of the clinics generate strong margins in any given year, at least one-fourth operate at a loss.
- Staffing levels are growing rapidly, particularly for support staff, highlighting increased provision of ancillary services as well as the growing importance of clinics as employers and economic forces in their communities.
- Overall activity is increasing at the site level. Patients, visits, and staffing are all growing at a faster rate than the number of clinic sites in the state.
- Financially strong clinics tend to be large in terms of revenue (over $15 million), serve a high number of low-income patients, and have high reimbursement levels compared to financially weak clinics.
- Both strong and weak clinics have similar productivity and expense levels on a per-visit basis.
- The smallest clinics in terms of revenue are more likely to experience financial difficulty and have reimbursement levels that are half that of the largest clinics.

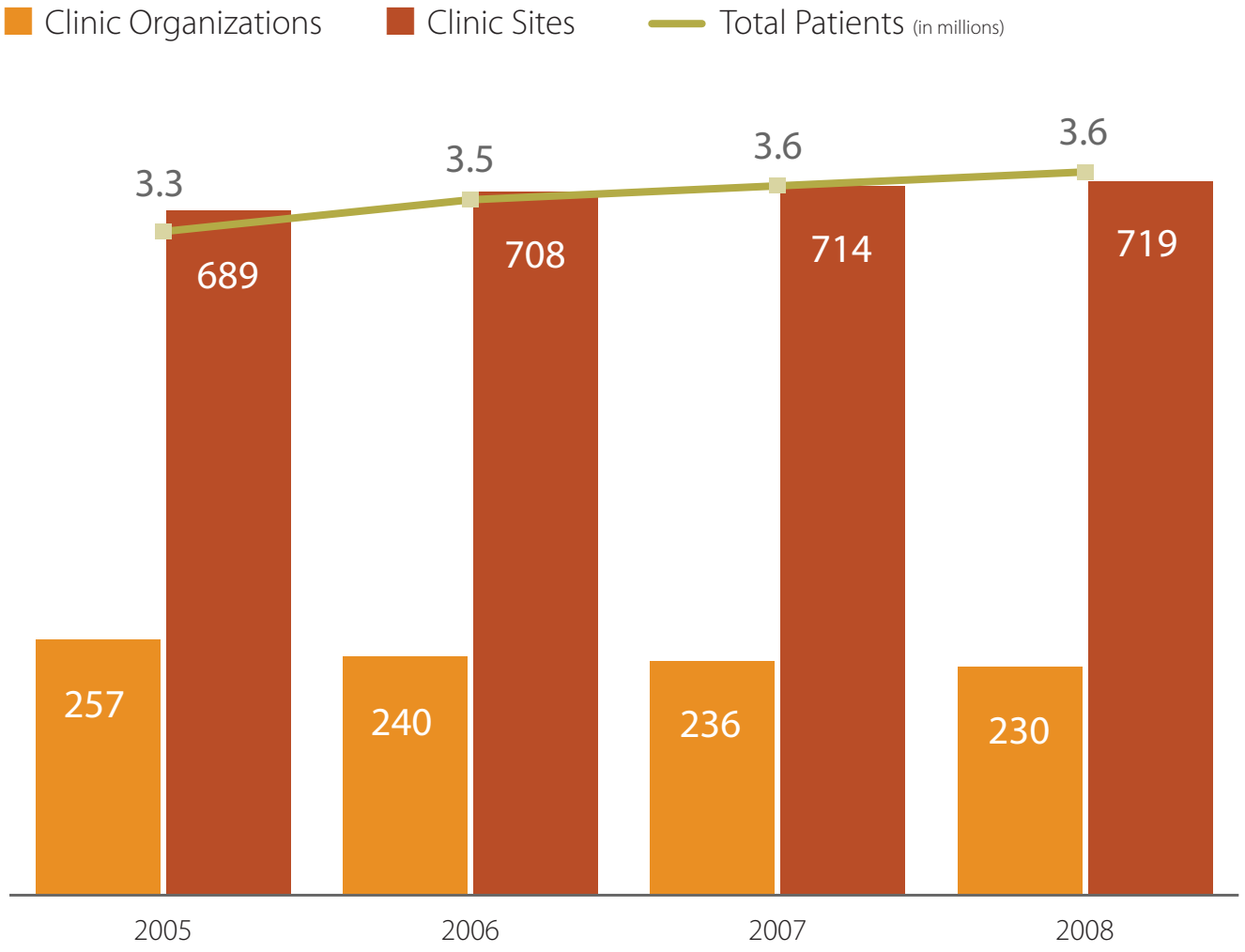
*See **Clinic Definitions** on page 28 for a description of FQHCs and list of other types of community clinics included in this report.

†The full report by Capital Link, *California Community Clinics: A Financial Profile, 2010,* can be downloaded at www.caplink.org.

<< RETURN TO CONTENTS

CONTENTS

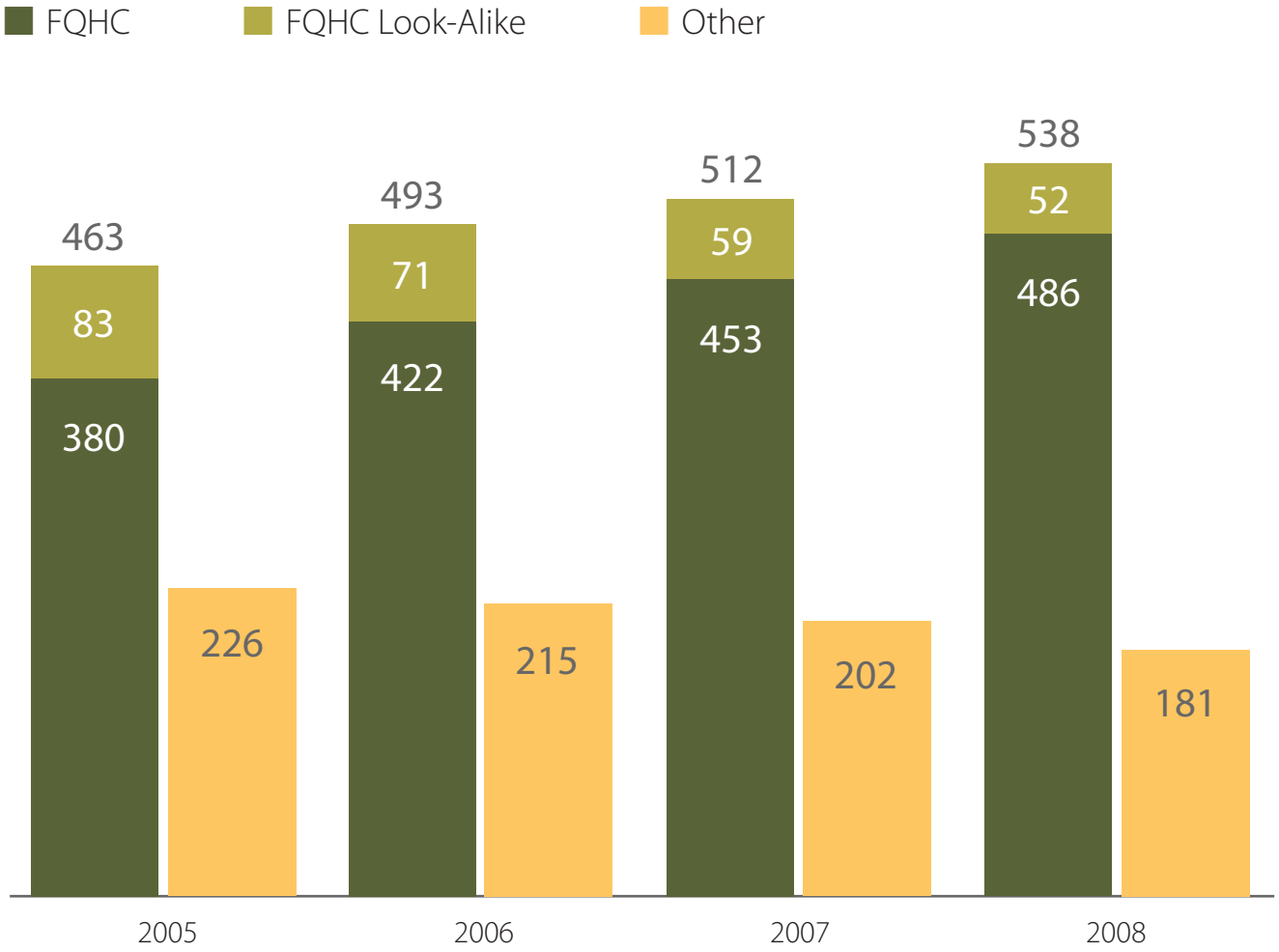
Clinic Organizations, Sites, and Patients, 2005–2008



Source: Capital Link, *California Community Clinics — A Financial Profile,* 2010.

The number of patients seen at California clinics increased 9 percent between 2005 and 2008, from 3.3 million to 3.6 million. While the number of clinic sites grew 4 percent during the period, the number of clinic organizations decreased by 11 percent.

Community Clinic Sites, by Type, 2005–2008

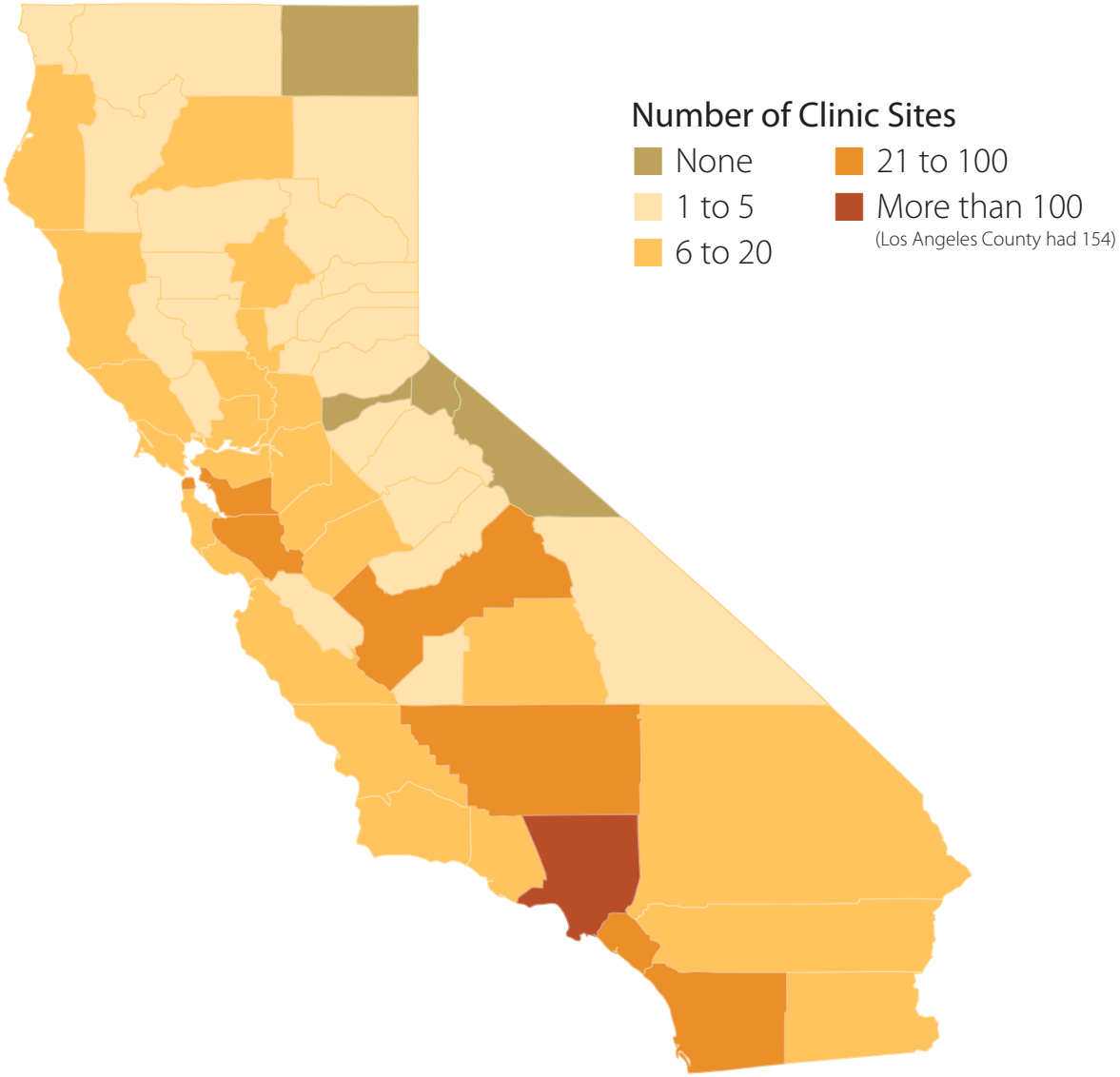


Note: See Clinic Definitions on page 28 for a description of FQHCs and list of other types of community clinics included in this report.

Source: Capital Link, *California Community Clinics — A Financial Profile,* 2010.

The number of Federally Qualified Health Center sites grew 28 percent between 2005 and 2008, while FQHC look-alikes and other types of community clinics experienced a sharp decline in sites.

Geographic Distribution of Community Clinic Sites, 2008

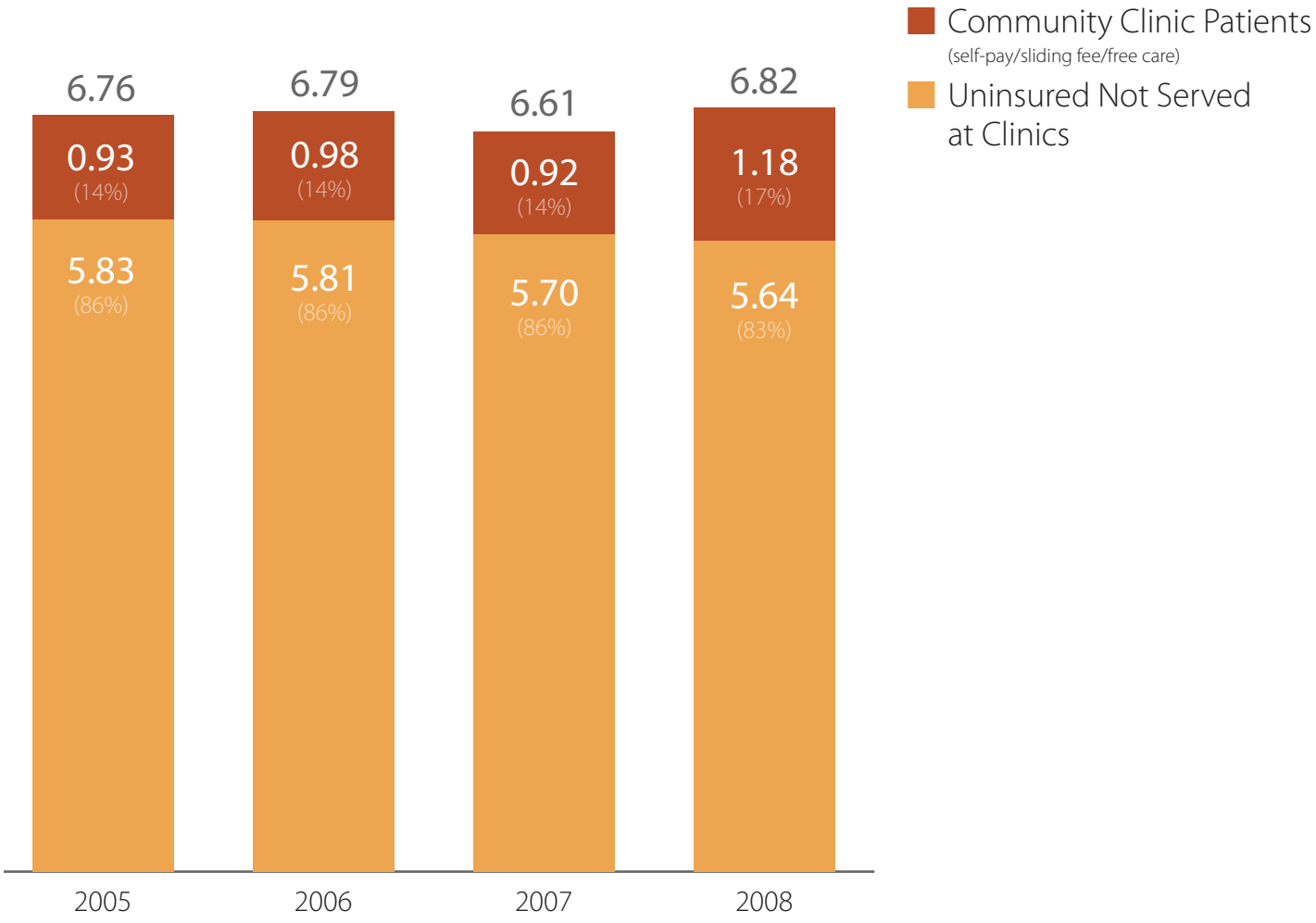


Source: Capital Link, *California Community Clinics — A Financial Profile,* 2010.

Clinics are located throughout the state, but are more concentrated around dense population areas.

Uninsured Californians Served by Clinics, 2005–2008

IN MILLIONS



Note: Segments may not add to totals due to rounding.

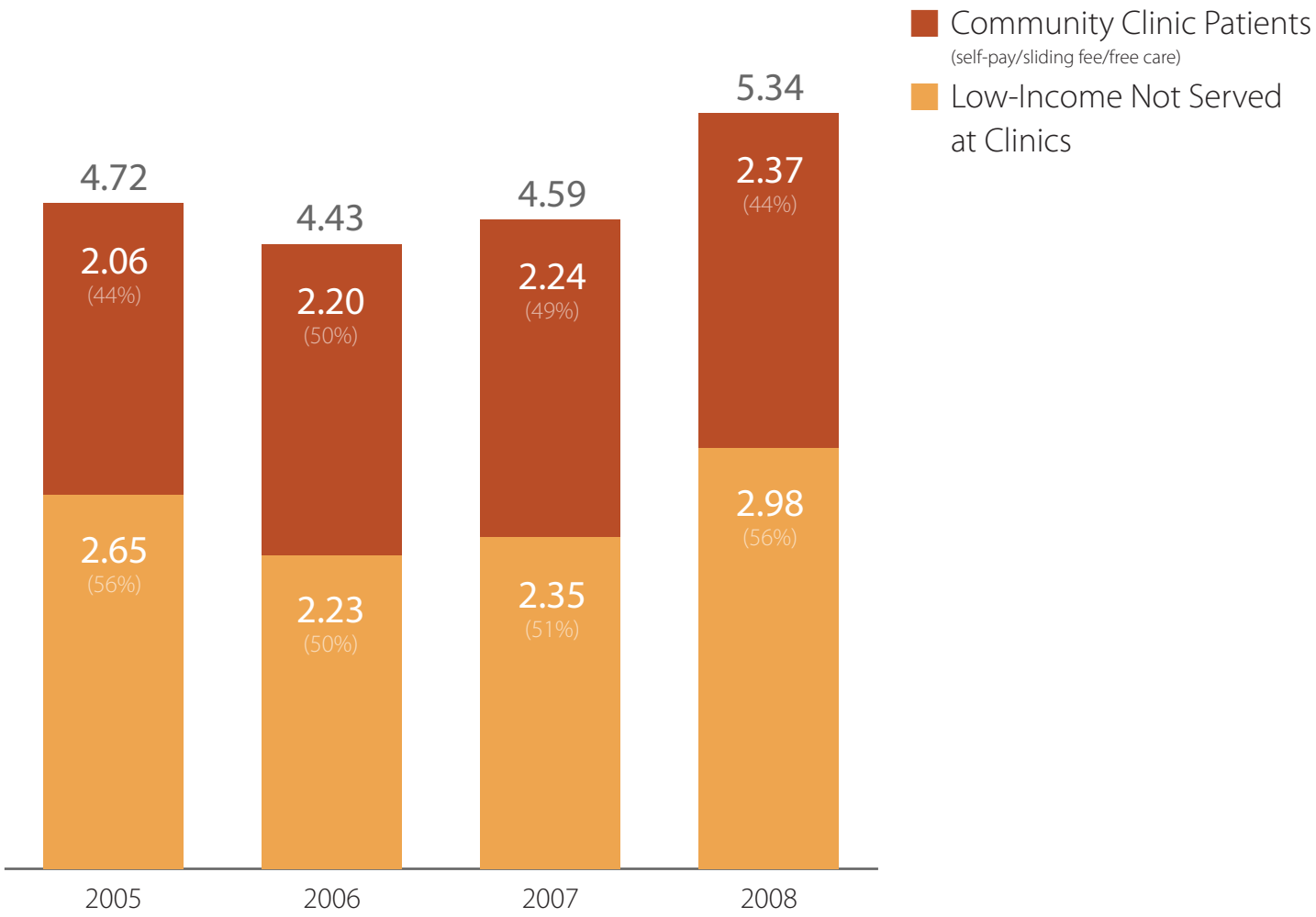
Source: Capital Link, *California Community Clinics — A Financial Profile,* 2010.

California's uninsured population grew less than 1 percent from 2005 to 2008, but the proportion served in clinics increased 27 percent. In 2008, clinics treated 17 percent of uninsured people, which means that 83 percent were not served in a clinic.

Low-Income Californians Served by Clinics,

Patients Below 100 Percent of FPL, 2005–2008

IN MILLIONS



Notes: FPL stands for federal poverty level. Segments may not add to totals due to rounding.

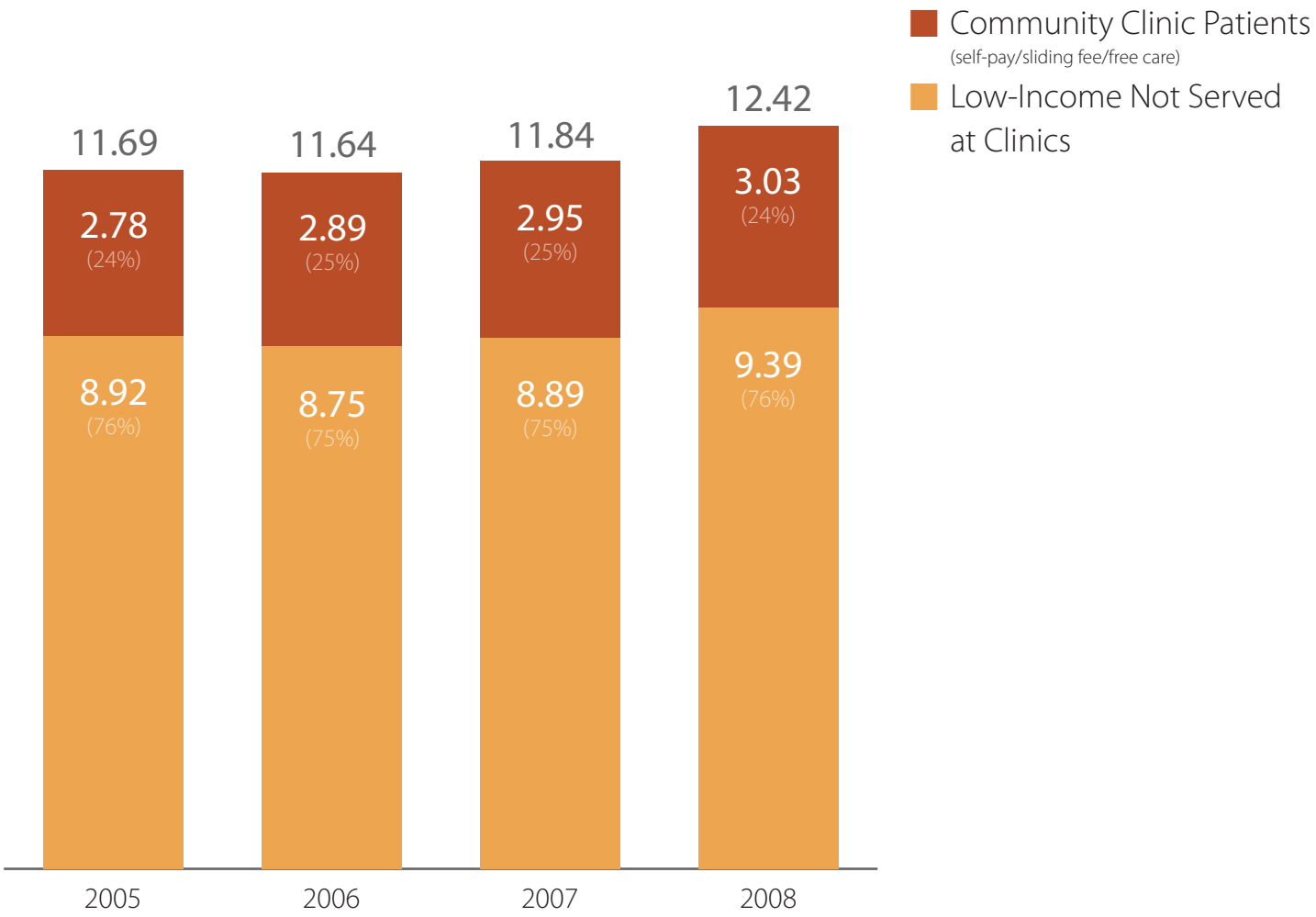
Sources: Capital Link, *California Community Clinics — A Financial Profile,* 2010. U.S. Census Bureau, California Population Census, *Current Population Survey's Annual Social and Economic Supplement*, www.census.gov.

The number of Californians living below 100 percent of FPL grew 13 percent from 2005 to 2008, and, on average, almost half of those individuals used a clinic for primary care. During that period, the number of low-income individuals treated in clinics rose by nearly 15 percent.

Low-Income Californians Served by Clinics,

Patients Below 200 Percent of FPL, 2005–2008

IN MILLIONS



Notes: FPL stands for federal poverty level. Segments may not add to totals due to rounding.

Sources: Capital Link, *California Community Clinics — A Financial Profile,* 2010. U.S. Census Bureau, California Population Census, *Current Population Survey's Annual Social and Economic Supplement*, www.census.gov.

Nearly one-fourth of Californians living below 200 percent of FPL were treated at clinics in 2008, while three-fourths were not. Between 2005 and 2008, the total population of Californians under 200 percent of FPL grew 6 percent while the number of those treated by clinics rose 9 percent.

Clinic Visits,
by Payer and Clinic Type, 2008

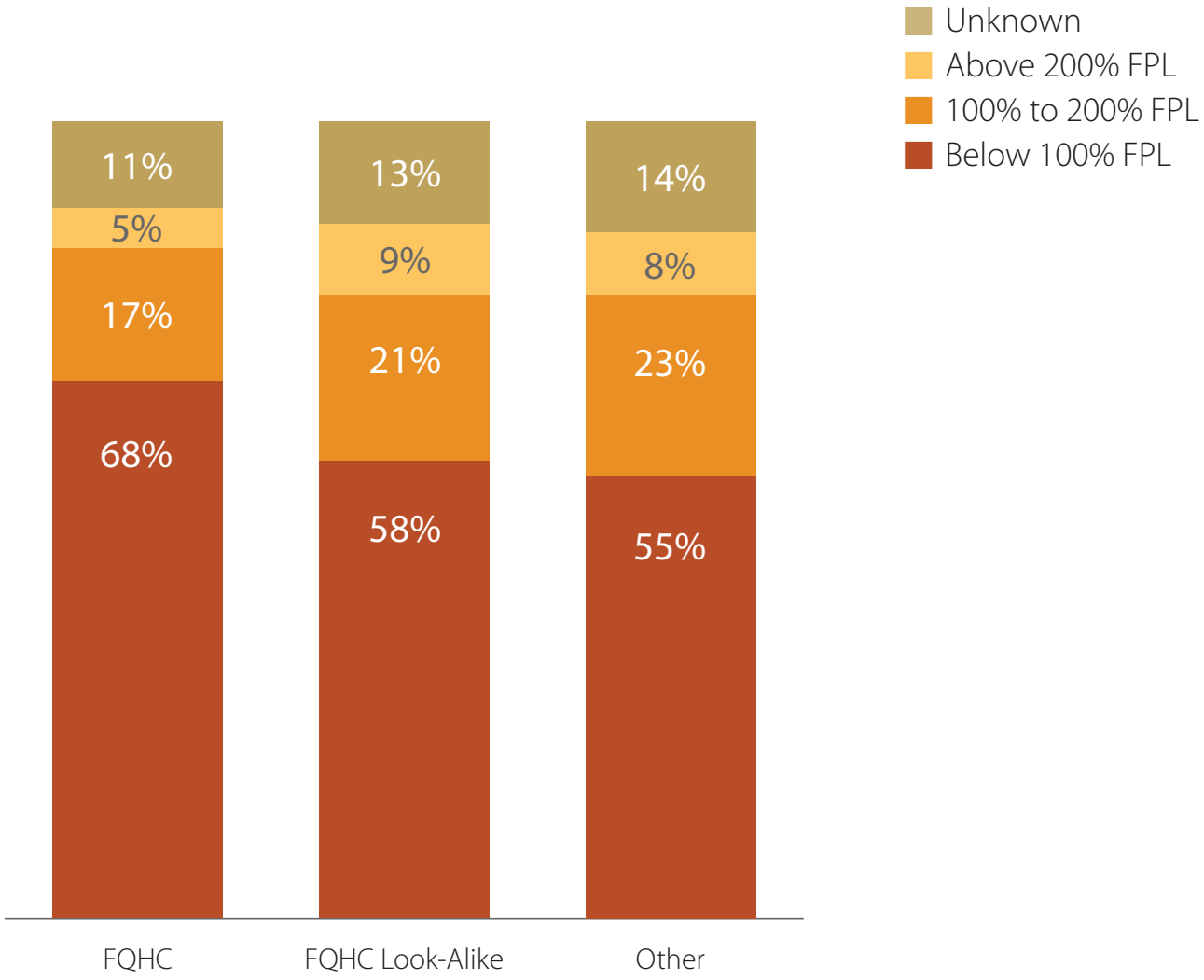
	PERCENTAGE OF VISITS		
	FQHC	FQHC LOOK-ALIKE	OTHER
Medicare	7%	6%	5%
Medi-Cal FFS	48%	47%	43%
Medi-Cal Managed Care	14%	14%	9%
Medi-Cal Breast Cancer and CHDP	3%	3%	2%
Medi-Cal Family PACT	5%	6%	20%
Private Insurance	5%	5%	5%
All Others	17%	19%	15%
Self-Pay / Sliding Fee / Free Care	12%	7%	19%

FQHCs have the highest proportion of Medicare and Medi-Cal fee-for-service visits. Clinics other than FQHCs and FQHC look-alikes see the highest proportion of Medi-Cal Family PACT and self-pay / sliding fee / free care visits.

Notes: See **Clinic Definitions** on page 28 for a description of FQHCs and list of other types of community clinics included in this report; as well as definitions for specific programs included under Medi-Cal Episodic and All Others.

Source: Capital Link, *California Community Clinics — A Financial Profile,* 2010.

Patient Income,
by Clinic Type, 2008



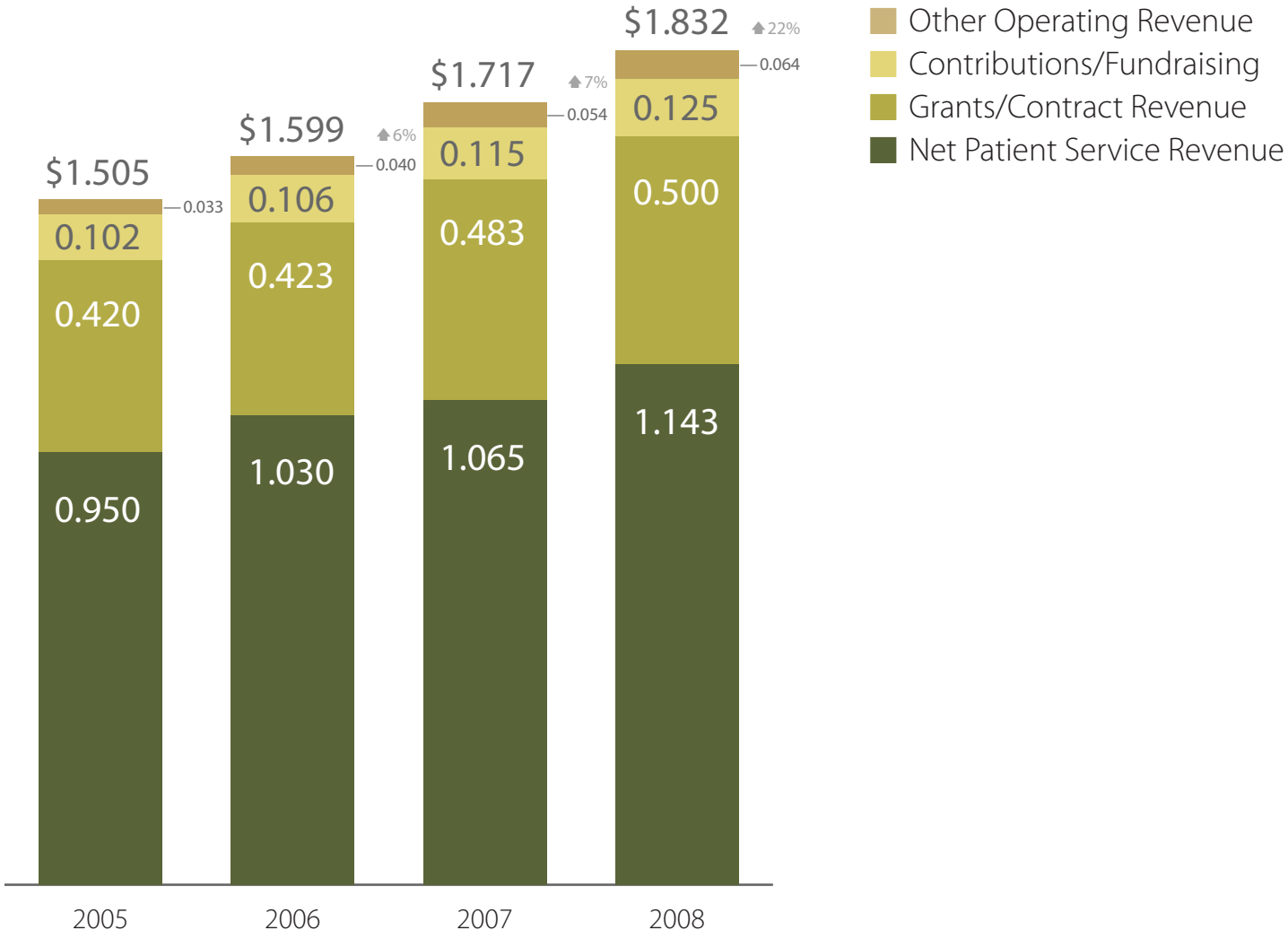
Notes: See **Clinic Definitions** on page 28 for a description of FQHCs and list of other types of community clinics included in this report. FPL stands for federal poverty level. Segments may not add to 100 percent due to rounding.

Source: Capital Link, *California Community Clinics — A Financial Profile,* 2010.

FQHCs had more low-income patients than other types of clinics. In 2008, two-thirds of FQHC patients had incomes under 100 percent of the FPL.

Clinic Operating Revenue Mix and Annual Growth, 2005–2008

IN BILLIONS

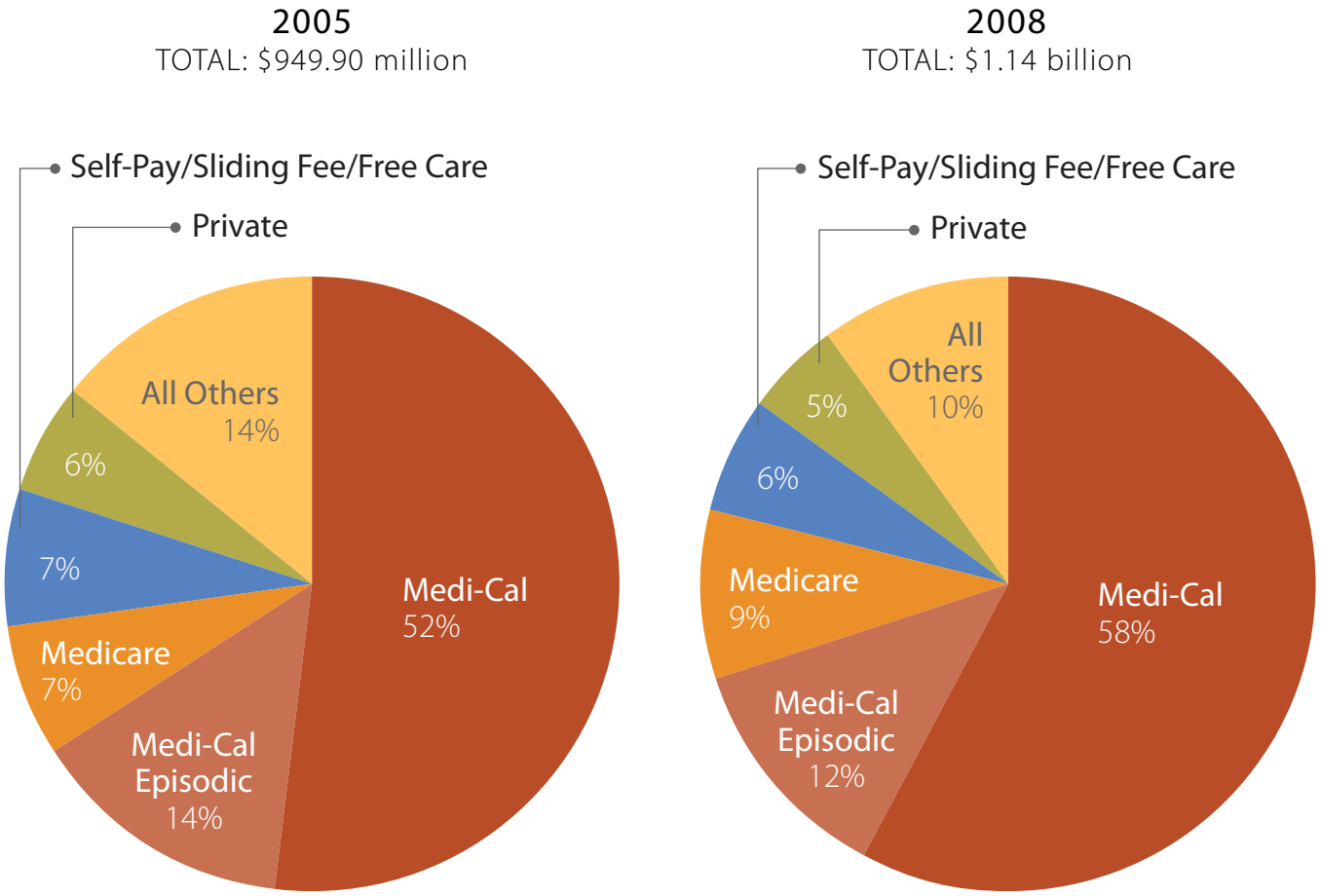


Note: Segments may not add to totals due to rounding.

Source: Capital Link, *California Community Clinics — A Financial Profile,* 2010.

From 2005 to 2008, operating revenue grew 22 percent, to $1.8 billion, while the mix of revenue sources remained fairly stable. Almost two-thirds of revenue came from patient services and about one-fourth from grants and contracts.

Net Patient Service Revenue,
by Payer, 2005 and 2008



Notes: Medicare, Medi-Cal, and All Others include managed care. Self-Pay/Sliding Fee/Free Care includes uninsured patients. See Payer Definitions on page 28 for specific programs included under Medi-Cal Episodic and All Others.

Source: Capital Link, *California Community Clinics — A Financial Profile,* 2010.

The Medi-Cal portion of net patient service revenue grew from 52 percent in 2005 to 58 percent in 2008. Altogether, Medi-Cal and Medi-Cal Episodic programs provided 70 percent of patient revenues in 2008 — about $805 million.

Clinic Operating Revenue Mix, by Source, 2008

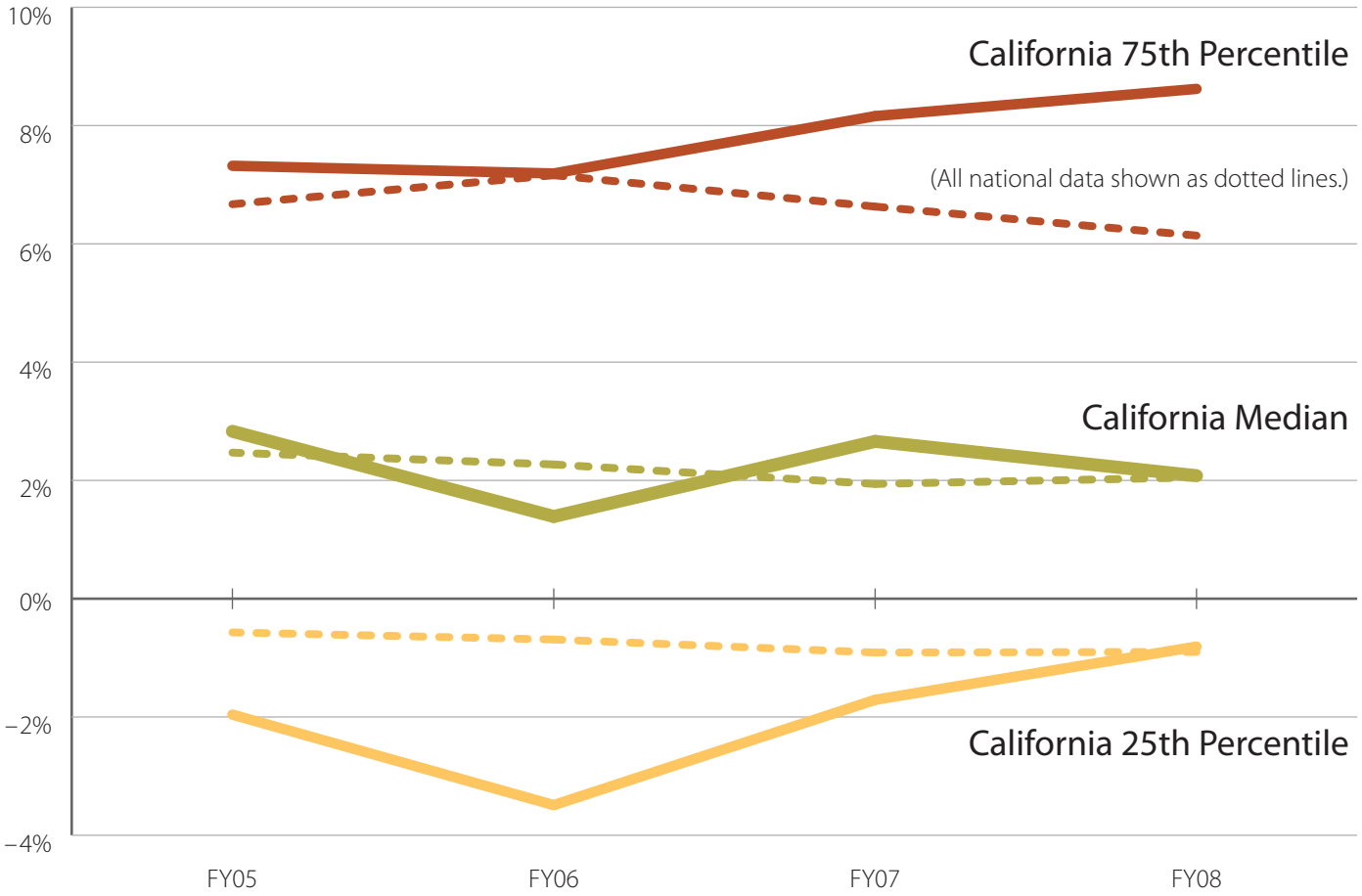
	REVENUE	PERCENT OF TOTAL
Net Patient Service Revenue	**$1,142,685,744**	**62.4%**
Medicare (FFS and Managed Care)	$99,090,814	5.4%
Medi-Cal (FFS, Managed Care, and Episodic)	$805,995,872	44.0%
Private Insurance	$60,830,466	3.3%
Self-Pay / Sliding Fee / Free Care	$69,403,194	3.8%
All Others	$107,365,398	5.9%
Grants and Contract Revenue	**$500,420,348**	**27.3%**
Federal Funds	$292,731,113	16.0%
State Programs	$70,011,252	3.8%
County and Local Programs	$137,677,983	7.5%
Contributions / Fundraising	**$125,358,667**	**6.8%**
Other Operating Revenue	**$63,682,699**	**3.5%**
TOTAL (FROM 230 CLINIC ORGANIZATIONS)	**$1,832,147,458**	**100.0%**

In 2008, 62 percent of clinic revenue came from patient services, and 44 percent from Medi-Cal programs. Grants and contracts provided 27 percent of revenue. Only about 7 percent came from private insurance, self-pay, or sliding fee payment.

Note: See Payer Definitions on page 28 for specific programs included under Medi-Cal Episodic and All Others.

Source: Capital Link, *California Community Clinics — A Financial Profile,* 2010.

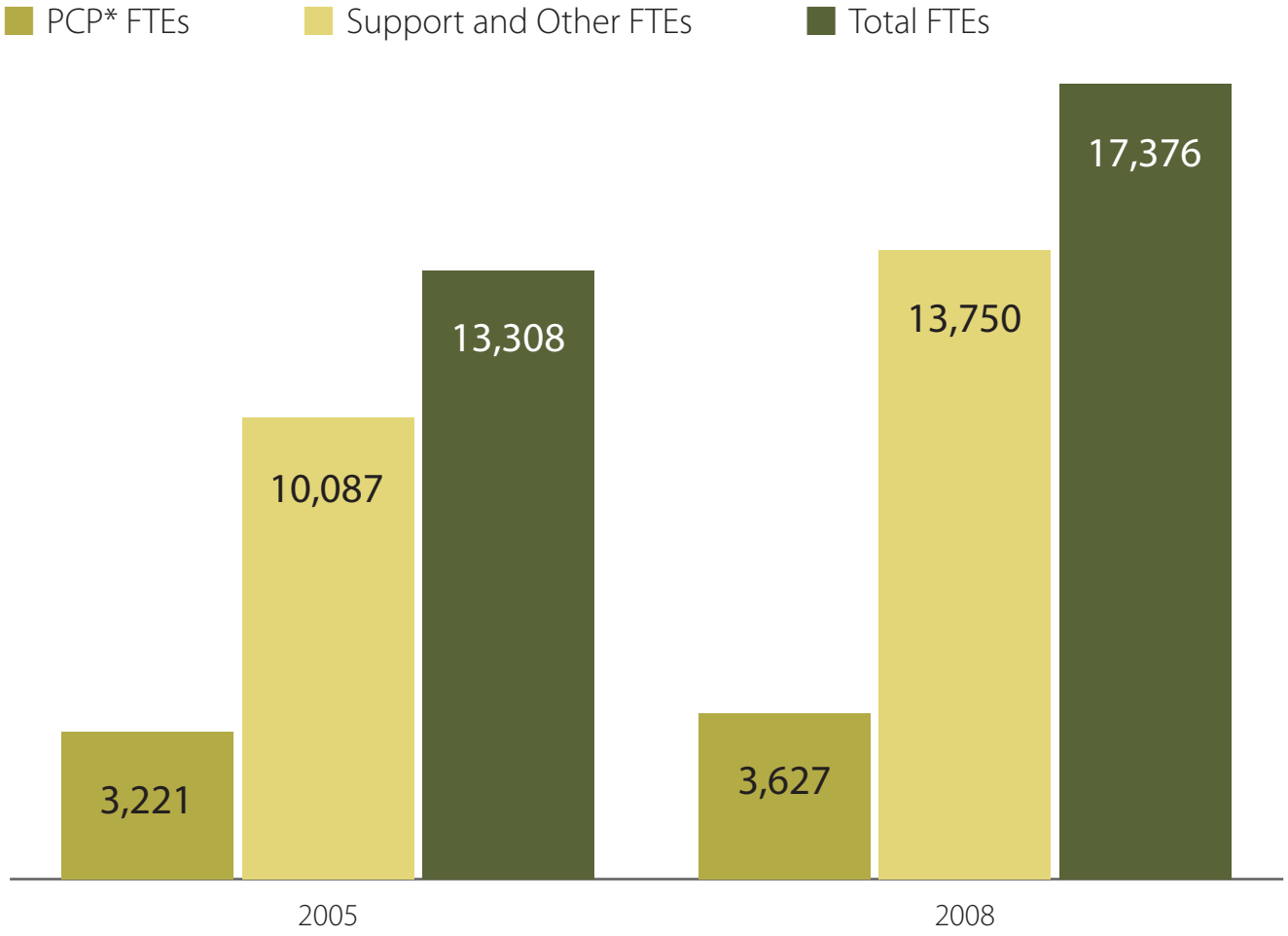
Clinic Operating Margin,
California vs. United States, 2005–2008



Source: Capital Link, *California Community Clinics — A Financial Profile,* 2010.

The financial performance of California community clinics varies widely. About one-fourth are able to generate strong margins in any given year. However, the bottom fourth operate at a loss of about 2 percent or more and have historically performed worse than elsewhere in the nation.

Clinic Primary Care Providers and Other Personnel, 2005 and 2008



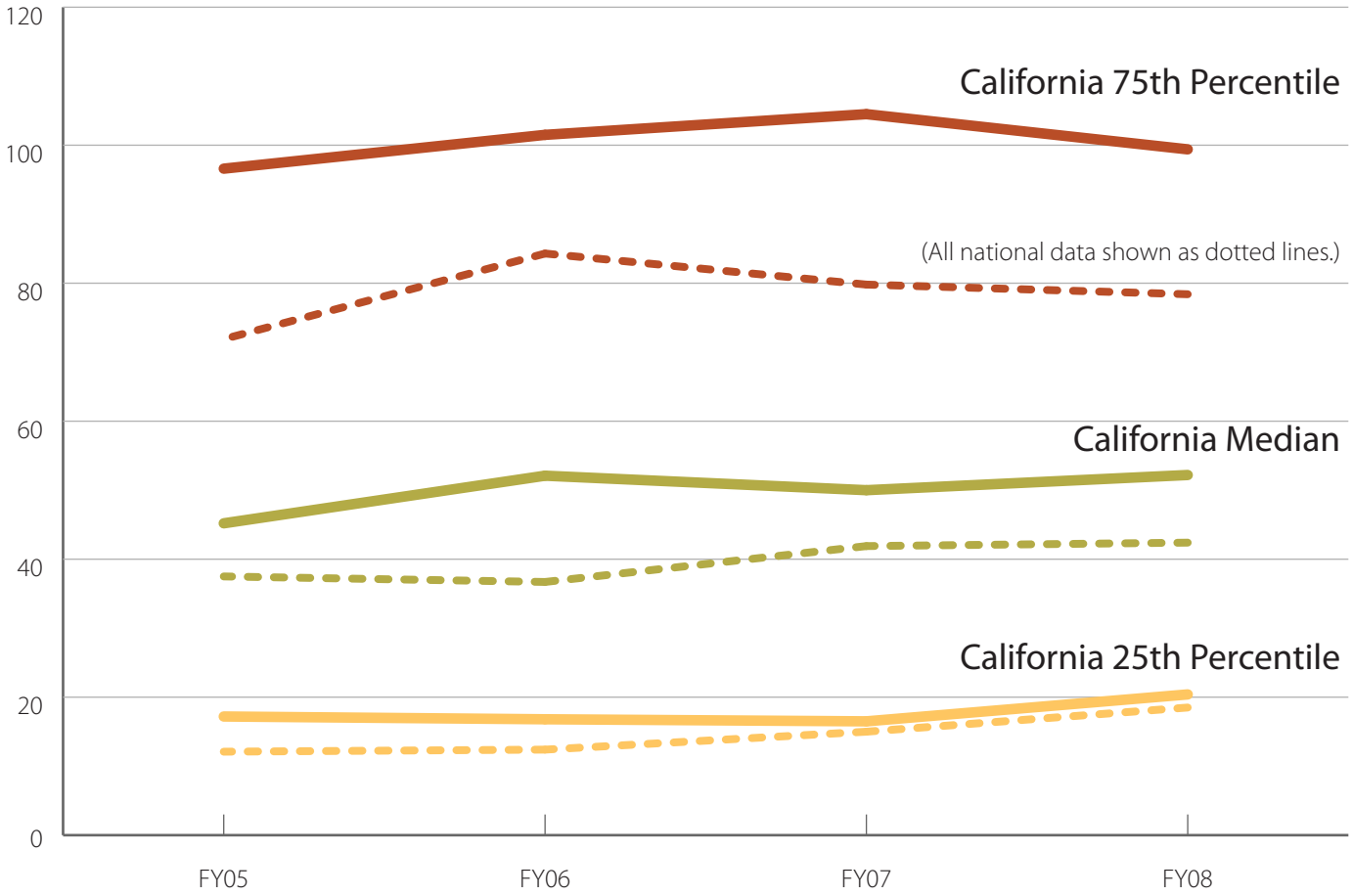
Note: OSHPD did not capture complete data on support and total full-time equivalents (FTEs) until 2005.

*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,* 2010.

Support personnel grew 36 percent from 2005 to 2008, while primary care providers only increased by 13 percent. This trend may indicate an increasing level of supplementary services provided to meet the health needs of target populations.

Clinic Days Cash on Hand,
California vs. United States, 2005–2008

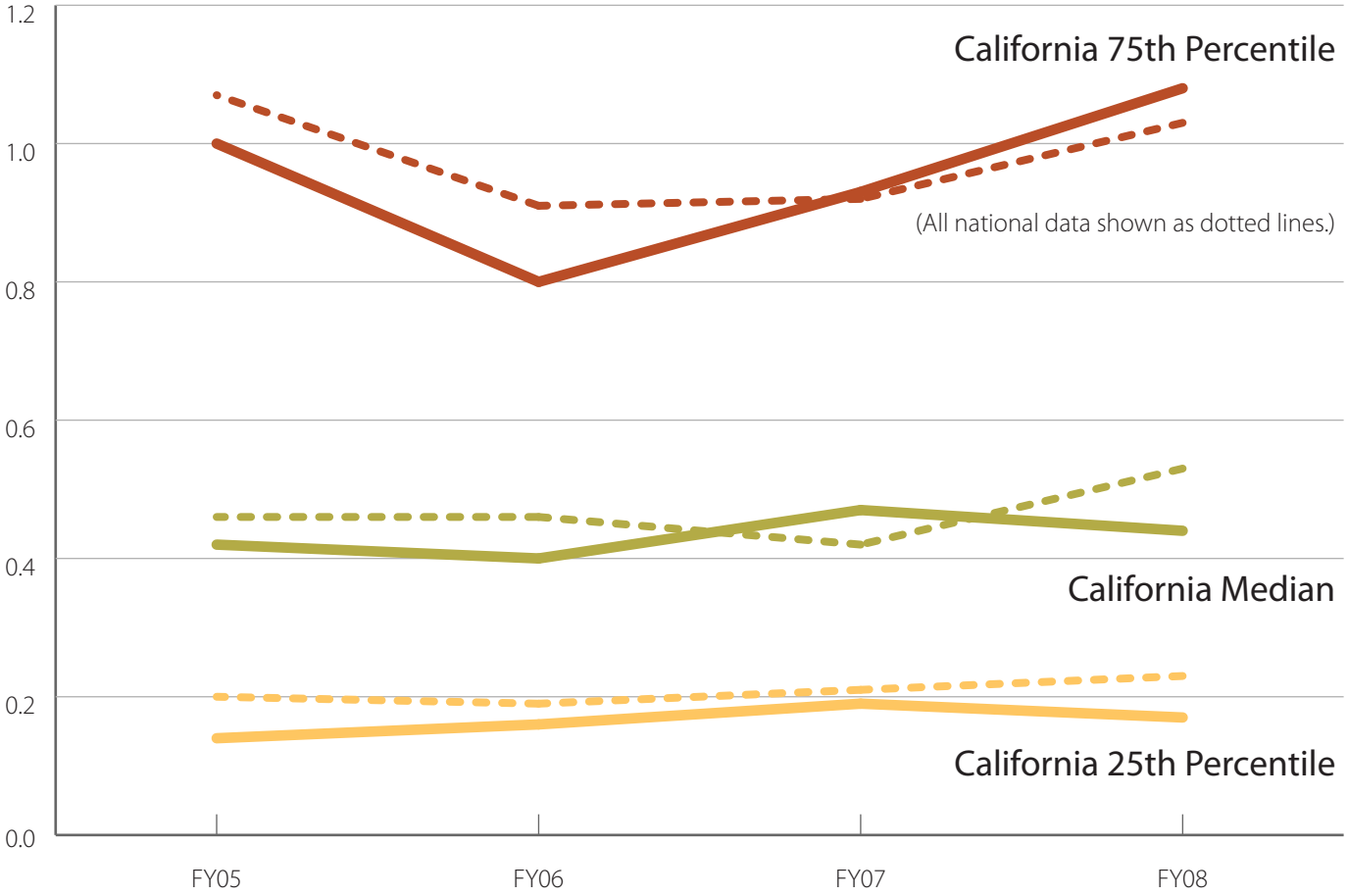


Note: Days cash on hand means the number of days of operating expenses (less depreciation) that can be met with available cash and liquid investments if no additional revenue were received. For efficient operation, it is generally recommended that clinics have at least 30 to 45 days of cash on hand.

Source: Capital Link, *California Community Clinics — A Financial Profile,* 2010.

The median California clinic had 52 days cash on hand in 2008, higher than the national median of 42 days. However, the bottom 25 percent had less than 20 days, making them vulnerable to any interruption in revenue flow, such as that caused by state budget shortfalls.

Clinic Debt Ratios,
California vs. United States, 2005–2008

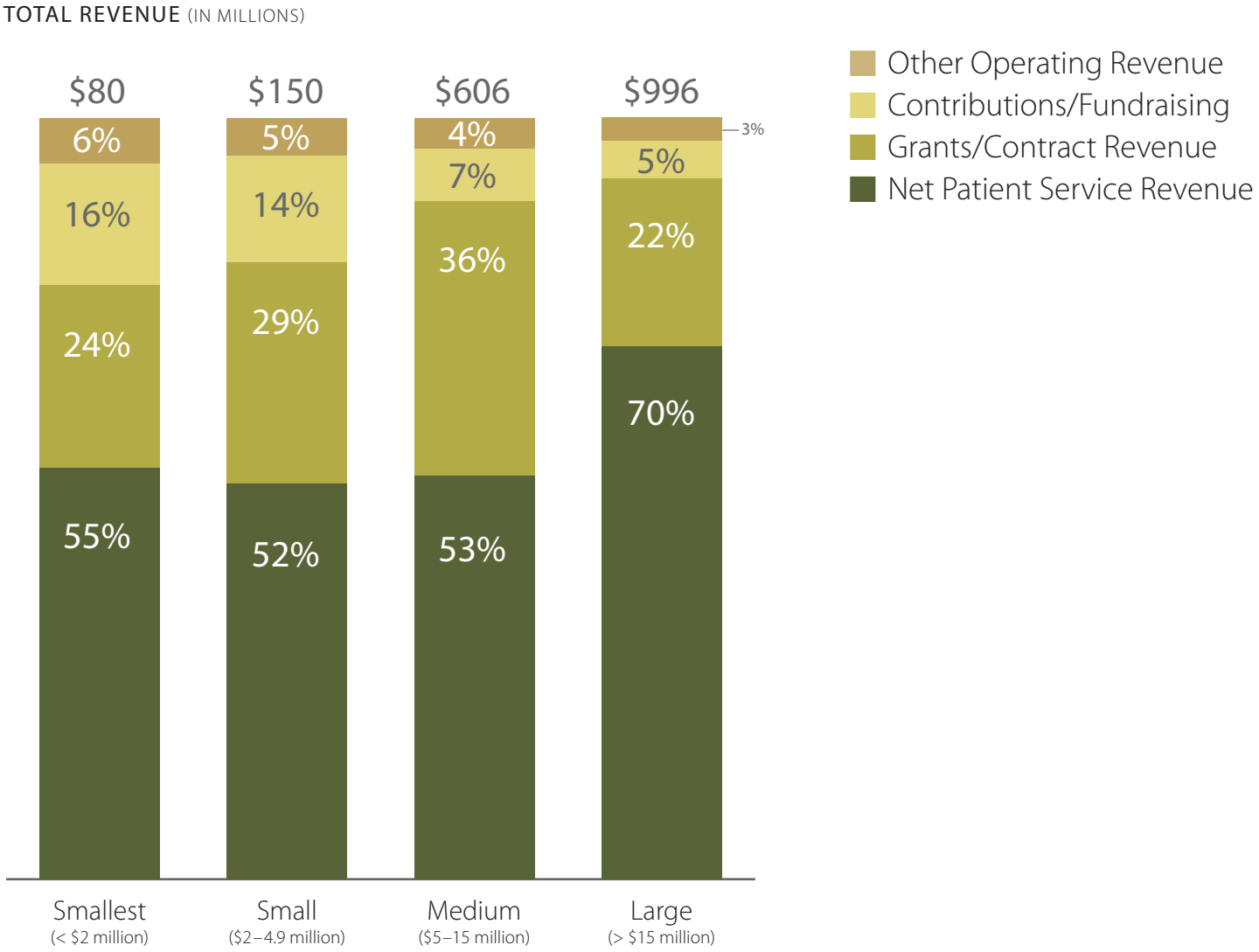


Note: The leverage ratio measures a clinic's total liabilities in relation to its net assets. It is generally recommended that the ratio not exceed 2.5 to 1.0.

Source: Capital Link, *California Community Clinics — A Financial Profile,* 2010.

Most clinics operate with very low leverage — carrying little debt relative to assets. This suggests that clinics have not invested heavily in buildings, technology, and equipment or that clinics have relied on grants and cash reserves to fund capital projects.

Operating Revenue Mix, by Clinic Size, 2008

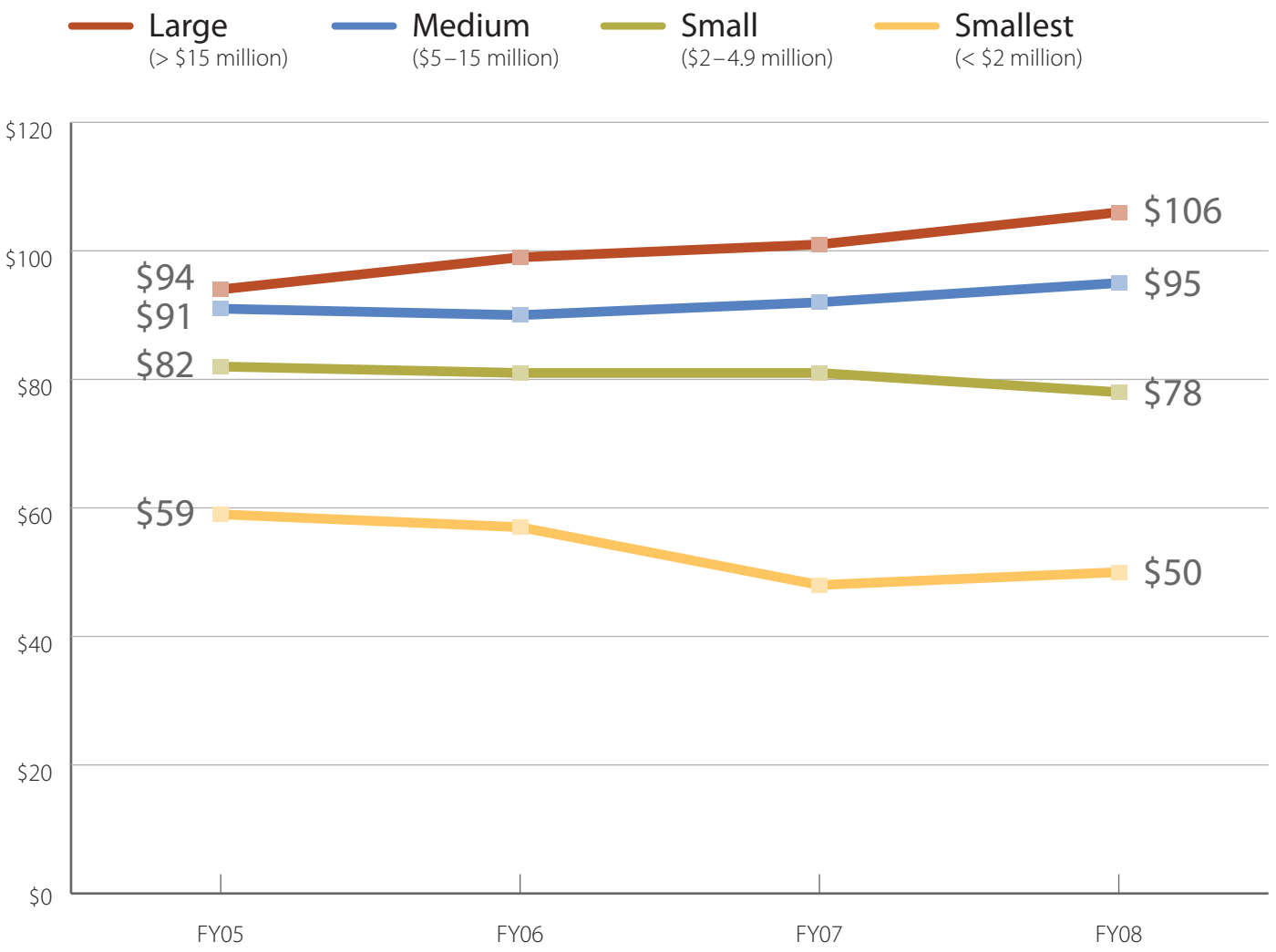


Note: Segments may not add to 100 percent due to rounding.

Source: Capital Link, *California Community Clinics — A Financial Profile,* 2010.

The largest clinics in terms of annual revenue earned 70 percent of their revenue from patient services. Medium-size and small clinics earned only a little more than half their revenue on patient care, relying more heavily than larger clinics on grants/contracts and contributions/fundraising.

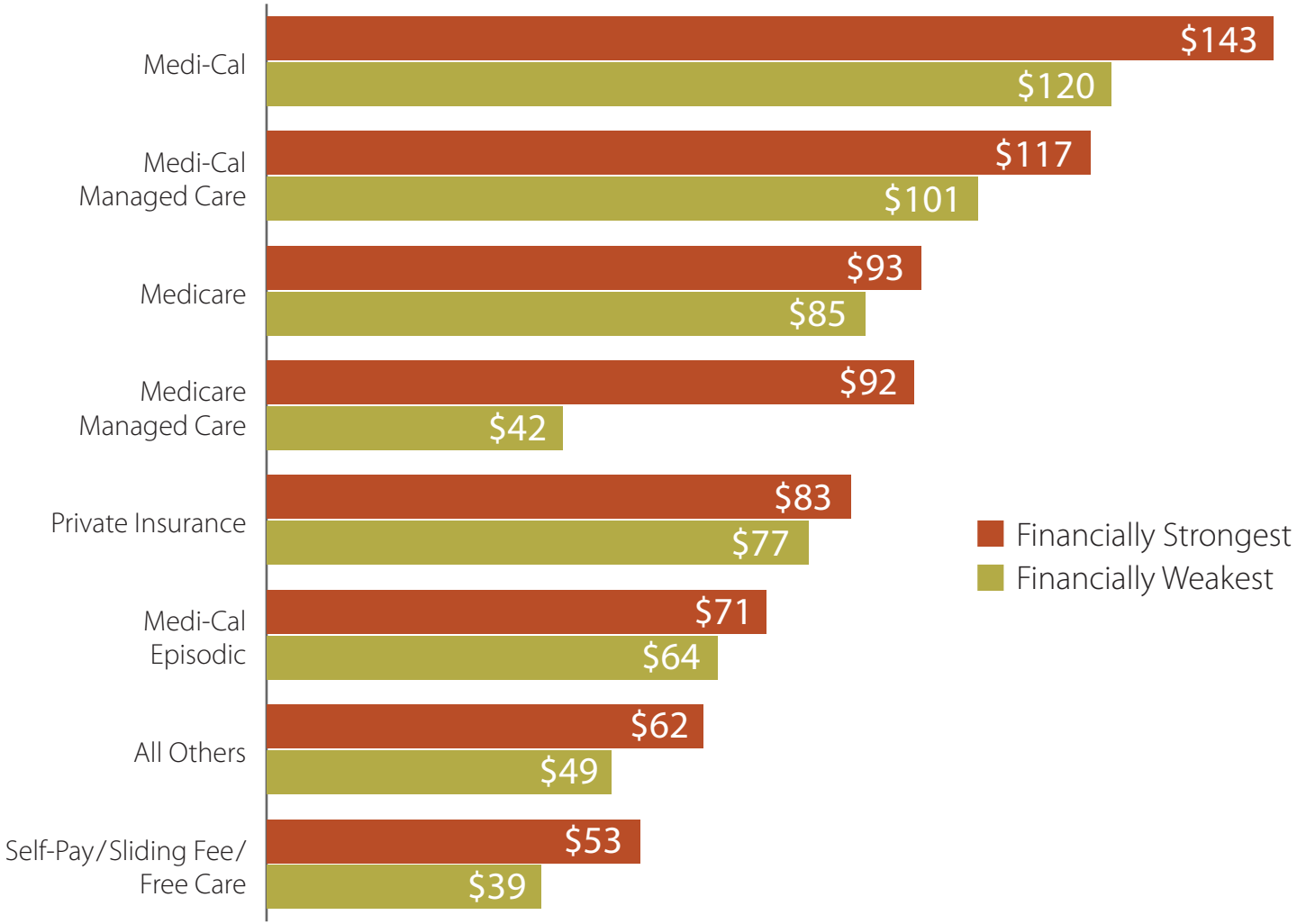
Revenue Per Patient Visit,
by Clinic Size, 2005–2008



Source: Capital Link, *California Community Clinics — A Financial Profile,* 2010.

Median revenue per patient visit for the large clinics was more than double that of the smallest in 2008. The revenue per encounter dropped $9 from 2005 to 2008 for the smallest clinics, while it rose $12 for the largest ones.

Median Net Patient Service Revenue Per Visit,
by Payer and Clinic Financial Strength, 2005–2008 Average

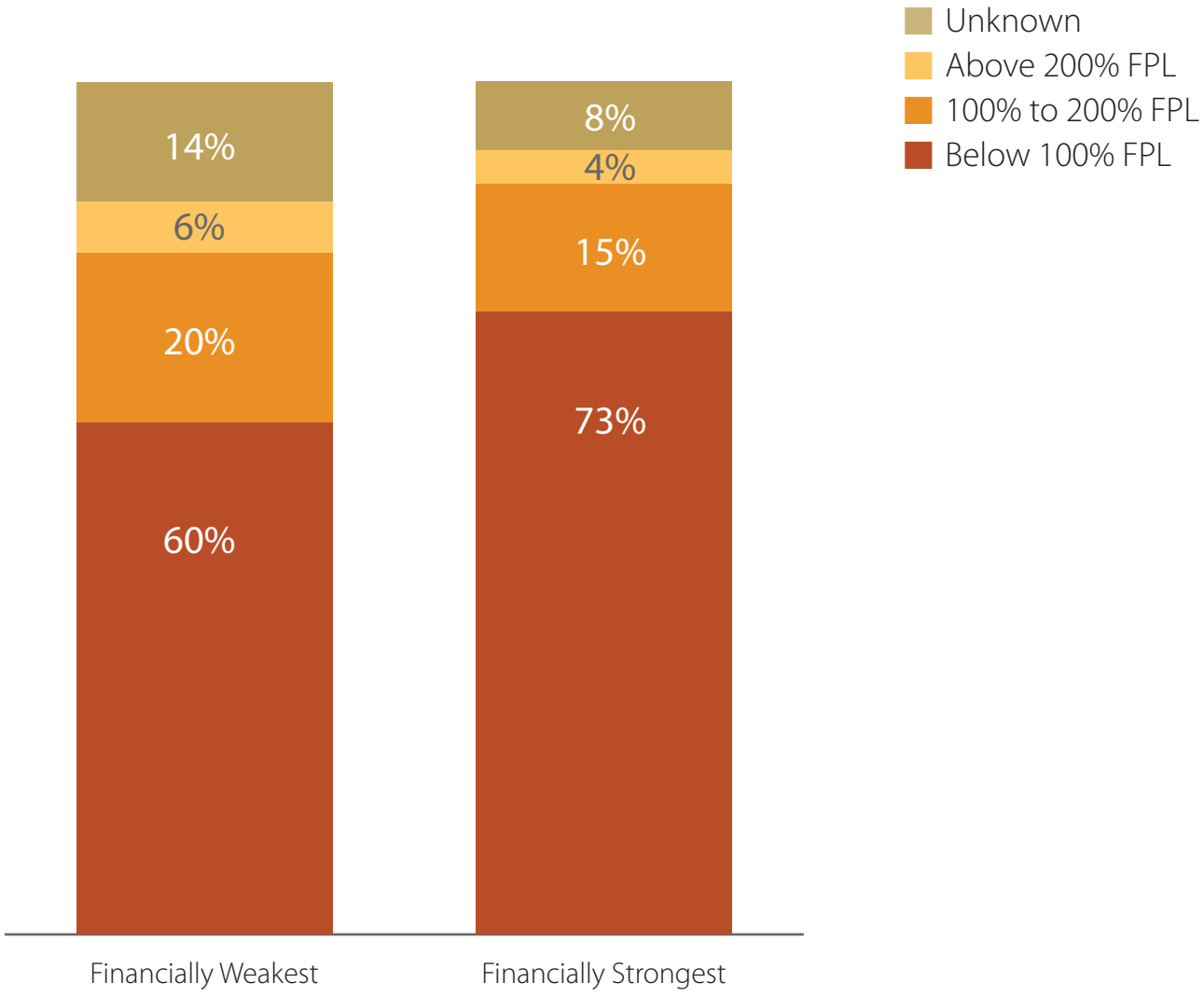


Notes: See Payer Definitions on page 28 for specific programs included under Medi-Cal Episodic and All Others. The community clinics were ranked and tiered into five groups (quintiles) based on overall financial performance. The highest or financially strongest (top 20 percent) and the lowest or financially weakest (bottom 20 percent) were then analyzed to examine factors that may affect the financial performance and financial condition of these cohorts. For more information, see the Methodology section of the full report by Capital Link at www.caplink.org.

Source: Capital Link, *California Community Clinics — A Financial Profile,* 2010.

The clinics ranked as financially strongest had higher reimbursement per patient visit for all payers.

Income Level of Patients Served by Clinics,
by Clinic Financial Strength, 2008

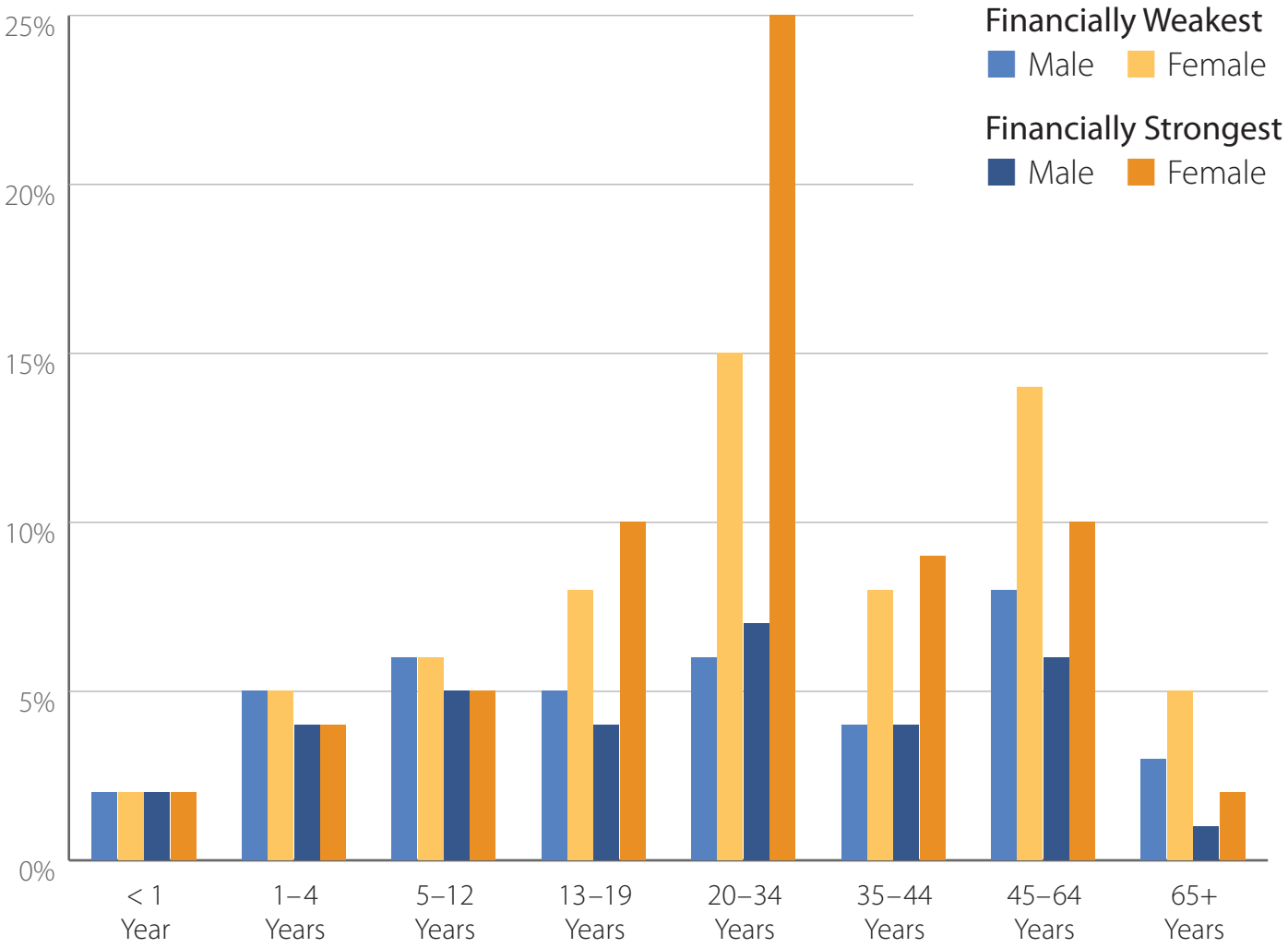


Clinics rated as financially strongest treated a relatively larger share of the lowest-income Californians than did the financially weakest clinics.

Notes: FPL stands for federal poverty level. The community clinics were ranked and tiered into five groups (quintiles) based on overall financial performance. The highest or financially strongest (top 20 percent) and the lowest or financially weakest (bottom 20 percent) were then analyzed to examine factors that may affect the financial performance and financial condition of these cohorts. For more information, see the Methodology section of the full report by Capital Link at www.caplink.org.

Source: Capital Link, *California Community Clinics — A Financial Profile,* 2010.

Patient Age and Gender Distribution,
by Clinic Financial Strength, 2008

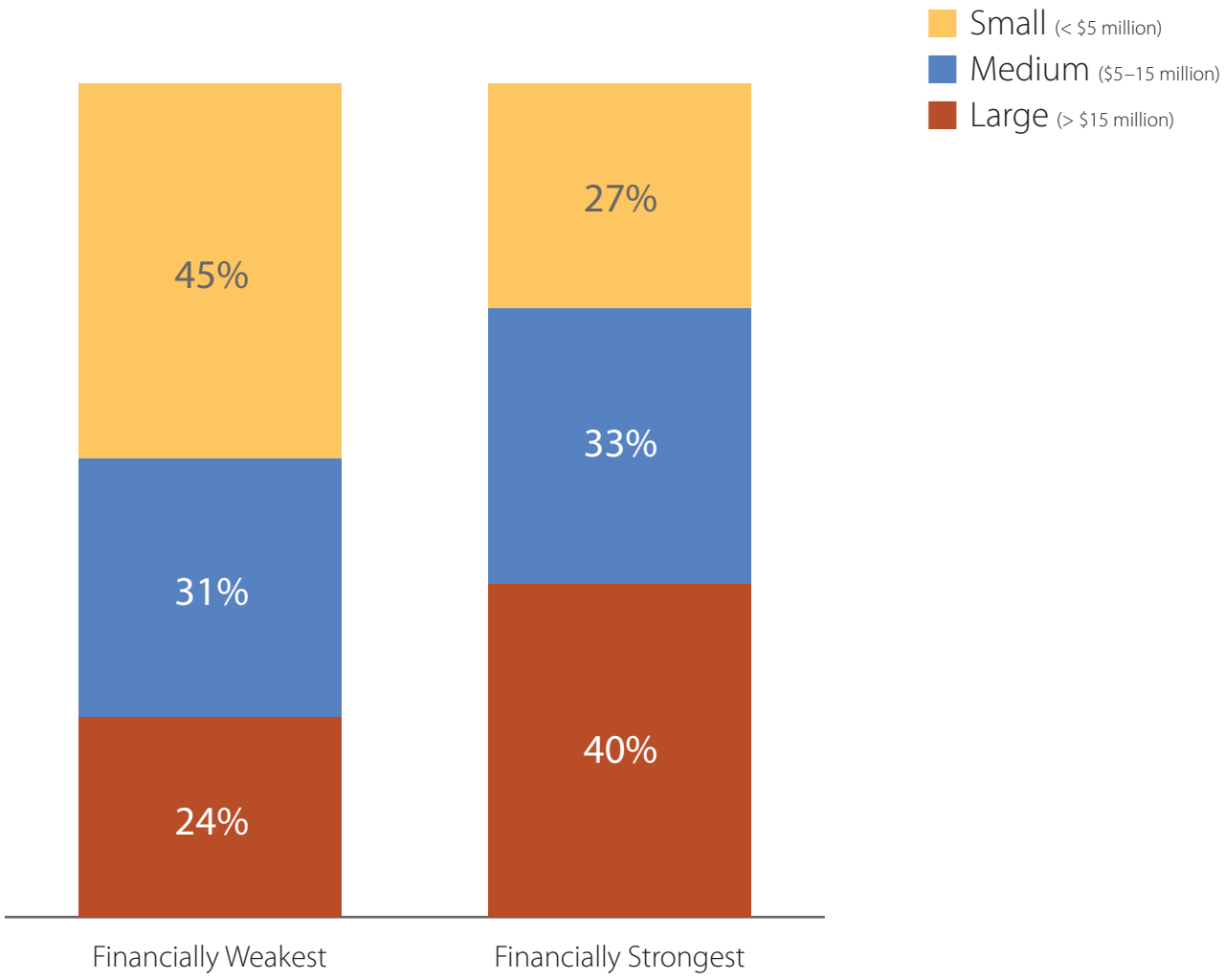


Note: The community clinics were ranked and tiered into five groups (quintiles) based on overall financial performance. The highest or financially strongest (top 20 percent) and the lowest or financially weakest (bottom 20 percent) were then analyzed to examine factors that may affect the financial performance and financial condition of these cohorts. For more information, see the Methodology section of the full report by Capital Link at www.caplink.org.

Source: Capital Link, *California Community Clinics — A Financial Profile,* 2010.

The financially strongest clinics saw more children and women of child-bearing age than other clinics in 2008.

Total Revenue Distribution,
by Clinic Financial Strength and Size, 2008

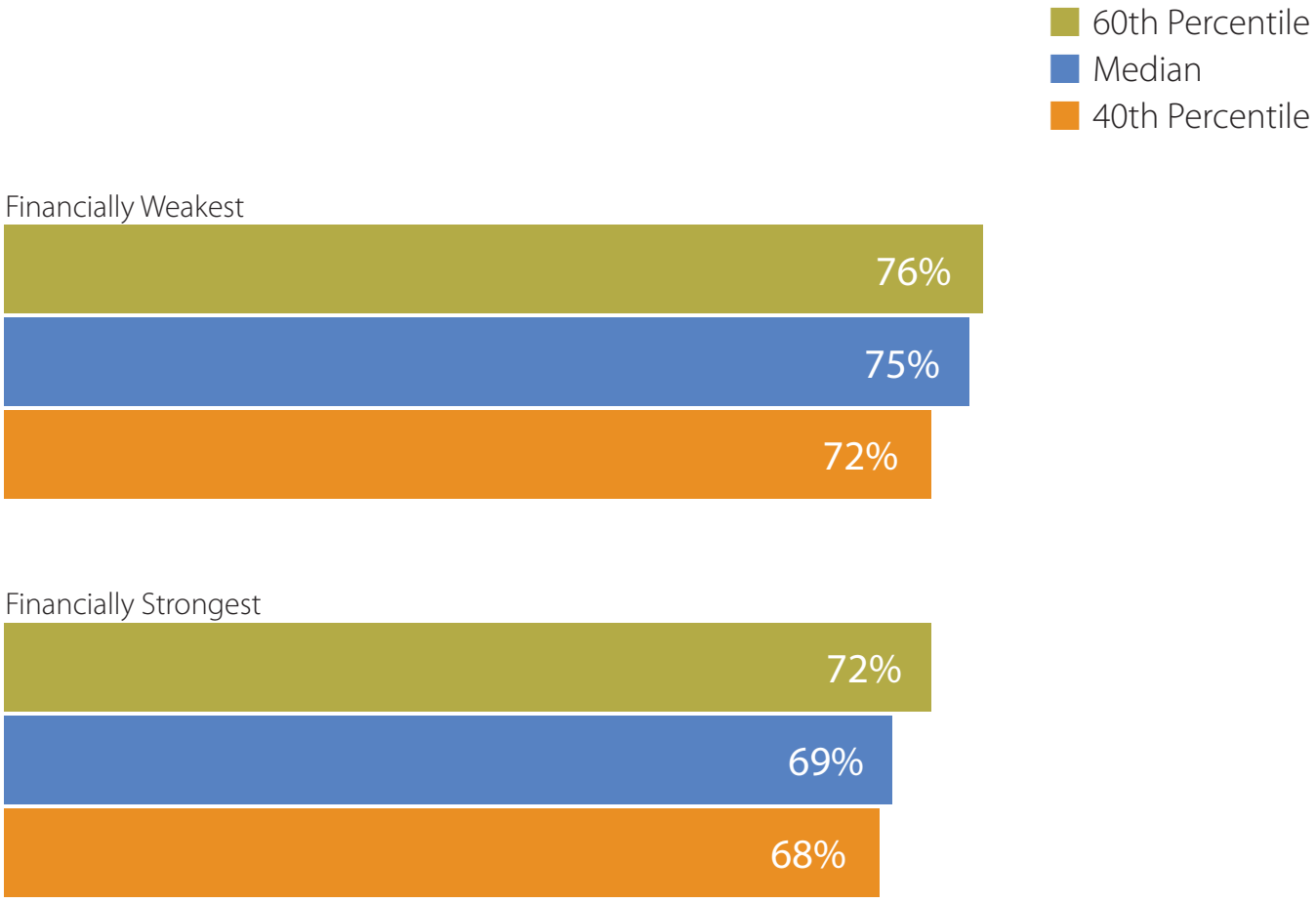


Note: The community clinics were ranked and tiered into five groups (quintiles) based on overall financial performance. The highest or financially strongest (top 20 percent) and the lowest or financially weakest (bottom 20 percent) were then analyzed to examine factors that may affect the financial performance and financial condition of these cohorts. For more information, see the Methodology section of the full report by Capital Link at www.caplink.org.

Source: Capital Link, *California Community Clinics — A Financial Profile,* 2010.

Clinics that are the strongest financially are more likely to be larger clinics with more than $15 million in revenues.

Salary Expenses as Percent of Total Operating Revenue,
by Clinic Financial Strength, 2005–2008 Average

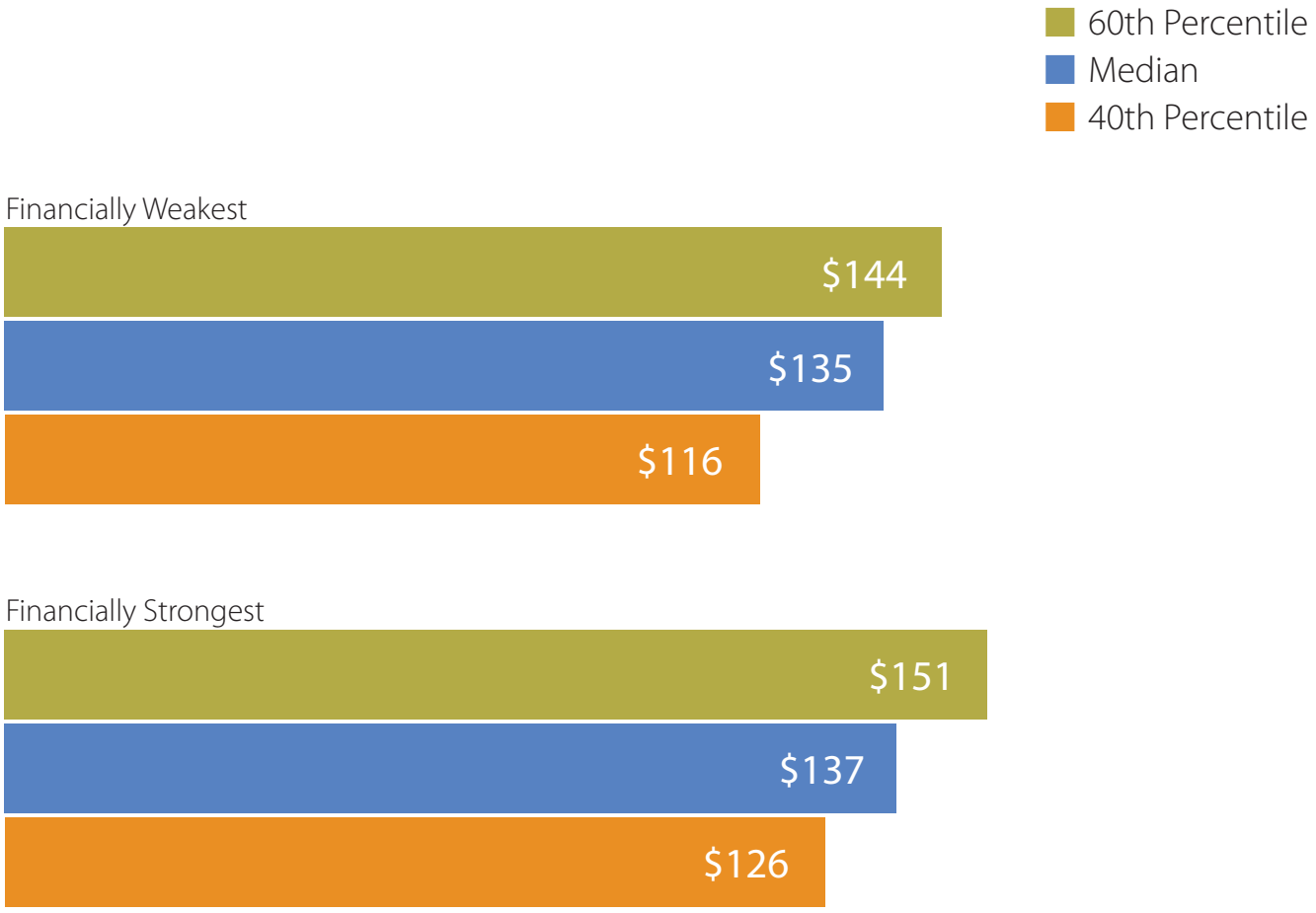


On average, the financially strongest clinics were more likely to have lower salary expenses as a percent of total revenues, from 2005 to 2008.

Note: The community clinics were ranked and tiered into five groups (quintiles) based on overall financial performance. The highest or financially strongest (top 20 percent) and the lowest or financially weakest (bottom 20 percent) were then analyzed to examine factors that may affect the financial performance and financial condition of these cohorts. For more information, see the Methodology section of the full report by Capital Link at www.caplink.org.

Source: Capital Link, *California Community Clinics — A Financial Profile,* 2010.

Operating Expense Per Patient Visit,
by Clinic Financial Strength, 2005–2008 Average

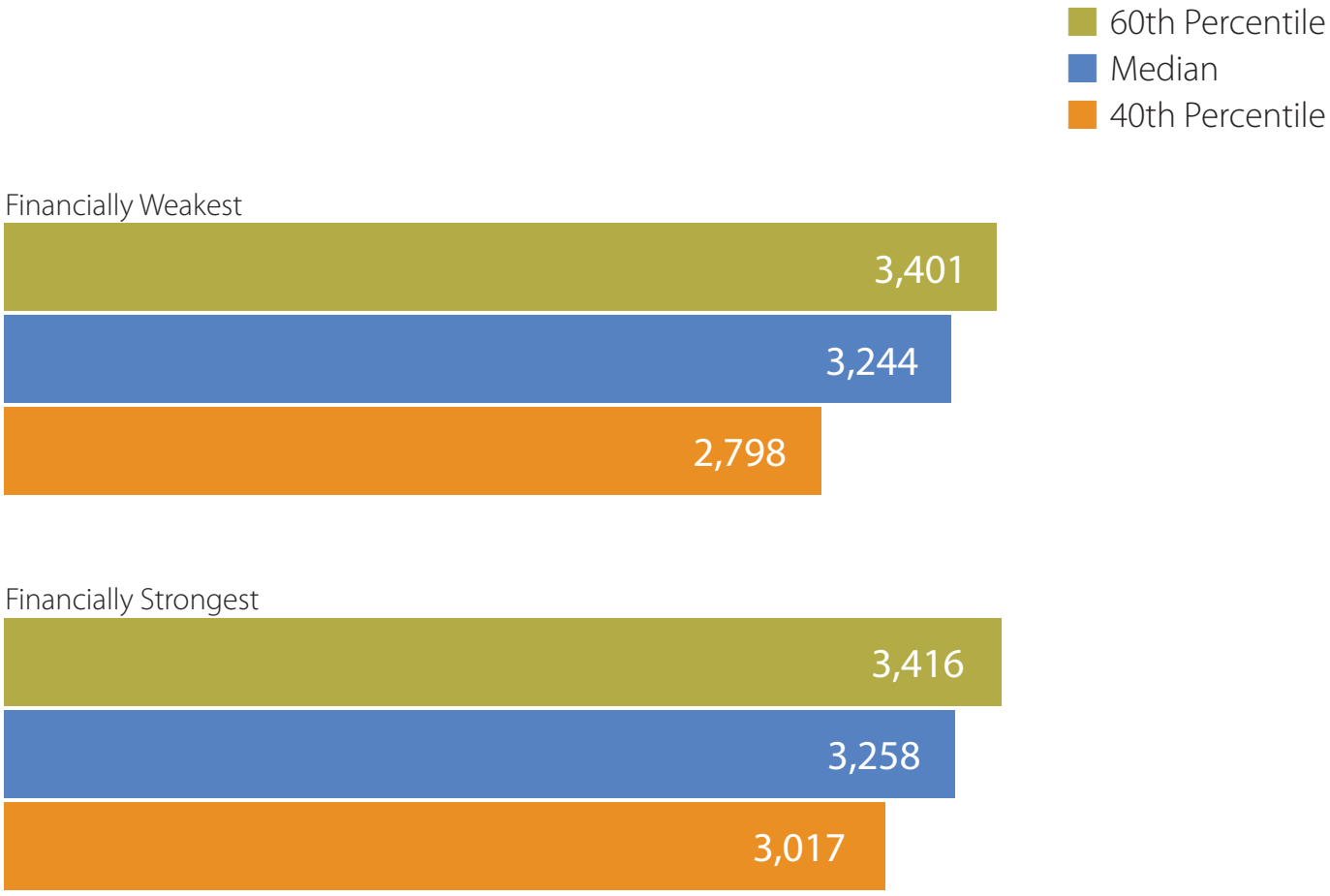


The financially strongest and weakest clinics had similar expenses per encounter, on average, from 2005 to 2008. However, the strongest clinics had higher reimbursement rates.

Note: The community clinics were ranked and tiered into five groups (quintiles) based on overall financial performance. The highest or financially strongest (top 20 percent) and the lowest or financially weakest (bottom 20 percent) were then analyzed to examine factors that may affect the financial performance and financial condition of these cohorts. For more information, see the Methodology section of the full report by Capital Link at www.caplink.org.

Source: Capital Link, *California Community Clinics — A Financial Profile,* 2010.

Patient Visits Per Primary Care Provider,
by Clinic Financial Strength, 2005–2008 Average



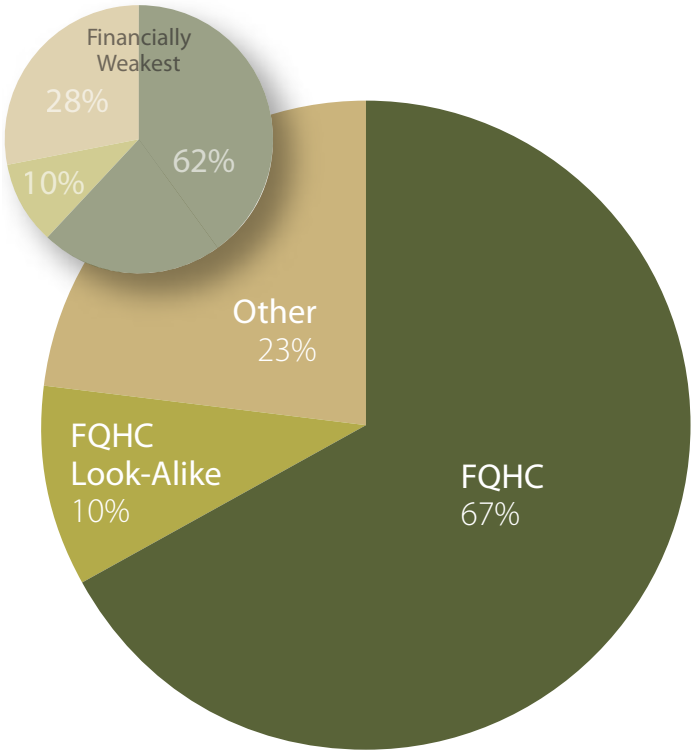
Productivity does not appear to significantly influence financial performance. The highest and lowest performing clinics had similar numbers of visits per primary care provider, on average, from 2005 to 2008.

Note: The community clinics were ranked and tiered into five groups (quintiles) based on overall financial performance. The highest or financially strongest (top 20 percent) and the lowest or financially weakest (bottom 20 percent) were then analyzed to examine factors that may affect the financial performance and financial condition of these cohorts. For more information, see the Methodology section of the full report by Capital Link at www.caplink.org.

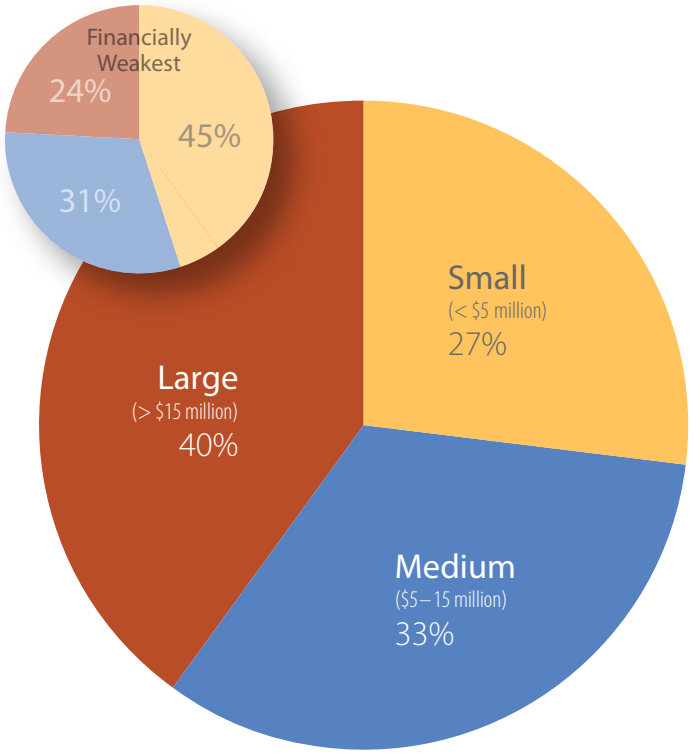
Source: Capital Link, *California Community Clinics — A Financial Profile,* 2010.

Clinic Type and Size,
by Financial Strength, 2008

Clinic Type
Financially Strongest



Clinic Size
Financially Strongest



Clinic type does not appear to significantly influence financial performance. The strongest and weakest performers have similar percentages of clinics by type.

However, size does correlate with performance; larger clinics are more likely to be financially strong.

Notes: See Clinic Definitions on page 28 for a description of FQHCs and list of other types of community clinics included in this report. The community clinics were ranked and tiered into five groups (quintiles) based on overall financial performance. The highest or financially strongest (top 20 percent) and the lowest or financially weakest (bottom 20 percent) were then analyzed to examine factors that may affect the financial performance and financial condition of these cohorts. For more information, see the Methodology section of the full report by Capital Link at www.caplink.org.

Source: Capital Link, *California Community Clinics — A Financial Profile,* 2010.

Clinic Definitions

Federally Qualified Health Centers (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"** community clinics included in this report: nonprofit Rural Health Clinics; free clinics; and other licensed safety-net clinics, including family planning and school-based clinics.

Payer Definitions

Medi-Cal Episodic

- Breast Cancer Programs, including the Breast Cancer Early Detection Program and the Breast and Cervical Cancer Treatment Program
- Children's Health and Disability Program (CHDP)
- California Family Planning, Access, Care and Treatment (Family PACT)

All Others

- County Indigent / CMSP / MISP
- Healthy Families / State Children's Health Insurance Program (SCHIP)
- Expanded Access to Primary Care program — patient collections (EAPC)
- San Diego County Medical Plan
- Los Angeles County Public Private Partnership
- Alameda Alliance for Health (Family Care)
- Other County Payers

Data Resources

Authors

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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).

This report applied a screening methodology to each OSHPD annual data set to include only those clinics providing comprehensive primary care services, resulting in a clinic list that varied in each year of the analysis. For more information, download the report, *California Community Clinics — A Financial Profile, 2010,* at www.caplink.org.

FOR MORE INFORMATION

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