

Community Health Center Financial Perspectives

Issue 6

Identifying the Risks of Health Center Lending

A Guide for Lenders



Acknowledgements



Capital Link is a national, non-profit organization that has worked with hundreds of health centers and Primary Care Associations over the past 15 years to plan capital projects, finance growth, and identify ways to improve performance. We provide innovative advisory services and extensive technical assistance with the goal of supporting and expanding community-based health care. Established in the late 1990s as a joint effort of the National Association of Community Health Centers (NACHC), several state-based Primary Care Associations (PCAs), and the Bureau of Primary Health Care, Capital Link grew out of the community health center family and continues to support it through creative capital development and analytic activities. For more information, visit www.caplink.org.



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Community Health Center Financial Perspectives

This series of resource documents is sponsored by the Citi Foundation and prepared by Capital Link, in collaboration with Community Health Center Capital Fund. Its goal is to illuminate the financial and operational trends of the industry in order to increase the breadth and depth of information available on community health centers. The series consists of reports on select topic areas produced utilizing Capital Link's database of health center financial audits and data from the Health Resources and Services Administration's (HRSA's) Bureau of Primary Health Care's Uniform Data System (UDS). Each report contains two issues: one written to address an audience of community health center leaders and another directed toward lenders and investors.

Other reports in the series include:

Community Health Center Financial Perspectives, Issues 1 and 2: Financial and Operational Ratios and Trends of Community Health Centers, 2008-2011

The first topic in the publication series provides multi-year insight on national health center financial and operational performance metrics and trends.

Community Health Center Financial Perspectives, Issues 3 and 4: Impact of Capital Projects on Health Centers: Growth, Financial Trends, and Operational Transformation

The second topic in the series details the impact capital projects have on health centers' financial and operational performance and health.

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Executive Summary

This report examines the factors that may contribute to default and demise in the health center sector and serves as *Issue 6* in the series entitled *Community Health Center Financial Perspectives*, supported by the Citi Foundation and prepared by Capital Link in collaboration with Community Health Center Capital Fund. Written for prospective health center lenders, this document takes a data-informed approach to understanding the nuances of the health center business model, and raises key issues and questions that lenders may wish to consider when underwriting loans for this sector.

Key Findings

Of the more than 1,280 organizations that have ever been free-standing federally-funded health centers (Section 330 grantees) from 2000 – 2012, fewer than 7% failed or merged with another entity. While this track record is quite strong as compared to other sectors, lenders and investors can learn from the experience of troubled health centers—to help them better understand the warning signs of weak performance and assess the risks of lending in this sector. Based on a financial and operational performance analysis of 29 health centers that failed or are currently at risk of failing over a four-year period leading up to the centers' demise, the data supports the following findings:

Cumulative Effect of Multiple Risk Factors: Many test group attributes differed markedly from the control group but there did not seem to be one universal or definitive causal factor in the test centers' distress. Significant variation between quartiles was common, suggesting that the test group centers shared few common high-risk factors, but all demonstrated multiple measures of financial and operational distress.

Health Center Size: The centers in the test group were uniformly smaller than their control group counterparts when measured by patients, visits, full-time equivalent employees (FTEs), and revenues. Fifty-two percent had total revenues below \$5 million in the year they failed and 86% had revenues below \$10 million—placing the majority below the 25th percentile in terms of revenue for the sector as a whole and almost all below the median, based on 2011 data.¹

Stagnating Growth: For the most part the centers in the test group experienced stagnating or declining revenues and shrinking numbers of patients, visits, and FTEs, as compared to their control counterparts. While approximately 25% did show initial growth in these areas, they appeared to falter and reverse course, perhaps as a result of undertaking a capacity expansion that failed to produce the expected results.

Payer Mix: Surprisingly, the test centers did not demonstrate a significantly higher percentage of

¹ Capital Link, *Community Health Center Financial Perspectives, Issue 2: Financial and Operational Ratios and Trends of Community Health Centers, 2008–2011*, p. 14.

uninsured patients than the control group. This hypothesis seemed to be one of the most likely conclusions preceding this study but that proved not to be the case. Test centers saw proportionally fewer Medicaid patients than their more successful counterparts. As the top payer for health centers, a lower proportion of Medicaid patients would certainly have had a negative effect on revenue. However, it's not clear if this lower proportion was due to fewer Medicaid-eligible patients in the health centers' service areas or if it was due to the centers' poor enrollment efforts—or if it was a combination of the two. The test centers also saw a higher proportion of Medicare patients than their control counterparts. Given that until recently, health centers operated with a cap on Medicare reimbursement, this payment cap would have had a disproportionately negative affect on the test group.

Collections/Allowances: One clear conclusion from this study that points to a management-related function is the relatively poor performance of the test centers' accounts receivable collections efforts—and the resulting higher levels of allowances. While billing and collections are complex processes in the health center sector, centers cannot afford to leave money on the table, and this is what uncollected accounts receivable appears to represent.

Productivity: Under the fee-for-service reimbursement system that currently prevails across the country, individual provider productivity (number of billable visits per day/month/year) is the fuel that drives the revenue engine. Lower productivity translates into lower revenue, and all of the test centers reported significantly lower levels of physician and mid-level productivity compared to the control group. The factors that affect productivity in the health center industry are many and varied, and this study attempted to use the data to drill down and determine commonalities. Electronic Health Record (EHR) implementation is one likely reason for diminished productivity, but that is difficult to substantiate through the data. Support staffing levels are also relevant, but for a health center under financial stress, provider turnover is likely a major contributor to which the available data can only hint.

Management: The conclusions pointed out in the study will be helpful underwriting tools, but the study does not provide lenders with a free-pass on the most basic challenge of underwriting any loan: evaluating the quality of the management team. The quality of management (how well a business model is executed) varies greatly across similar organizations in all industries, and health centers are no exception. While the longevity of the health center model attests to the overall strength of managers and boards working together to provide effective, sustainable, community-based care, some managers and boards have struggled with this task. That said, the industry has grown to its current size facing similar challenges and has mostly thrived.

Default and Loan Loss for the Sector as a Whole: As a part of this study, a survey of 16 Community Development Financial Institutions (CDFIs) with a history of lending to health centers was conducted in order to explore their experience in underwriting loans in this sector. Results showed that health centers

appear to present a remarkably low portfolio risk to lenders. Since 2004, the surveyed CDFIs made a total of 439 loans for a total of over \$587 million. Of the total loans closed, the vast majority were for real estate-related purposes and 184 (42%) currently have outstanding balances. The percentage of loans that have been 60 or more days past due at any time since closing was only 1.1% and less than half of 1% resulted in any loss to the lender.

This report is organized in the following sections:

- Section I:** Introduction
- Section II:** Methodology
- Section III:** Health Center Data Analysis Results – Potential Indicators of Health Center Financial Challenges
- Section IV:** Summary of Community Development Financial Institutions (CDFIs) Survey Results
- Section V:** Conclusion

Section I: Introduction

The following report examines the differences between failed or failing health centers and their more successful counterparts, shedding light on the factors that may contribute to health center failure. This analysis seeks to provide lenders with the insight necessary to determine the potential early warning signs of future financial distress when underwriting health center loan requests—whether for capital project financing, working capital, or growth capital.

Currently the largest network of primary care providers nationally, Federally Qualified Health Centers (FQHCs) are expected to grow from serving 22.3 million patients in 2012² to 30-35 million patients over the next several years, as a result of the Patient Protection and Affordable Care Act (ACA). This level of projected growth is even greater than the growth health centers experienced between 2005 and 2011, during which time they grew from serving 15.9 million to 21.1 million patients.

Overview of the Health Center Business Model

As noted in previous issues of the *Community Health Center Financial Perspectives* series, the FQHC business model is complex, but for the majority of the approximately 1,200 FQHCs in the country, it has proven to be sound when competently implemented. Not all FQHCs have implemented it successfully, however, and the result is that some have failed outright and liquidated their assets while others were forced into mergers with other health centers and in the process, lost their unique identity.

The basic FQHC business model involves a trade-off between the expense of providing a standard set of primary care services for every patient (without concern for their ability to pay), and the enhanced revenue from significant federal grant subsidies and full-cost Medicaid reimbursement. While reimbursement amounts may vary widely from patient to patient (especially for the Medicaid-enrolled and the uninsured), the package of services an FQHC must offer to qualify for the program is standardized. This dichotomy creates the potential for built-in financial stresses, especially in the early growth phase of most health centers when patient numbers are still low but the cost of complying with program and payer regulations can be disproportionately high. A center with a lower percentage of Medicaid-enrolled patients may face more financial challenges than one with a higher percentage. In addition, a center with a high percentage of undocumented patients may face an even steeper challenge as this population can never qualify for Medicaid or Medicare regardless of how much a center spends on outreach and enrollment efforts.

It is important to note that while Medicaid is a federal program that states must offer, individual states are allowed a significant amount of leeway in how the program is implemented because the states themselves

² As of 2012, according to the nationwide Uniform Data System (UDS) Roll-up Report that tabulates FQHC and FQHC Look-Alike data.

are responsible for approximately half of the program costs. The result can vary widely across state borders. For example, eligibility is generally dictated by patient income, but the qualifying threshold varies from state to state. Rules regarding the frequency of re-confirming eligibility also varies from state to state. Additionally, full Medicaid cost reimbursement does not promise equal payment for equal service across state lines—or even for health centers within a given state—since rates can vary substantially based on when visit costs were originally established. The result is that while the business model looks similar at the “10,000-foot level,” it can vary significantly between centers—even those in the same city. Medicaid is such a critical payer for all health centers, which is why this report provides detail on the variation in Medicaid payer mix, collections, and allowances between the test and control groups.

During the period covered by this study, Medicare reimbursed health centers for qualifying patient visits at either a capped urban rate (\$128 in calendar year 2013) or a capped rural rate (\$110.78). As a result of the passage of the ACA, Medicare will soon be establishing a payment system for FQHCs similar to the Prospective Payment System (PPS) utilized by Medicaid (this is described in greater detail in the Bad Debt Analysis section of this report). The outcome is likely to be a substantial increase in net Medicare reimbursements to FQHCs beginning October 1, 2014.

Both Medicaid and Medicare can be difficult to bill accurately due to complex eligibility criteria and extensive documentation requirements. An FQHC’s efficient collection from these two government payers is a prerequisite to generating positive margins. Health centers are challenged to both maximize enrollment in these programs and maximize collections for qualified billable visits.

As previously mentioned, a financial benefit of FQHC designation is the annual operating grant from the Bureau of Primary Health Care. Grant amounts vary from center to center and, once established, can change only by a Congressional budget action (i.e., a base grant adjustment), a “Change in Scope” (i.e., HRSA-approved addition of new service lines like dental or behavioral health), or a “New Access Point” award from HRSA (i.e., a new location within the service area for provision of primary care services).

Another aspect of the FQHC business model that varies among centers is participation in the 340B Drug Pricing Program. A health center must apply and be approved for designation as a “Covered Entity” by HRSA in order to purchase discounted pharmaceuticals to sell to their patients (but not to the general public). There are several ways to implement this program (i.e., in-house pharmacies, provider/in-house dispensing, and contracted pharmacies), and it is generally accepted that as a Covered Entity, a center needs to fill a minimum number of prescription medications per day in order to break-even. However, a well-run 340B Program can be very lucrative for a health center.

It is clear that while all FQHCs share a similar basic business plan structure, enough to collectively call them an “industry,” many factors conspire to make operating one health center very different from the next.

Risks Unique to the Health Center Industry

Health centers have existed in a government-encouraged growth mode almost since their inception, nearly doubling the number of patients served each decade. With the ACA calling for health centers to provide care for approximately 35 million patients by 2020, their growth trajectory will only continue. But rapid growth in any industry comes at a cost. This observation is especially true when the engine of that growth is a large number of individual, diverse, community-based, and non-profit organizations. This structure is both the bedrock of the health center industry—which still refers to itself as a “movement,” but has effectively evolved beyond the grassroots stage—and the cause of tremendous variability in the implementation of the common business plan. This variability will likely increase with the rapid changes occurring in the health care environment, including:

Evolving Payment Systems: The current fee-for-service payment system endemic in the health care system is rapidly evolving into a global payment system, whereby providers are rewarded not simply for providing visits but for keeping their assigned patients healthy. Based on a population health model, many primary and specialty care providers and hospitals are forming Accountable Care Organizations (ACOs) to manage patient care in this new reimbursement environment—with various risk-based incentive models. FQHCs are already being challenged to negotiate with ACOs for monthly, per-member per-month payment rates that adequately cover their operating costs along with a shared savings plan that rewards them for providing quality care. With a comprehensive set of medical, dental, behavioral health, and enabling services to offer, FQHCs appear to be uniquely positioned to both make good on the promise of better health outcomes and benefit from the savings generated. However, the turbulence this payment change will create in the operating environment will continue to test the strength and agility of FQHC management to respond in new ways to the evolving market.

Shortage of Primary Care Providers: The shortage of primary care providers has been a looming problem in the industry for some time, and is due in large part to the significant and growing disparity in pay between primary care and specialist physicians. The changes brought on by the ACA will intensify this shortage as many health systems seek to hire or contract with primary care providers to help manage care for the newly-insured. Many, if not most, of these newly-insured individuals reside in the low-income communities FQHCs serve. In states that have chosen to expand Medicaid, the effect is magnified and health centers are already experiencing a wave of new patients and new constraints on capacity.

Increasing Competition as a Result of the ACA: Private practice physicians already see the writing on the wall; under the ACA, Medicaid is being expanded and it will become more difficult to grow a practice without serving this population. Moreover, the ACA boosts reimbursement rates for private primary care providers to Medicare levels (a distinct improvement) in an effort to expand the network of providers willing to accept Medicaid patients. As a result, even though health centers will still receive higher Medicaid reimbursements than private physicians, there are many more doors open to Medicaid patients than ever before. Health centers need to be sure they do not take this population for granted as they will

still be expected to see every uninsured patient that walks through their doors; if Medicaid patients begin to go elsewhere, the expected improvement in the health center payer mix may not occur.

Pressure to Integrate Mental Health and Substance Abuse Services: One of the core tenets of the ACA is an attempt to ensure that all health insurance options cover at least a core package of health care services—known as Essential Health Benefits. One of the essential health benefits is mental health and substance abuse services. While health centers have been slowly integrating behavioral health services into their practices, the ACA will accelerate that process. Unfortunately, in many states, reimbursement rates for mental health and substance abuse services are notoriously low. In addition, there is a growing shortage of mental health providers due to the sudden increase in demand for their services as the health care system begins to finally acknowledge the frequent existence of co-occurring mental and physical disorders (especially in the “hot-spotter” population—those who are the highest utilizers of emergency rooms and other subsidized health care services). While the broader provision of behavioral health services will be essential to achieving the national goal of reducing overall health care costs, the delivery of these services at the clinic level can be expensive and may put negative pressure on operating margins.

Pressure to Expand to Serve Almost Twice the Current Patient Base: As stated, the goal of the current administration is to eventually grow the number of patients served by health centers to nearly 35 million. Given the aforementioned provider shortages, this level of growth will be a challenge to accomplish. However, this growth mandate is reflected in HRSA’s ongoing effort to provide grant opportunities to all health centers. As described in more detail in this analysis, it appears that poorly planned or implemented capacity growth may have contributed to some of the financial problems experienced by the test group.

Finally, there are two basic characteristics of the health center business model that have nothing to do with the changing healthcare environment but still must be evaluated or acknowledged by any lender underwriting a health center loan application:

Heavy Reliance on Government Grants and Government Payers (Medicaid/Medicare): Given the importance of federal Section 330 operating grants and Medicaid/Medicare as payers to health centers, a chance taken on any given health center is a chance taken on the federal budget and on the longevity of a social safety net that is broadly (but not universally) popular. Mounting political pressures due to the cost of these two large entitlement programs will challenge health centers to navigate through potentially turbulent waters.

Significant Reliance on Donated Goods and Services: Despite what is arguably a viable basic business model, many health centers need to raise charitable donations and/or secure donated goods and services in order to break even. It is not uncommon for health centers to secure low- or no-rent space from their local hospital or a government entity, and these arrangements represent true cost savings. In some newer and/or more rural health centers, local doctors may donate their time. This has a positive financial impact on the center, but also adds uncertainty as it relies on the donor’s continued generosity.

Terminology

This document refers to a category of primary health care providers known variously and colloquially as “community health centers,” “neighborhood health centers,” “community clinics”—and sometimes by the technical terms “Federally Qualified Health Centers” or “FQHC,” “Section 330” health centers or “Look-Alikes (LALs).” These references generally denote a type of “safety net” provider that serves primarily low-income and uninsured patients regardless of their financial status. This document assumes a working knowledge of the definition of FQHC (including Section 330s and LALs) and will refer to the group generally as “health centers” unless we are specifically referencing subgroups of this “universe” of providers.

Section II: Methodology

Health Center Study Methodology

In order to identify a clean list of health centers that failed or are currently at risk of failing, Capital Link took the following approach. First, through a review of all annual health center UDS reports, we were able to compile a list of centers whose history of submitted reports abruptly ended prior to the latest year (2012). HRSA assigns a unique identification number to each health center, so any center that changed its name was not included the list. We initially identified 85 health centers that had either failed or merged with another health center and ceased reporting independently, or were known to be experiencing serious financial difficulties. Then, we cross-referenced that list with our database of audits beginning with the last year the UDS report was submitted (“Year 0”) and the three years prior. For the years that audited financial information was not available, we substituted 990 non-profit tax return data obtained from GuideStar.³

To further parse the list, any health center with insufficient data was removed. We then examined the available financial data and conducted web-based searches to eliminate all centers that appeared to have merged with another organization due to strategic, non-financial purposes (i.e., to consolidate programs—the “buy or build” decision, capitalize on complementary service area coverage, coincide with leadership turnover, etc.). Further web-based research on the remaining “failed” health centers uncovered many and diverse reasons for failure, from basic mismanagement to accusations of fraud. We ended up with a final group of 29 “test” centers, all of which had four years of usable financial and UDS data and appeared to have experienced financial difficulties leading to their demise.

As a basis for comparison, we also assembled a like-sized control group of centers that had continuous operation through the review period. Because the four-year review period for many of the test centers was different (i.e., Year 0 could be any year from 2004 to 2012), we established control groups of 30 centers for each potential four-year period. As a result, a total of approximately 800 health centers were used in one or more control group.

In an effort to find financial or operational statistics showing meaningful differences between the test and control groups, we developed over 100 formulas that utilized audit data, UDS data, or both. To highlight variations within the two groups, the data queries for most of the formulas were done at the 25th percentile, the median, and the 75th percentile.

³ Note that IRS 990 tax return data is not as complete as audited data, which prevented us from examining certain ratios. The 990 data was also not available for all previous years.

Community Development Financial Institutions (CDFIs) Survey Methodology

Capital Link conducted a survey of the 16 Community Development Financial Institution (CDFI) members of the Lenders Coalition for Community Health Centers, based on the members' actual lending history to health centers. The survey asked for details about the number, size, terms, and performance of the portfolio of loans made to health centers since 2004. The second part of the survey asked similar questions about specific health center loans that had been delinquent at any time for more than 60 days, put on non-accrual status, and/or had been written-off. This section also inquired about the reasons for the poor loan performance from the perspective of the lender. The results were tabulated and analyzed to determine the incidence of problem loans, defaults, and loan losses for this group of active lenders to health centers.

Section III: Health Center Data Analysis Results – Potential Indicators of Health Center Financial Challenges

As indicated by this analysis, there is no single reason as to why health centers experience financial challenges and fail or are forced to merge. The results are much more nuanced, suggesting that the management of some back-office functions (such as billing and collections) may be just as important as payer mix or provider productivity. The following section details the factors that appear to be the most relevant indicators of risk and demise in the health center sector.

Health Center Size

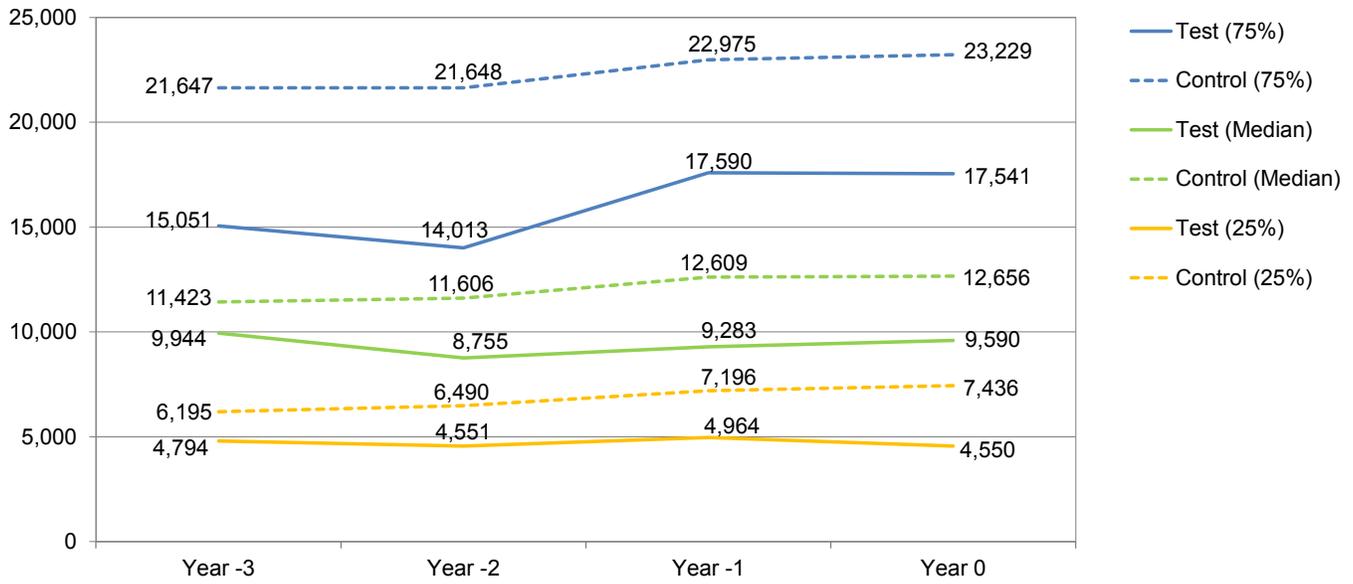
This first portion of the study examines whether there are any fundamental size differences between the test and control groups when evaluated by quartile.

Patients

As shown in the following chart, the health centers in the test group generally serve a significantly smaller number of patients than the control group centers. On average across the four years, the 75th and 25th percentile test centers saw 40% fewer patients than their respective control groups and the median reported almost 30% fewer. From Year -3 to Year 0, the control groups averaged over 12% growth in patients (ranging from 7% in the largest centers to 20% in the smallest) while the median and 25th percentiles of the test group lost between 4% and 5% of their patients over the same period. Lower patient demand would clearly have impacted the financial results of those health centers, putting pressure on productivity and demanding changes in staffing levels. There are several possible reasons for a decline in patient numbers: new competition in the service area, dissatisfaction with the quality of care (causing patients to seek care elsewhere), and overall population decline (between 2011 and 2012, for the first time in history, rural counties as a whole experienced a decline in population).

Interestingly, the 75th percentile of test centers grew rather strongly (17%) over the four year period. This finding suggests that health centers in this group may have embarked on a capital project early in the review period, which increased capacity, but could not successfully translate into financial success. This hypothesis—that a portion of the test centers had difficulty managing the ramp-up of a capital project—is further supported elsewhere in this analysis.

Total Patients

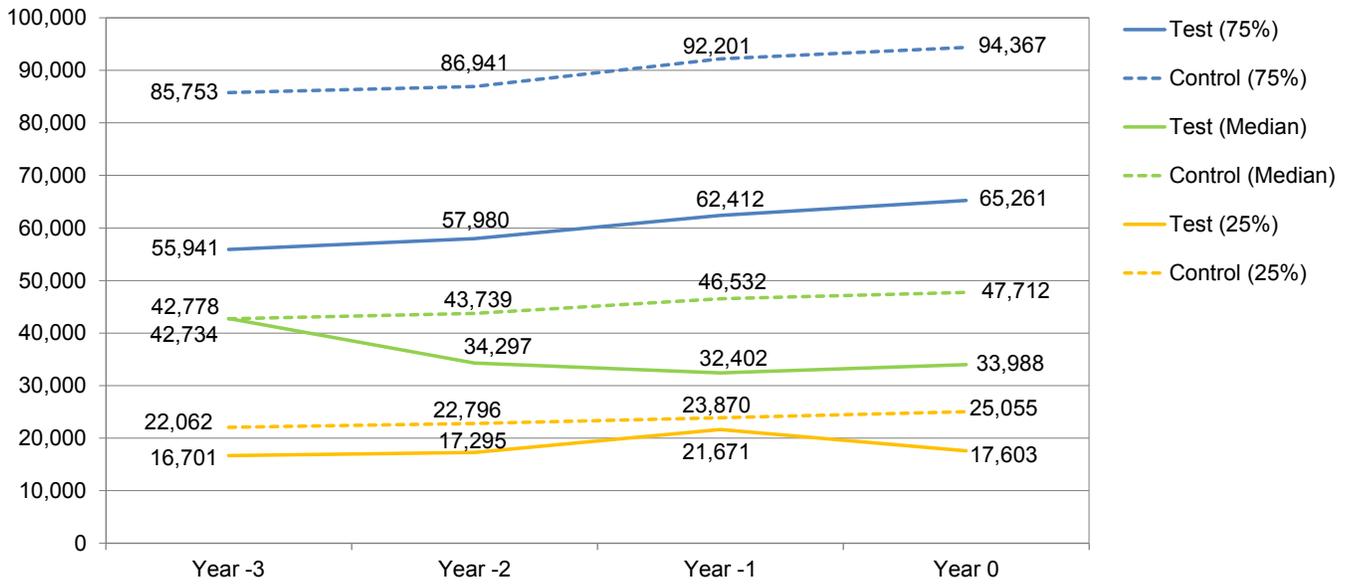


Visits

Evaluating the two groups by total visits resulted in a similar conclusion to the patient analysis above—the test center group provided fewer visits than the respective control group quartiles, and in the case of the 75th percentile, significantly fewer. The median and 25th percentiles saw approximately 30% fewer visits than the control group but the 75th percentile saw 50% fewer visits. The median test group started off in Year -3 effectively equal to the median control group, but from that point forward the two groups headed in opposite directions; the control group’s visit count grew slowly from year-to-year while the test group’s number declined.

Under a predominantly fee-for-service reimbursement system, declining patient visits is the worst case scenario. However, lenders should take note that under a managed care reimbursement system it is possible that these centers could have survived a reduced visit count. Indeed, under this alternative (and future?) payment system, a consistent reduction in visits could reflect clinical success and a potential financial advantage with a steady revenue stream and lower variable costs. Under managed care, declining patient counts will be a sure sign of financial stress while steady, or slightly declining, visits may not send the same message.

Total Visits

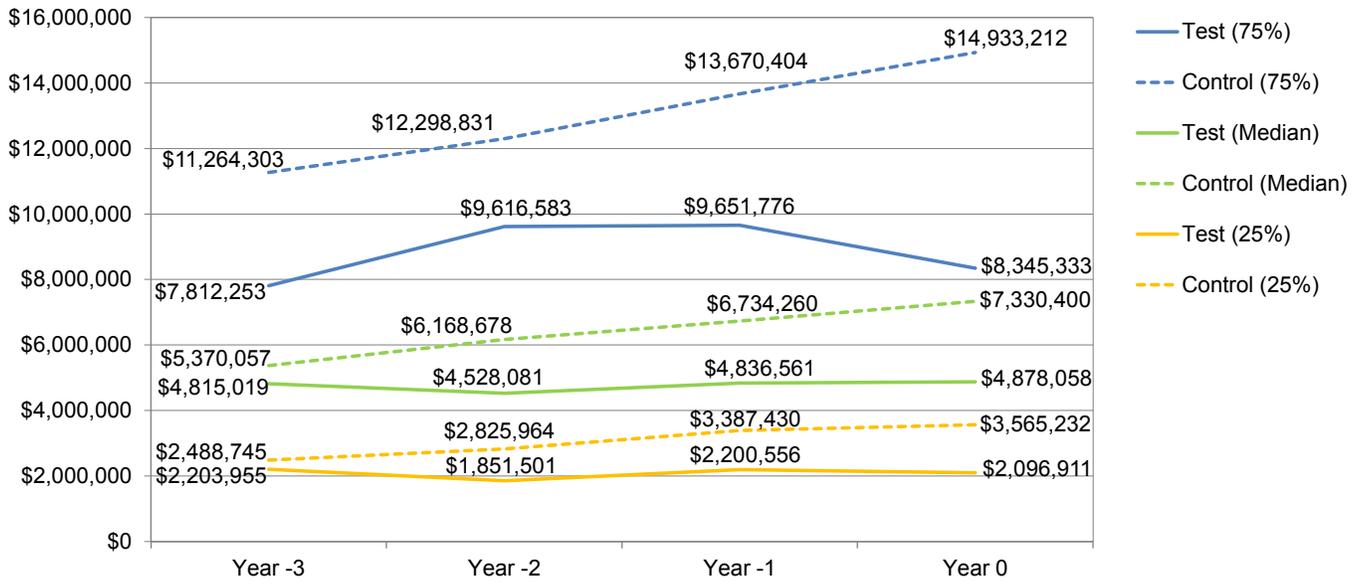


Total Revenue

The comparison of total revenue illustrated in the following chart suggests a similar conclusion as that reached above; the test groups' total revenue was below that of the respective control groups' and the gap between them widened as time passed. For the test centers in the median and 25th percentiles, total revenue in Year -3 was not that different from their control group counterparts, but that changed in subsequent years. While revenues of the control group grew steadily, revenues at the 25th and 50th percentiles for the test group were relatively flat or declining. The 75th percentile test group had revenues that were significantly lower than the control group quartile at the outset. The test group at this quartile showed significant revenue growth for two years before reversing these gains by year 0. This pattern provides additional supporting evidence that at least some of the test group centers may have opened new capacity at the beginning of the review period—which although initially resulting in revenue growth, appears to have been unsustainable over time.

Lenders may want to note that the year-to-year revenue growth in the control group was remarkably consistent within each quartile. It would be reasonable to conclude that positive year-over-year operating revenue growth is generally (though not always) a positive performance factor for underwriting—while revenue stagnation or decline is a negative indicator, absent strong mitigating factors. It is also important to note that capital grants, which could periodically distort the total revenue trend, are not included in these operating revenue totals.

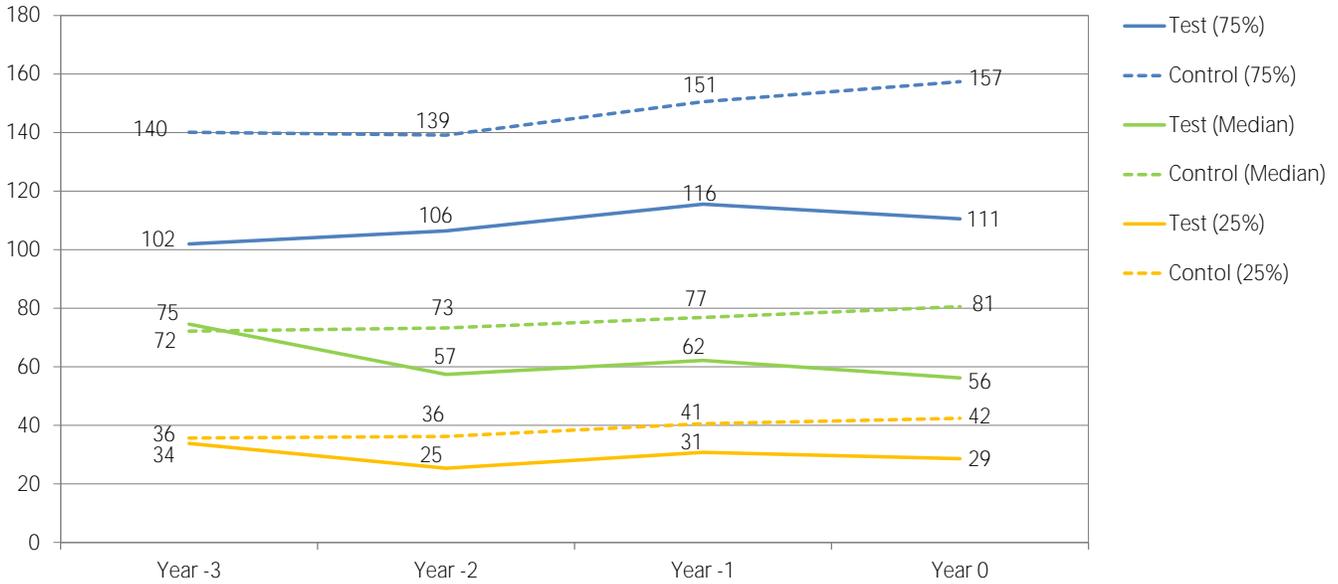
Total Operating Revenue



Full-Time Equivalent Employees (FTEs)

The data in the chart that follows indicates that all the centers in the control group grew their full-time equivalent employee (FTE) count by between 12% and 19% over the four year period, while only the 75th percentile of the test centers grew over that same timeframe. The other test centers reported an overall loss in FTEs of 25% (median) and 16% (25th percentile)—as well as year-to-year fluctuations in numbers of FTEs, suggesting challenges with recruitment and retention. As was the case in the analysis of visits, the median and 25th percentile of the test centers were effectively the same size as their control group counterparts in Year -3, but then began to shrink. This trend suggests a possible loss in providers, negatively impacting both visits and revenues, or alternatively, a declining patient base leading to layoffs. However, the rate of reduction in FTEs was lower than the rate of reduction in patients, visits, and revenue, likely accelerating the financial stress on the organization.

Full-Time Equivalent Employees (FTEs)



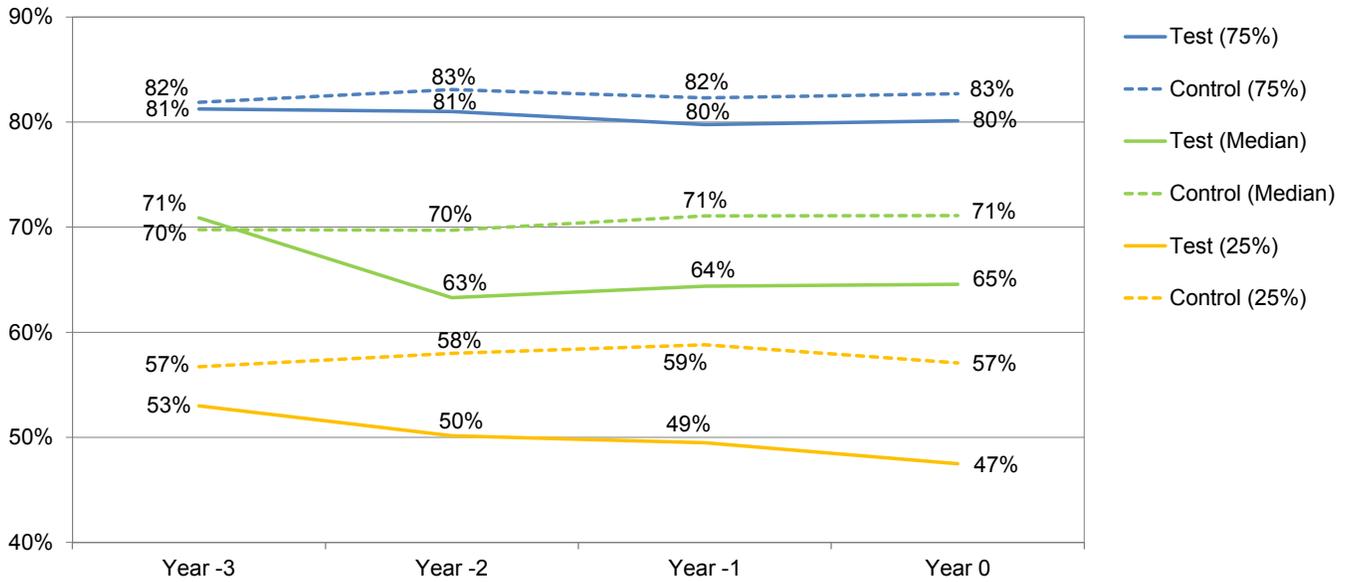
Patient Income

Patient Income <100% of the Federal Poverty Level

All FQHCs share a mission to serve the primary care needs of the lowest income residents of their respective service areas. Depending on their income and insurance status, these patients pay for the care they receive on a sliding fee scale. Those who earn below 100% of the Federal Poverty Level (FPL) typically pay nothing. (As a point of reference, the FPL for a family of four in 2014 is \$23,850.)

It might seem logical to conclude that health centers with the highest percentage of very low-income patients would struggle the most financially, but that is not what the data suggests. As the following table shows, the test group saw a lower percentage of patients with incomes below 100% of the FPL than the control group. For the 25th percentile, the difference was almost 10 percentage points by Year 0, and across all quartiles the difference grew between Year -3 and Year 0. While this result may be counterintuitive, it makes sense in the context of Medicaid eligibility. In most states during the timeframe of this study, pregnant women and children below 100% of the FPL were eligible for Medicaid or the Child Health Improvement Program (CHIP). Given that the test health centers had lower proportions of Medicaid-eligible patients than their more successful peers, they were not as able to benefit from favorable Medicaid reimbursement—and therefore may have struggled financially as a result.

Patient Income <100%

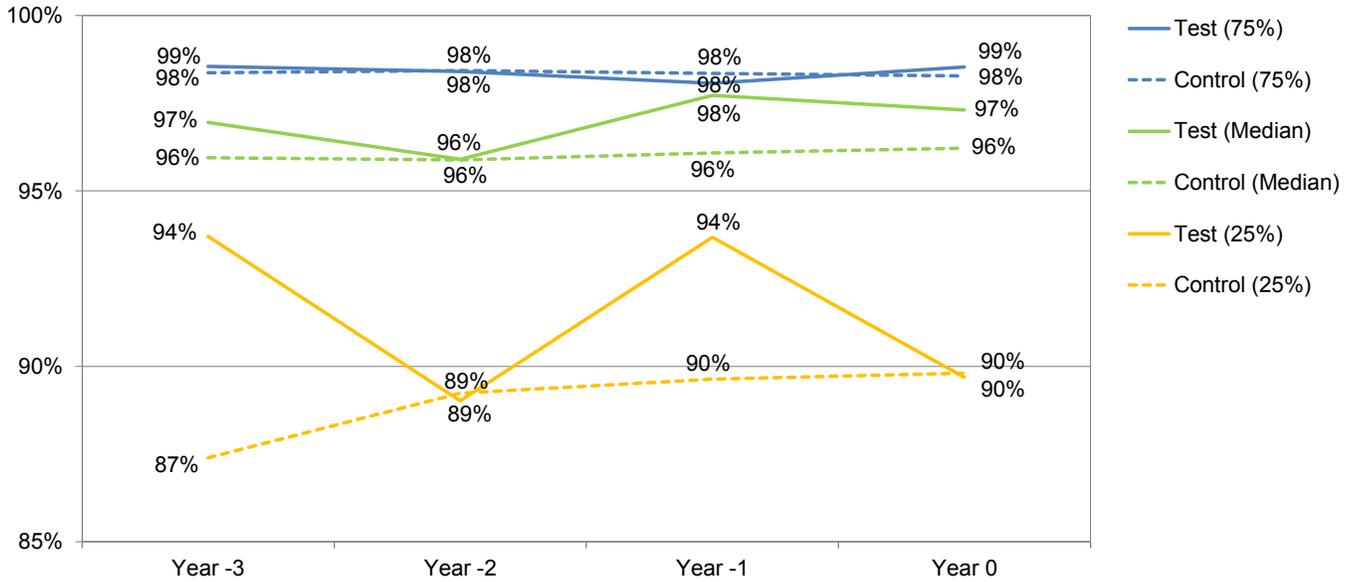


Patient Income <200% of the Federal Poverty Line

Given the counter-intuitive results of the data for the patient population who earn below 100% of the FPL, it is interesting to see that the trend is different when the pool is expanded to include patients below 200% of the FPL. In general, the test centers served a higher proportion of patients between 100% and 200% of the FPL than their peers in the control group. Both of these patient populations earn a very low nominal amount of income, but those who are between 100% and 200% of the FPL may represent a larger proportion of the population that is considered the “working poor”.

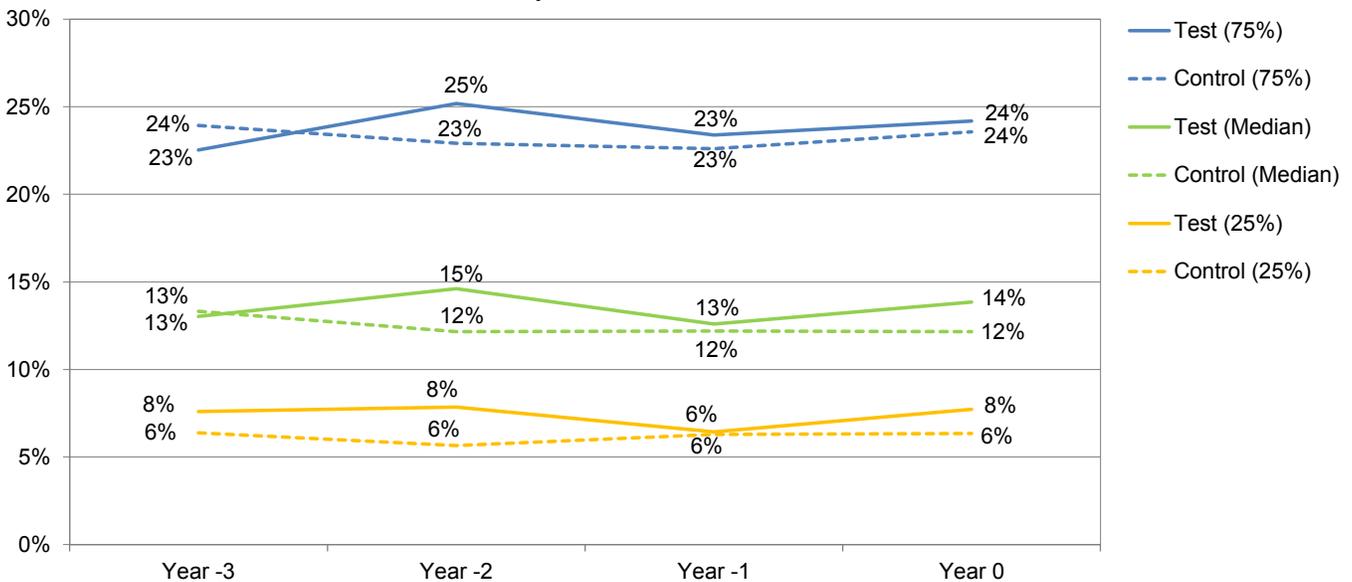
During the period analyzed, patients with incomes over 100% of the FPL may not have qualified for Medicaid in many states (prior to the implementation of the ACA in January 2014) but may still have qualified for a steep discount on a sliding fee scale. Likewise, some patients in this group may have had some form of private insurance through their employers. The policies offered to the working poor often have high deductibles and limited coverage—leading to an underinsurance problem requiring heavy use of health centers’ sliding fee discounts. The following chart shows that almost all the test centers reported a higher percentage of privately insured patients than the control group. This finding helps to substantiate the hypothesis that, in general, the test centers had a less favorable patient payer mix than their peers—serving a lower proportion of Medicaid and a slightly higher proportion of privately insured patients (which is a less favorable payer category than Medicaid).

Patient Income <200%



Both of these factors may have increased the failing centers' reliance on their 330 grants (which is discussed later in the report). The revenue composition analysis in Section III delves more deeply into these scenarios.

Payer Mix – Private Insurance

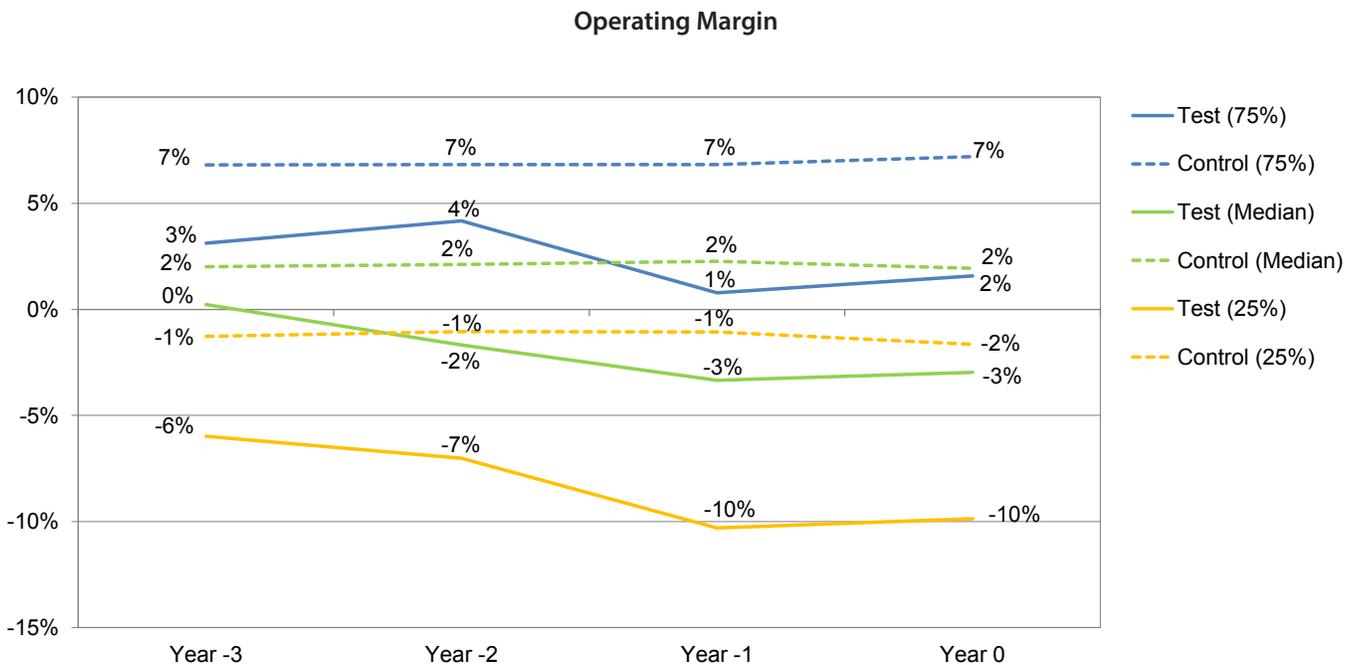


Operating Margin

(Note: The following financial ratios are defined in Exhibit A.)

As shown in the following chart, the centers in the median and 25th percentiles of the test group experienced a decline in operating margins over the review period. It is interesting to note that the 75th percentile reported lower margins in the later years but not losses, suggesting they may have recognized their financial challenges and chose to merge with another health center rather than struggle to remain independent.

The margins of the test group at the median dropped from breakeven in Year -3 to -3% operating losses in the final two years. The situation was significantly worse for the 25th percentile, beginning with -6% operating losses in Year -3 and declining to -10% in Year 0. These operating losses suggest serious and persistent problems with either generating revenue growth or matching changes in revenue growth with changes in expenses (or both). As noted previously, revenue growth for most of the test centers was anemic, indicating that management apparently failed to reduce expenses in a timely fashion. For a service business, remedying this expense misalignment would have likely meant laying off personnel—something many managers choose to postpone until it is too late.

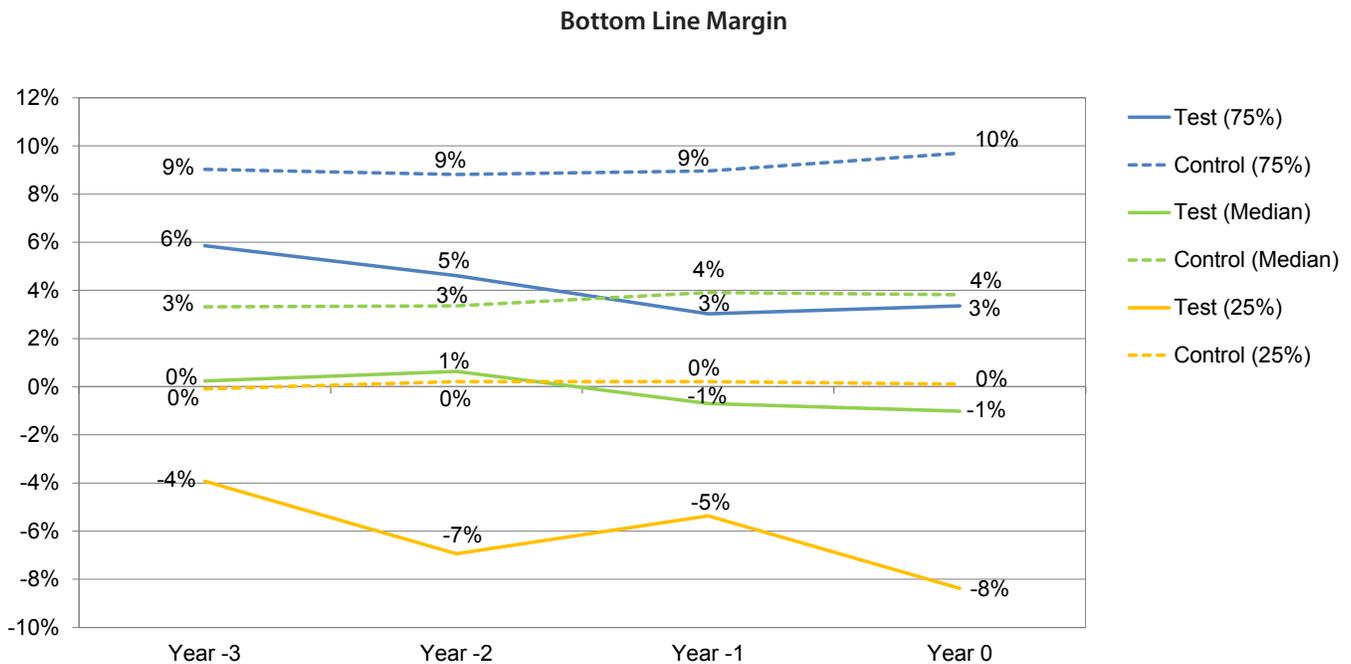


A significant and persistent mismatch between revenue growth and expense growth is what creates operating losses. This mismatch can be due to a variety of factors, including, but not limited to:

- Low provider productivity (e.g., low-income patients often present with multiple issues—not all of which are acute—preventing providers from efficiently managing visit times)
- Poor understanding of the operating margins for each business unit (e.g., the health center is unaware of losses within its dental practice)
- Failure to secure augmented reimbursement rates (i.e., the center is not filing complete and accurate Medicaid Cost Reports)
- Failure to maximize visit coding (and hence reimbursement) to medically justifiable levels

The 2% median operating margin of the control group illustrates the challenge that individual health center managers face daily—that there is little room for error when juggling the various inputs and outputs of this complicated service business.

The bottom line margins of the test and control groups were generally better than the operating margins but demonstrated a similar trend.



The difference between these two profitability measures is usually capital grants, changes in restricted assets, and interest income. Struggling health centers are less likely to embark on capital projects—though there is evidence that a portion of the test group did just that, which may have contributed to their demise. A poorly planned or overly aggressive capital project can be a driver of operational losses. Also, as can be seen

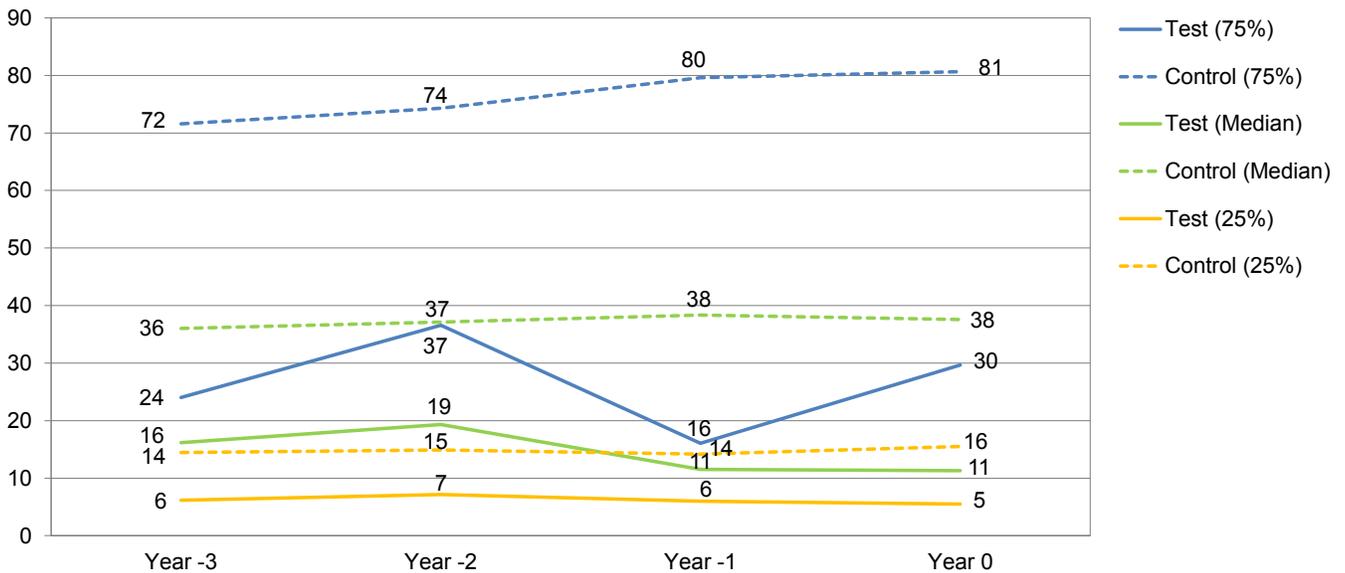
in the days cash on hand chart in the Balance Sheet section below, the test group clearly had no excess cash in investment accounts and therefore had no interest income to speak of.

Balance Sheet

Days Cash on Hand

Days cash on hand are predictably low for the test group as compared to their respective control group quartiles. The 75th percentile of the test group demonstrates the most variability, but the reported levels of days cash are generally adequate to maintain operations. The median and 25th percentile groups reported levels of cash that would frequently have been inadequate to make a bi-weekly payroll. What is interesting in the 25th percentile cash figures is that these centers were experiencing cash flow problems even before Year -3. It is important to view these figures in conjunction with the collections and allowances analysis later in this document, as it appears that the center’s cash problems may have been due, at least in part, to back office issues. For lenders, days cash on hand is an important indicator of financial health but, as can be seen in the next section, health centers will delay payments to vendors to the extent possible before running out of cash completely. Trends in days cash on hand and accounts payable need to be interpreted together in order to get an accurate picture of a health center’s financial condition. It is also important to note that many health centers that do not fail have relatively low days cash on hand and manage to continue their operations without major negative financial consequences.

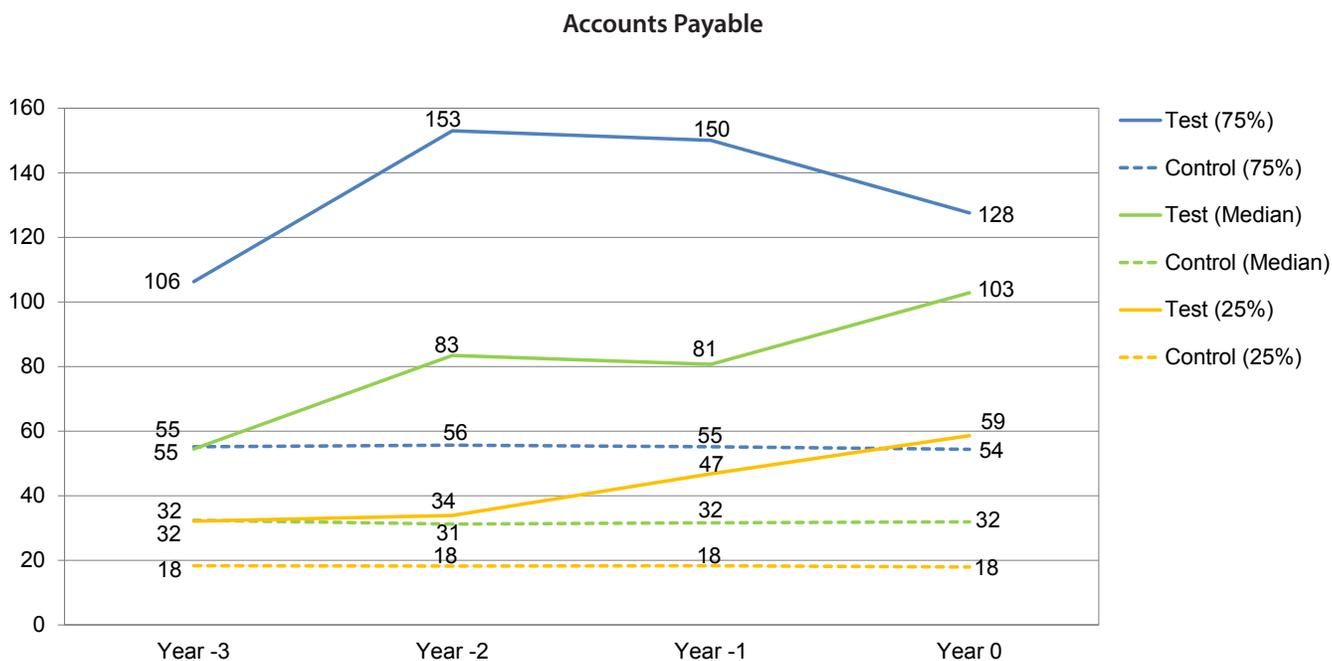
Days Cash on Hand



Accounts Payable

An increasing inability to maintain timely payments to vendors may be a useful leading indicator to lenders of severe financial distress. If health centers don't make payroll, they'll need to close their doors. So the only "give" in the system when cash becomes constrained are the bills owed to vendors. Most of the test centers showed increasing levels of days in accounts payable as they approached their final year. (Though when the accounts payable days for the 75th percentile declined in Year 0, they were at such a high level already that this "improvement" in accounts payable may represent the center's utilization of all remaining cash to pay what they could at the end).

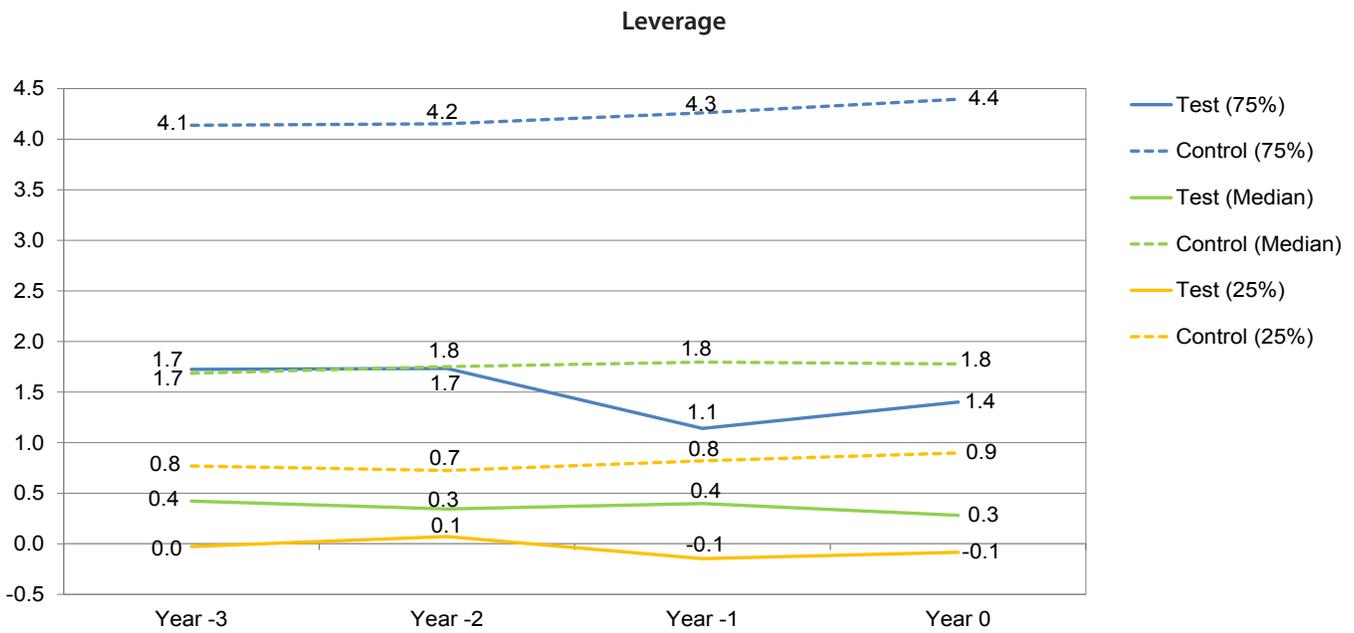
The accounts payable days of the 75th percentile of the control group are consistent across the review period at a level below 60 days. This level may represent a payment frequency at which vendors likely draw the line before ceasing to work with a customer. It is interesting that the 25th percentile of the test group just reached this level in Year 0—suggesting that their deteriorating working capital situation may have driven them into a merger decision.



Leverage

The leverage ratio of the test group across all quartiles is well below that of their respective control group. This finding suggests that most of the centers that experienced financial difficulty did not do so because of over-leveraging their balance sheet. For the most part, the leverage ratio was flat or declined over the four-year period indicating that the failing centers were unable to borrow additional working capital and actually may have used scarce cash to reduce debt. For the 75th percentile group, that appears to have been the case in Year -1.

It is possible that the low leverage ratios of the test centers indicate that some of the centers may have been operating out of older and possibly sub-standard facilities—a situation that could have contributed to their difficulties. Other evidence suggests that at least some of the test centers appear to have added capacity in Year -3 or earlier, but this analysis seems to show they did not take on excessive amounts of debt in the prior four years in order to do so. Instead, it appears these centers secured grant funding for their projects, a conclusion that is supported by the grants and contracts revenue analysis.



Revenue Composition

Revenue composition and payer mix are two different but extremely important factors to consider in underwriting a health center. The revenue mix at FQHCs is generally divided into three categories, net patient service revenue (NPSR, which is patient-derived revenue), grants and contracts (GCR, including but not limited to the federal 330 grants), and all other operating revenue (OOR, primarily fundraising proceeds, in kind contributions, space rentals, and miscellaneous income). In Capital Link’s experience, a mature health center typically reports its revenue mix as follows⁴:

- NPSR = 58%
- GCR = 33%
- OOR = 4%

Payer mix, on the other hand, refers to the proportion of patients that carry a particular type of insurance or, alternatively, the proportion of NPSR that is collected from each of those payers: Medicaid, Medicare,

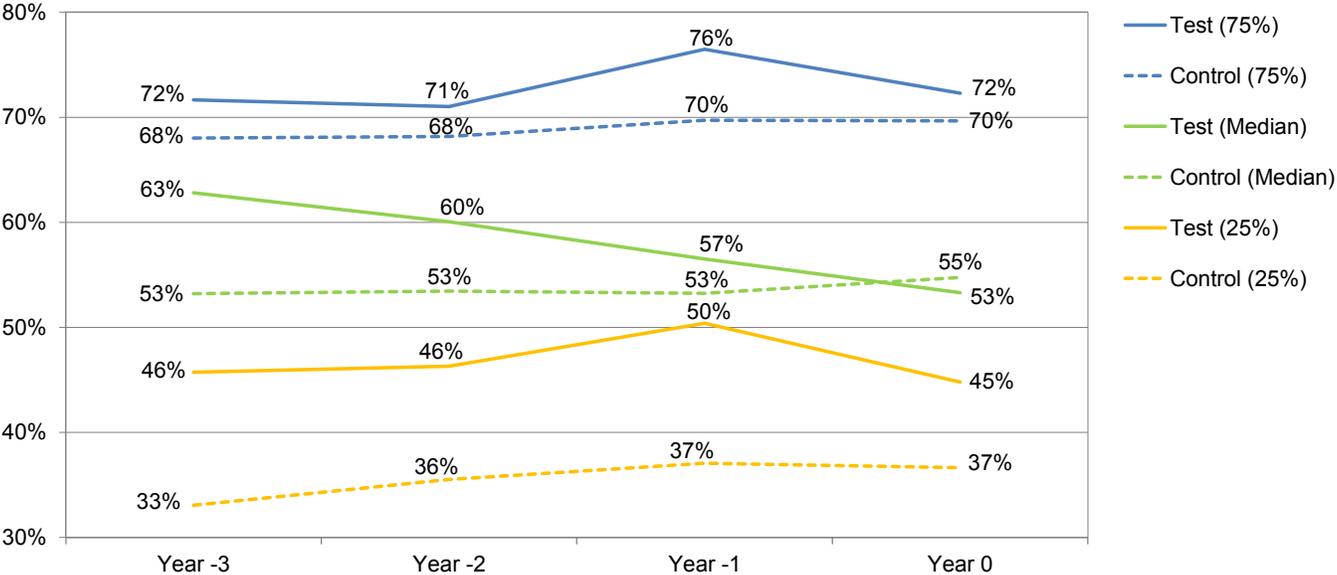
⁴Total does not equal 100% because these are the median values for each revenue category.

other public insurance (usually a minor category), private insurance, and self-pay (the uninsured). It is important to look at both the mix of patients with a given insurance and the mix of collected revenue from those various payers, as they are rarely proportional. That difference can be a key factor in whether an individual center is successful in implementing the FQHC business model.

Net Patient Services Revenue

The results of the analysis of net patient service revenue are somewhat counter-intuitive. It might be reasonable to expect that failing health centers are relying too heavily on their grant income and not focusing on maximizing the billing/collections from their patient population. The data indicates this assumption is not necessarily correct. While the median test centers did show a declining percentage in revenue from patients, the results were higher than that for the control group in all but Year 0. This result was also true for both the 75th percentile and (especially) the 25th percentile. It is important to note that these high ratios do not necessarily equate to high nominal levels of patient revenues. What this result could be indicating is that the test centers are securing grant income and other operating income relatively poorly, thereby driving up the percentage that is earned as NPSR, even if just slightly.

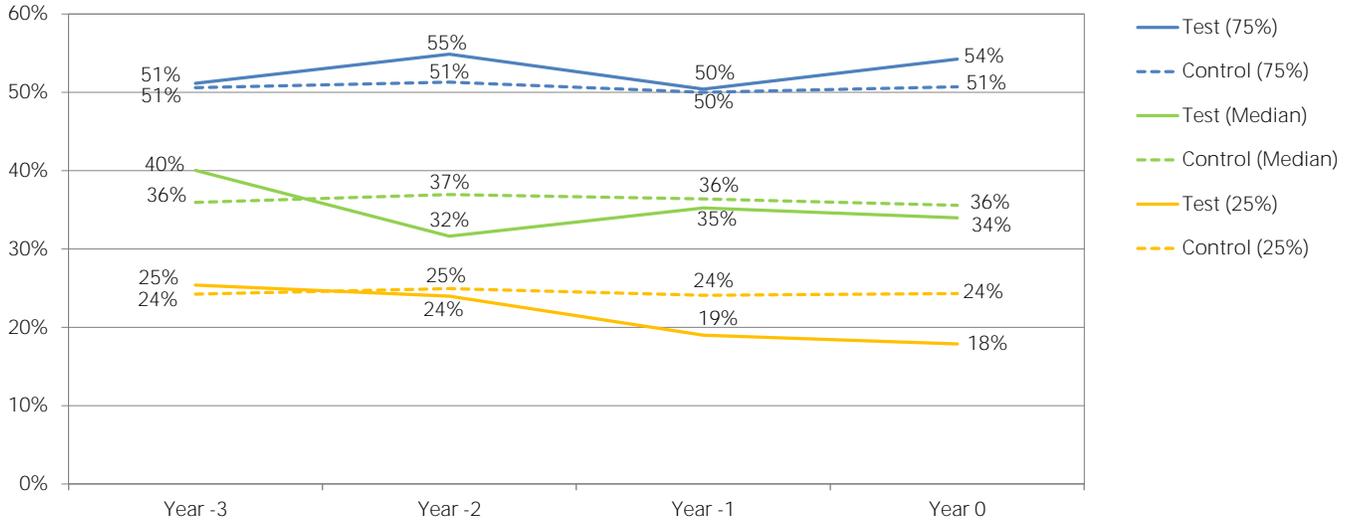
Net Patient Services Revenue (NPSR) as a Percentage of All Revenue



Self-Pay

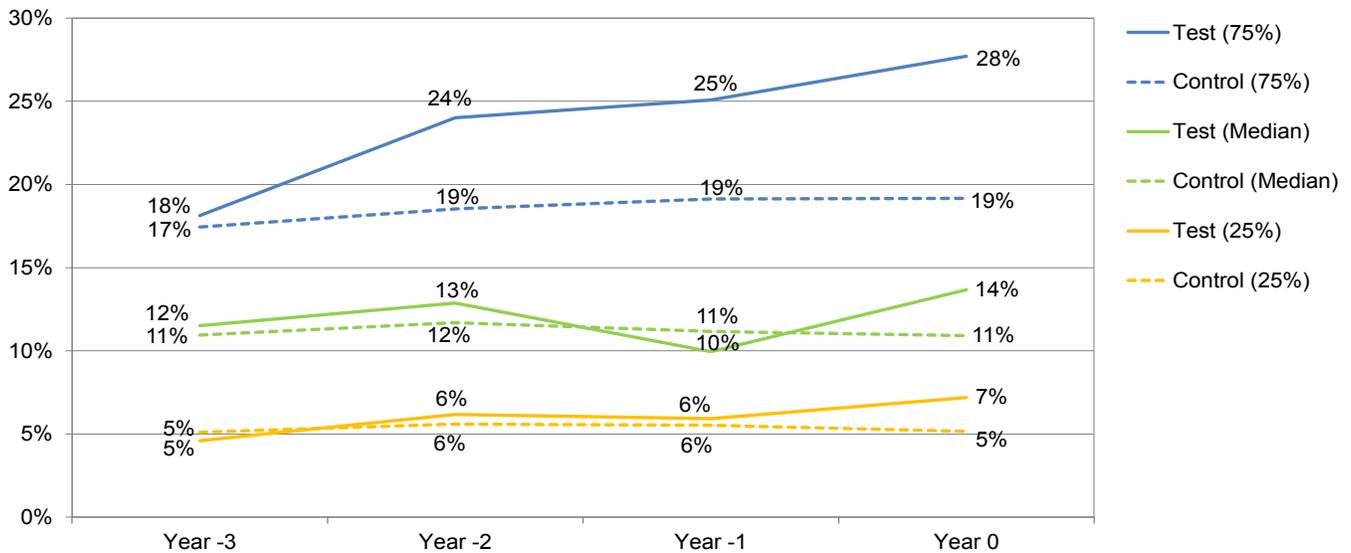
We might also expect to see a relatively higher proportion of NPSR if the test centers were forced to stretch their 330 grant dollars across too many patients who qualify for the sliding scale. This situation could occur if the test centers were seeing a higher percentage of the uninsured than their control counterparts—but as we see in the following chart, this scenario does not appear to be the case. In fact, the median and 25th percentiles saw proportionally fewer uninsured patients as compared to their control group counterparts.

Patient Mix (Self-Pay)



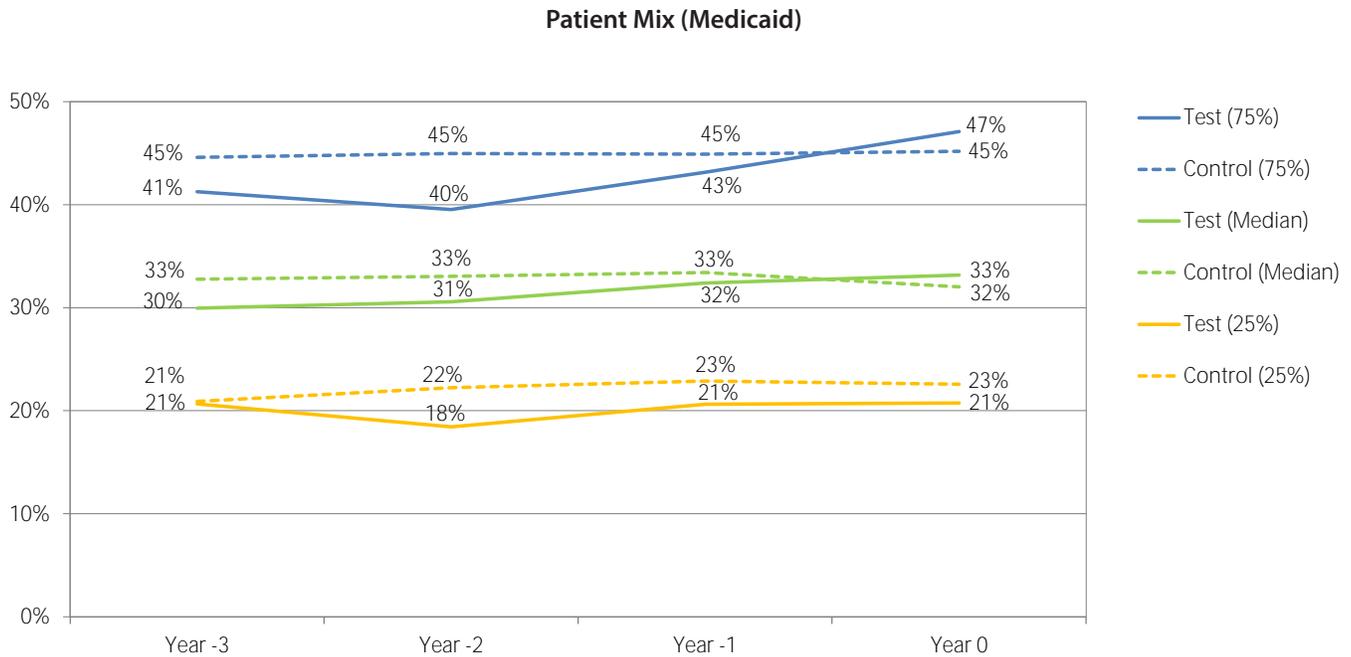
As noted in the introduction to this section, payer mix by insurance type tells one story but payer mix by percentage of cash collected may tell another. The chart below illustrates self pay collections as a percentage of total collections. This data suggests that for the 75th percentile the test centers realized a much higher percentage of their total patient revenues from self-pay clients than the control group. This result was also true, but only marginally, for the median and 25th percentiles. What this data tells us is that many of the test group centers were likely not collecting a proportionate amount from the other payers—Medicaid, Medicare, and private insurance—that actually reimbursed the center at a reasonable level.

Self-Pay Collections as a Percentage of Total Collections



Medicaid

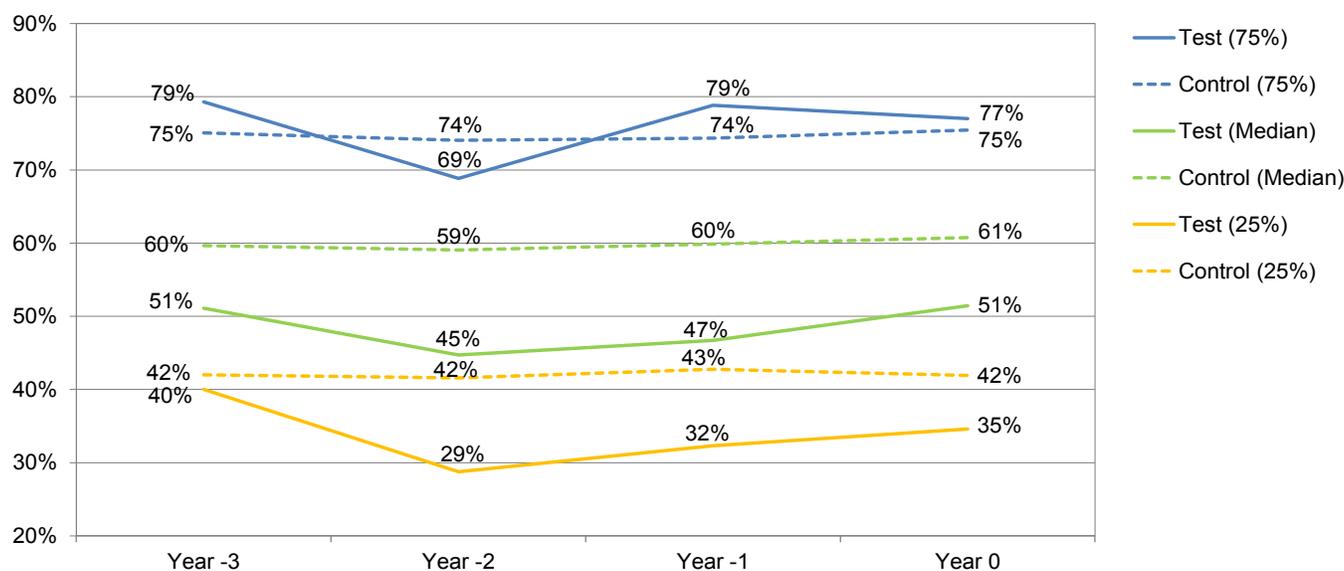
The hypothesis with respect to self-pay collections would be supported if the data also suggested that Medicaid collections were disproportionately low for the percentage of patients enrolled in Medicaid. The chart below compares the Medicaid payer mix over the review period and suggests that the test group saw a slightly lower percentage of Medicaid patients than their control group counterparts in all years and all quartiles. It appears that the test centers made an effort to improve their Medicaid patient mix near the end, but the effort may have been too little and too late.



The data in the Medicaid collections chart, however, indicates that the test group collections from Medicaid were significantly below the control group's at the median and 25th percentiles. So while a health center's Medicaid patient percentage may be similar to its peers and industry averages, its ability to collect from that payer may not be proportional.

This disparity between payer mix and collection percentage mix can occur for many reasons. Medicaid eligibility rules differ from state to state and a claim that is perfectly good one week, can be denied the next if the patient did not maintain program eligibility. It is essential for a health center to have adequately trained front desk staff, enrollment specialists, billers, and collection staff on hand who understand the rules. However, implementing correct procedures can be difficult. Some health centers have found this to be such a challenge that they outsource their billing, but the results are not always positive.

Medicaid Collections as Percentage of Total Collections



This study also examined the collection history for the other major health center payers: Medicare, private insurance, and other public insurance. While some of the test group data was inconsistent from year to year, the results suggest that the test centers' collection experience with these payers was similar to that of the control group. One result to note is that it appears the test centers saw a disproportionately high percentage of Medicare patients compared to the control group. While Medicare is not a dominant payer for any health center, payment rates for Medicare have been capped at a rate that is below cost for most health centers (see discussion on page 7 of this document). As a result, having a higher proportion of Medicare patients could have put pressure on the test group's operating margin.

Allowances/Bad Debt

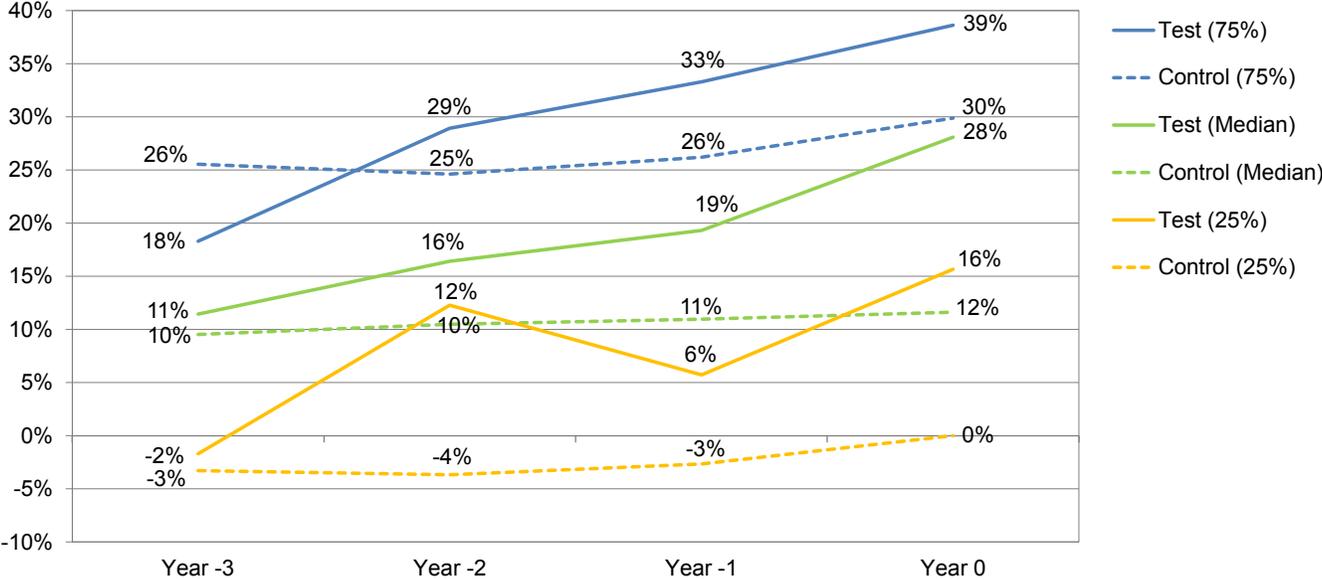
It is not surprising that the data reinforces the importance of full-cost Medicaid reimbursement to the financial viability of health centers. However, simply having a high Medicaid patient payer mix may not guarantee financial stability. Accurate billing and diligent collections of all accounts receivable is mandatory and the UDS report provides a window on the efficiency of these back-office functions. For each major category of payer, the UDS reports the amount of allowances, which represents the difference between what a health center is billed and what is paid. This difference could be the result of:

- Contractual allowances (the amount providers agree upon up-front to discount the price of their services in exchange for the benefits of being in a private insurance company's network)
- Sliding fee discounts offered to self-pay patients based on their family income
- Denied claims to government payers (Medicaid and Medicare) as a result of eligibility problems, claim errors (usually paperwork), coding errors, etc.)

The percentage of allowances for any given payer are perhaps best evaluated in comparison to the comparable figures for the average health center in their state (available from the UDS State Roll-Up reports published annually by HRSA). However, given that the centers in this study were located in 20 different states, we compared the performance of the test group to the control group by payer type. From an underwriting perspective, the following analysis provides *some measure* of the efficiency of a given center’s billing and claims processing, but the reasons for variable allowances are complex and a center should be given the opportunity to explain high allowance levels.

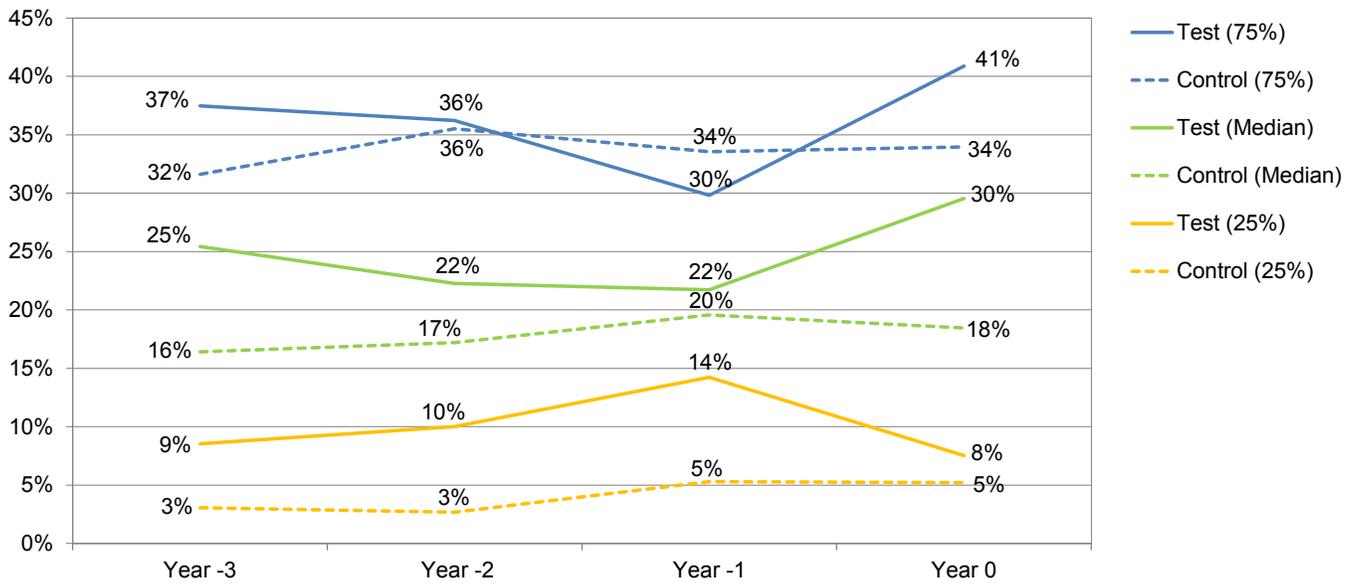
Medicaid Allowances: The first chart below shows Medicaid allowances as a percentage of Medicaid charges. This is one of the clearest examples of a deteriorating ratio as the timeline progresses from Year -3 to Year 0. The importance of Medicaid as a payer has been discussed, but the inability of a health center to collect on Medicaid billings has a negative leverage effect. In other words, an uncollected self-pay charge on the sliding scale might be \$35 in lost revenue while an uncollected Medicaid charge could be over \$200 depending on a center’s Prospective Payment System (PPS) rate. The fact that the data in Year -3 is comparable between the test and control groups suggests a strong correlation between this measure and the deteriorating operating margins that resulted in financial failure or merger.

Medicaid Allowances as Percentage of Total Medicaid Charges



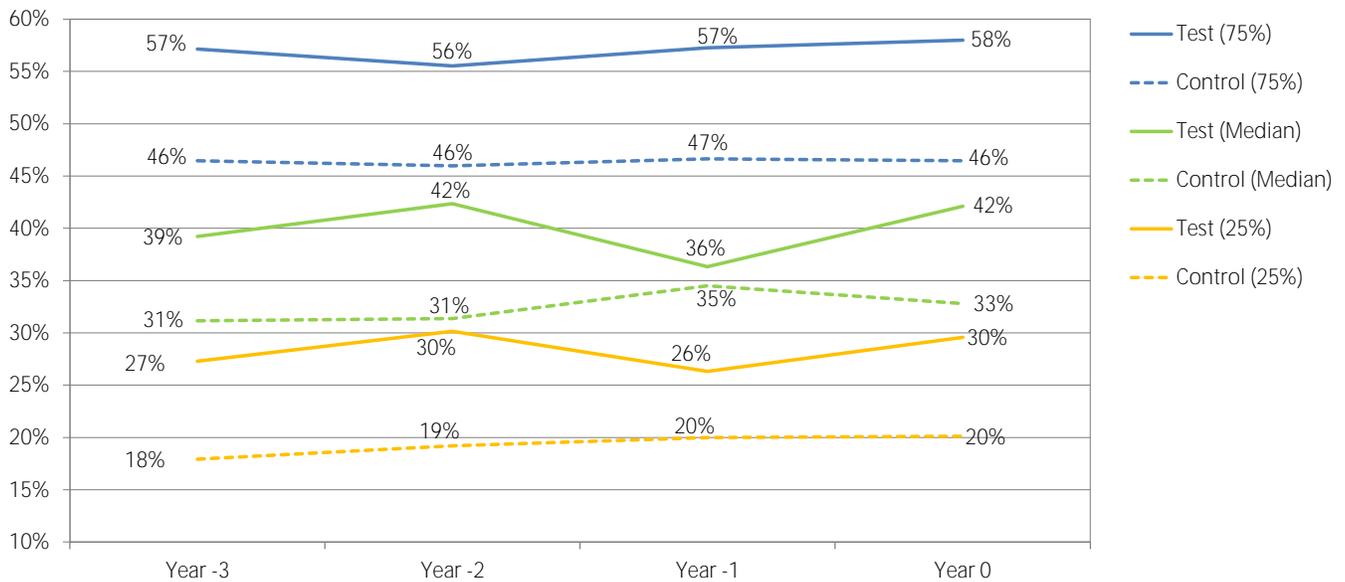
Medicare Allowances: For Medicare, the results also show consistently higher allowances for the test group in comparison to the control group across the four-year period, but less of a deteriorating trend over time. The fact that the test centers also had a somewhat higher proportion of Medicare patients and apparently less successful collection efforts than their peers only magnifies the conclusion that poor back office functions contributed to the financial stress facing these centers.

Medicare Allowances as Percentage of Total Medicare Charges



Private Insurance Allowances: The chart below reflects the allowances associated with billings to private insurance companies. The conclusions reached regarding Medicaid and Medicare are further supported by the analysis of private insurance. While the allowance trends do not generally appear to have worsened over time, as was the case for Medicaid, the differences between the test and control groups is significant and consistent—and reflects patient-derived revenue that was never collected (though the services were provided). Clearly this result would have had a negative impact on operating margins.

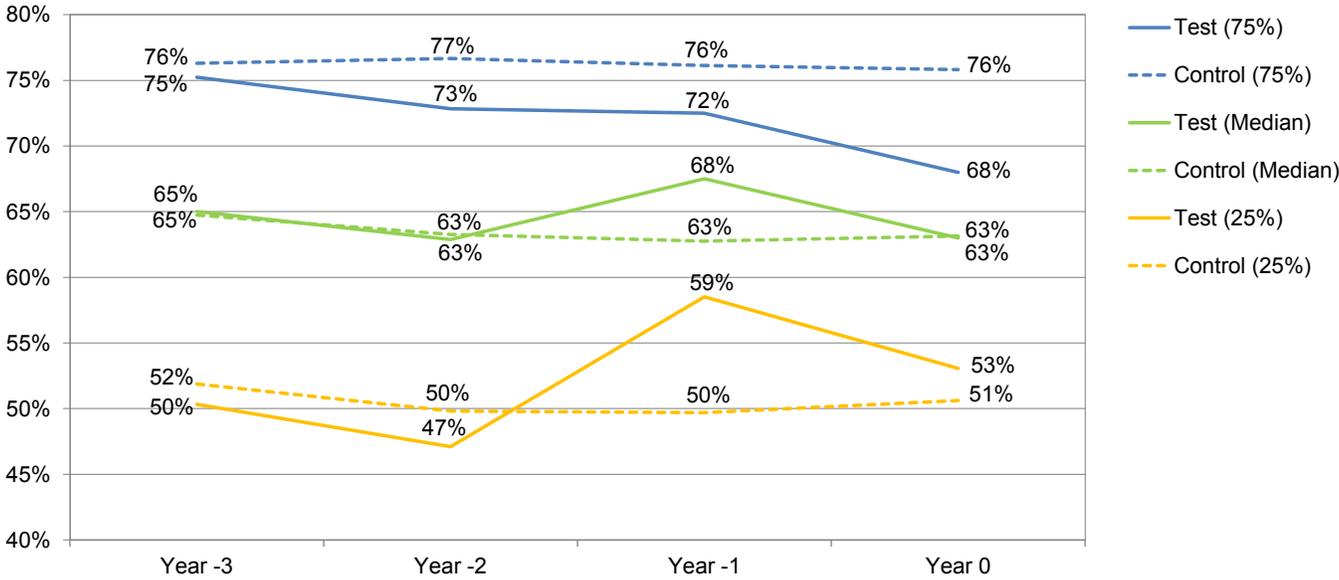
Private Insurance Allowances as Percentage of Total Private Insurance Charges



Self-Pay Allowances: The final chart in this set examines the ability of the centers in the two groups to collect from self-pay patients. It should be noted that there are two possible general conclusions to be drawn from the quartile data. Sliding fee discounts are allocated based on a patient’s family income and calculated based on formulas set as policy guidelines by each health center individually. As a result, a high percentage of sliding fee discounts compared to charges (the centers in the 75th percentile in this chart) may represent those with the poorest patient populations or poor implementation of the health center’s policy on income verification. While centers are required to secure income verification from individuals seeking a sliding fee discount, not all patients are willing to provide that information, not all the information provided is accurate, and when faced with a non-compliant patient, most centers stick to their mission and provide the care “without concern for the ability to pay.”

Some indication of how well this front desk function is being implemented can be seen in Table 4 of the UDS, which indicates the patient population by income specifying how many patients are of “unknown” income. To be fair to all centers, income documentation may be one of the hardest administrative functions at a health center and it is usually assigned to the front desk staff who are some of the lowest paid employees. It is an art to consistently be able to cajole income information from patients knowing that they will likely get the care even if they refuse. This task is made even more difficult when you consider the fact that in many centers, the patients know the health center staff personally because they live in the same neighborhood. These nuances put the information in the chart below in a different light than the other insurance allowances:

Self-Pay Sliding Fee Discounts as Percentage of Total Self-Pay Charges



It is noteworthy that while the test groups’ median and 25th percentile sliding fee results are generally comparable or slightly higher than the control group, the 75th percentile is lower and improves over time—

even for those headed toward their final year as independent entities. This finding may not be as counter-intuitive as it appears. Recall that the 75th percentile represents those centers with either the poorest patients or those granting the maximum discount without supporting documentation. For centers such as these, securing at least a minimum payment at the door is one way to be sure to collect something from all patients. As a center faces greater financial stress, one of the most common responses is to increase these minimum payments. There has been an evolution in this policy at health centers over time. Ten years ago, it was not uncommon for centers to have no minimum charge at the door, then \$20 became the standard, and now it is not uncommon for centers to charge \$35 or more. It is possible that the decline in the percentage of sliding fee discounts for the 75th percentile in the chart above reflects this belated effort to collect more cash.

Bad Debt Analysis

Accounts receivable management and bad debt write-offs are an area of financial management where industry practice varies widely. Some health centers do not report any bad debt expense on their audited statements. Presumably this is because they have built in sufficient reserves when booking receivables so the uncollectible debt can be balanced through the management of those reserves. Others report substantial levels of bad debt write-offs, suggesting that they prefer to book revenue much closer to the full amount of charges and have their statements reflect bad debt equal to the amount they are unable to collect. As a result of this difference in the treatment of uncollectible accounts, lenders should carefully evaluate accounting practices rather than assume a health center with no bad debt on its audit is running a tighter ship than one that shows high levels of bad debt.

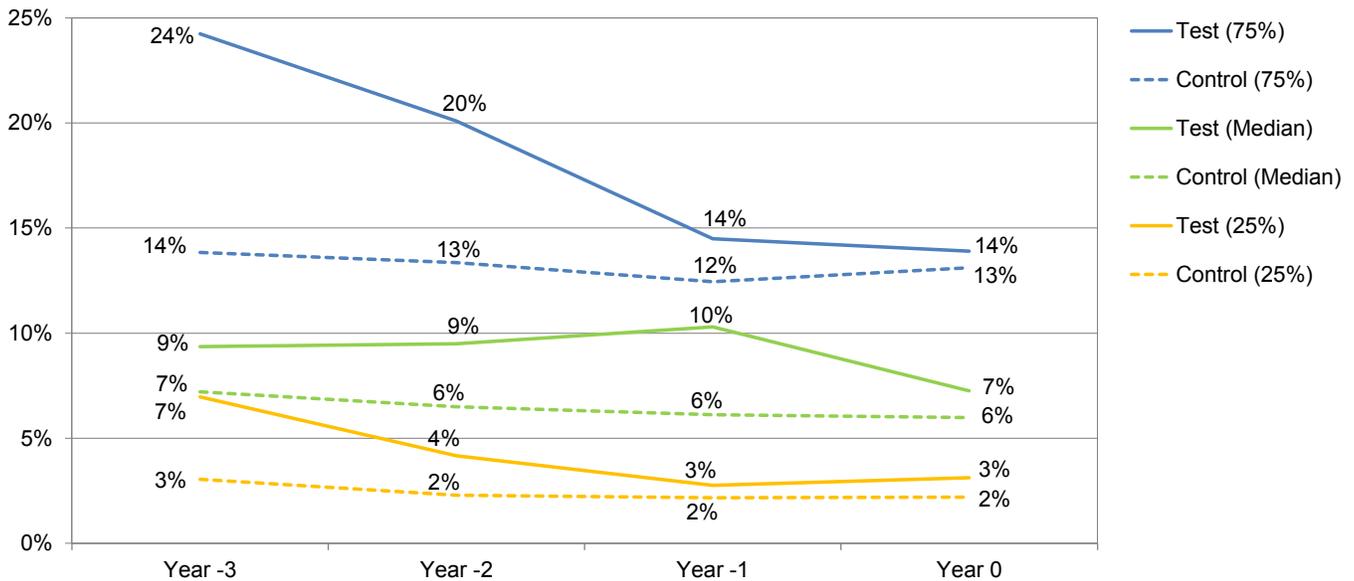
Many health centers, especially those experiencing financial stress, have been known to allow uncollectible accounts to accumulate on their balance sheet. An optimist would view this response as being due to the center's belief that intensive collection efforts will ultimately secure payment; a pessimist would suggest that the center's management does not want to acknowledge the negative impact on margins that a realistic assessment of collectability would likely have. Some centers contract with collection agencies to which they send their most uncooperative accounts, but doing so can be a politically difficult decision in a low-income community. Management must walk a fine line between being seen as just another business pressuring poor people for money they don't have, and being seen as effectively a free clinic. Even in areas of high poverty, the cash brought in from self-pay patients is an important element of the revenue model. Centers need to set revenue recognition and collection policies that do not leave these decisions to employees on a case by case basis. Lenders might be wise to inquire about the existence and nature of these policies and how they are implemented both in the back-office and at the front desk.

The following chart suggests that all the test centers reported higher bad debt expense than their control group counterparts for the entire review period, but the gap between the groups diminished over time. The reduction in test group bad debt could be due to intensified collection efforts as cash balances declined or the aforementioned tendency not to write off all potentially uncollectible accounts as the financial losses mounted. For lenders, if an applicant reported 24% bad debt, as the 75th percentile did in year -3, this fact

would certainly be a red flag but it would be critical to get more information before rushing to judgment. This result could be a one-time cleaning of the books (frequently the result of the hiring of a new CFO or auditor, and usually a painful but necessary course of action) or an implication of a substantial change to the center’s revenue recognition policy.

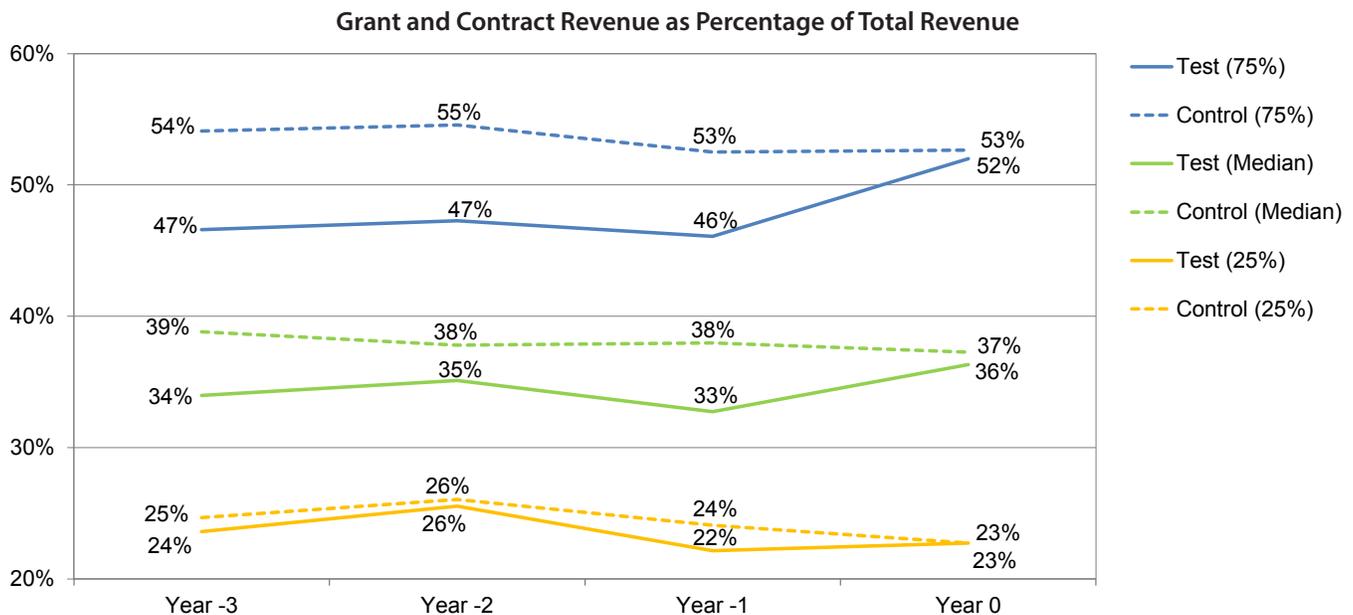
As part of their standard due diligence process, most lenders will request an aging of accounts receivable. While this is a sound lending practice, account officers need to be familiar with the intricacies of the health center’s Medicaid reimbursement system. The PPS for health center Medicaid payments is implemented differently from state to state. In some states, the center gets paid a fraction of its PPS rate at the time of service and the difference between that amount and the PPS rate at some later date after reconciliation of claims. That reconciliation/payment process can happen monthly or quarterly depending on the state. Since centers know their PPS rate in advance of the fiscal year, most will book an estimate of the amount of the anticipated reconciliation and in those cases, old accounts receivable could still be of high quality. In other states, the Medicaid agency agrees to pay the center the amount of the PPS rate for all claims at the time of submission and then the eventual reconciliation may actually result in the health center owing money back to the state. As a result of these payment and processing differences, accounts receivable aging reports should not be taken at face value.

Bad Debt Write-offs as Percentage of Total Self-Pay Charges



Grants and Contract Revenue (GCR)

As surmised in the NPSR analysis, grant and contract revenues as a percentage of all operating revenues are significantly lower among the test centers than the control group. This difference is especially true of the centers most dependent on their grant revenues, which in the chart below are in the 75th percentile. Most likely the centers in this group are also in the 25th percentile of NPSR, as the data points are inversely correlated. Again, this analysis does not focus on the nominal amount of grant and contract revenue—it focuses on the fact that the test centers in general generated a lower proportion of their total operating revenue from GCR than the control group until Year 0, when the test group’s percentages match the control group’s across the board. This result in the final year may indicate a last ditch effort to raise grant and contract funds in order to keep the center open.



Unfortunately, not all grant programs are actually good for a health center. Grant-seeking is a classic problem for FQHC managers and many health centers fail to apply strict cost accounting principles when budgeting for a grant opportunity (apparently under the “free money can’t be bad” theory of management). The result is they contract with funders for programs under which the grant revenues do not adequately reimburse the center for the full costs of the program, including overhead. Centers that develop a rigorous cost accounting model for all their programs find that many grant-supported programs cost the center more to perform than they generate in revenue. This phenomenon is especially true if a center does not clearly understand their overhead burden and allocate the appropriate costs to a grant program before accepting it. The result can be to overload existing staff with extra work, or the need to hire and manage temporary or part-time employees in order to meet grant requirements—all of which can lead to net financial losses on these grants. During the underwriting process, a lender may want to inquire whether the health center’s CFO applies cost accounting tools when evaluating grant opportunities.

Components of Grant Income

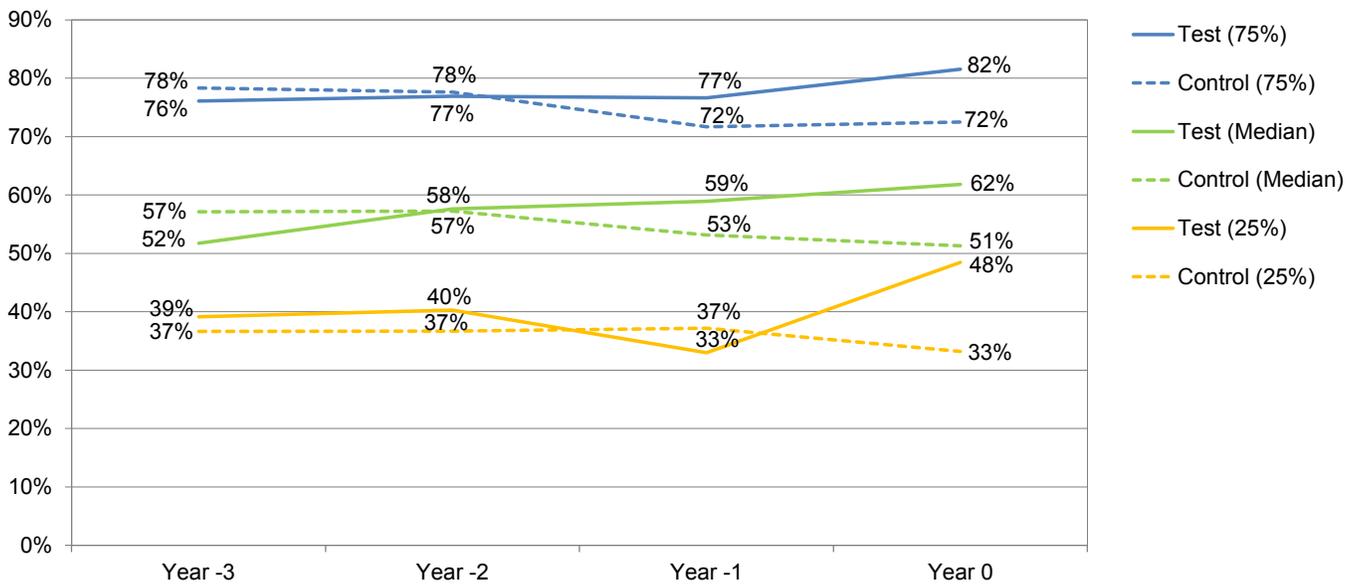
Grant income is one of the bedrock funding sources of the FQHC business model and one of the defining elements of the program is the Section 330 operating grant (referring to Section 330 of the Public Health Services Act). While the 330 grant is essential for sustaining health center operations, FQHCs are eligible for, and typically strive hard to obtain, grants from a variety of other sources. The success of centers in securing these other grants appears to play role in their sustainability. As noted above, it would appear that the test centers underperformed compared to their control group peers in securing grant income. This section will break down the grant sources of the test and control group centers to clarify this distinction.

The data in this section is from Table 9E of the UDS but given that all UDS data is based on the calendar year, the nominal figures may not coincide with the grant and contract revenue line on the audit income statement for the same year if the center operates on a different fiscal year. These charts focus on whether the test centers received a proportionate amount of their grant revenue from the same category of grantors as compared to the control group.

Section 330 Operating Grants

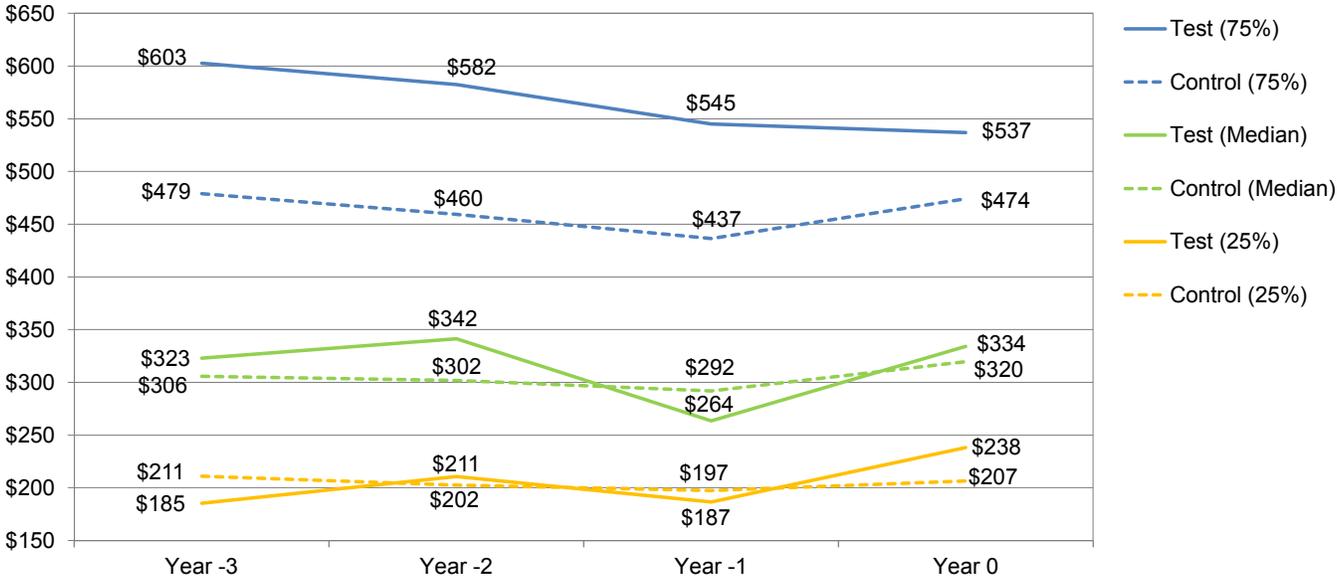
The chart below shows the 330 operating grant revenues of the test and control centers as a percentage of all their grant income. It would appear that the test and control groups obtained a comparable percentage of their grant income from this source. If, as might be expected, the test centers were simply not as good at raising grant funds from other sources as the control group, then one would expect that the 330 grant would account for a much higher share of the total grant income. This result does not appear to be the case until the last two years when, predictably, other grantors may have soured on supporting the test centers.

330 Grants as a % of All GCR



As noted in the introduction, it is clear from the analysis that no single reason stands out as to why health centers experience financial challenges and fail. A basic tenet of any business however is that the revenue generated per unit of sales/service must exceed the costs of providing that unit. Section 330 health centers are tasked with providing care to patients without insurance and in return receive the 330 operating grant from the federal government. Given the high percentage of uninsured patients at most health centers, one way to measure the reasonableness of this tradeoff is to compare the per patient grant revenue to the cost of care. It might be expected that the test group would be receiving fewer 330 grant dollars per uninsured patient but as the chart below reveals, this is not the case. Indeed for the 75th percentile, their 330 grant dollars per uninsured patient are dramatically higher than for the comparable control group; and for the median and 25th percentile they are comparable.

330 Grant Dollars per Uninsured Patient



Of course it is important to look not only at how these figures compare between the groups but also to evaluate whether the grant dollars per uninsured patient are adequate to cover the cost of care. As shown in the total cost per patient chart on page 41, it appears that for most of the test health centers the “effective reimbursement” per uninsured patient derived from the 330 grant does not come close to covering the cost of care.

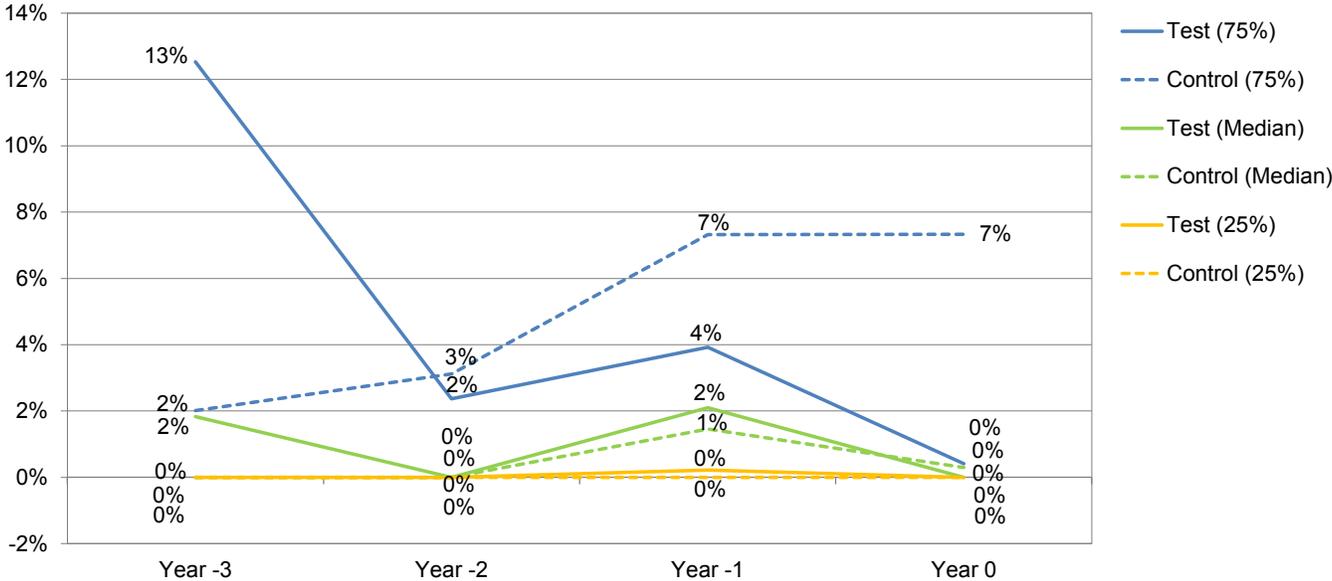
HRSA Capital Grants

From time to time, FQHCs have been eligible for capital grants from the federal government as an incentive to encourage the growth of health center industry capacity. As noted elsewhere in this analysis and suggested in the following chart, it appears that for some of the test centers the financial stress leading to their ultimate demise may have been due to ill-planned or poorly-timed capital projects. The

dramatically higher percentage of capital grants in the 75th percentile of the test group in Year -3 cannot be ignored. Accounting for 13% of all grant revenue, these grants appear to be large grants that would have been sufficient to boost capacity and not just purchase equipment or an EHR system. The lesson for lenders here might be to conduct extra due diligence on health centers that have recently completed a capital project—perhaps asking for historical statements for that location alone if there is any indication that a relatively recent project is causing financial distress.

Issue 4 of Capital Link’s *Community Health Center Financial Perspectives* series highlighted the fact that capital projects often cause the most financial stress for health centers in the year after the project is completed and during the early ramp-up period. The report also found that health centers that began projects in a relatively weak financial state often ended up even weaker post-project than they had been before. It’s possible that some of the test centers experienced this challenge as they struggled to implement capital projects that ultimately did not live up to expectations.

Federal Capital Grants as a % of All GCR



Other Federal Operating Grants

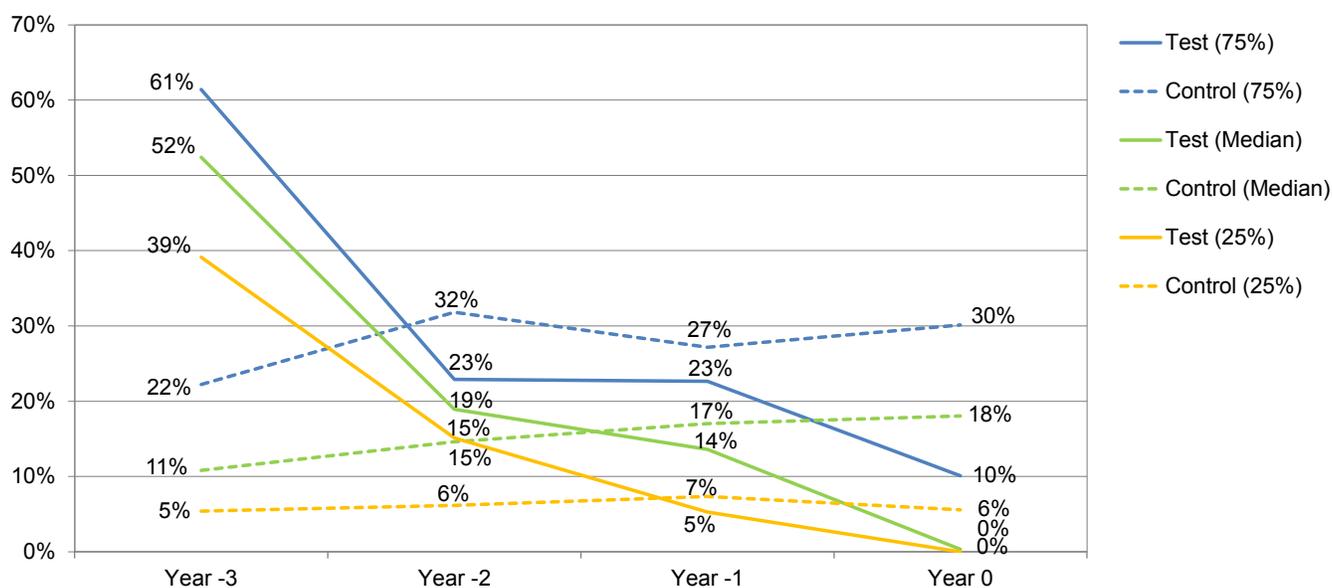
In addition to the 330 operating grant that most FQHCs receive, health centers can be eligible for other program-specific federal grants including:

- Ryan White grants – Covering the cost of HIV treatment.
- New Access Points grants – Operating grants for clinics opening in new service areas (these grants are ultimately added to the annual 330 grant).

- Increased Demand for Services grants – awarded to all FQHCs in 2009 and 2010 as part of the American Recovery and Reinvestment Act economic stimulus effort in anticipation of an increase in uninsured patients due to the recession. These grants are also “rolled into the base” 330 grants.
- EHR Meaningful Use incentive grants – to encourage the adoption and use of Electronic Health Record systems.

The difference in the trend lines between the test and control groups for these other federal grants is large and consistent across all quartiles. The test group started out in Year -3 receiving a dramatically higher percentage of their total grants and contracts from this source, but that percentage declined precipitously over the next 3 years potentially indicating that test centers attempted to open new access points, which were ultimately unsuccessful.

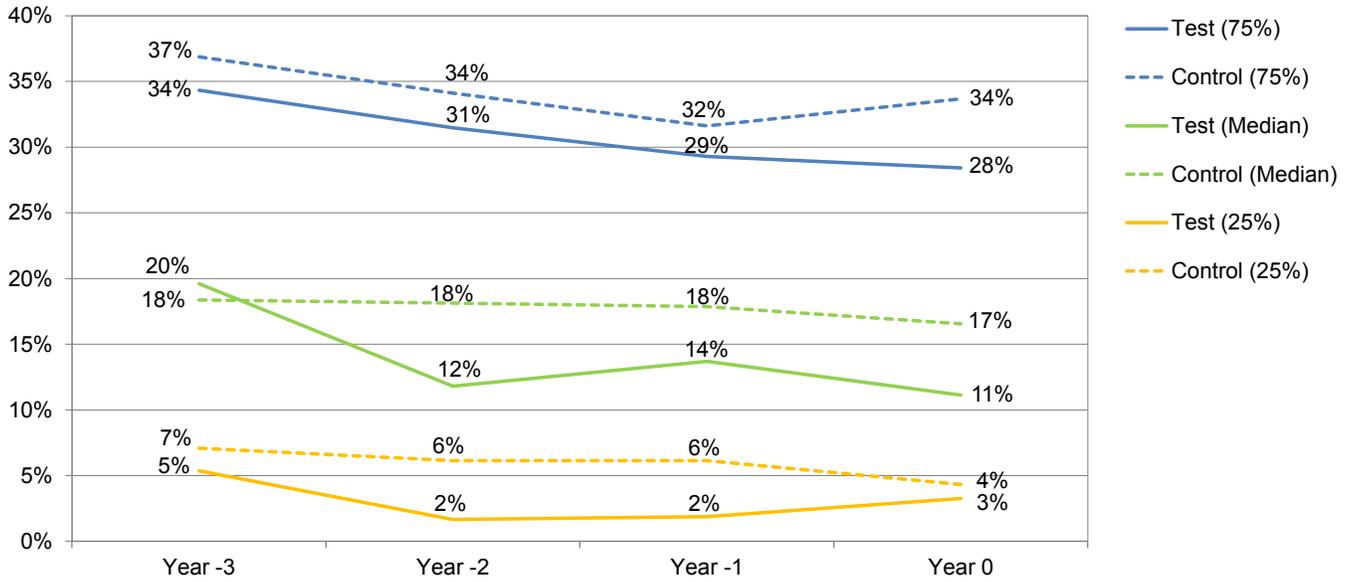
Other Federal Grants as a % All GCR



State and Local Grants

While most FQHCs receive a federal 330 operating grant, not all are located in states that provide consistent additional grant support for their health centers. This difference is clearly evidenced in the following chart by the wide variation between the quartiles. However, if all the test centers were congregated in the states that did not provide additional grant support to FQHCs, the chart would look much different. While the test group all received a lower percentage of their total grant and contract revenue from state and local sources than their respective control group counterparts, the differences are not dramatic enough to identify this as a major factor causing their financial troubles. This analysis suggests that while the playing field is not level across the country, it would be a mistake for a lender to avoid underwriting FQHC loans in these less supportive states. As might be expected, the conclusions are more nuanced, as clearly there are successful health centers within the states that provide little or no support.

State & Local Grants as a % All GCR

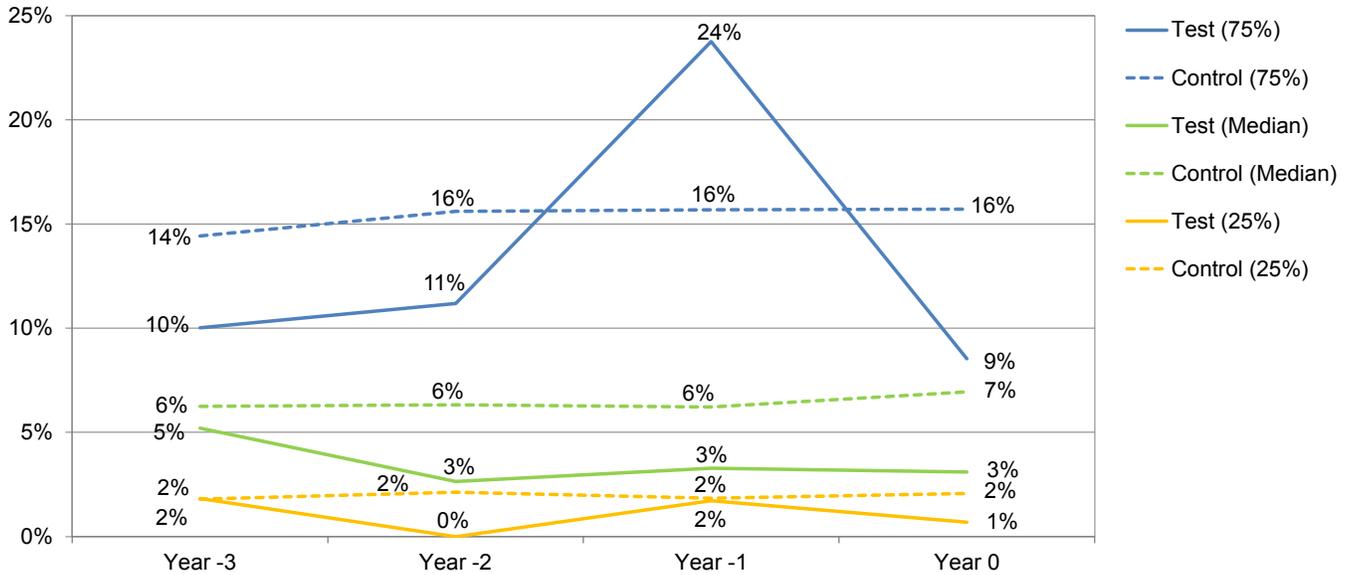


Private Foundation Grants

There is one additional major source of grant funding for health centers—private foundations. It is important to note that the UDS instructs health centers to include only grants from private foundations or corporations in this line, and *not* charitable contributions. Donations from individuals or from fund raising events are included as other non-patient-related revenue (see next section).

Health centers demonstrate great variability in their ability to secure grants from local/regional foundations. For the majority of FQHCs that do not employ development staff, fundraising falls to the CEO and possibly the CFO who (as can be imagined) are often otherwise occupied. The results in the chart below indicate that the test centers were uniformly less successful than the control group in attracting this form of grant support. The most intriguing result is the spike in the percentage of all grants secured by the 75th percentile in Year -1. It seems reasonable to hypothesize that faced with imminent financial collapse some centers mustered a strong outreach effort to local foundations in an effort to “save the health center.” Foundations are typically not good sources of emergency funds, but in some communities, requests such as this, with a well-written application or close personal connection to decision-makers, can get an audience.

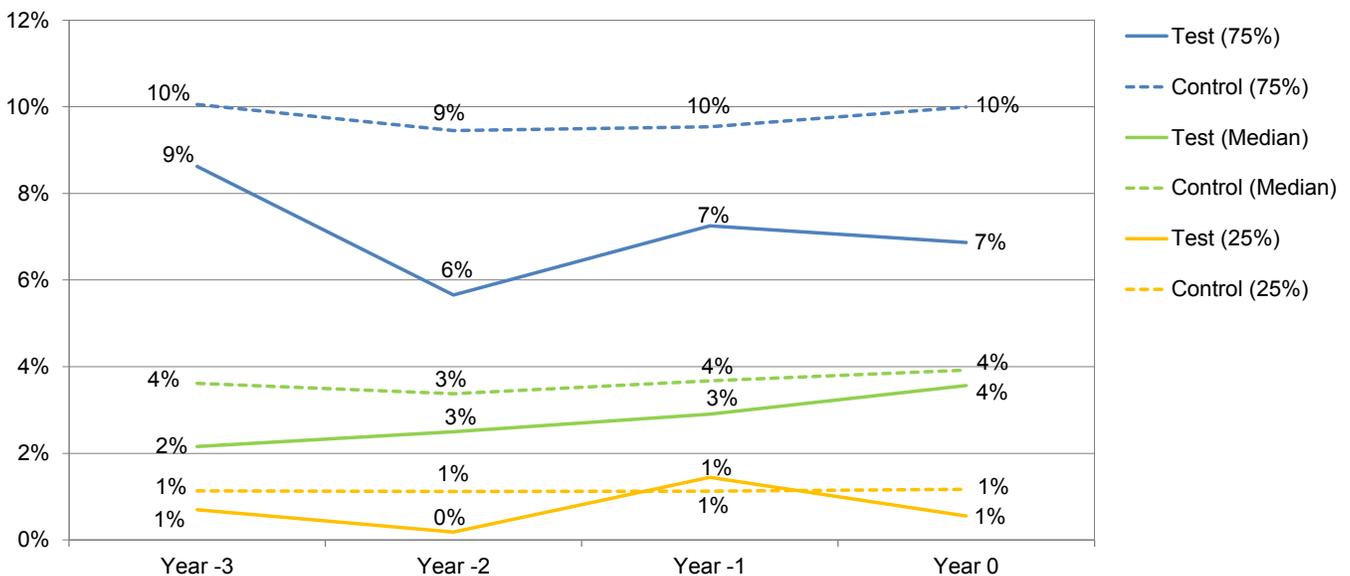
Foundation/Private Grants as a % of All GCR



Other Operating Revenue

The third general classification of FQHC revenue is other operating revenue (OOR), which primarily represents charitable contributions, space rental, sale of assets, patient record fees, and other miscellaneous income. As shown in the chart below, while the percentage of total operating revenue represented by OOR is relatively small, the test group reported slightly lower levels than the control group.

Other Operating Revenue



It is somewhat surprising that health centers as a whole (both the test and control groups) do not obtain a larger portion of their operating budgets from charitable contributions. This reality may reflect an effort to keep administrative costs down, which translates into an unwillingness to hire the development professionals required to build an effective program for attracting charitable donations.

Expenses

Clearly there are two aspects to maintaining profitability in any business: maintaining and/or growing revenues and controlling expenses. This section examines expenses of the test and control groups by looking at employment-related expenses and at total cost per patient, as further discussed below.

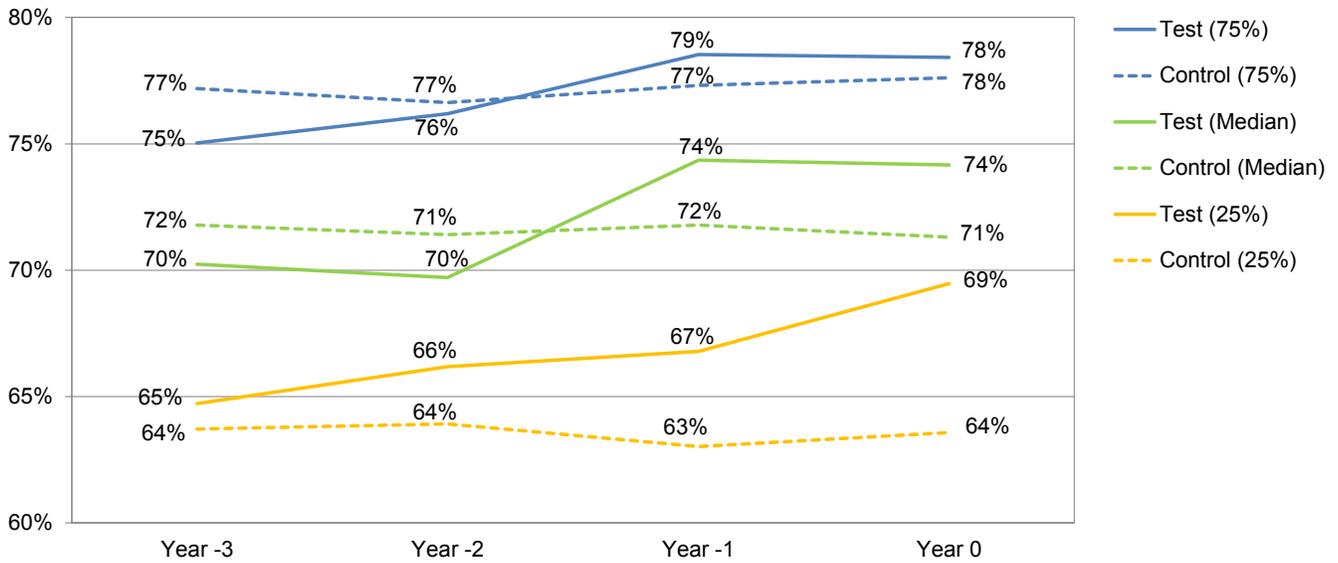
Employment – Personnel Ratio

For a service business, the largest category of expenses for all FQHCs is personnel-related, including direct salaries, payroll taxes and fringe benefits, and professional fees (which are typically dominated by payments to contracted providers and temporary staff required to fill in during periods of staff turnover and vacations). In Capital Link's experience, total personnel costs as a percentage of total revenue should remain below 70-75% for a center to maintain positive operating margins (though this threshold can vary somewhat by center depending on the makeup of the revenue mix).

As noted in the chart below, this ratio for test centers in general increased from Year -3 to Year -1 before declining in the last year (probably due to "last minute" layoffs). It is interesting to note that for the median and 75th percentiles, the test group actually started (Year -3) with a lower personnel expense ratio than the control group but quickly rose to exceed the respective control group quartile. Mathematically, this can only be the result of either rising personnel costs (perhaps due to a decision to grow between Year -3 and Year -2 causing an increase in personnel expense) or declining total revenues, or both.

In fact, the total operating revenue chart shows that total revenue for the test group did decline from Year -3 to year -2 for the median and 25th percentiles, but increased rather significantly for the 75th percentile (23%). Although not shown in this analysis, employment-related expenses per FTE for the test group at the median increased significantly in Year -1. Coupled with the decline in FTEs between Years -2 and Year -1, the data suggests that employee turnover may have forced the test centers to pay more to replace key employees. This observation could even be tied to the relatively dramatic decline in provider productivity from Year -1 to Year 0 as new providers struggled to adapt to a new system and fill their panels. Or perhaps out of desperation, the centers were forced to contract with *locum tenens* (temporary provider staff) who were relatively expensive and unmotivated to keep their productivity up since they knew they were just temporary.

Employment Related Expense as Percentage of Operating Revenue

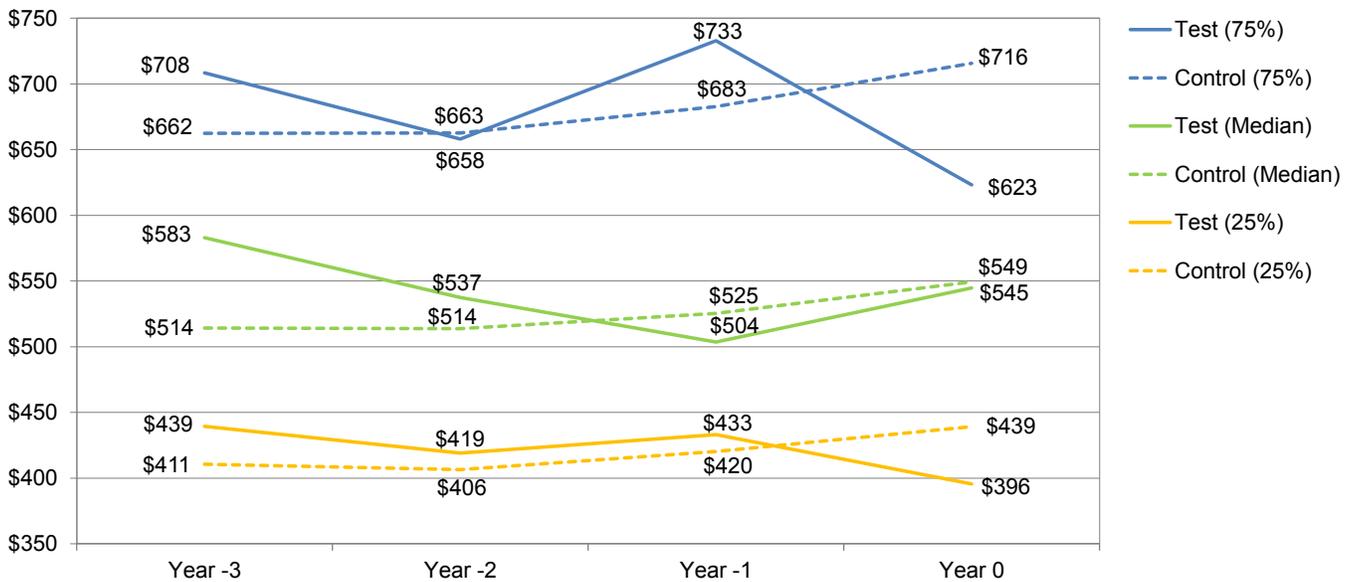


It is clear from the total FTE chart that at the median and 25th percentiles, the test centers reduced FTEs while at the 75th percentile they grew slowly (4.3%). One could conclude from this data that a minority of centers may have “grown themselves into trouble” (perhaps through a failed capacity expansion) while the majority appear to have begun something of a “death spiral”—shrinking revenues followed by insufficient cost cutting, leading to further losses and erosion of cash reserves. As the test centers’ management tried to bring this situation back into balance, they depleted their cash and either failed or were forced to merge.

Cost Per Patient

While the control group exhibits a normal pattern of relatively steady, moderate year-over-year increases in cost per patient, the test group has more erratic and mostly higher costs per patient. Given the current national focus on reducing the cost of care in the entire health care system, the variability in the total cost per patient illustrated in the chart below is interesting. The difference between the 75th percentile and the 25th percentile for the control group averages \$263 over the four year period—a level of variability that highlights the need for centers to have their reimbursement rates more closely tied to their costs, which the 330 grants, in general, are not. While a center’s 330 grant might increase from time to time as a result of a base grant adjustment, those Congressionally-approved increases are irregular and typically set at rates well below the rate of health care cost inflation. As time passes, the presumption that the 330 grants will cover the cost of the uninsured becomes more questionable and the reliance on full cost Medicaid reimbursements even more important to health center viability. That factor in turn, makes the timing of the changes in Medicaid brought about by the ACA even more important for health centers and will undoubtedly create a fault line over time between the performance of health centers located in states that chose to expand Medicaid and those in states that chose not to.

Cost Per Patient



One might expect that the test centers would report a higher cost per patient than the control group, and by and large this appears to be the case. It is notable that in the final Year 0, all the quartiles of the test group were able to drive cost per patient down below that of the control group. This is likely due to draconian cost reduction efforts, which were too little and too late to save the center. Lenders should be wary of drawing any hard and fast conclusions from a quick cost per patient calculation and comparing it to the statewide average for all FQHCs from the state UDS roll-up report. Costs can vary dramatically across a state especially between urban and rural centers and of course, the key is not the nominal amount of cost or revenue per patient but the difference between them that will determine if a health center is operating at break-even or better. The cost per visit data (not shown) was very comparable to the cost per patient data.

Productivity

There are two primary systems for calculating clinical reimbursement in primary care: fee-for-service and managed care (or capitation). Fee-for-service (FFS) has been the dominant payment system for FQHCs, paying them on the basis of valid, qualifying visits coded for acuity under the current ICD-9 system. FFS rewards providers for providing unique incidences of care, which are referred to as visits or encounters in the health center world.

Capitation on the other hand, is designed with completely different incentives. Under managed care, patients are assigned to a primary care provider (who would typically be affiliated with a hospital and a group of specialists) who collectively assume the financial liability for a given patient's health in exchange for a negotiated monthly payment that is made regardless of whether that patient seeks care or not. On its face, the incentive under this system is to minimize visits to keep costs down, but in actuality, the system encourages periodic provider-patient interaction so that any potentially serious (and expensive) developing conditions can be caught and treated early.

Under the predominant FFS system, providers are rewarded for seeing the maximum number of patients in a given period of time, which depending on the payer mix of patients, should also maximize revenue. This system has driven the design of most primary care clinics so that optimally each provider is allocated several exam rooms (three is the most common number). While one patient is being seen, two others are either in the process of being prepped or leaving the clinic post-visit. The system is designed to minimize provider downtime (therefore maximizing provider productivity). Based on licensure, only time spent with certain providers is actually billable by the clinic:

- Physicians (mostly family practice, internal medicine, OBGYNs, or pediatricians, though some FQHCs also employ specialists such as podiatrists)
- Mid-levels (a group of less highly trained medical providers including nurse practitioners, physician assistants, and certified nurse midwives)
- Dentists, and in most but not all states, dental hygienists
- Behavioral health practitioners including psychiatrists, psychologists, and licensed clinical social workers

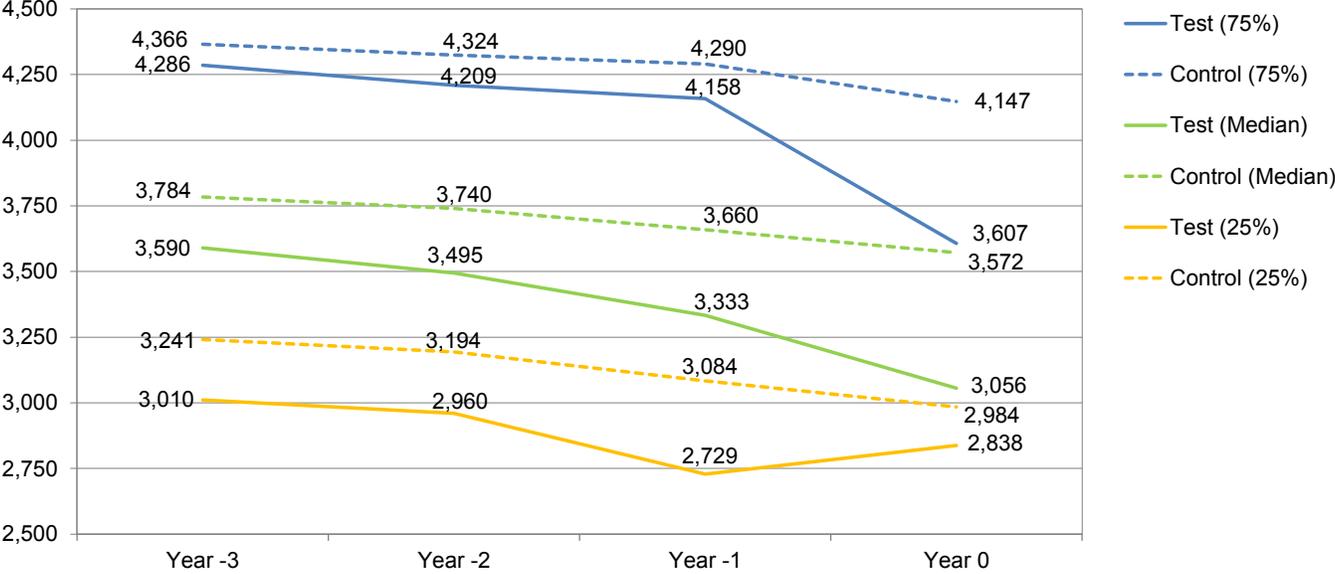
Given the preeminence of the FFS system, clinic managers typically monitor provider productivity very carefully. As with the level of payment allowances discussed above, the best way to evaluate whether a given clinic's productivity is good or bad, is to compare it by provider type to other FQHCs using the national or statewide UDS Roll-up reports published annually by HRSA on its website <http://bphc.hrsa.gov/healthcenterdatastatistics/>. The sections below describe this study's examination of whether low productivity might be a contributing factor to financial distress in the test centers.

Physicians: In the following chart, all physician visits are consolidated and evaluated collectively. As might be expected, physician productivity at the test centers declined steadily and significantly over the four years. It would appear that the test group's physicians were reporting relatively poor productivity even before Year -3, and this factor could have been an early warning sign of pending financial stress. Certainly, this lower productivity would have had a significant negative impact on the test health centers' financial viability.

It is worth noting that the productivity of the physicians in the control group also declined over the four-year review period, but at a much slower pace. At least some of this industry-wide decline is likely attributable to the implementation of electronic health record (EHR) systems over the last 10 years. While EHR systems allow better tracking of patient care, which may result in better health outcomes, it usually takes more time to enter information into the system at each visit. This lengthening of the average visit negatively impacts provider productivity. Since 2012, the UDS report has required FQHCs to report on the status of their EHR system implementation and usage, but data for earlier periods is not available. As a result, we do not have the data to determine if the financial distress of the test group was exacerbated by their efforts (perhaps failed efforts) to introduce electronic health records—but it would be a reasonable conjecture that it may have been a contributing factor.

Lenders are advised to inquire about the status of a center’s EHR implementation and whether it has received federal “Meaningful Use” payments (incentive grant payments for centers that can demonstrate that providers are trained in and are using their EHR system). These payments have been awarded each year since 2011 and will continue through 2016 using a graduated scale of demonstrated use. The awards were, reportedly, easy to qualify for in the early years but have gradually become more difficult since health centers will eventually be required to use their EHR’s full functionality.

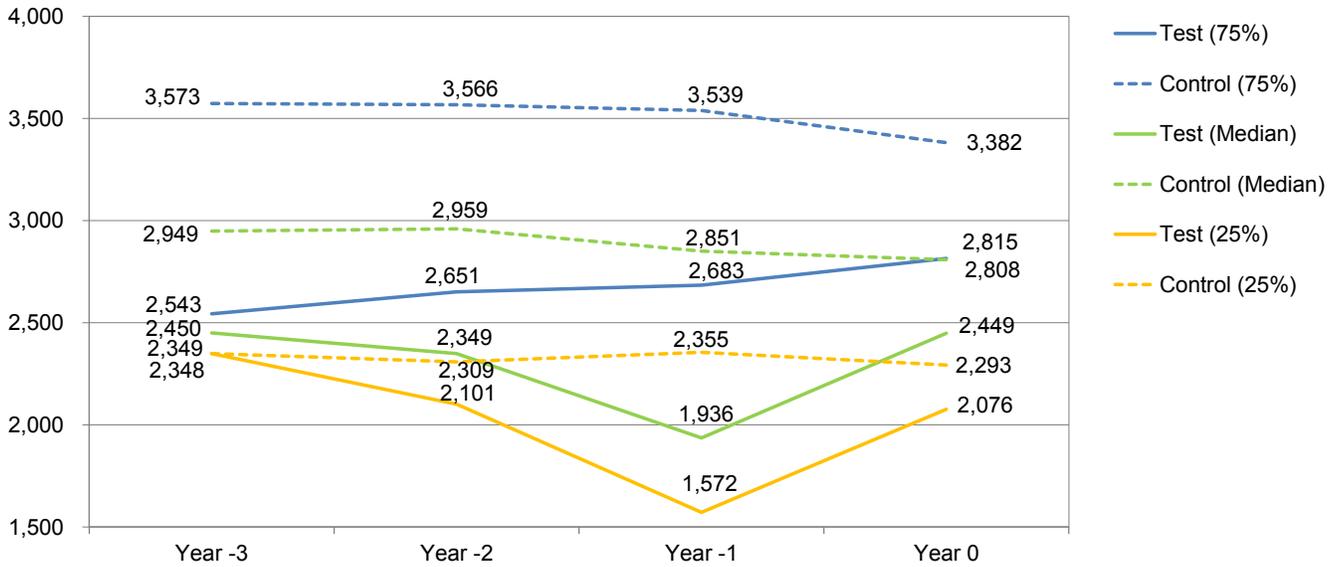
Physician Productivity



Mid-Level Providers: In the primary care setting, many patients present with conditions that do not require the expertise of a physician to diagnose and treat. As a result, most centers employ a number of mid-level providers (as defined in the introduction to this section). Mid-levels are compensated at a lower level than physicians so there is an economic incentive for the health center to employ more mid-levels and fewer physicians. Increasing the ratio of mid-levels to physicians is now a trend in the industry and can be a wise management decision. As a result, lenders should not interpret a declining number of physicians at a health center as a sign of financial stress. It could just reflect the difficulty in recruiting primary care physicians and/or an effort to adjust the balance of mid-levels and physicians.

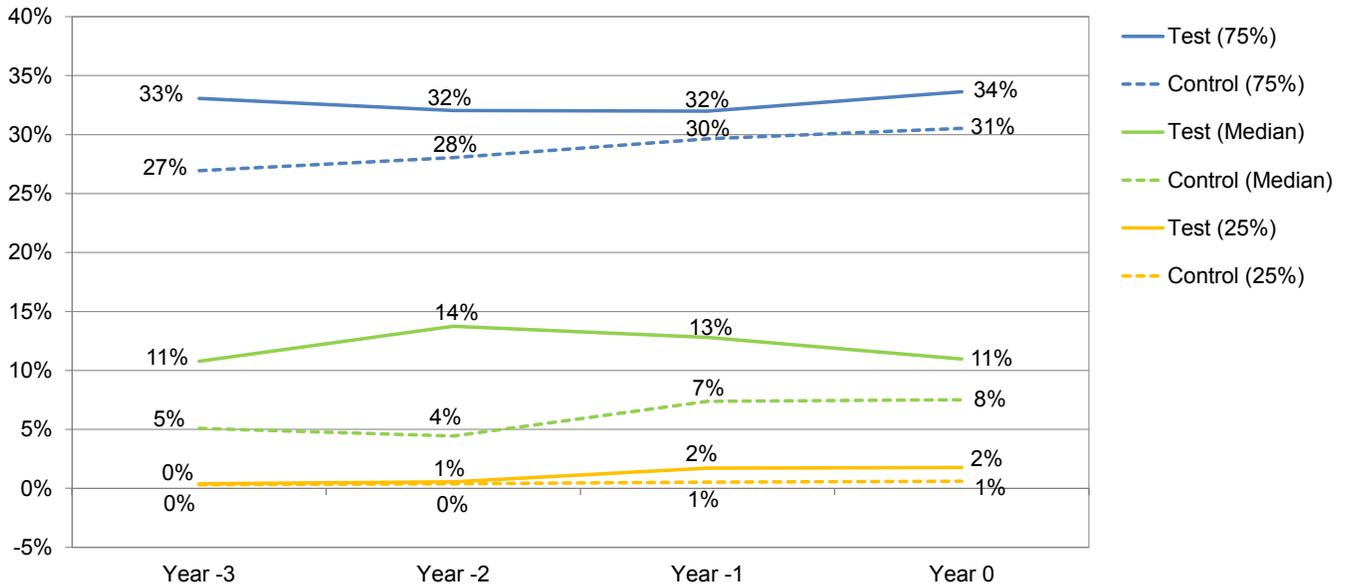
In general, mid-level productivity has been declining slowly over time in a similar way to that of physicians (discussed above) and likely for the same reasons. In that context, it is interesting to see that while the test group’s productivity in all quartiles was dramatically lower than that of the control group, the 75th percentile for the test group actually rose over time, reflecting some level of effort to improve productivity results. However, the relative levels of productivity were so much lower than the control group’s even after taking into account some positive movement at the 75th percentile, the data supports the conclusion that the test center group’s inability to improve mid-level productivity had a serious negative impact on revenue generation and therefore contributed to the test centers’ growing financial distress.

Mid-level Productivity



Translation Services: Health centers located in communities with high populations of refugees or immigrants are typically challenged to provide primary care services in many languages. Those centers that report a high number of patients requiring some form of translation services (especially in languages other than Spanish for which bilingual providers are more numerous) clearly have an additional cost factor compared to other centers that do not serve these populations. Patient visits requiring translation also reduce provider productivity for obvious reasons, and clinic design can even be affected since a visit to the doctor in some cultures can be considered a family affair. Not all of the centers in the test group reported significantly high levels of patients requiring translation services but there was a significant positive variance reported in the median and 75th percentiles. It is safe to assume that the proportionally higher need for translation services may have contributed to lower productivity—and the costs of translation may have contributed to the test centers’ higher cost per patient.

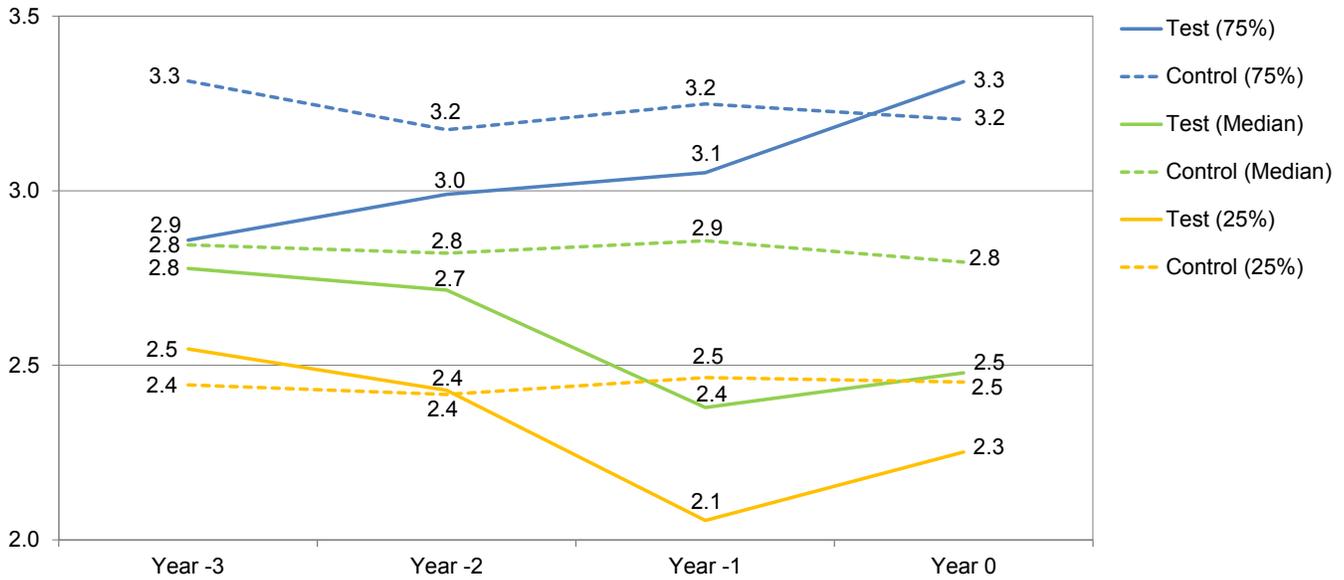
Percentage of Patients Best Served in a Language other than English



Medical Support Staff: Another major factor in a provider’s ability to meet productivity expectations is the amount and type of assistance they get with each patient encounter. Typically medical patient support staff is composed of nurses and/or medical assistants (MAs). While nurses are much more highly trained (and expensive) than MAs, neither position is billable. So the logic of a clinic’s support staffing structure depends on its practice pattern. For extremely crowded clinics, a highly trained nurse can help alleviate waiting room over-crowding by triaging and possibly treating walk-in patients with non-serious ailments. For uninsured walk-ins, the income loss to the center is minimal. MAs are not qualified to perform these functions, but if a health center’s practice pattern is for a nurse to bring patients to the exam room, take vitals, and prepare the EHR for the provider, these are functions an MA can do and at a much lower cost. Lenders may want to check the UDS for the support staff structure and query management as to the reasoning behind any obvious over-weighting one direction or the other.

While this study does not differentiate between the types of medical support, it does compare the number of medical staff per FTE provider. There is an unusual dichotomy in the results in that for the 75th percentile, the test group started out significantly lower than the control group and grew to exceed the control group by Year 0. The exact opposite results are evident for the median and 25th percentile, where the groups started at approximately the same place but the test group cut back on support staff until the final year when both measures increased somewhat. The cut-back in the median and 25th percentiles makes some logical sense as support staff are usually some of the first to be cut through layoffs or attrition as a cost cutting move. The increase in the 75th percentile over time may have been the mathematical result of accelerated turnover in the provider staff who sensed the organization’s instability and looked for work elsewhere.

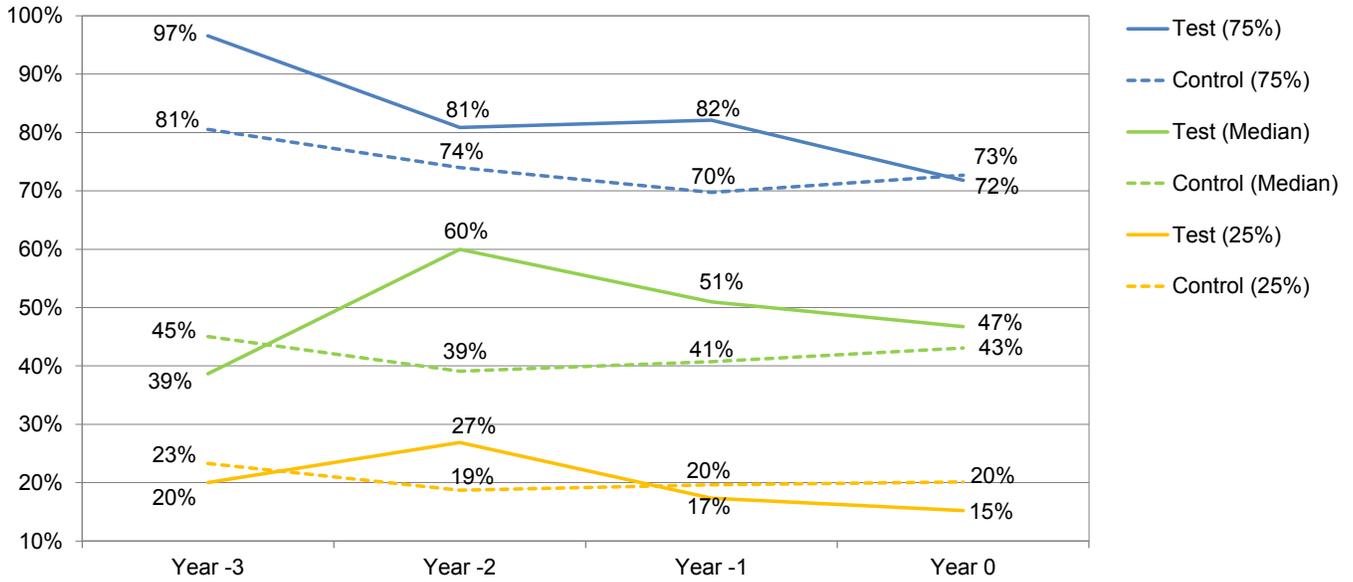
Medical Support Staff Per Medical Provider



Enabling Services: All FQHCs offer a range of patient services that go beyond the provision of direct medical, dental, and behavioral health care. Some of these services such as case management, health education, outreach, transportation, insurance eligibility assistance, and interpretation are tracked on the UDS form by the number of FTEs involved, but not all by the number of associated visits. The variety of enabling services offered speaks to the complexity of maintaining patient health and providing quality health care services to a primarily low-income and diverse patient base that has typically not enjoyed ready-access to these services. It is also important to note that the provision of these types of non-billable services is one of the most important ways in which an FQHC differs from a private primary care practice.

In the chart on the following page, we examined the number of FTE employees involved in enabling services as a percentage of all providers (medical, dental, and behavioral health, not including related support staff). At the 75th percentile, the test group started out with a higher proportion of enabling services staff per provider than the control group, which persisted over time until the final year. At the 25th percentile and median, the levels started out closer to their control peers but varied more over the period, with a higher proportion at the median in Years -2 and -1. This divergence from the steadier, generally lower proportions seen in the control group could reflect a somewhat higher set of patient needs in the test group or management's failure to align costs with revenues in a timely manner (or both).

Enabling Services FTE as Percentage of All Provider FTEs

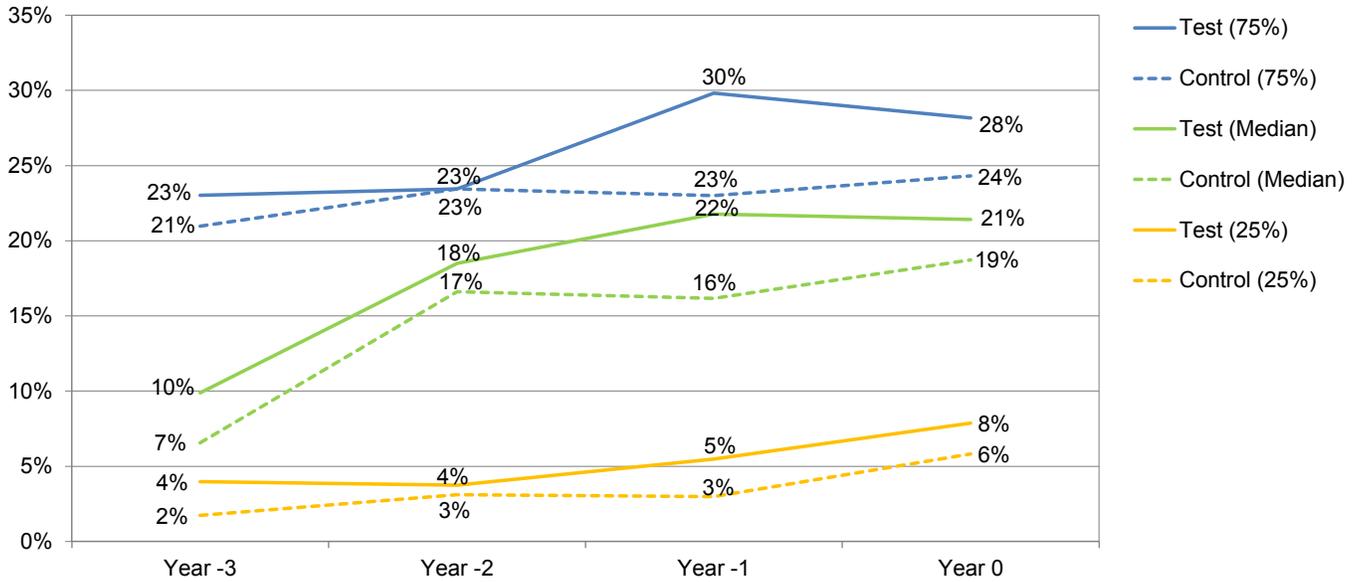


It is also important to recall that the centers in the test group were smaller than the control group based on all measures (FTEs, patients, visits, and total revenue). As FQHCs grow, they seem to hit certain milestones where additional administrative functions and FTEs must be added in order to manage the growing size and complexity of the organization. At those points, it takes additional time and continued growth to optimally leverage that additional administrative capacity before the organization reaches the next milestone and repeats the process. Since enabling services are generally not billable, these costs in some sense are akin to overhead and must be supported by grants or other aspects of the organization's revenues. While it is relatively easy for management to determine when to add an additional billable staff member, it can be more difficult to make those same decisions when adding enabling staff. It is possible (but unfortunately difficult to verify from the data) that the centers in the test group were caught at one of these inflection points and could not grow revenues sufficiently to optimally leverage the additional overhead. One way to try to verify this hypothesis is to look at administrative overhead and see if a similar over-staffing existed in the test group.

Overhead

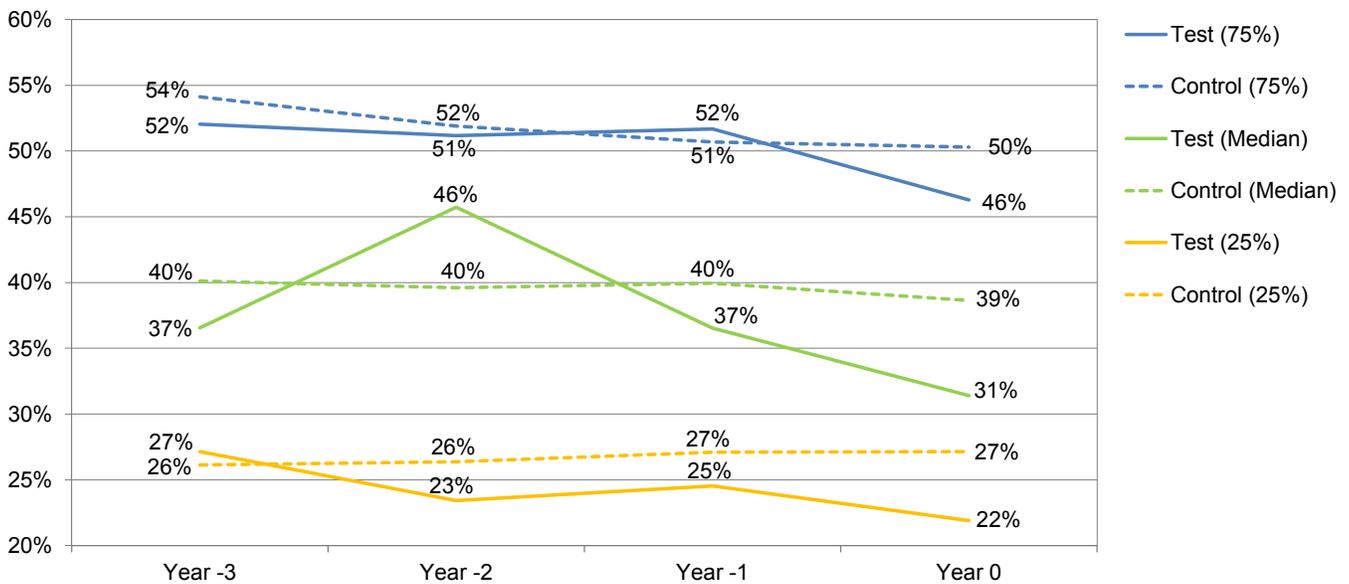
Administrative: The table below suggests that in fact the test group did have a higher percentage of administrative, information technology and facility staff as a percentage of all FTEs than the control group – and in some years the difference was significant. It should also be noted that with the exception of the facility FTEs this group is typically well-compensated, so a high administrative ratio can have a significant bottom line impact on a health center.

Administrative / IT / Facility Staff as a Percentage of All Staff



Patient Support Staff: The final group of overhead staffing to be analyzed is known as patient support staff. These are primarily front desk/reception positions, and often are the lowest-skilled and lowest-paid in the health center. As opposed to the trend we saw in the other classifications of administrative FTEs, it appears that as the test group experienced financial problems, they chose to lay off some of this staff. From a bottom line perspective, doing so probably had very little impact but to the extent these layoffs delayed patient processing, they may have negatively impacted the patient experience and/or productivity and billing.

Patient Support Staff as a Percentage of All Provider FTE



Diagnoses Prevalence

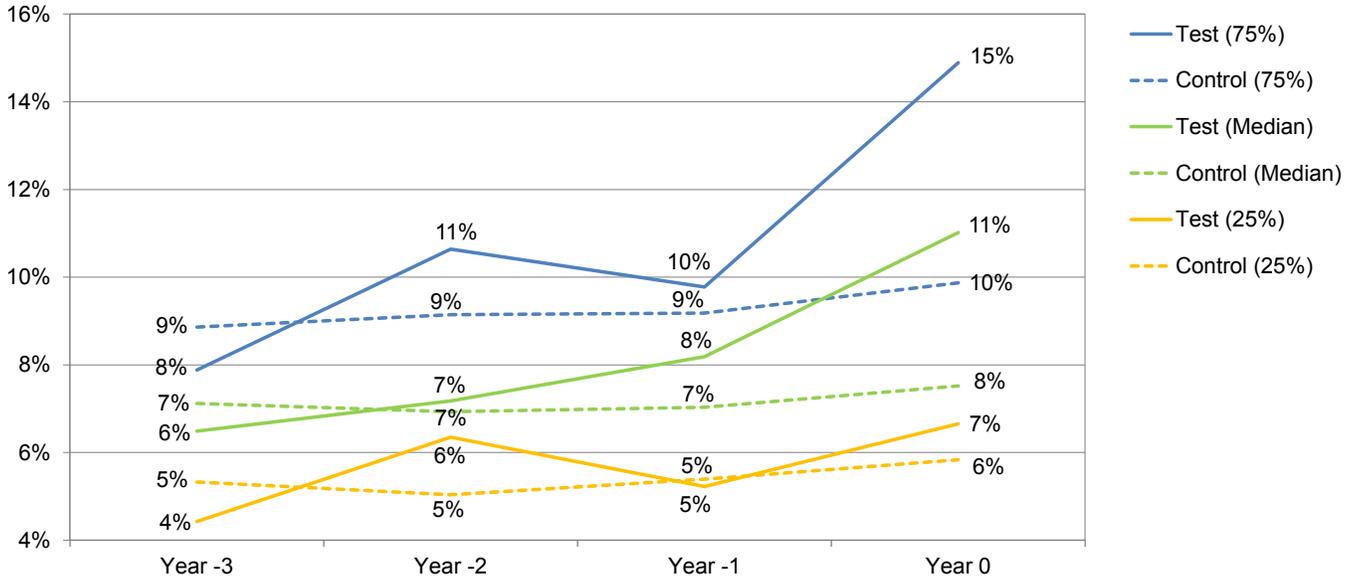
FQHCs were originally created to address a lack of access to primary care services in low-income communities. For private practice providers, a high percentage of uninsured residents combined with the poor reimbursement rates under Medicaid (for non-FQHC providers) did not create an attractive business environment. The result was a lack of primary care capacity in these communities leaving many residents to utilize hospital emergency rooms (ERs) for basic care. Beyond the high cost of the inappropriate use of hospital ERs for primary care, the regularly-scheduled treatment that is necessary to effectively manage chronic conditions (such as diabetes and hypertension/high blood pressure) does not occur in this type of care environment. The existence of an FQHC in a low-income community provides affordable access to these crucial services with a business model that can actually work given the resident's income and insurance status. In communities where the residents' basic health care needs have been ignored, patients are likely to have complicated health issues that can lead to longer visits, lower productivity, and greater financial challenges for the health center.

The data suggests that the test centers may have had a higher proportion of somewhat sicker patients requiring a higher level of care than their control counterparts. The following two charts present data on diabetes and hypertension diagnoses prevalence between the test and control groups. It is interesting to note that:

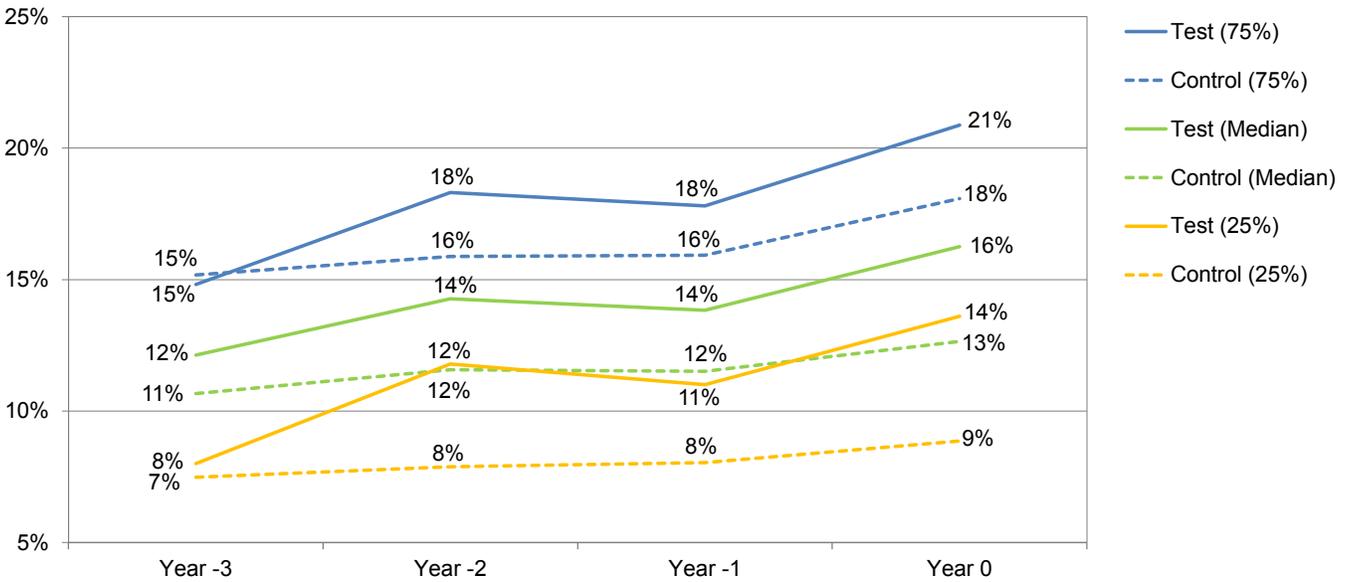
1. The results are strikingly similar between the two conditions.
2. In Year -3, the test group reported lower or very comparable prevalence to the control group, but this prevalence quickly changed over the review period.

It should be kept in mind that the four years under review could span from 2000 to 2012, and there was a dramatic increase in awareness of the need to test for Type 2 diabetes during that time. That said, the methodology of the study actually controls for this factor so that any effect is reflected in both test and control groups. The increase over time is relatively consistent across all quartiles suggesting there was something more than chance at play. It is possible that these centers, which were smaller than their control counterparts and had a higher number Enabling Services FTEs, may have undertaken intensive outreach efforts to attract more patients in an effort to grow, and as a result increased the awareness of the clinic in the community and attracted more chronically ill individuals. Alternatively, the test centers may have just happened to be located in areas with higher health disparities than their control counterparts. These centers would likely have had higher costs per patient, requiring both adequate revenues to support this care and excellent management/administrative systems to ensure sufficient collection of revenue in order to remain financially viable. Undoubtedly, the test centers had major challenges in these areas—all of which likely contributed to these health centers' financial demise.

Diabetes Diagnoses as Percentage of All Medical Patients



Hypertension Diagnoses as Percentage of All Medical Patients



Section IV: Summary of CDFI Survey Results

As the second part of this study, Capital Link conducted a survey of 16 Community Development Financial Institutions (CDFIs) that are members of the “Lenders Coalition for Community Health Centers” (the “Coalition”)⁵. The Coalition is an unincorporated advocacy and information sharing collaborative whose main goal is to advocate for resources and policies that create greater access to affordable capital for the community health center sector. As a group, the members of the Coalition represent the most active CDFI lenders to the health center industry. Clearly all health centers have banking relationships and many have borrowed from local/region/national banking corporations. However, polling all potential bank lenders to the industry was infeasible so the survey was limited to those lenders represented by the Coalition.

CDFIs are mission-based organizations and many accept higher levels of loan risk than state or federally chartered banks. As a result, we believe that the results of this survey, while not encompassing all loans made to health centers, likely reflect the high end of the risk spectrum. In other words, the results of the study and the conclusions drawn regarding the riskiness of health center lending are probably overly conservative, therefore potentially painting a worse picture than if all health center loans had been evaluated.

That said, the survey results from CDFIs in the Coalition reflect an industry that appears to present remarkably low portfolio risk to lenders. This finding seems to be the case even though, as mission-based organizations, health centers are confronted with cash flow challenges and daily decisions concerning the allocation of resources to improve community health as opposed to building reserves. The relatively low default history described in this section suggests that on the whole, the health center business model, when well implemented, can responsibly utilize debt to help fuel growth.

Coalition members were asked to respond to a questionnaire containing a range of questions related to the number, purpose, term, and performance of loans made to health centers since 2004. Loans reflecting Qualified Low-Income Community Investments (QLICIs) within New Markets Tax Credit structures were not included except for any portions thereof that represented true hard debt to the borrower.

Of the 16 CDFIs that were polled, 12 had made a significant number of loans to health centers. The following sections provide a graphical analysis of:

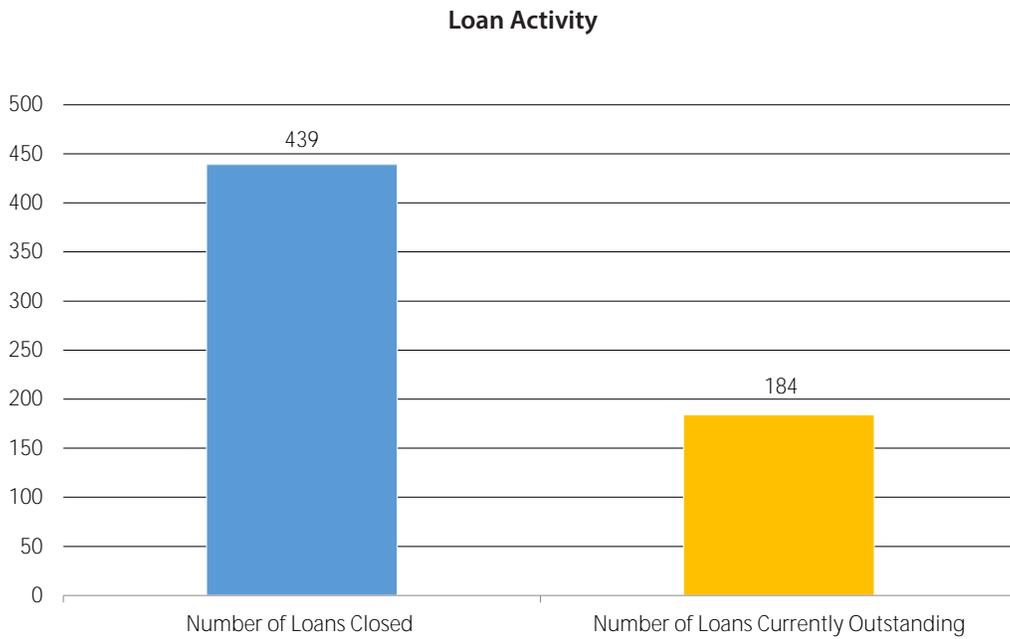
- Loan activity (number and original amount of loans made to health centers by Coalition Members)
- Types of loans (construction, equipment, and working capital)

⁵ <http://lcchc.wordpress.com/>

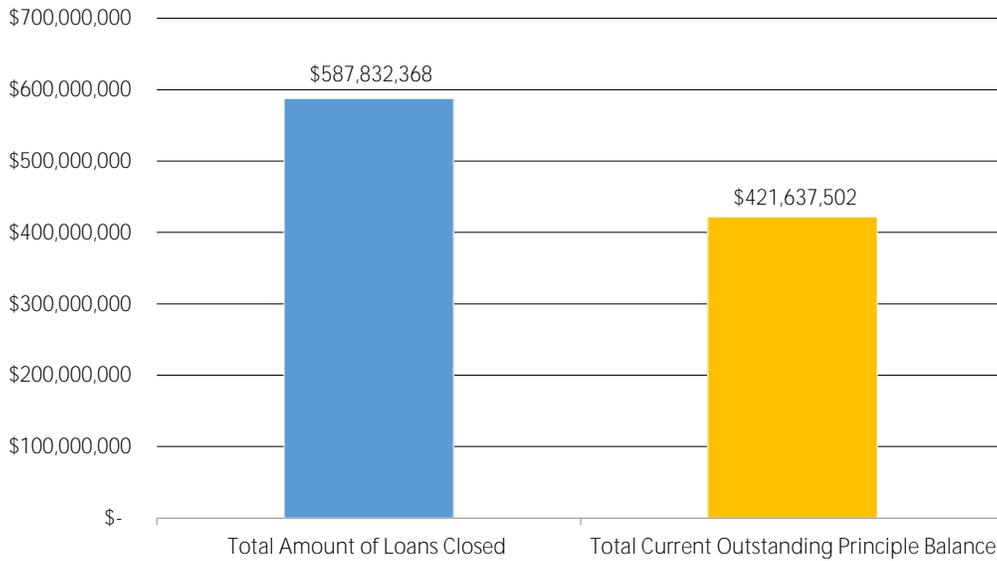
- Terms (interest rate, term, and amortization period)
- Number and amount of loans that became delinquent (60 days plus, plus % of total)
- Number and amount of loans put on non-accrual at any time (plus % of total)
- Number and amount of loan charge-offs (plus % of total)

Loan Activity

The chart below shows that since 2004, Coalition members made 439 loans totaling \$587,832,368. Of the total loans closed, 184 (42%) currently have outstanding balances. Paid off loans represent 58% of the total loans made. Of the 439 loans made, 17 (3.9%) had credit enhancement or a guarantor. The CDFIs approved 95% of the applications submitted.

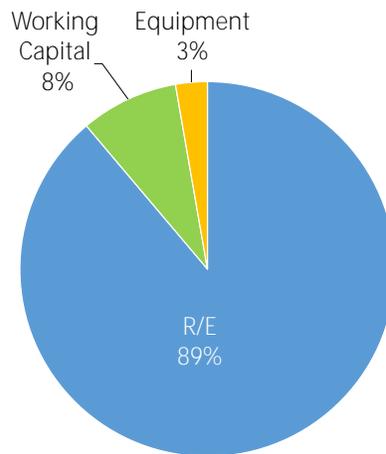


Total Amount of Loans



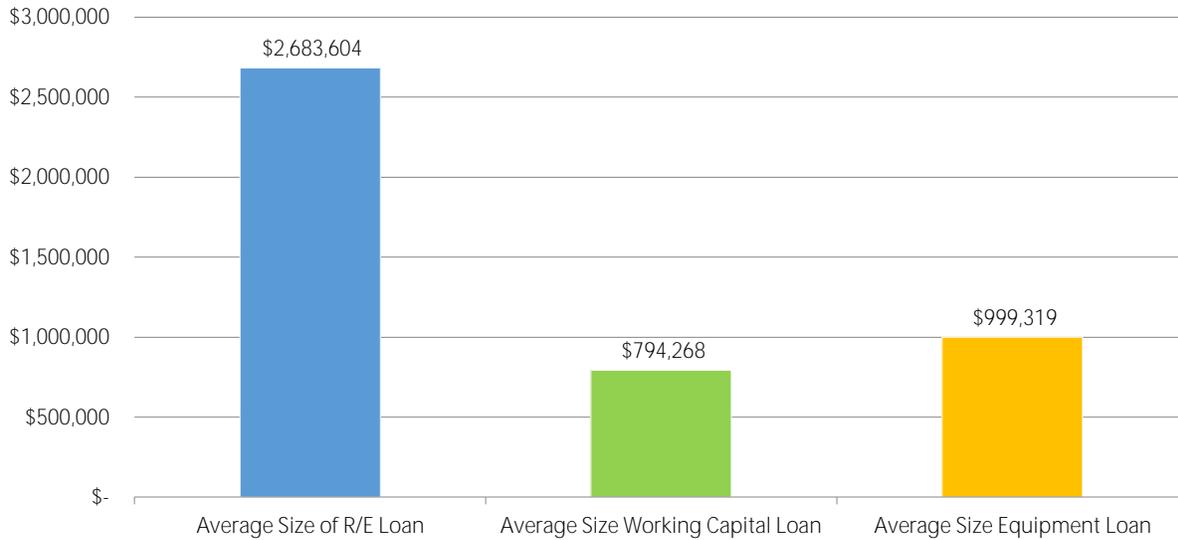
The vast majority of the loan originations (89%) were for real estate acquisition and improvement. Working capital loans (8%) were the next most prevalent followed by equipment loans, which comprised just 3% of the total.

Loans by Purpose



Not surprisingly, loans for real estate acquisition and improvement had the largest average size at \$2,683,604. Loans for equipment had an average size of \$999,319, and working capital loans averaged \$794,268.

Average Loan Size



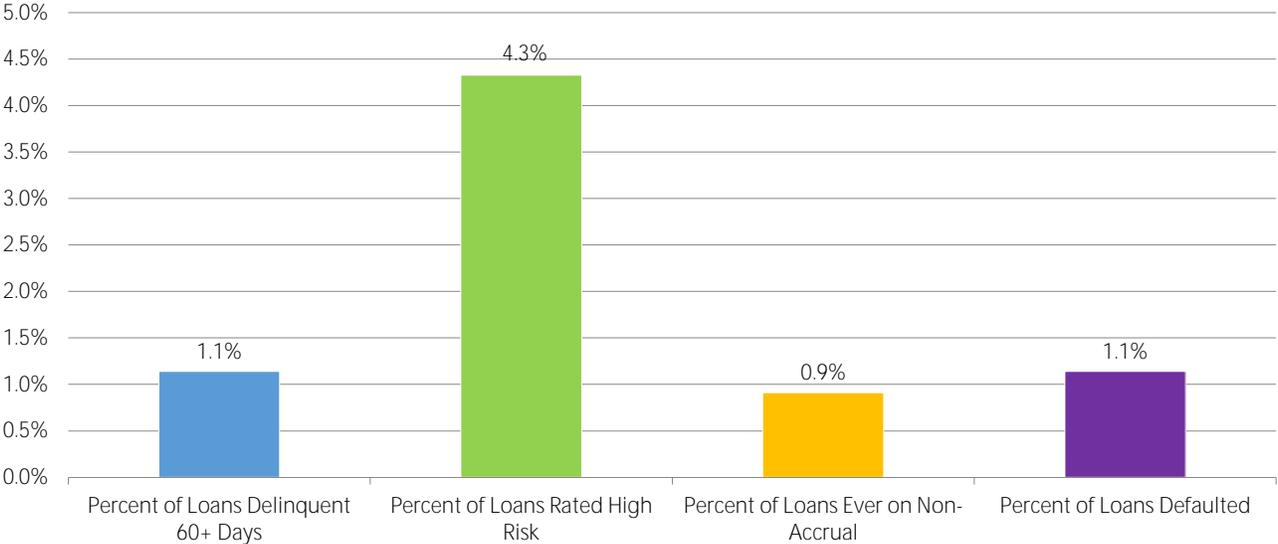
Loan Performance

The CDFIs surveyed have experienced strong repayment results. The highest risk rating at any time during the loan term was assigned to 4.3% of all loans made to FQHCs. Risk ratings are portfolio management tools in which all the loans in a portfolio are regularly assigned a score based on the likelihood of the CDFI collecting all the principal and interest owed. A higher risk rating equates to a higher risk that a loan will not be repaid.

The percentage of loans that had been 60 days or more past due at any time since closing, totaled 1.1% of loans made. Loan payments are usually scheduled to be paid monthly and lenders are usually fairly tolerant of an occasional late payment. However, borrowers that are late by two or more payment periods (60 days), typically come under much greater scrutiny. Such events are technically considered “Events of Default” under the loan documentation but are often not immediately declared to be such by the lender. Usually these issues are resolved with a phone call or meeting to discuss the reason for the specific non-performance. Default can be financial (failure to make a payment) or technical (failure to submit one or more required documents to a lender such as quarterly financial reports, audits, etc.). However, if a borrower is chronically late with payments, becomes more than 90-120 days behind, or fails to submit statements for an extended period of time, a lender may declare, in writing, that the borrower is officially in default. Under the terms of most loan agreements, this declaration gives the lenders a new, enhanced set of rights and options to pursue in order to ensure the collection of the money owed to them. This study revealed that the percentage of loans in default matched the percentage of loans that were 60 plus days behind schedule (1.1%).

Typically, the next step after an official declaration of default is to put a loan on non-accrual status. Most lenders assume a loan payment will be made and book the associated monthly interest income based on this assumption. However, when a borrower fails to make payments for an extended period of time, the lender changes the way it books interest earnings to a cash basis. This is a serious decision for any lender that may lead them to write off interest already booked to income and take steps to address the possibility of losing some or all of its loan principal. Fortunately, of the loans in the study, only .9% were ever placed on non-accrual. This is a low level for almost any industry or loan type.

FQHC Loan Performance



Only two of the 439 loans were foreclosed, or charged off. One of the loans charged off was for real estate and the other was for working capital. The charged off loans totaled \$967,000, or roughly .2% of the total loans closed. One of the charged off loans was for a new clinical site.

Finally, the CDFI survey provided the opportunity for the respondents to identify specific problem borrowers and discuss their perceptions of the reasons behind each center’s loan repayment problems. A total of 10 loans were identified as “problem loans” (2.3% of total loans) and respondents commented on six. There was no consistent theme in the notes included with the statistics on the problem loans. Several experienced construction-related problems (i.e., cost over-runs, late design changes, or failure to raise all anticipated contributions). It also appears that as part of the loan work-out process in at least two transactions, the health center made management changes. Other reasons for the financial trouble experienced by borrowers ranged from delayed government payments to management teams that were inexperienced with changing reimbursement systems.

Section V: Conclusion

While this study has focused on a relatively small group of health centers that have experienced financial difficulties over the last 14 years, it is important to put the results in perspective. Of the more than 1,280 health centers that have ever been free-standing FQHCs (1,198 reported to HRSA at the end of 2012 plus 85 that stopped reporting at some point over the last 12 years), fewer than 7% failed or merged with another entity. Considering only the 29 centers included in this study that experienced severe financial distress leading to their failure, the percentage falls to 2.2% of all FQHCs. An even lower proportion—1.1% of all loans made by Community Development Financial Institutions to health centers—were ever seriously delinquent on loan payments (60 days past due).

These summary statistics suggest that the incidence of health center failure and loan default is quite low and has remained so for some time. As a result, for lenders, this industry data suggests that the health center sector offers a reasonably sound credit profile with limited risk of loan loss. That said, the business model that health centers work under is complex and the challenges they face are complicated by:

- Growing federal deficits
- A rapidly evolving health care environment and changing reimbursement systems
- Growing income disparity in the country that economically isolates the low-income populations health centers serve
- Increasing expectations as to the number of patients health centers will serve
- A shortage of primary care providers to service a growing number of patients
- A need for (and high expectations of) improved health outcomes, especially among the high-utilizers of safety net services

As presented in this analysis, there are many reasons as to why some health centers experience financial challenges and fail or are forced to merge. The X-factor underling all the conclusions in this report, which is difficult to associate directly with any of the results, is, of course, management. The quality of management (how well a business model is executed) varies greatly across similar organizations in all industries, and FQHCs are no exception. Certainly, the operating environment of any particular health center could stack the deck against even the most skilled and enlightened of managers—reimbursement rates, provider skill, patient acuity, neighborhood politics, and local fundraising support are all factors that management can influence over time, but not quickly. So while this study points out some interesting similarities among the centers that failed, it seems likely that across the industry other centers faced some or all of these same issues and overcame them.

Beyond the challenge of managing a complicated, heavily-regulated business that provides primary care services to sick patients with multiple needs, health center managers answer to community-based boards with varying levels of expertise in the business of running a health center and who may be differentially prepared to face the major waves of change breaking on the industry.

While the longevity of the health center model attests to the overall strength of managers and boards working together to provide effective, sustainable, community-based care, some managers and boards have struggled with this task. That said, the industry has grown to its current size facing similar challenges and has mostly thrived. The conclusions pointed out in the study will be helpful underwriting guideposts, but the study does not provide lenders with a free pass on the most basic challenge of underwriting any loan: evaluating the quality of the management team.

Exhibit A

Formulas for Calculating Financial Ratios

Operating Margin	$\frac{\text{Change in Operating Net Assets}}{\text{Total Operating Revenue}}$
Bottom Line Margin	$\frac{\text{Change in Net Assets}}{\text{Total Operating Revenue}}$
Current Ratio	$\frac{\text{Current Assets}}{\text{Current Liabilities}}$
Days in Net Patient Accounts Receivable	$\frac{\text{Net Patient Accounts Receivable}}{\text{Net Patient Service Revenue} / 360}$
Days in Accounts Payable	$\frac{\text{Accounts Payable}}{(\text{Total Operating Expenses minus Salaries and Depreciation}) / 360}$
Days Cash on Hand	$\frac{(\text{Unrestricted Cash} + \text{Investments})}{(\text{Total Operating Expenses} - \text{Depreciation}) / 360}$
Leverage	$\frac{\text{Total Liabilities}}{\text{Total Net Assets}}$
Employment-Related Exp. as % of Operating Income	$\frac{\text{Salaries \& Related Expenses} + \text{Fringes \& Payroll Taxes} + \text{Professional / Contracted / Consultant Fees}}{\text{Total Operating Revenue}}$