California Community Clinics

A Financial and Operational Profile, 2008–2011

Prepared by

CAPITAL LINK

Sponsored by

Blue Shield of California Foundation and
The California HealthCare Foundation

TABLE OF CONTENTS

INTRODUCTION

This report, prepared by Capital Link for Blue Shield of California Foundation and the California HealthCare Foundation, examines California clinic financial trends and highlights strengths and weaknesses in their overall performance. The research was conducted to better understand the financial health of the California clinic safety net as well as those critical factors that may positively influence the development of high performing health clinics.

Covering the period from 2008 to 2011, this study serves as a follow up to "***California Community Clinics: Financial and Staffing Analysis, FY2006-2009,***" released by Capital Link in 2010.[1] After examining data from audited corporate financial statements as well as data reported to the California Office of Statewide Health Planning and Development (OSHPD), the resulting profile shows that the clinics have sustained consistent growth despite the ongoing challenge of tight margins and limited cash reserves. The analysis also demonstrates the critical role clinics play in providing services to the uninsured residents in their communities.

This study further focused on analyzing organizational factors that may most influence clinic financial and operating performance. Since clinic leaders are interested in understanding their financial profile more specifically as it compares to their peers, the research also developed a framework for grouping clinics by similar operational characteristics to enable financial benchmarking and sharing of best practices.

The analysis has been structured into four separate, but related sections:

Section I includes the financial and operational profile of 158 California community clinics for which financial data was available over the four-year review period 2008-2011. The study group represents approximately 75% of all California primary care clinic utilization data that was reported to OSHPD in 2011.

Section II provides a more focused financial analysis of the 125 Federally Qualified Health Centers (FQHCs) and Look-Alike (LAL) clinics within the data set. This section also investigated the apparent associations of specific organizational characteristics with financial performance. In addition, operational characteristics such as patient mix, payer mix, and service mix were analyzed, providing insights for assessing programmatic factors as drivers of financial performance.

Section III provides a framework for integrating the results from Sections I and II for the purposes of performance benchmarking among clinics with organizational or operational similarities.

Section IV uses the available data set to run a financial sensitivity analysis to assess the impact of possible Medi-Cal funding reductions.

INTRODUCTION

Key Findings

The analysis of the 158 California community clinics for which financial data was available over the four-year review period 2008-2011 resulted in the following finanical and operational profile:

Financial and Operational Profile
All Community Clinic Types

Strong Growth:

Over the four-year study period (2008-2011), clinics continued to demonstrate strong growth. Total revenues increased 10% annually from $2 billion to $2.7 billion, average revenue per clinic organization grew from $13.2 million to $17.3 million, and the number of sites per clinic organization increased from 3.8 to 4.4. In 2011, four million patients were served by the clinic organizations in the study—up from 3.2 million in 2008, representing a 26% increase.

Tight Margins:

Clinic margins remained tight for the vast majority of clinics (2% at the median) with at least 25% of clinics operating below a financial breakeven level. Clinics operated at the median with just over 1.5 months of cash reserves (48 Days Cash on Hand), while 25% of clinics operated with just three weeks of cash (22 Days) or less.

Payer Mix:

Medi-Cal remains the most important payer source for clinics, covering 43% of patient visits while generating 56% of patient revenue. Within Medi-Cal, there was a shift from traditional fee for service reimbursement system to a managed care model. Approximately 18% of clinic patient visits were uninsured (free care and sliding scale visits).

A focused analysis of the 125 Federally Qualified Health Centers (FQHCs) and Look-Alike (LAL) clinics, representing 87% of the utilization of the full data set, illustrates that several organizational factors were important determinants of a clinic's financial and operational performance, as outlined on the following page.

INTRODUCTION

Key Factors Impacting Clinic Financial Performance
Federally Qualified Health Centers and Look-Alike Clinics

Type of Clinic:

Federally Qualified Health Centers (FQHCs) and FQHC Look-Alike (LAL) clinics generally outperformed other types of community clinics, primarily related to their revenue mix and enhanced reimbursement rates received from Medi-Cal.

Location of Clinic:

The general financial profile of clinics varied notably according to whether they were primarily located in urban or rural communities, highlighting the significant financial management challenges faced by rural clinics. Urban clinics earned higher margins and had more cash reserves than rural ones, attributable in part to the fact that rural clinics spend a higher portion of their operating budget on salary-related expenses than their urban counterparts. Clinics in certain regions also performed differently, suggesting that future analysis may shed light on the factors contributing to the identified geographic variances. For example, clinics in the Central and Southern regions of the state showed stronger performance than those in the San Francisco and the Northern Regions.

Size of Clinic:

Larger clinics generally outperformed smaller ones. This was true whether size was measured by revenues, number of employees or patients, or other metrics. Larger clinics had stronger operating margins and also performed better on other key metrics.

Number of Clinic Sites:

In the study group, a clinic expanding from one to two sites did not have a significant impact on operating margin or growth rates. However, once a clinic organization grew to three to four clinic sites, operating margins began to slip. Clinics with five to nine sites had healthier margins, while clinics with 10 or more sites enjoyed even stronger operating performance. The impact of the number of sites should be further reviewed to better understand whether consolidation of activities or other influences are responsible for the apparent improved performance in larger clinic organizations with five or more sites.

Key Factors Impacting Clinic Financial Performance
Federally Qualified Health Centers and Look-Alike Clinics

Payer and Patient Mix:

Clinics with a large number of patients under 100% of the Federal Poverty Level (FPL) had stronger financial performance. Also, those with higher Medi-Cal and/or Medicare payer mixes, regardless of clinic type, enjoyed stronger operating performance. These results are consistent with the higher reimbursement rates for these clients.

Service Mix:

A clinic's service mix did not play a clear role in its financial and operational results. Clinics offering mental health services, hospital services, or maternity care and delivery did not have significantly different operating or financial metrics than those that did not. Although clinics that offered dental services showed worse financial results than those clinics that did not, this may be attributed to recent reductions in Medi-Cal eligibility to program funding for adult dental services.

Developing Peer Clinic Groups and Performance Benchmarks

Classify Clinics into Peer Groups:

With the objective of creating a relevant performance benchmarking framework for clinics, the process should initially classify clinics into peer groups or tiers based on several key factors which have been demonstrated to influence financial and operational results.

Develop High Performance Benchmarks for Peer Groups:

High performance benchmarks can then be developed for each tier by summarizing target ranges for the highest, average, and lowest performance metrics for each key indicator. Clinics would strive to perform at the highest level within their tier.

Assist Clinics in Analyzing Results:

Clinics will likely require hands-on assistance and training to analyze results and identify opportunities for improving performance. Mechanisms for sharing information and best practices within and between tiers must also be developed in conjunction with the peer performance framework.

Medi-Cal Sensitivity Analysis

5% Reduction in Funding:

A 5% reduction in Medi-Cal funding causes the four-year median operating margin to drop from 2% to 1%. This 1% margin represents a very narrow operating surplus that threatens financial stability for at least 50% of the clinics in the study group.

10% Reduction in Funding:

A more dramatic 10% reduction in Medi-Cal funding would lower the four-year median operating margin to 0.1%, or essentially a financial breakeven level. At this level of performance, the clinic operations of approximately half of the clinics in the study group would generate financial losses, thereby threatening their ongoing viability. If, as a result, clinics closed or reduced services, patients might have to seek services in higher-cost alternatives, such as emergency rooms.

Methodology Summary

Capital Link compiled a four-year financial data set based on audited financial statements for California clinic corporations covering the fiscal years 2008-2011. The total number of audits available varied between 156-158 for each year of the review period. The majority of audits were collected by Blue Shield of California Foundation via their core support grant program; these were combined with financial audits from Capital Link's audit database. The final list of 158 clinics for which audited financial data was available for the four-year period included 105 FQHCs, 20 LALs, and 33 non-FQHC clinics ("Neither" or "Other" clinics). The clinic organizations included in this analysis comprised 75% of the primary care clinic utilization (patients and encounters) reported to OSHPD in 2011; therefore the data set is considered to be representative of community clinics throughout California.

OSHPD annual utilization data was downloaded for the 2008-2011 period, and site level data was then aggregated at the parent corporation level. Utilization data was combined with audited financial data to develop the complete sample set for parent clinic organizations. It is important to note that the OSHPD data was based on calendar year performance, while the financial audits covered fiscal years. It was determined, in consultation with the advisory group, that this combination of data sources, although imperfect, provides the most accurate analysis currently possible given the differences in collection methods for clinic financial and operational data.

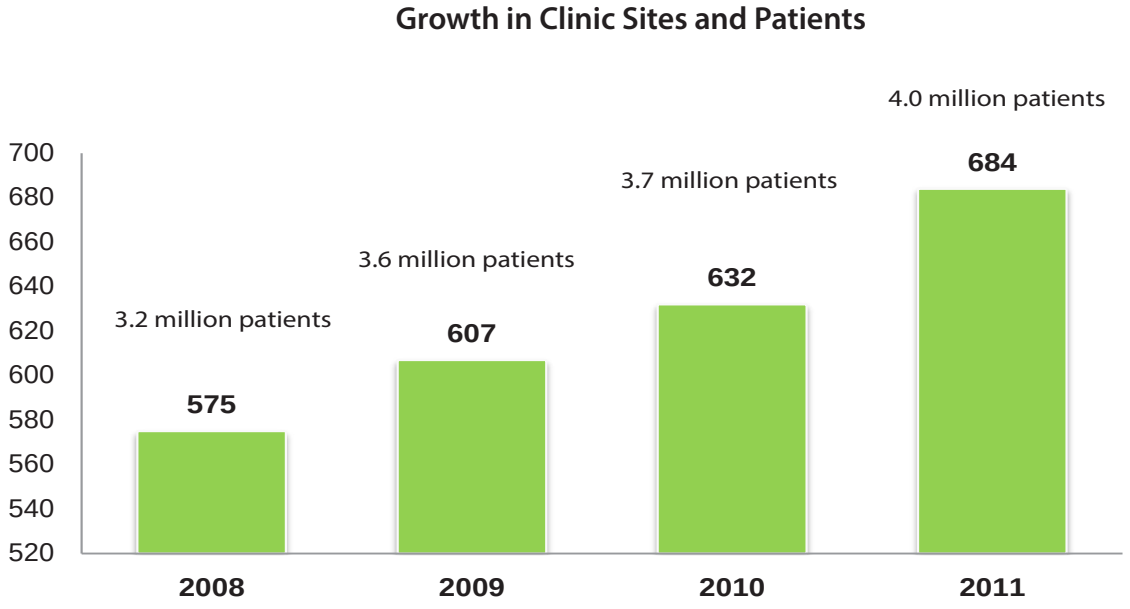
Capital Link completed this study under the guidance of a clinic advisory group comprised of various leaders from the California clinic community. A complete list of the advisory group members is provided on page 46.

SECTION I: FINANCIAL & OPERATIONAL PROFILE OF CA COMMUNITY CLINICS

Section I illustrates the financial and operational profile of 158 California community clinics for which data was available over the four-year review period 2008-2011. The clinic data set includes up to 105 FQHC clinics, 20 LAL clinics, as well as 33 "Neither" clinics (licensed as primary care providers, but not as either an FQHC or LAL clinic). The analysis represents approximately 75% of all California primary care clinic utilization data that was reported to OSHPD in 2011.

Clinic Sites, Patients and Operating Revenue

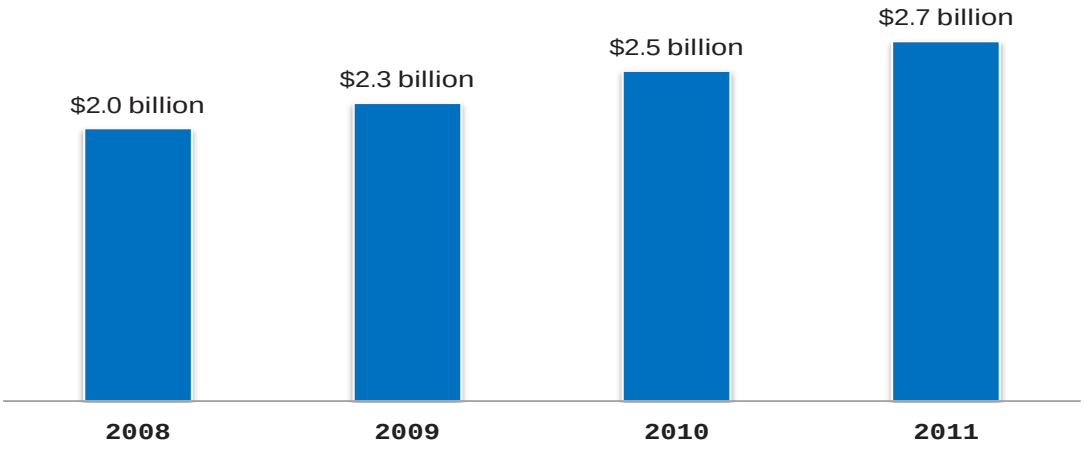
The total patients for this clinic group increased 26% over the four-year study period from 3.2 to 4 million patients, while visits grew 22%. Clinics generated an average of 3.1 visits per patient per year. For the clinic organizations included in the study, the number of sites per clinic organization grew from 3.8 in 2008 to 4.4 in 2011.



I: FINANCIAL & OPERATIONAL PROFILE OF CA COMMUNITY CLINICS

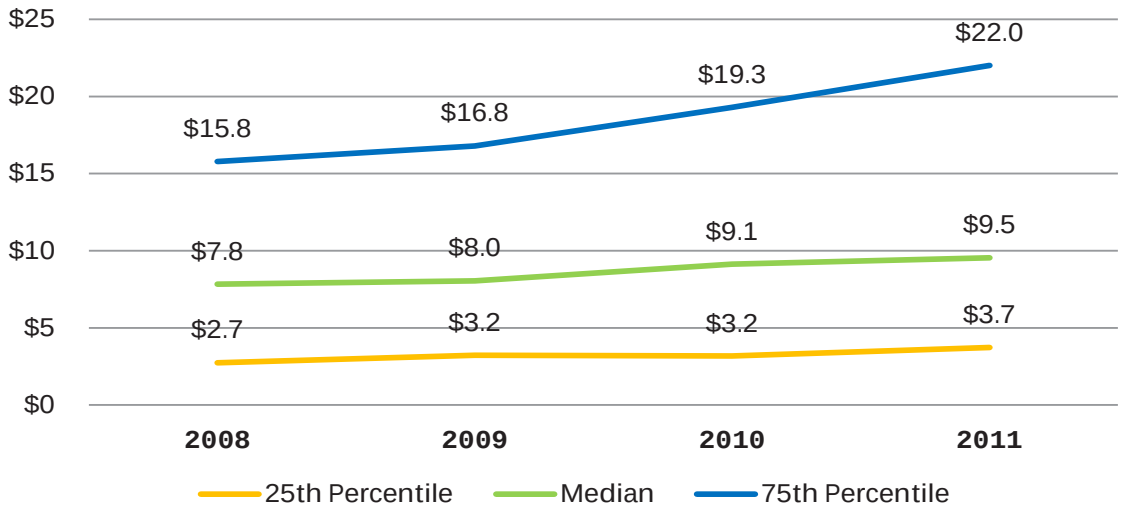
The combined operating revenue for the clinics in the study group grew an average of 9.7% annually over the study period, increasing from $2 billion in 2008 to $2.7 billion in 2011.

Combined Operating Revenues, All Clinics



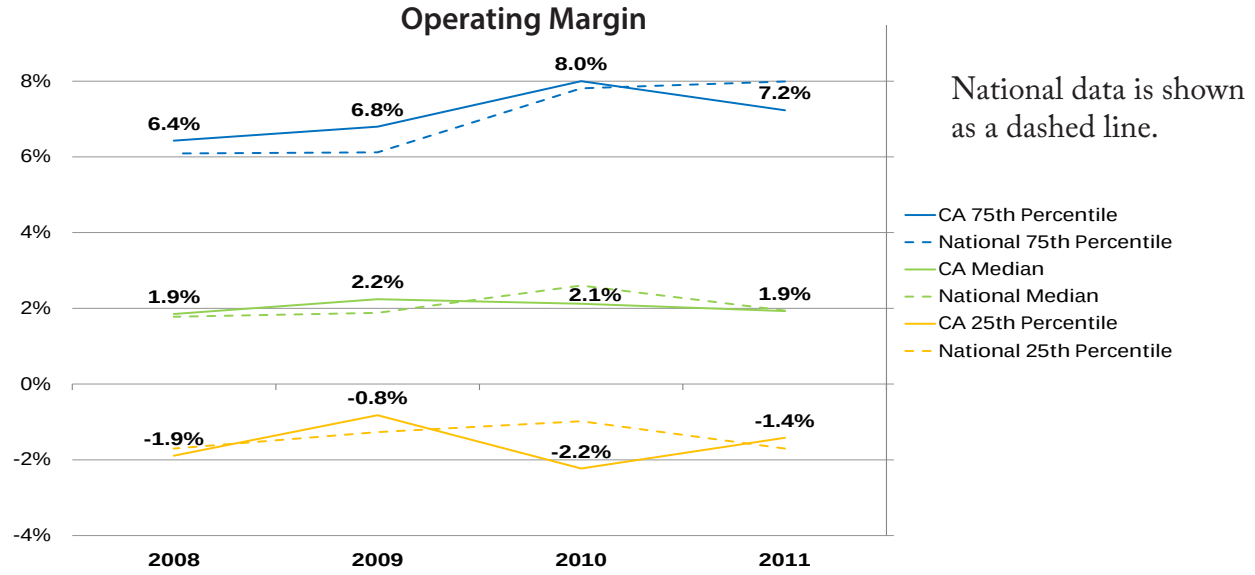
When clinics were separated into quartiles based on their revenue size, the median clinic grew 22% over the four-year period to $9.5 million. However, the largest clinics (as represented by the 75th percentile) as well as the smallest clinics (represented by the 25th percentile) both generated a significantly higher four-year growth rate of approximately 37%.

Clinic Operating Revenue Size by Quartile, 2008-2011 (in millions)

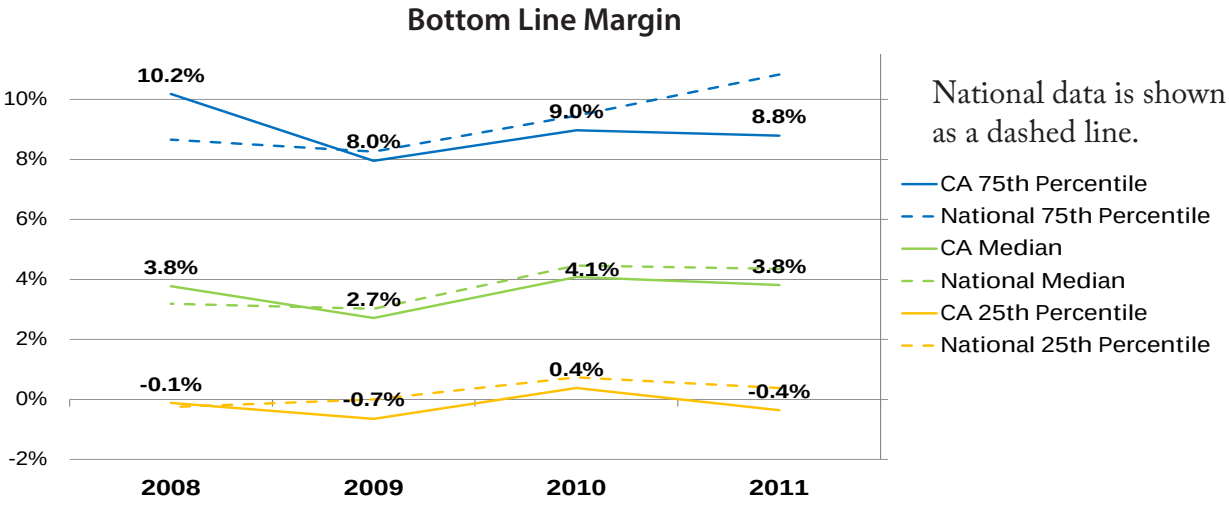


Operating and Bottom Line Margins

The clinics in this analysis operate with relatively tight margins, with a median operating margin of only 2%. The highest performing clinics (75th percentile) generated an average 7.1% operating margin over the four-year period, while the lowest performing clinics (25th percentile) generated an operating margin that averaged -1.6%. These results indicate that at least one quarter of the clinics in the data set operate with negative margins. Notably, the performance of California clinics was very similar to that of their national counterparts in any given year.

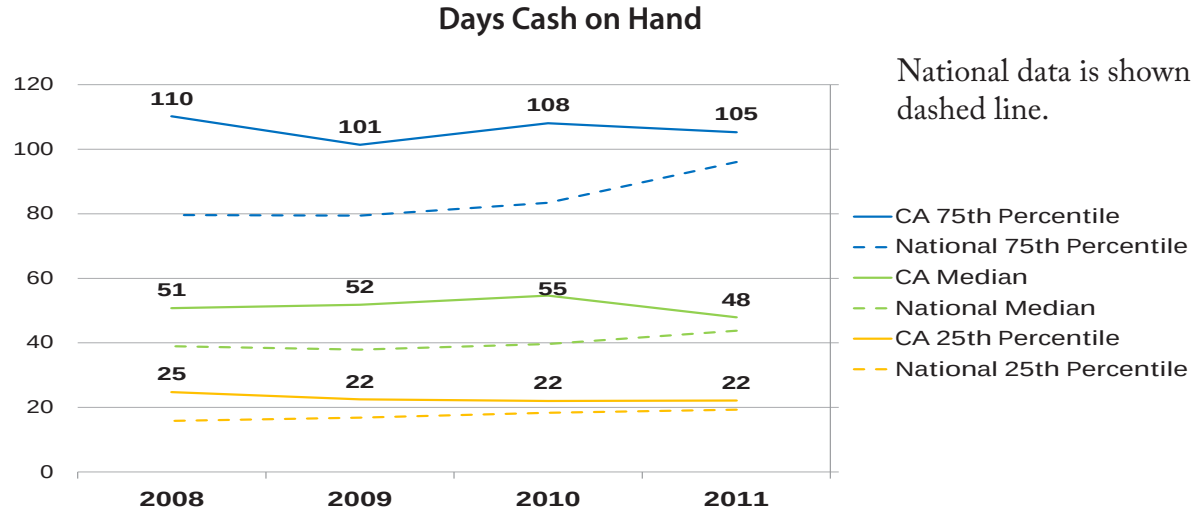


Clinics may also receive funding to support non-operating expenses such as capital expansion. When including non-operating sources of revenue in the analysis, clinic performance improved at the median level to a 3.6% bottom line margin (four-year average), though the lower quartile of clinics had negative earnings of -0.2% or lower (four-year average). The performance of California clinics was mostly consistent with their national peers.



Days Unrestricted Cash on Hand (DCOH)

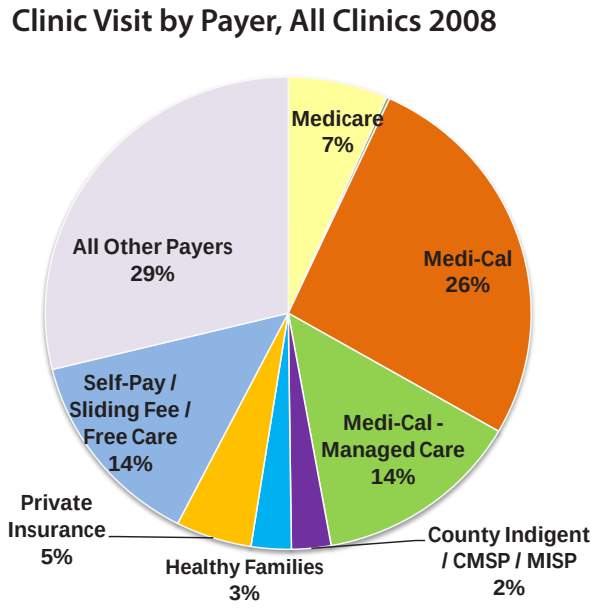
Clinics averaged 51 DCOH at the median level over the 2008-2011 period. 25% of clinics operated with just 23 DCOH or lower, which represents less than one month of cash reserves to fund their operations. While California clinics had higher levels of cash reserves than their national peers, the low cash levels for the weakest centers remain a cause for concern.

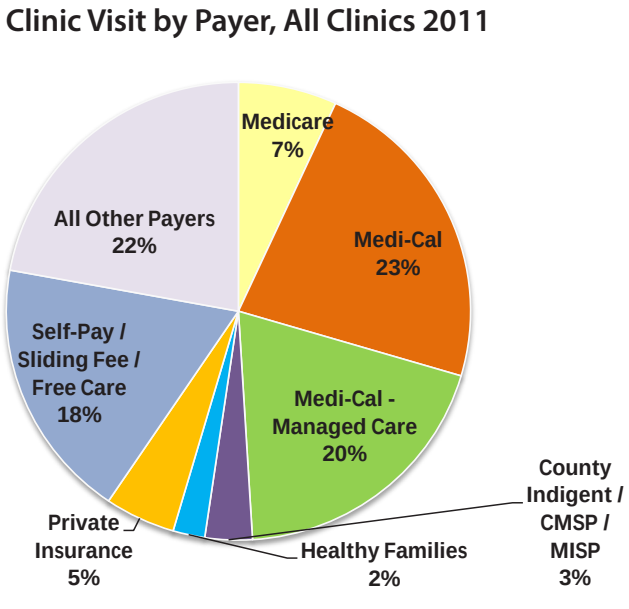


National data is shown as a dashed line.

Clinic Visits by Payer; Clinic Visits by Payer by Type

In 2011 approximately 43% of clinic patient visits were covered by Medi-Cal, including managed care, and 7% were visits by Medicare patients. Notably, 18% of clinic visits were sliding fee or free care visits.



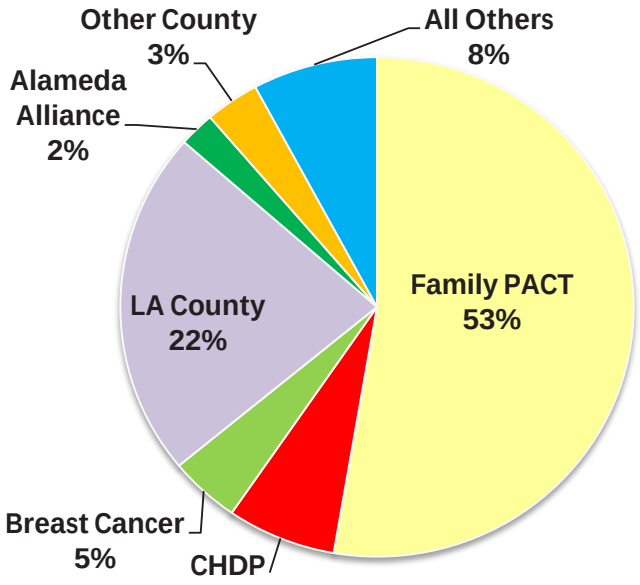


FQHC clinics had the highest percentage of combined Medi-Cal visits (46%), while Medi-Cal covered 33% of patient visits for LAL clinics and 17% for "Neither" clinics. These "Neither" clinics generated almost no Medicare covered patient visits (1%).

2011 Payer Source	Combined (157)	FQHCs (105)	LAL (20)	Neither (32)
Medicare	7%	8%	9%	1%
Medi-Cal	23%	25%	18%	8%
Medi-Cal - Managed Care	20%	21%	15%	9%
County Indigent/CMSP/MISP	3%	4%	3%	2%
Healthy Families	2%	3%	1%	0%
Private Insurance	5%	5%	5%	2%
Self-Pay/Sliding Fee/Free Care	19%	19%	19%	18%
All Other Payers	22%	16%	30%	61%
Total	**100%**	**100%**	**100%**	**100%**

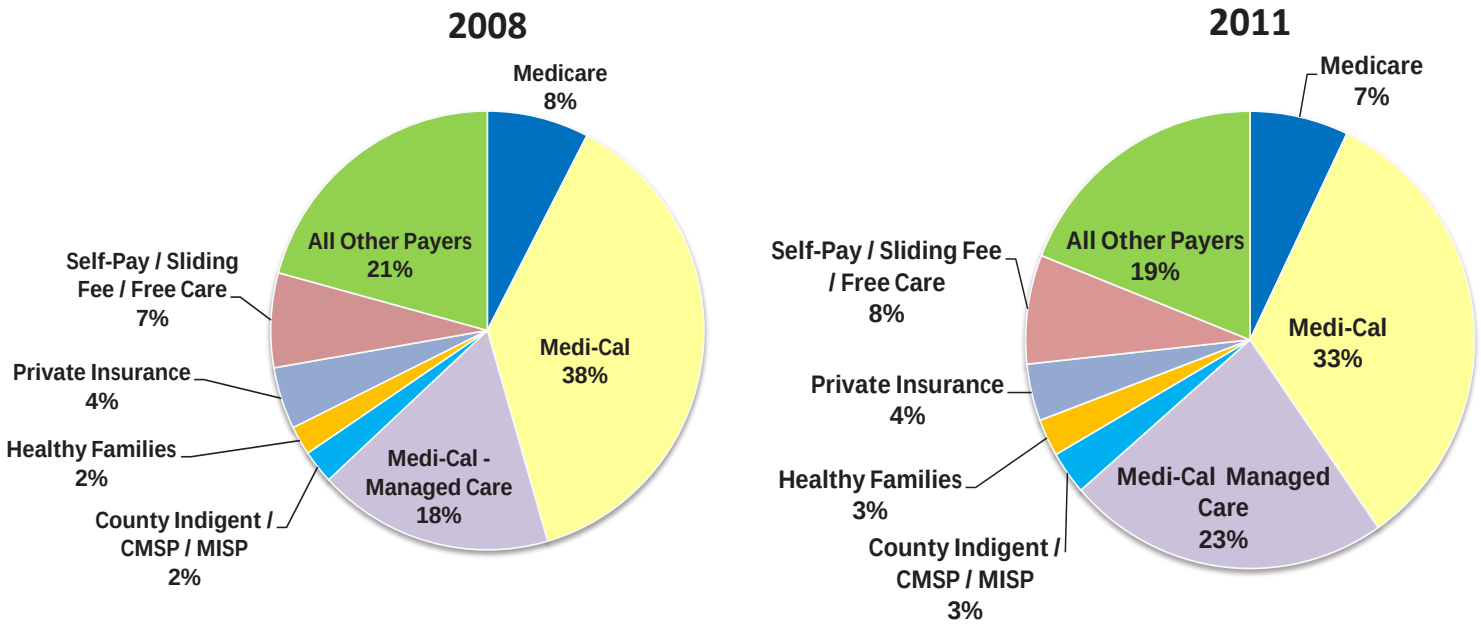
Within the "All Other Payers" category, Family PACT[2] covered over half of the patient visits (53%) for the combined clinic data set. For the "Neither" clinics, the majority of visits (61%) were categorized under "All Other Payers," almost all of which were Family PACT visits (97%).

"All Other Payers" Breakout, Patient Visits 2011



Net Patient Revenue by Payer

Clinics earned a total of 56% of their patient revenue from Medi-Cal in both 2008 and 2011, including fee for service and managed care, but the mix between these two programs shifted considerably during the period. The portion of Medi-Cal revenue from managed care rose from 18% to 23%, while the Medi-Cal fee for service revenue experienced a corresponding decrease from 38% to 33%.



Medi-Cal Utilization

Clinic utilization by patients with Medi-Cal remained level over the assessment period at 3.6 visits per year. However, 2011 utilization by Medi-Cal managed care patients (3.1 visits per year) was one-third lower than that of traditional fee for service utilization (4.1 visits per year). Additionally, Medi-Cal fee for service utilization increased 9% over the study period, while managed care utilization declined by 4%.

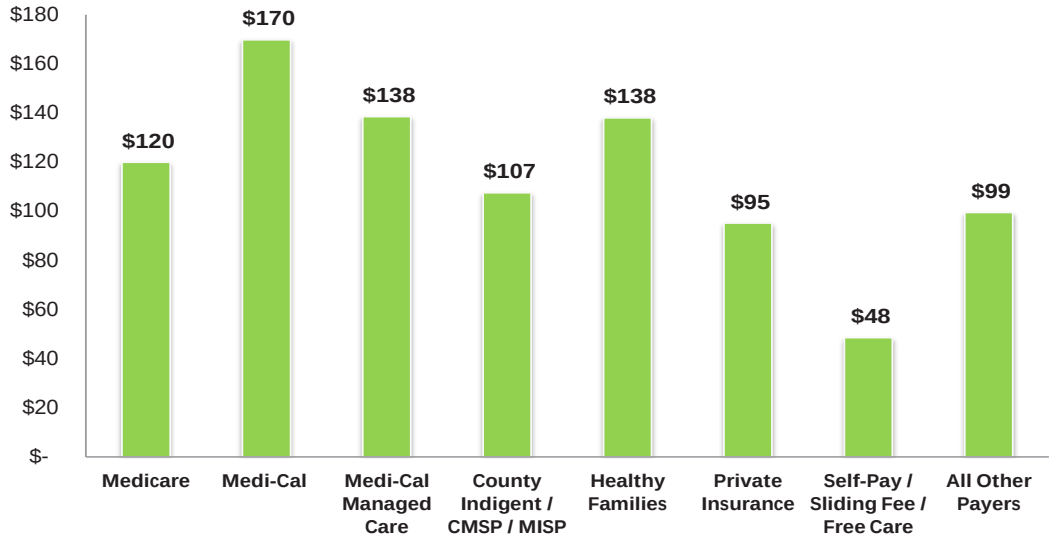
Average Visits Per Patient	2008	2011	% Growth
Combined Utilization	3.6	3.6	0%
Medi-Cal	3.8	4.1	9%
Medi-Cal Managed Care	3.2	3.1	-4%
% Difference in utilization	16%	32%	

I: FINANCIAL & OPERATIONAL PROFILE OF CA COMMUNITY CLINICS

Average Net Revenue per Visit by Payer

The average reimbursement among all payers rose to $117 from $99 over the study period, an increase of 18%. Medi-Cal continues to be the highest payer for clinics[3], averaging $170 per visit in 2011. Clinics averaged $48 per uninsured visit in 2011.

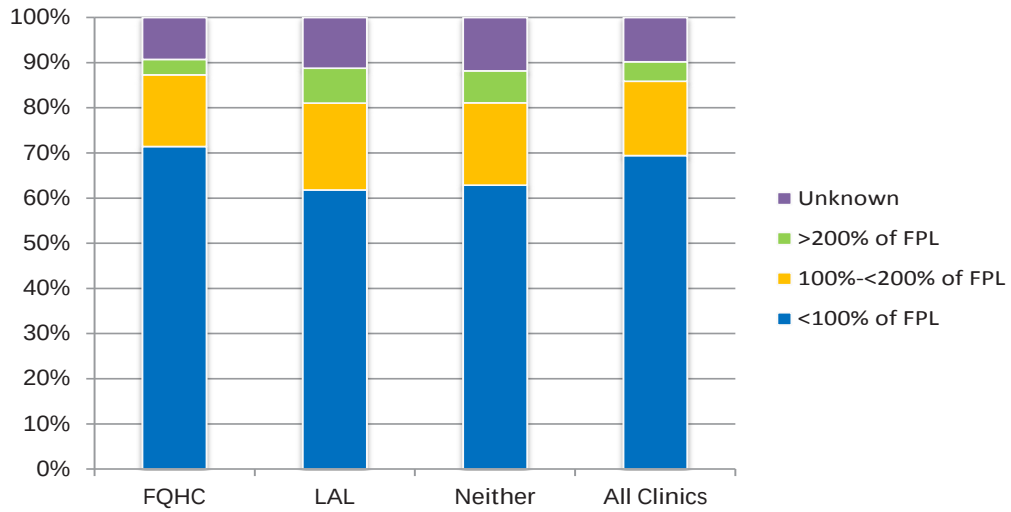
Average Net Patient Revenue Per Visit by Payer, 2011



Patient Income by Clinic Type

In 2011 for all clinics combined, 85% of patients were under 200% of the Federal Poverty Level (FPL), while just 4% were above 200% of FPL. Income data is not available on another 10%, though most of these patients were also likely to be under 200% of FPL. FQHC clinics had the lowest portion of patients above 200% of FPL (3%). This distribution of patient income is relatively consistent with the 2008 distribution, highlighting the clinics' ongoing importance as primary care providers to the poorest residents of the state.

Patients by Income Level, 2011



SECTION II: OPERATIONAL INDICATORS & FINANCIAL PERFORMANCE

While it is important to illustrate the aggregated financial and operational profile for community clinics, section II further investigates clinic sub-groupings as well as utilization and operational indicators that trend with clinic financial performance. The analysis provides further context for FQHC and LAL clinics as they consider their own performance results and offers insights for further understanding of key contributing factors.

Using specific operational and utilization identifiers, clinics were grouped and analyzed within the framework of financial performance in order to highlight the profile of these clinic sub-groups and possible correlations with financial performance. The defining characteristics for these groupings include the following and are discussed in more detail below:

Type of Clinic

FQHC, Look-Alike Clinic or "Neither" Clinic

Location of Clinic

Urban vs. Rural

Size of Clinic:

Operating Revenues, Number of Sites, Number of Patients, Number of Visits, and Number of Full Time Equivalent Employees (FTEs)

Patient Mix:

Poverty level (percentage of the total patient mix which are under 100% of the Federal Poverty Level, between 100-200% FPL, over 200% FPL, and unknown), Demographics (percentage of the total patient mix which is in each gender and age group: Females ages 20-34, Females ages 35-64; and the total over age 65; percentage of population that is Hispanic and percentage for whom English is not their first language)

Payer Mix:

Percentage of total Med-Cal, Medi-Cal managed care, Medicare and Uninsured

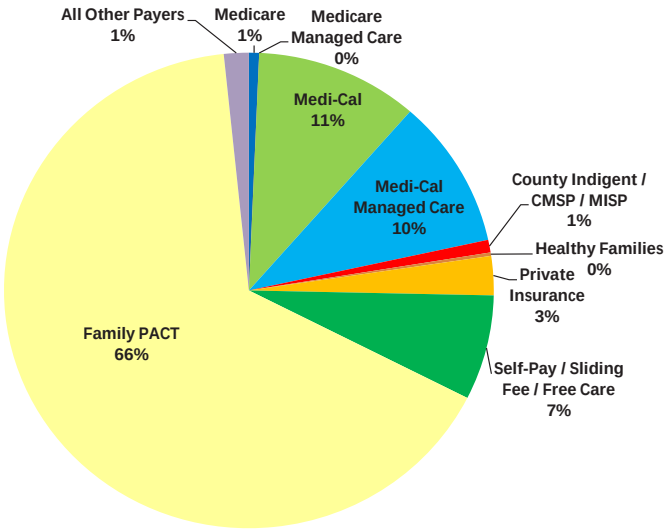
Service Mix:

Availability of Dental Services, Mental Health Services, Hospital Services on-site, Maternity Care and Delivery Services

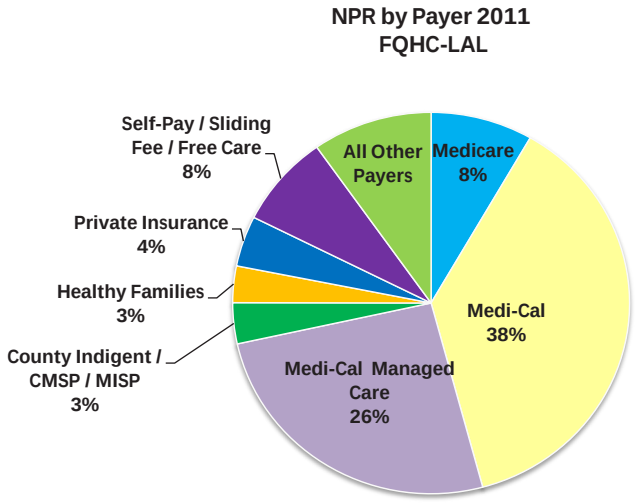
Clinic Type (FQHC & LAL)

This sub-group analysis focused specifically on the aggregate financial and operational profile of the 125 FQHC and LAL clinics included in the data set. The full data set analyzed in Section I included 33 "Neither" clinics, which includes "free" clinics as well as Planned Parenthood clinics among safety net providers. However, since "Neither" clinics have specialized operational profiles, their business model and financial profile are quite distinct from FQHC and LAL clinics as shown by the following charts:

Net Patient Revenue by Payer, "Neither" Clinics, 2011



Net Patient Revenue by Payer, FQHCs & LALS, 2011

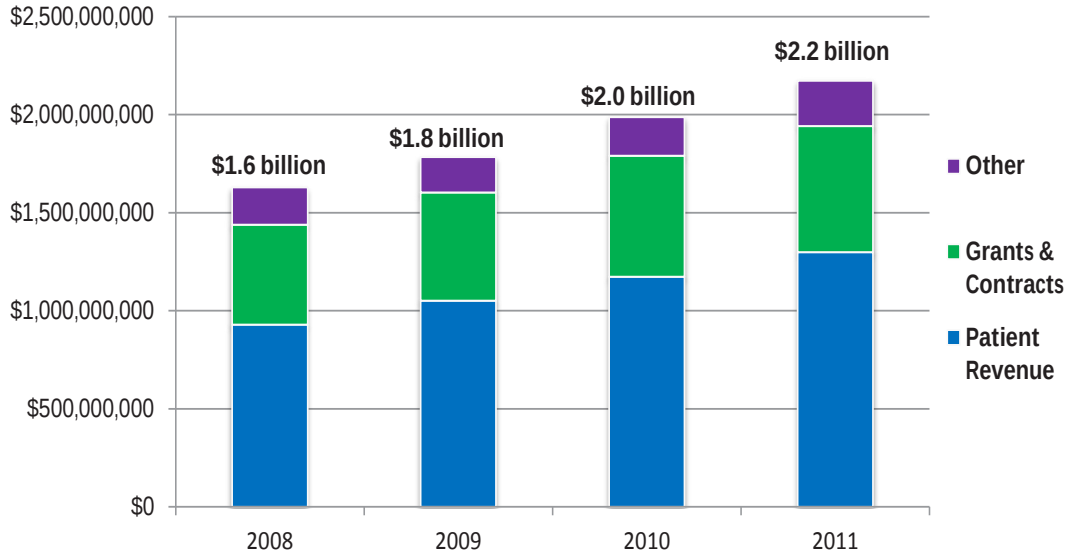


The following section therefore specifically highlights the combined financial profile of the FQHC and LAL clinics as a targeted subset of the full list of clinics in the data set.

Operating Revenue Mix

The total operating revenues for FQHCs and LAL clinics grew from $1.6 billion in 2008 to $2.2 billion in 2011, representing growth of 33%. On average, FQHCs and LALs earned approximately 60% of their 2011 operating revenue directly from patient services and 30% from grant and contract sources, with the remaining 10% coming from other sources. This proportion stayed relatively consistent over the four-year study period.

Operating Revenue Growth, FQHCs & LALs, 2008-2011

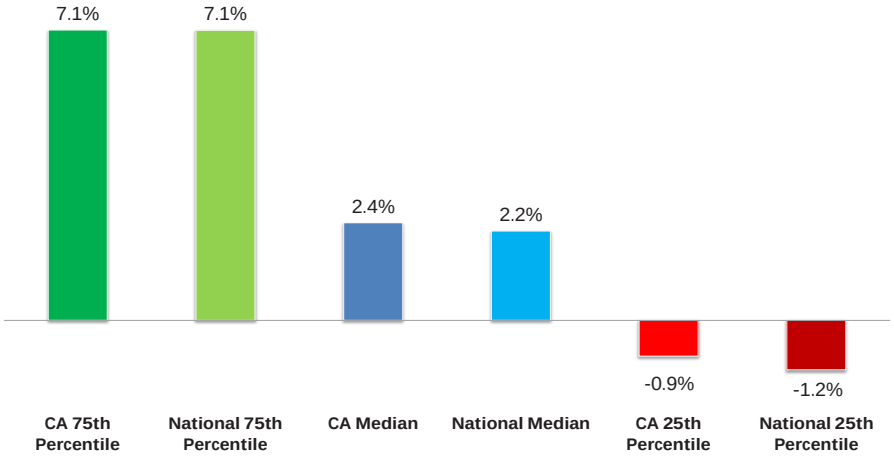


II: OPERATIONAL INDICATORS & FINANCIAL PERFORMANCE

Operating Margin

The median operating margin for FQHC and LAL clinics averaged 2.4% over the four-year period, while the top 25% of clinics generated a 7.1% margin or higher. The bottom 25% operated with a -0.9% margin or worse, illustrating the financial vulnerability of a significant portion of clinics. The operating performance of California FQHCs and LALs mirrored that of their national counterparts over the analysis period.

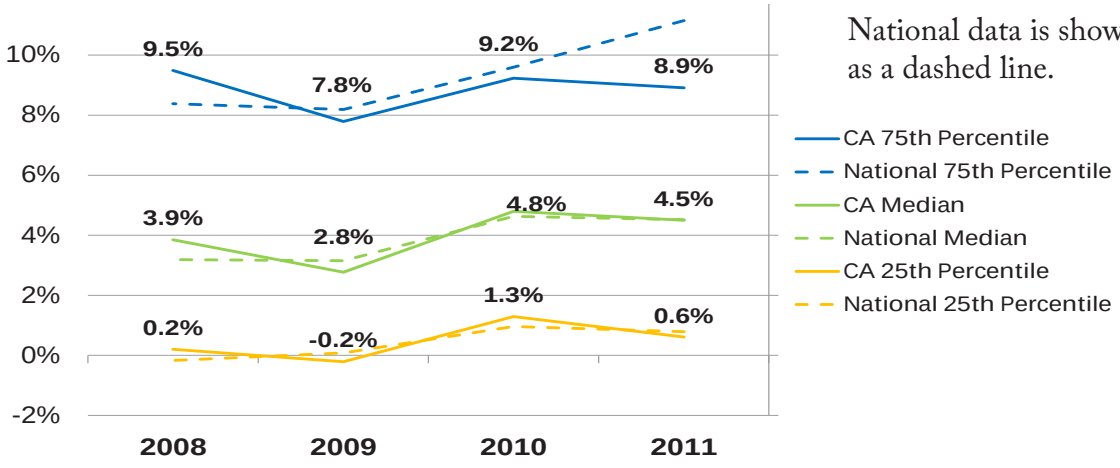
Operating Margin, FQHC & LAL Clinics, 2008-2011 Averages



Bottom Line Margin

When non-operating sources of clinic funding were included, clinics generated a median bottom line margin of 4%, while the top 25% of clinics earned a margin of 8.9% or higher. The lowest performing 25% of clinics averaged a bottom line margin of 0.5% or lower, a risky position. The bottom line performance of California FQHC and LAL clinics was remarkably consistent with that of the national clinic sample over the four-year assessment period, though the 75th percentile of the national sample improved its margin in 2011, while the California group experienced a slight decline.

Bottom Line Margin, FQHC & LAL Clinics

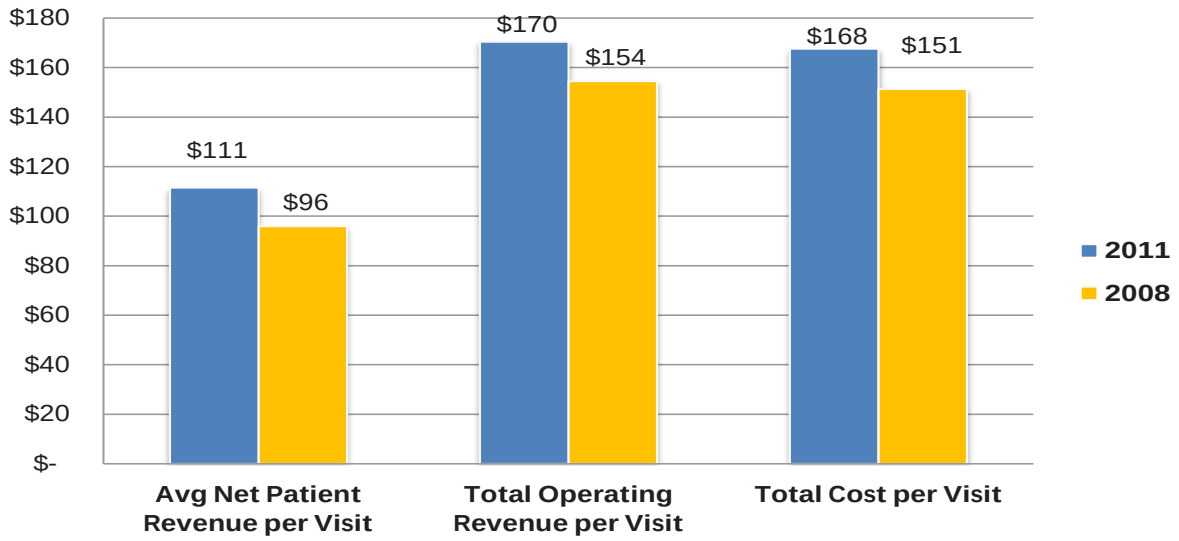


II: OPERATIONAL INDICATORS & FINANCIAL PERFORMANCE

Revenue & Cost per Patient Visit

The total cost per visit grew slightly more than the revenue per visit over the period measured. Clinic patient revenue covered approximately 66% of the cost of patient visits, and other sources of funding were needed to cover the full cost of providing clinic services. For FQHC clinics, HRSA's[4] Section 330 operating grant was the main funding source used to help offset the full costs of providing comprehensive primary care services, including uninsured and underinsured patient visits.

FQHC-LAL Average Revenue & Costs per Visit, 2008 vs 2011



Salary-Related Expenses

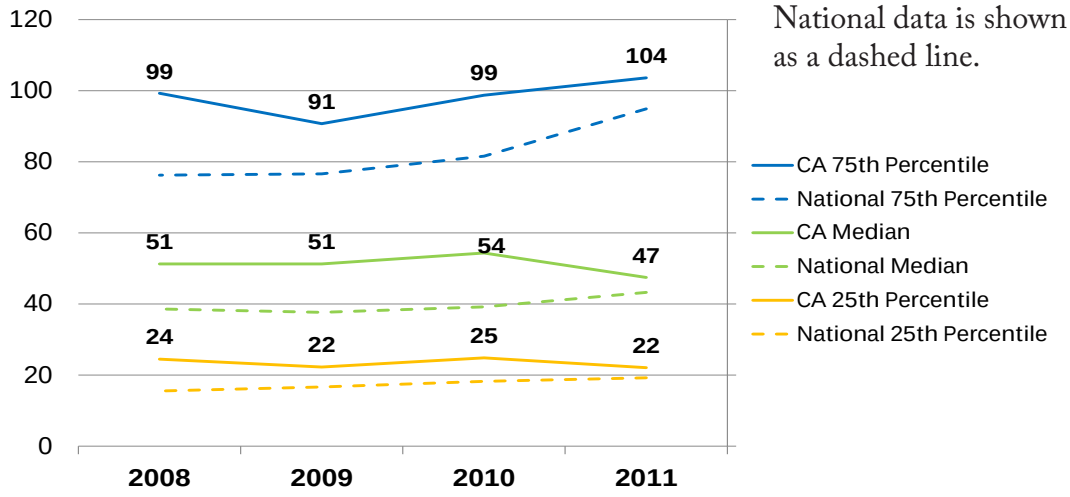
Salary-related expenses are generally the most significant component of clinic operating budgets, and the ability to control salary costs is critical for financial success. At the median, California clinics spent 74% of their operating revenues on salary-related expenses. This figure was 2% higher than the national median of 72%, but consistent with Capital Link's recommendation that clinics maintain salary-related expenses at a maximum of 70-75% of revenues. However, 25% of California clinics spent 78% or more of their operating budgets on salary-related expenses, leaving limited budget flexibility to cover other operating expenses. When salary-related expenses exceed 75% of operating revenues, the result is often negative operating margins.

Salary-Related Expense as a % of Operating Revenues, 2008-2011 Averages	
California 75th Percentile: 78%	National 75th Percentile: 78%
California Median: 74%	National Median: 72%
California 25th Percentile: 67%	National 25th Percentile: 65%

Days Unrestricted Cash on Hand (DCOH)

On average, California clinics operated with 51 DCOH at the median level over 2008-2011, though 2011 results were a bit lower than in prior years. Additionally, 25% of clinics operated with 23 days or less of operating cash on average, making them extremely vulnerable to even short-term interruptions in cash flow. Capital Link recommends that clinics have a minimum of 45 DCOH to facilitate smooth operations. California clinics generally had slightly higher cash reserves than their national counterparts.

Days Cash on Hand, FQHC & LAL Clinics



National data is shown as a dashed line.

Days Net Patient Receivables

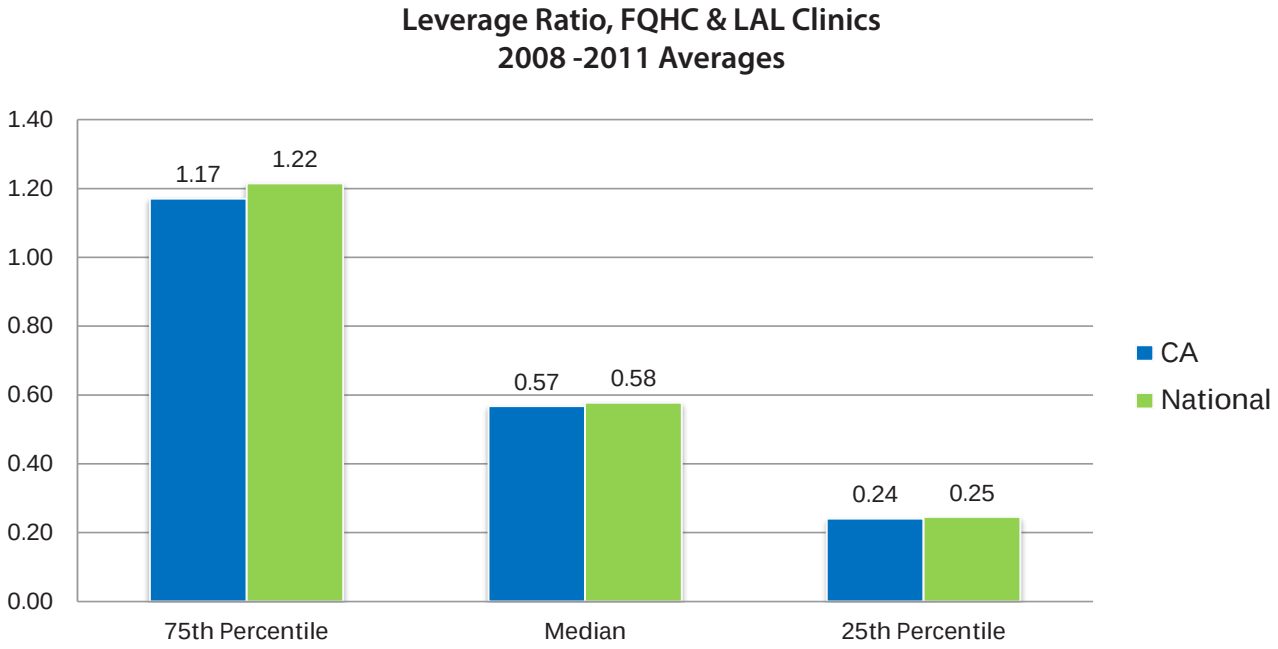
At the median, clinics collected their patient receivables in 48 days, which is within Capital Link's recommended range of 30-60 days. However, 25% of clinics were taking 70 days or more to collect on their patient accounts receivables, which is likely contributing to a weaker cash position for those organizations. The collection period for California FQHCs and LALs was similar to that of the national sample.

Days Net Patient Receivables 2008-2011 Averages	California FQHCs & LALs	National
75th Percentile (Highest 25%)	70	73
Median	48	49
25th Percentile (Lowest 25%)	31	32

Leverage Ratio (Debt to Equity)

As shown below, clinics generally carried very low levels of debt relative to their net assets. At the median, clinic liabilities (debt) were less than half (0.48) the value of their equity (net assets), while 25% of clinics had a leverage ratio of 0.25 or lower (four times as much equity as debt). This low leverage position may represent an opportunity for California clinics since it is one factor that impacts a clinic's ability to take on additional debt to increase operational and capital growth needs. Based on Capital Link's project financing experience, lenders prefer that leverage ratios be kept under 2.5.

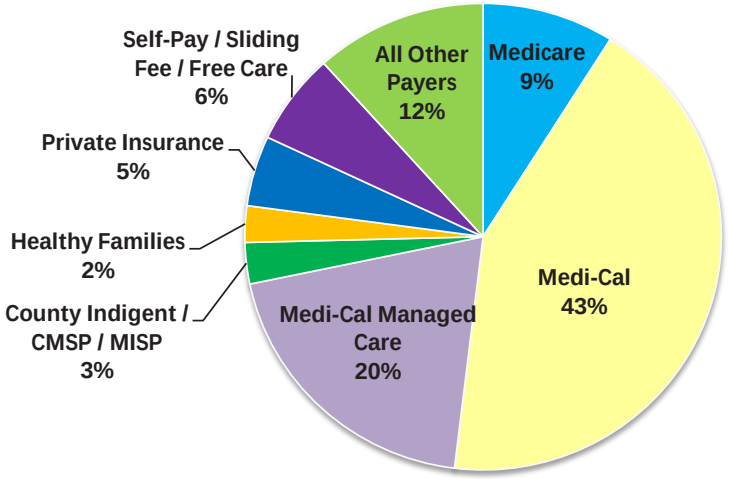
The leverage position of the California clinics mirrored that of their national peers.



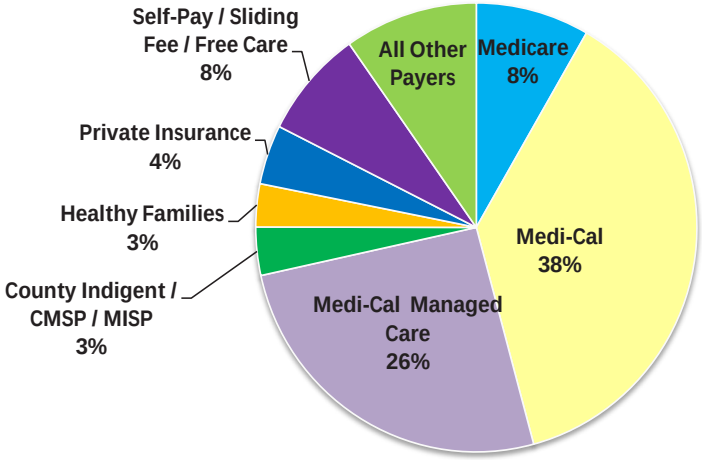
Net Patient Revenue by Payer

The sources of Net Patient Revenue (NPR) by Payer remained relatively consistent between 2008-2011. Most significantly, Medi-Cal revenue continued to comprise 63-64% of NPR for all clinics, but shifted towards Medi-Cal managed care. This transition was driven by a number of efforts by the California Department of Health Care Services to shift Medi-Cal recipients into managed care arrangements, including the mandatory enrollment of seniors and people with disabilities into managed care and the expansion of Medi-Cal managed care to new counties. [5]

Net Patient Revenue by Payer, 2008
FQHCs and LAL Clinics



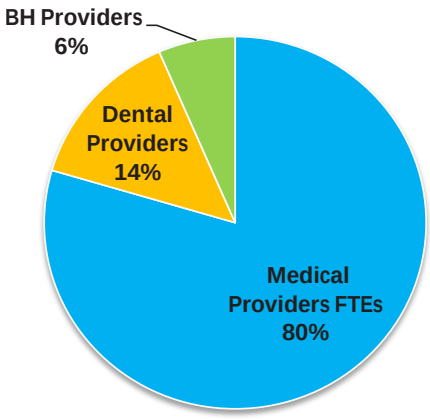
Net Patient Revenue by Payer, 2011
FQHCs and LAL Clinics



Provider Staffing Profile

Of the nearly 5,500 providers employed by FQHC and LAL clinics, 80% are medical providers. Clinics reported 1.5 physicians per mid-level provider in 2011, consistent with levels from the prior few years.

Provider Staffing, 2011, FQHCs and LAL Clinics

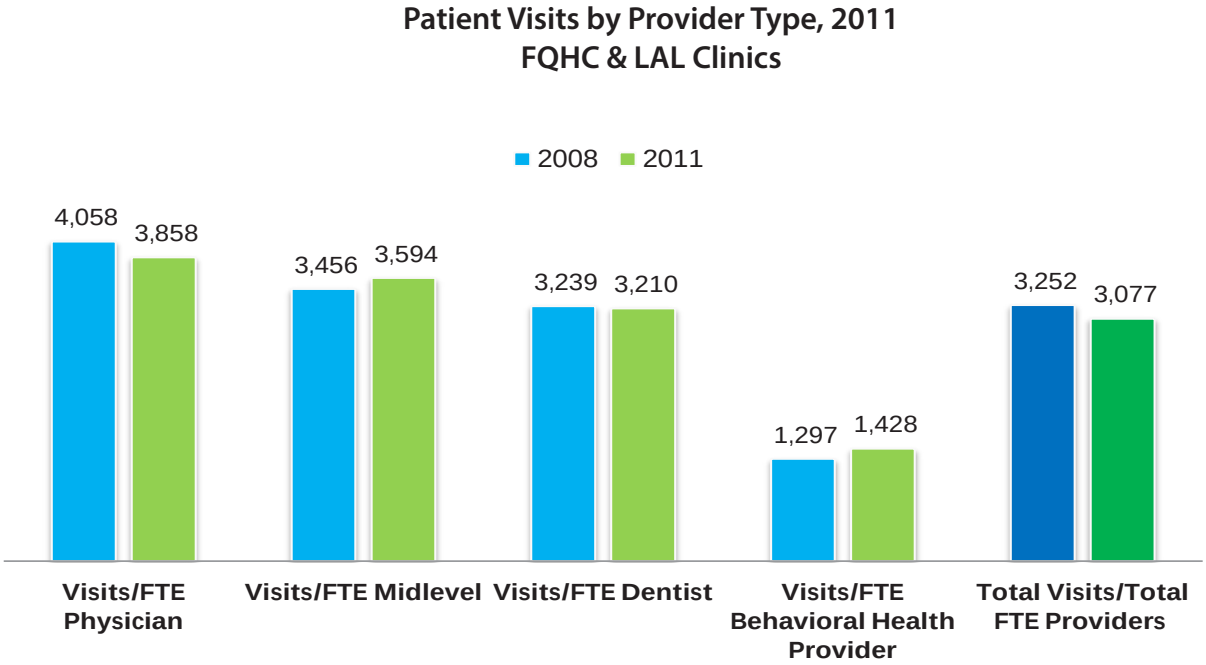


Productivity by Provider Type

The average productivity for California clinics in 2011 was just under 3,100 visits per year per provider, slightly lower than the 2008 average of about 3,250 visits per provider. This differential may be attributed to various factors, including the increasing medical complexities of clinic patients and the gradual Medi-Cal transition to a managed care model.

In 2011, physicians generated the highest production at 3,850 visits per year, while mid-level providers averaged nearly 3,600 visits per year. Behavioral health encounter rates generally ran much lower than those of medical and dental providers primarily because the appointment times are longer.

The two areas showing improvement in provider productivity over the period measured were behavioral health and mid-level providers. It is important to note that a clinic's service mix—and any changes in it—will impact its overall productivity, so any statistics must be reviewed accordingly.



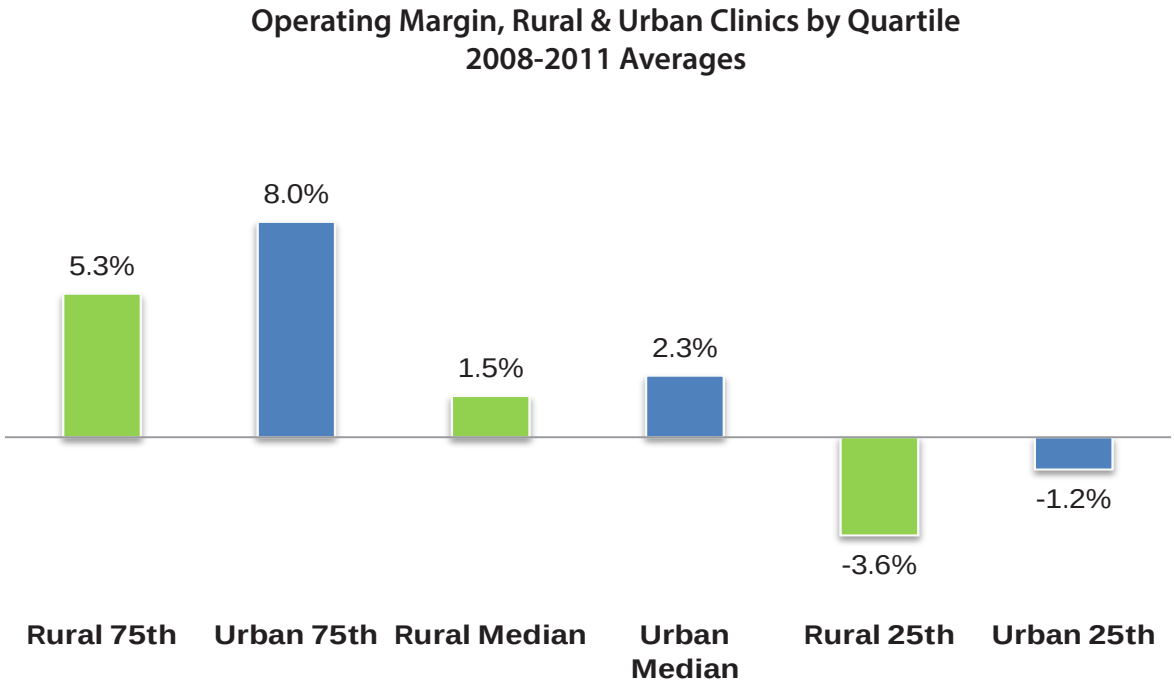
Clinic Location: Rural vs. Urban

The FQHC and LAL data set was further sorted by clinic location in rural or urban areas. The resulting data sets included 115 urban clinic organizations and 43 rural clinic organizations. [6]

Rural & Urban Clinics: Operating Line Margin

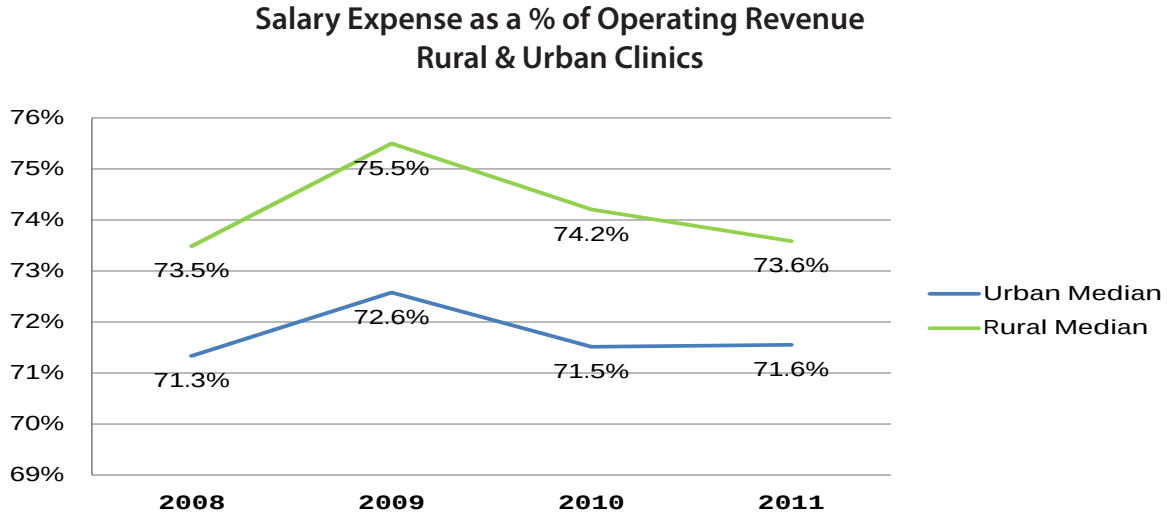
The rural or urban location of clinics had a significant impact on operating performance. Key benchmarking metrics such as operating margin, salary expense as a percent of revenues, DCOH, payer mix, and reimbursement patterns differ for each group.

For example, urban clinics as a whole generated higher margins than rural clinics. Over the four-year period tracked, at the median level urban clinics averaged a 2% margin, while rural clinics averaged a 1.5% margin. The highest performing urban clinics (75th percentile) generated an average operating margin of 8%, while their rural peers averaged 5.3%. The lowest performing 25% of clinics in each group both operated with negative margins, with rural clinics generating a -3.6% margin or lower, substantially below the urban group's -1.2% margin.



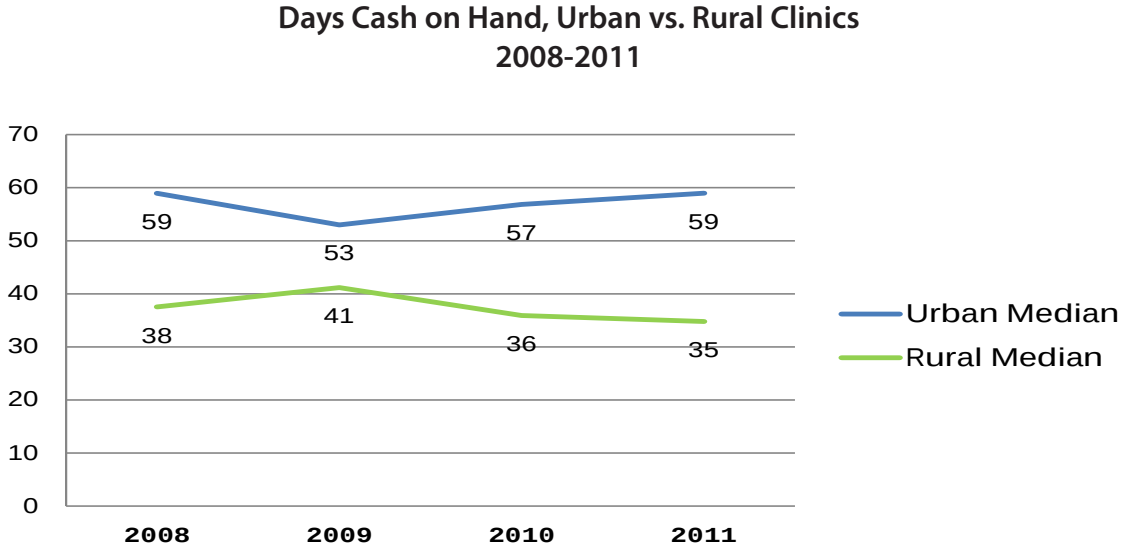
Rural & Urban Clinics: Employment-Related Expenses

Rural clinics spent roughly 2% more of their budgets on salary-related expenses on average than urban clinics, which was a primary driver of the differentiation in operating margin between the two clinic groups.



Rural & Urban Clinics: Days Cash on Hand (DCOH)

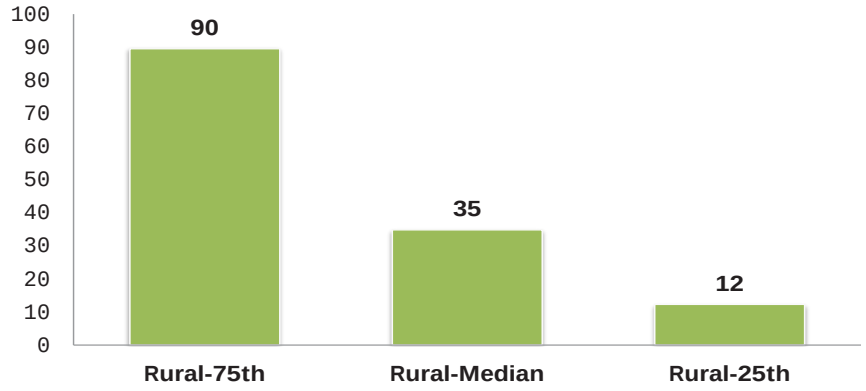
On average, the median rural clinic operated with 20 fewer DCOH than its urban counterpart over the 2008-2011 period.



II: OPERATIONAL INDICATORS & FINANCIAL PERFORMANCE

At least one-fourth of rural clinics operated with 90 days (three months) or more of operating cash, a healthy level that allows these clinics to maintain smooth operations despite a sometimes erratic reimbursement environment. However, 25% of rural clinics operated with 12 DCOH or less in 2011, highlighting the vulnerability of their operations to even small disruptions in cash flow.

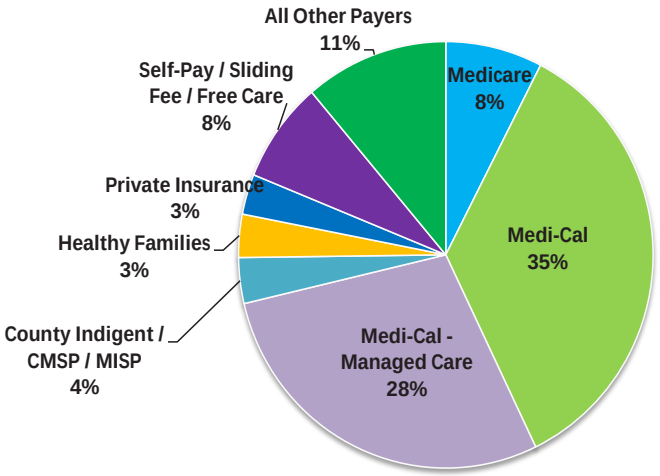
Days Cash on Hand, Rural Clinics by Percentile, 2011



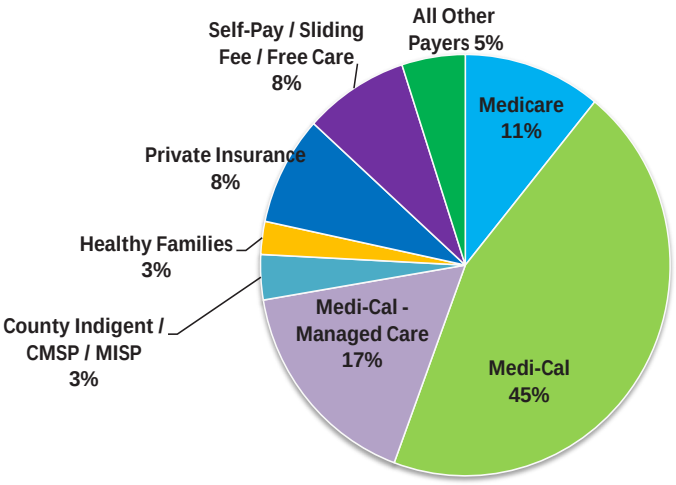
Rural & Urban Clinics: Net Patient Revenue by Payer

Rural and urban clinics were similar in the proportion of patient revenue from the Medi-Cal program as a whole. However, rural clinics earned less of their Medi-Cal revenue from managed care programs, which illustrates how urban counties have transitioned to a Medi-Cal managed care model ahead of most rural counties in the state.

Net Patient Revenue by Payer, 2011
Urban FQHCs and LAL Clinics

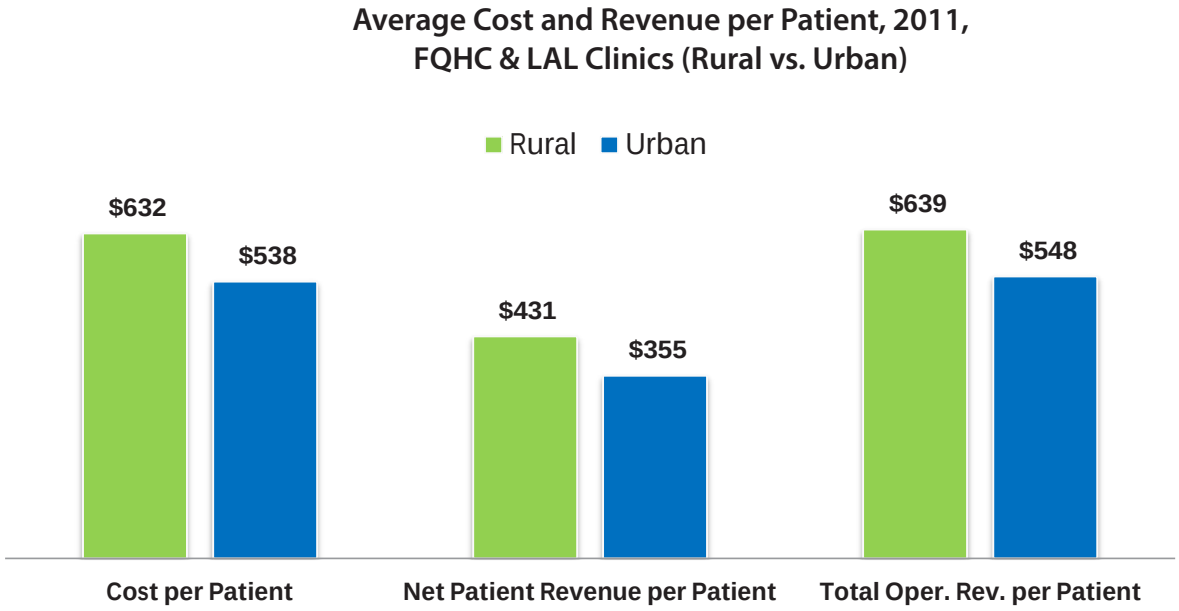


Net Patient Revenue by Payer, 2011
Rural FQHCs and LAL Clinics



Rural & Urban Clinics: Revenue & Cost per Patient & Per Visit

Rural clinics had a higher average cost and revenue per patient compared to urban clinics. They also saw patients more frequently, generating 3.7 visits per patient per year on average versus 3.2 visits per year for urban clinics.



This chart illustrates how the average cost of providing patient services is higher than the direct patient revenue collected to pay for those services. However, clinics are generally able to make up this gap with other sources of funding such that total operating revenue remains slightly higher on average than total costs. Notably, patient revenue covers a lower percentage of costs for rural clinics (65%) than for urban clinics (67%).

Region

An analysis of clinics by region, based on six regions defined by Blue Shield of California Foundation, showed that clinics in certain geographic areas performed better than others. For example, operating margins ranged from a high of 3.7% in the Central region to a low of 1.3% in the San Francisco region. Revenue growth was also shown to be strongest in the Sacramento, South, and San Francisco regions. It is difficult to assess what factors contributed to these variances without further study, but it is important to note that clinics have varying profiles according to their region. For details on which counties are included in the regions listed above, please see page 47.

Region	Number of Clinics	Operating Margin	Days Cash	Current Ratio	Revenue Growth
Central	16	3.7%	39	2.3	9%
South	16	3.6%	44	2.2	12%
Sacramento	7	3.0%	36	2.3	14%
Median		2.4%	39	2.5	9%
Los Angeles	33	2.3%	31	2.7	8%
North	23	1.9%	40	1.9	8%
San Francisco	30	1.3%	43	3.2	11%

Conducting an analysis of clinics by county highlights similar variances, indicating that a clinic's county also has an impact on financial performance. One limitation with this analysis is that several counties had a very small numbers of clinics. Since only counties with a minimum of five clinics were considered, the findings deserve further review.

County	Number of Clinics	Operating Margin	Days Cash	Current Ratio	Revenue Growth
San Diego	12	4.1%	46	2.4	12%
Alameda	8	2.4%	43	2.8	10%
Los Angeles	32	2.3%	31	2.6	9%
Santa Clara	8	2.1%	69	4.1	9%
Sonoma	5	1.6%	33	3.4	15%

Note: Only includes counties with at least five clinics.

II: OPERATIONAL INDICATORS & FINANCIAL PERFORMANCE

Clinic Size: Revenues, Sites & Patients

Clinic size can be measured in numerous ways including annual operating revenues, clinic sites, patients, visits, and FTEs. Looking at these various characteristics over the 2008-2011 period in terms of four key financial measures (DCOH, Operating Margin, Current Ratio, and Revenue Growth) it is evident that the larger the clinic, the better the operating margin.

Clinics by Revenue Size

Sorting clinics by operating revenue size revealed that clinics with greater operating revenue generally outperformed those clinics with smaller operating budgets. Specifically, those with less than $5 million in annual revenues generated a 1.7% operating margin at the median over the four-year period, while clinics with operating revenues of over $30 million generated a 2.8% margin.

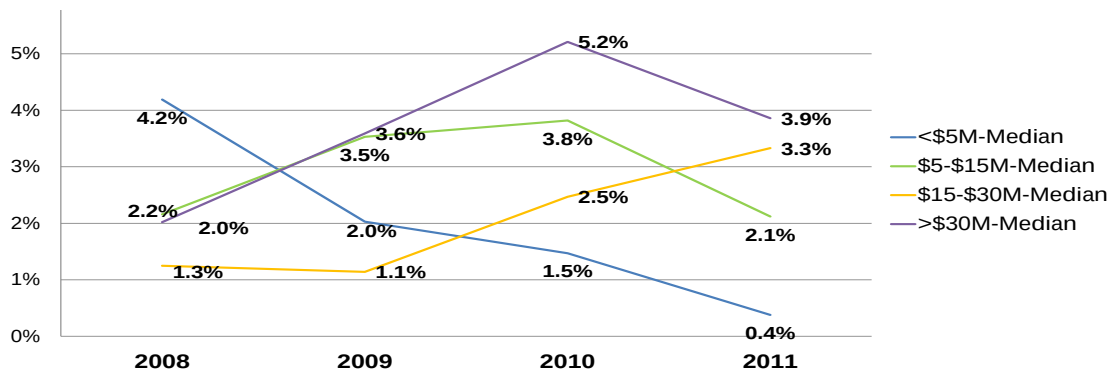
Operating Revenue Size

Revenues	Number of Clinics	Days Cash	Operating Margin	Current Ratio	Revenue Growth
<$5M	25	47	1.7%	2.8	9.5%
$5-15M	39	29	2.2%	2.3	9.0%
$15-30 M	36	40	2.5%	2.5	11.2%
>$30M	25	42	2.8%	2.6	9.3%
Total	**125**	**39**	**2.4%**	**2.5**	**9.3%**

Operating Margin

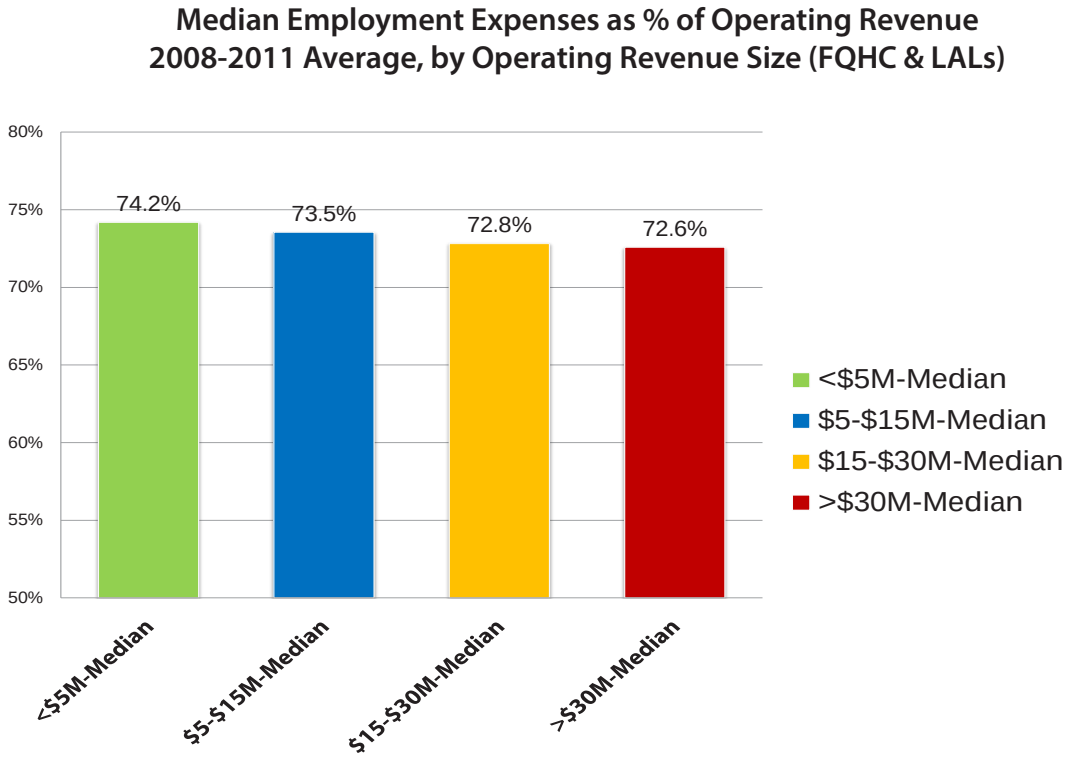
Over the four-year study period there was significant fluctuation in annual performance among clinics of different revenue sizes. However, the smallest clinics showed consistently decreasing margins. Given that smaller clinic organizations are often located in rural communities, the drop in performance of the smallest clinics may correlate with the state-wide health program funding reductions of 2008-2009 that significantly impacted rural clinics, including cuts to Expanded Access to Primary Care (EAPC), rural farmworker health programs, and other county-funded rural health initiatives.

Operating Margin, Median, by Operating Revenue Size, (FQHC & LAL Clinics)



Employment-Related Expenses

Clinics of all size groups had employment-related expenses in the recommended 70-75% of revenues range, but there was a consistent distinction between the groups based on size. The smaller clinics, on average, had higher employment-related expenses than the larger ones. This differentiation is consistent with the variance in operating margins between the largest and smallest clinics.



Clinics by Number of Sites

An analysis of the number of sites per clinic organization resulted in a more limited, but nevertheless notable performance difference. Specifically, a clinic increasing from one site to two did not have a significant impact on operating margin or growth rates. However, once a clinic organization grew to three to four clinic sites, margins began to slip. The chart also highlights the healthy margins and growth rates for those clinics with five to nine sites. Clinics with 10 or more sites enjoyed even stronger operating margins at a level of almost 4%.

Clinic organizations with one to nine sites had stronger cash reserves of about 40 days, while the larger clinics (those with 10 or more sites) had 32 days of cash. Current ratios did not vary based on the number of sites.

Number of Clinic Sites

Number of Clinics	Number of Sites	Operating Margin	Revenue Growth	Days Cash on Hand
35	1	2.3%	8%	47
18	2	2.2%	9%	47
19	3	2.0%	9%	23
18	4	1.1%	9%	40
19	5-9	3.5%	13%	42
16	10 or more	3.9%	9%	32

Note that the observations regarding the apparent relationship between the number of clinic sites and financial performance are not statistically conclusive. The driving forces behind these metrics are impossible to determine from a top-line analysis and should be further reviewed. Better understanding of the challenges and opportunities of opening new sites and sharing best practice information would be beneficial.

Clinics by Number of Patients Served

The clinic size analysis also included a review of the number of patients served by each clinic organization to see if there was a relationship between patient volumes and financial performance. The results were consistent in that the smallest clinics (those with less than 7,500 patients) experienced lower operating margins and revenue growth than their larger counterparts. Notably, the smaller organizations had a healthier level of DCOH.

Clinic Size in Number of Patients

Number of Clinics	Number of Patients	Days Cash on Hand	Operating Margin	Current Ratio	Revenue Growth
43	Under 7,500	52	2.1%	3.0	6.8%
46	7,500-25,000	31	2.1%	2.4	10.4%
36	over 25K	40	3.5%	2.5	10.3%

Measuring clinic size in terms of visits and Full-Time Equivalents (FTEs) produced similar results to the above chart, with the larger clinics consistently showing stronger operating margins and higher revenue growth.

II: OPERATIONAL INDICATORS & FINANCIAL PERFORMANCE

Financial performance within the context of clinic size is the result of a combination of factors, including the extent to which operations may or may not be centralized, capacity limits, level of enabling services, and many others. Further analysis, including individual case studies, is necessary to identify best practices related to efficiently managing clinic growth from a smaller level of service activity to a larger scale operation.

Nonetheless, it is clear that size, in terms of operating revenues, sites, patients and visits, does play an important role in clinic performance. These factors should be taken into consideration when creating clinic peer groups for comparative purposes.

Patient Mix

Another factor that influences operating performance is the patient mix, including the percentage of patients under 100% of the Federal Poverty Level (FPL). As outlined in the chart below, clinics with 75%-100% of all patients falling below 100% of the FPL had operating margins of more than double and cash reserves significantly higher than clinics with smaller percentages of patients below that level. The variance is likely attributable to the payer mix. Clinics with larger portions of patients under 100% FPL are paid through sources with a higher reimbursement rate, such as Medicare.

Percentage of Clinic Patients Below 100% of Federal Poverty Level

Number of Clinics	Percentage of Patients	Days Cash on Hand	Operating Margin	Current Ratio	Revenue Growth
43	Under 60%	32	1.8%	2.4	10.4%
36	60-75%	43	1.8%	2.4	7.8%
46	75-100%	44	4.1%	2.6	10.2%

Other patient characteristics such as age and ethnicity were also reviewed, but they were found not to have a significant impact on a clinic's financial performance.

Interestingly, those organizations that had a higher percentage of patients who did not speak English as a first language had stronger financial metrics than others. In the table below, organizations where 25% or less of the patient population was non-English speaking had median operating margins over the period of 1.9% and revenue growth of 8%. In those clinics where non-English speaking patients comprised more than 25% of the population, the operating margin was almost double at 3.4% and revenue growth approached 11%.

Percentage of Population for which English is not the First Language

Number of Clinics	Patients for Which English is not First Language	Days Cash on Hand	Operating Margin	Current Ratio	Revenue Growth
41	25% or less	35	1.9%	2.4	8.4%
46	26-60%	40	3.5%	2.7	10.9%
38	Over 60%	40	3.4%	2.7	10.9%

Urban and rural clinics were affected differently by the percentage of patients for which English was not the first language. Urban clinics were positively affected by having a higher percentage of those patients, while rural clinics were not impacted by this factor. Further operational analysis of the clinics studied is necessary to better understand which combining factors are influencing performance to derive lessons learned.

Payer Mix

Closely related to the patient mix is the clinic's payer mix, which also has a significant impact on clinic performance. Not surprisingly, clinics with a higher percentage of patients qualifying for any type of Medi-Cal reimbursement had healthier operating margins and growth rates than their peers over the period as outlined below:

Percentage of Medi-Cal Reimbursement - Median

Number of Clinics	% Medi-Cal Patients	Days Cash On Hand	Operating Margin	Current Ratio	Revenue Growth
44	Under 33%	27	1.5%	2.4	7.1%
41	33-47%	47	2.1%	2.5	10.9%
40	Over 47%	43	4%	2.5	11%

These relative performance results, i.e. higher Medi-Cal reimbursement trending with better performance results, held true for both rural and urban clinics. Clinics with a higher percentage of patients enrolled specifically in Medi-Cal managed care also performed well, as shown in the table below. These clinics generated higher operating margins, cash reserves, and revenue growth over the period. This is especially relevant given the transition of the Medi-Cal program to managed care throughout the state.

Percentage of Clinics with Medi-Cal Managed Care Reimbursements

Number of Clinics	% Medi-Cal Managed	Days Cash On Hand	Operating Margin	Current Ratio	Revenue Growth
40	Under 2.5%	36	2.2%	2.4	6.7%
42	2.5-20%	34	2.5%	2.6	8.9%
43	Over 20%	44	3%	2.6	11%

Furthermore those clinics which had Medicare patients in their mix, about one-third of the organizations, showed operating margins almost twice as high as those without them. However, Medicare only represented 7% of patient revenue and 5% of total operating revenue for the clinics tracked.

Clinics with Medicare Patients/Reimbursements

Number of Sites	Medicare	Days Cash On Hand	Operating Margin	Current Ratio	Revenue Growth
81	No	37	2.0%	2.6	8.6%
44	Yes	39	3.9%	2.4	11.2%

Overall, patient mix emerged as a clear determinant of clinic operating performance and must be factored into any model of peer clinic comparison.

Service Mix

Various aspects of service mix were reviewed to identify their potential correlation with clinic financial performance. The most notable results were related to dental services. About 70% of the clinics measured offered dental services. These clinics had a median operating margin of 1.7% with 25 DCOH. For the 30% of clinics that did not provide dental services, the median operating margin was 3.7% with 45 DCOH.

Rural clinics did not experience a decline in operating margin when dental services were present, but their DCOH was considerably lower. Urban clinics offering dental services had lower operating margins, DCOH, current ratios, and revenue growth rates than those that did not offer dental.

The State of California eliminated most adult dental services from the Denti-Cal program in 2009. Therefore, the financial results mentioned above may reflect the erosion of coverage to dental care for clinic patients.

Other Factors

Other program areas that were tested for the sample data set and found not to trend with financial performance included whether mental health services, hospital services, or maternity care and delivery were offered on-site at a clinic. While those components of service mix may be less important to consider when creating peer groupings for review, some clinics may find them useful for comparison.

SECTION III: DEVELOPMENT OF CLINIC PEER GROUPS & PERFORMANCE BENCHMARKS

To facilitate financial performance benchmarking and encourage sharing of best practices among peer clinics, this section suggests methods for grouping clinics based on specific operational and programmatic indicators. Once peer clinic groupings are developed, benchmarks for performance can be established based on relevant indicators within those tiers. Clinics would then aim to rank in the top of their peer group on specific metrics as they strive to achieve high performance health care overall. The main challenge in developing an effective comparison mechanism is identifying clinics with enough similar characteristics to make analysis among them meaningful while understanding that some level of differentiation is inevitable. Recommended action steps are:

Step 1: Separate Clinics into Peer Groups or Tiers Based on Key Factors

Capital Link recommends a cumulative, layered approach whereby clinics are placed into "peer groups" or "tiers" based on various combinations of the key factors described in this report (clinic type, location, size, patient mix, payer mix, and service mix). The tier framework must be flexible enough to accommodate a top-level comparison (e.g. to allow a rural clinic to compare itself against all other clinics) as well as a more customized analysis (e.g. to facilitate that same rural clinic comparing its peformance against others with similar characteristics to itself: rural clinic, FQHC/LAL, below $5 million in operating revenues, with 75% of patients above 100% FPL, etc.).

Step 2: Define High Performance Benchmarks within each Tier

Following the peer group classifications, performance benchmarks would be developed for each tier to provide clinics with comparative measures to identify strengths, challenges, and opportunities for improvement. Specifically, for each tier, the 25th percentile, median and 75th percentile measures would be provided for each of the metrics listed below. Clinics might then set a goal of ranking in the top 75th percentile of their "tier" or peer group on each performance measure.

Key Financial and Operational Metrics to be Tracked	
Operating Margin	Cost/Patient
Bottom Line Margin	Clinic Visits by Payer
Revenue Growth Rates	Net Patient Revenue by Payer
Days Cash on Hand	Average Net Patient Revenue per Visit by Payer
Current Ratio	Revenue & Cost per Patient & per Visit
Salary-Related Expenses as a Percent of Revenues	Support Staff/Provider ratios
Days in Patient Accounts Receivable	Provider/Patient ratios
Revenue/Patient	

Step 3: Assist Clinics in Analyzing Results and Improving Performance

This framework would allow clinics to monitor their financial and operational performance against peers within the specific groupings. Clinics with weaker performance results could then be offered outside technical support to better understand operational and/or financial opportunities for improvement. At the same time, those clinics consistently scoring high on certain measures could share best practices with peer organizations that are performing below recommended ranges on selected indicators. In addition to the need for the development of an accessible framework for peer assessment, a convenient communication forum for sharing ideas is critical.

It is important to note that while the metrics are a useful comparative tool, they are not intended to be a substitute for hands-on operational review, assistance, and training. Providing a benchmarking tool without appropriate support could cause more harm than good by implying that the data itself tells the whole story. Instead, the findings should be utilized to highlight apparent strengths and weaknesses for additional review.

Furthermore, while this study identified a number of key factors that appear to impact clinic financial performance, several other items may have a significant impact as well and should be reviewed in a next stage analysis. Such factors include: the status of a clinic organization's Electronic Health Record and Practice Management Systems implementations, Patient Centered Medical Home certification, patient growth initiatives, the evolving reimbursement environment, the status of capital expansion plans, demand for enabling services, and other cultural considerations. Every clinic is different and must be reviewed with an understanding of its own unique characteristics.

Note that a clinic could move between tiers or peer groups if its revenues or number of sites grow substantially or other defining characteristics change (for example, a "Neither" clinic becomes a LAL organization.) Therefore, it is necessary to develop mechanisms to facilitate sharing of best practices within and between tiers.

Illustration of Clinic Peer Group Analysis

To better illustrate the tier framework discussed above, the following example compares the financial results of a hypothetical clinic organization within peer frameworks defined by specific operational and programmatic characteristics.

ABC Clinic
Clinic Type: FQHC in CA
Location: Rural
Revenue Size: $3.5 million
Patient Mix: 60% at 100% of FPL

ABC Clinic Comparison to All FQHC/LALs in CA

Peer Group: 125 Clinics	Days Cash On Hand	Operating Margin	Current Ratio	Revenue Growth
25th Percentile	18	-0.8%	1.5	2.3%
Median	39	2.4%	2.5	9.3%
75th Percentile	75	7.5%	4.3	16.9%
ABC Clinic	25	1.1%	1.5	6.0%

Comparing ABC Clinic to the overall grouping of FQHC/LALs, its financial profile is weaker than many of its peers. In fact, the clinic is operating between the 25th percentile and median of its peer clinic group. However, this "tier" is quite large, representing all FQHCs/LALs in California, so it may be more helpful to consider additional factors when developing the most useful peer clinic comparison.

When the characteristic of "rural" is added to further differentiate the clinics (see below chart) ABC Clinic looks somewhat stronger compared to its peers, performing closer to the median level. Note that the size of the tier has decreased from 125 to 37 clinics.

ABC Clinic Comparison to FQHC/LALs in Rural Locations

Peer Group: 37 Clinics	Days Cash On Hand	Operating Margin	Current Ratio	Revenue Growth
25th Percentile	16	-1.8%	1.3	2.4%
Median	32	2.2%	1.9	9.1%
75th Percentile	77	5.4%	3.7	16.5%
ABC Clinic	25	1.1%	1.5	6.0%

Further comparing ABC Clinic with the added dimension of revenue size (in this case reviewing the clinic vs. other rural FQHC's/LAL's with less than $5 million in annual revenues) makes the organization look even more favorable compared to its peers on most metrics. Notably, the size of the peer group has declined to 13 clinics.

Clinic Comparison to FQHC/LALs, Rural, <$5 Million in Revenues

Peer Group: 13 Clinics	Days Cash	Operating Margin	Current Ratio	Operating Rev. Growth
25th Percentile	22	-3.2%	1.2	0.9%
Median	41	1.9%	2.0	7.3%
75th Percentile	74	7.5%	3.8	16.2%
ABC Clinic	25	1.1%	1.5	6.0%

III: DEVELOPMENT OF CLINIC PEER GROUPS & PERFORMANCE BENCHMARKS

Finally, once the consideration of payer mix is added to the comparison (specifically including only those clinics where 60% or less of patients are at 100% of FPL) ABC Clinic's overall metrics come even closer to the median level. Indeed, the clinic's operating margin is considerably higher than the median, but the additional data cut decreases the peer group to 10 clinics making the base of comparison more limited.

Clinic Comparison to FQHC/LALs, Rural, <$5MM Revenues, <60% of patients at 100% of FPL

Peer Group: 10 Clinics	Days Cash On Hand	Operating Margin	Current Ratio	Operating Rev. Growth
25th Percentile	18	-6.3%	1.1	0.8%
Median	40	-0.3%	1.5	6.9%
75th Percentile	69	5.0%	3.7	15.7%
ABC Clinic	25	1.1%	1.5	6.0%

It is possible to cut the data any number of ways depending on what the clinics or other stakeholders would find most useful. However, as the number of comparative criteria increases, the comparative sample of clinics decreases.

Assuming the size of the peer group is large enough in this example to provide a relevant comparison, it appears cash reserves are particularly low for ABC Clinic. The clinic's operating margin is also weak, although it is higher than the median for this tier. Analyzing some efficiency metrics might provide a better understanding of the factors contributing to the relatively weak operating performance.

For example, a review of one productivity measure shows that ABC Clinic has a higher number of support staff to providers than similar organizations as outlined below:

Support Staff Per Provider Summary - Median

# of Organizations	Support/Provider	Days Cash on Hand	Operating Margin	Current Ratio	Revenue Growth
40	Under 3.25	42	2.7%	2.7	11.9%
52	3.25-5	41	2.5%	2.5	8.8%
33	Over 5	31	1.9%	2.3	8.4%
ABC Clinic	6.1	25	1.1%	1.5	6%

The clinic's high support staff to provider ratio is likely contributing to its weak financial performance. However, this observation is based only on top-line analysis and intended to provide suggestions for future investigation. Additional metrics to review more closely might include: salary-related expenses as a percent of revenues, days in patient accounts receivables, and cost per patient among others. Also, a deeper hands-on operational review would provide further guidance regarding potential opportunities for improvement.

SECTION IV: CLINIC SENSITIVITY TO MEDI-CAL REDUCTIONS

Despite the fluctuating fiscal fortunes of the state government, the Medi-Cal program continues to be the most significant payer source for California community clinics. Specifically, Medi-Cal supports 42.2% of patient visits, provides 56.5% of NPR, and generates 38.2% of total operating revenue. However, recent proposals to reform the Medi-Cal program include reductions to the overall program budget. Given that clinics operate with narrow margins and that at least 25% of clinics operate below a breakeven level, the stability of the health-care safety net is highly vulnerable to either reductions and/or interruptions to this critical funding source.

As discussed in Section I, the primary care clinics included in the study operated with a median operating margin that averaged 2% over the four-year period (2008-2011), and 25% of clinics operated with a margin of -0.2% or lower. To review the impact of Medi-Cal funding, we applied two hypothetical reductions in that payer source.

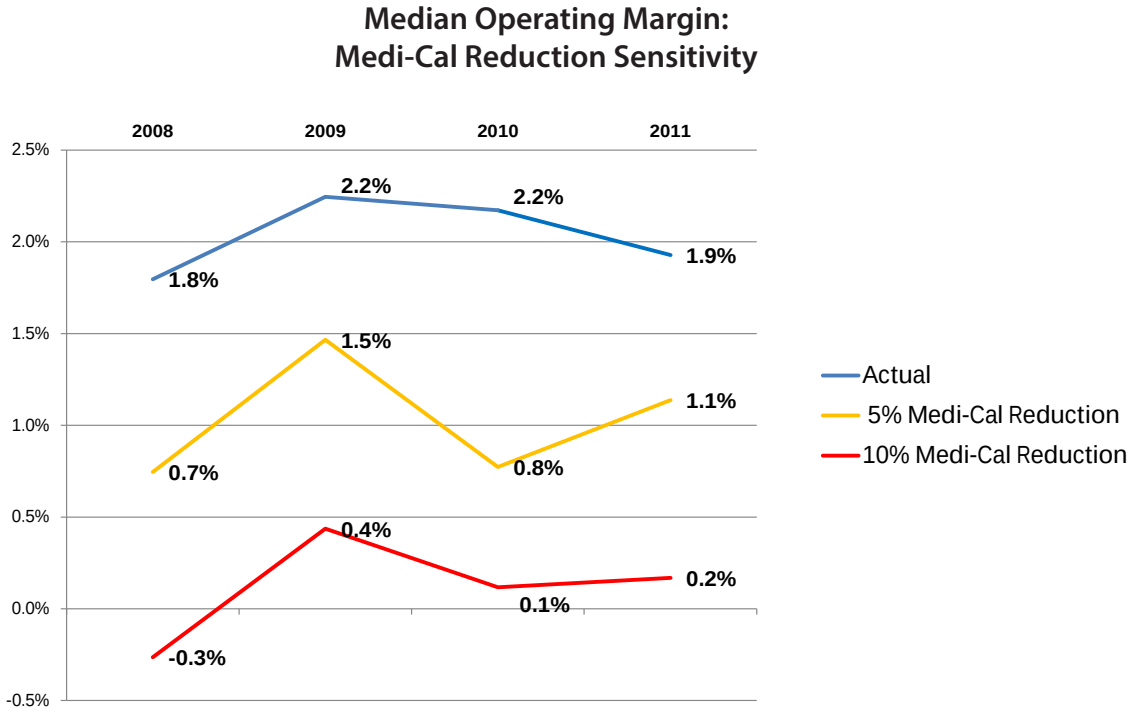
Applying a 5% reduction in Medi-Cal funding to the financial data set causes the four-year median operating margin to drop to 1%, representing a very narrow operating surplus that threatens financial stability for at least 50% of the clinics in the study group.

A more dramatic 10% reduction in Medi-Cal funding would lower the four-year median operating margin to 0.1%, a financial breakeven level. At this level of performance, the clinic operations of approximately half of the clinics in the study group would generate financial losses.

Median Operating Margin	2008-2011 Average
Operating Margin: Actual	2.0%
Operating Margin 5% Reduction	1.0%
Operating Margin 10% Reduction	0.1%

Clinics that generate negative operating margins must either deplete existing assets to support operations and/or take on additional debt, though both strategies can only be used as temporary remedies, if at all. Clinics that generate consistent operating losses would be forced to close, inevitably resulting in indigent patients which would more frequently utilize costlier healthcare service alternatives such as hospital emergency rooms.

IV: CLINIC SENSITIVITY TO MEDI-CAL REDUCTIONS



In order to understand whether any proposed Medi-Cal reductions would actually increase or decrease the overall costs to the entire health system, it would be necessary to fully evaluate the impact of possible clinic closures, including the economic impact of higher unemployment and shifting of patients to alternate settings.

METHODOLOGY

The analysis and results contained in this report are based on two major data sources:

- The Office of Statewide Health Planning and Development (OSHPD), and
- Audited financial statements of primary care clinic corporations

OSHPD collects data and distributes information on health and healthcare in California. All licensed clinics in California are required to submit an annual report to OSHPD that includes financial, utilization, and patient demographic information. The reporting period covers one calendar year.

Licensed primary care clinics include the following types of organizations:

- Federally Qualified Health Centers (FQHCs)
- FQHC Look-Alikes (LALs)
- Free-standing nonprofit Rural Health Clinics (RHCs)
- Indian Health Clinics licensed by OSHPD, some of which may be FQHCs
- Free Clinics
- Family Planning Clinics and other types of nonprofit community clinics serving specific populations

Primary care clinics self-report their clinic type under one of the following categories:

- FQHC
- FQHC LAL
- "Neither"

Clinics in the "Neither" category include all those clinic types not reported as an FQHC or FQHC LAL.

Development of Financial Audit Data Set

The clinics included in the analysis consisted of grantees of Blue Shield of California Foundation's (BSCF) Core Support Program. This data set included a majority of primary care clinics in California, including a large number of FQHCs and LALs. BSCF was able to provide multiple years of financial audits for most of these organizations. This allowed for a more detailed financial analysis than would have been possible if the publically available IRS Form 990 data had been used. After combining the audited data provided by BSCF with the financial audits independently gathered by Capital Link, the final data set for each year included 156-158 organizations over the four-year data analysis period.

Fiscal Year	2008	2009	2010	2011
Sample Size	157	158	156	158

METHODOLOGY

Development of OSHPD Data Set

This process included the downloading of 2008-2011 OSHPD data files for primary care clinics. The OSHPD data files are reported by primary care clinic site, though each clinic corporation may have various clinic sites that they operate. Capital Link consolidated the site level data into corporate level data sets based on parent corporation identifiers. The consolidation process resulted in a 2011 OSHPD data set that included 158 clinic corporations that operate 684 sites. The parent corporations were then given specific identifiers based on type (FQHC, LAL, and "Neither"), and further sorted by revenue size and location (rural/urban). Rural designations were given to clinic organizations in cities outside metropolitan statistical areas with populations of 20,000 or less. All non-rural clinics were designated as urban clinics. If a clinic organization had both rural and urban sites, it was also classified as urban.

The resulting 2011 OSHPD list of 158 clinics included 125 FQHCs and FQHC LALs as well as 33 clinics classified by OSHPD as "Neither" clinics.

The clinic organizations included in this analysis comprise 75% of the primary care clinic utilization (patients and encounters) reported to OSHPD in 2011. The data set is considered to be statistically significant and representative of the entire California clinic population.

Calendar Year	2011	2010	2009	2008
Number of Clinic Corporations	158	155	156	153
Number of Sites (operating)	684	632	607	575
FQHC	105	104	105	104
LAL	20	20	20	19
"Neither"	32	31	31	30

METHODOLOGY

Statistical and Financial Ratios and Data Sources

The financial ratios used in the analysis were generated using data from independent financial audits. These ratios were generated for the full clinic data set as well as for various sub-groupings of clinics and include the following:

- Operating Margin
- Bottom Line Margin
- Revenue Growth Rates
- Days Cash on Hand
- Current Ratio
- Salary-Related Expenses
- Days in Patient Accounts Receivable
- Leverage Ratio

The OSHPD data was used to generate all measures, ratios, and trends that include data on community clinic characteristics, patients, encounters, demographic information, and payer sources.

Measures calculated based on OSHPD data for the full clinic data set as well as for clinic sub-groupings include:

- Clinic Organizations & Clinic Sites
- Clinics by Type
- Clinics by Location (Urban vs. Rural)
- Clinic Visits by Payer
- Net Patient Revenue by Payer
- Average Net Patient Revenue per Visit by Payer
- Patient Income
- Revenue & Cost per Patient & per Visit
- Provider Staffing
- Productivity by Provider Type

While no ratios were generated using data elements from both data sources, several portions of the analysis involved integrating and comparing information and statistics between the two data sets. In such cases, fiscal year data from financial audits was compared to calendar year OSHPD data. It was determined, in consultation with the advisory group, that this combination of data sources, although imperfect, provides the most accurate analysis currently possible given the differences in collection methods for clinic financial and operational data.

METHODOLOGY

Comparison to National Database

In addition, the California community clinics' financial ratios and trends that were generated from audited data were compared to similar trends at the national level based on Capital Link's extensive database of health center and clinic audited financial statements. The number of audited financial statements included in the national sample is shown below:

Calendar Year	2008	2009	2010	2011
National Sample Size, All Clinics	653	643	606	418

Similar to the national universe of health centers and clinics, the majority of entities included in Capital Link's financial database are FQHCs and LALs. However, a number of "Neither" clinics are also included in the database. For the purposes of the FQHC and LAL sub-group analysis, the "Neither" clinics were removed from the national comparative sample, resulting in the following reduced sample size:

Calendar Year	2008	2009	2010	2011
National Sample Size, FQHCs & LALs Only	620	610	573	385

Median, 75th Percentile and 25th Percentile

Statistical measures used to describe the financial ratios and trends include the median, the 75th percentile, the 25th percentile and the mean.

The median is the number in the middle of a set of numerically ordered data; by definition, half the values in the set are greater than the median, and half are less. For example, the median value of the set {3, 8, 9, 10, 11, 11, 15} is 10. If there is an even number of values in the set, the median is calculated as the average of the two values in the middle of the set. The median is not skewed by extremely large or small values outside the typical range of the rest of the data. This attribute is particularly important when dealing with relatively small data sets. It is important to note that this presentation treats each clinic's data as having equal weight in the group. An organization with $40 million in annual revenue and an organization with $2 million in annual revenue will affect the results equally.

The percentile is the percentage of observations in a distribution that is at or below a given value. The 75th percentile is a value that is equal to or greater than 75 percent of the values. The 25th percentile is a value that is equal to or greater than 25 percent of the values. The 50th percentile is the same as the median value.

ACKNOWLEDGEMENTS

Capital Link was pleased to prepare ***California Community Clinics: A Financial and Operational Profile, 2008-2011*** with funding from Blue Shield of California Foundation and the California HealthCare Foundation and gratefully acknowledges the support of these foundations.

Blue Shield of California Foundation

Blue Shield of California Foundation (BSCF) is one of California's largest and most trusted grantmaking organizations. BSCF focuses its support in two program areas: Health Care and Coverage and Blue Shield Against Violence. The foundation's mission is to improve the lives of all Californians, particularly the underserved, by making health care accessible, effective, and affordable, and by ending domestic violence. For more information, visit www.blueshieldcafoundation.org.

California HealthCare Foundation

The California HealthCare Foundation is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, the Foundation's goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information, visit www.chcf.org.

About Capital Link

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 activities. For more information, visit www.caplink.org.

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REGIONS AND COUNTIES

In the analysis of clinics by region, each region contains the following counties. Only counties which had clinics included in the data set are listed in the table below:

Region	County
Central	Fresno, Kern, Kings, Madera, Merced, San Benito, San Joaquin, San Luis Obispo, Santa Cruz, Tulare, Ventura
Los Angeles	Los Angeles
North	Butte, Glenn, Humboldt, Lake, Lassen, Mendocino, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Trinity, Yuba
Sacramento Valley	El Dorado, Sacramento, Yolo
San Francisco Bay Area	Alameda, Marin, Napa, San Francisco, Santa Clara, Sonoma
South	Imperial, Orange, Riverside, San Diego

ENDNOTES

[1] In contrast to this report, the 2010 Clinic Financial Profile report used only publicly available data sources, including OSHPD and Form 990 financial information from the Internal Revenue Service.

[2] California Family Planning, Access, Care and Treatment (Family PACT) provides comprehensive family planning services to eligible low-income men and women.

[3] Clinics are able to adjust their Medi-Cal managed care reimbursements to be equivalent to their current Medi-Cal PPS rate through an annual reconciliation process with the Department of Health Care Services. Reconciliation payments may be recognized in subsequent fiscal year reporting.

[4] The Health Resources and Services Administration (HRSA), is an agency of the U.S. Department of Health and Human Services. It is the primary federal agency charged with improving access to healthcare services for people who are uninsured, isolated or medically vulnerable.

[5] http://www.californiahealthline.org/articles/2013/1/3/lawsuit-filed-against-dhcs-over-medical-managed-care-shift.aspx

[6] For more information on the designation of rural and urban clinics used for this study, please see the Methodology section.