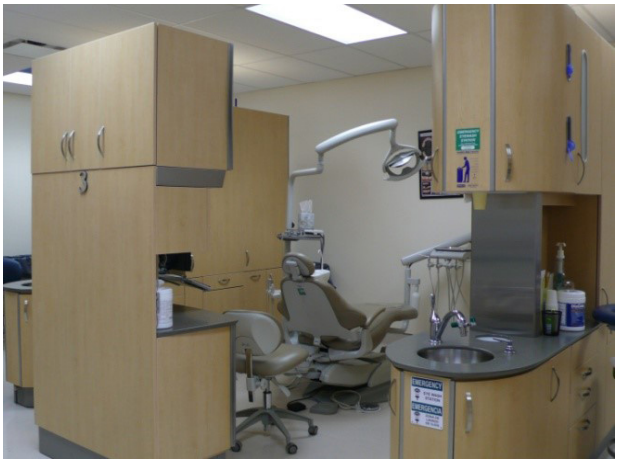

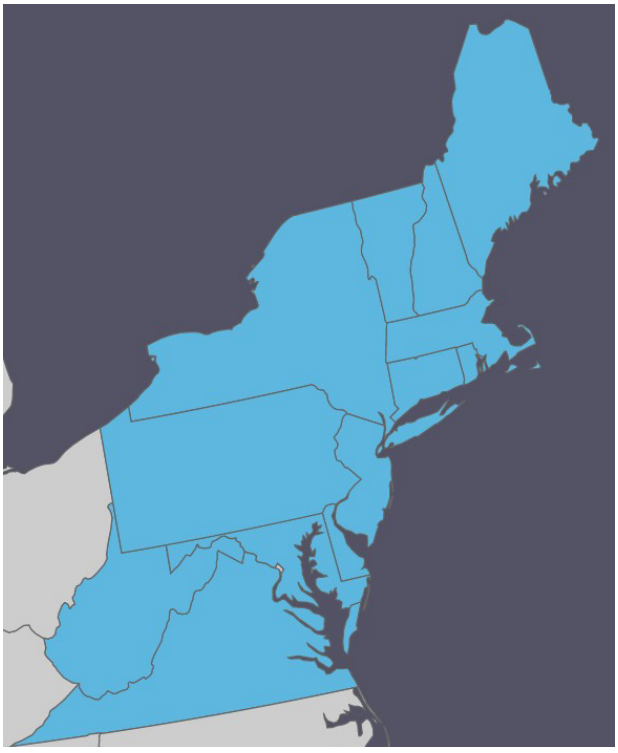

COMMUNITY HEALTH CENTER GROWTH & SUSTAINABILITY: *STATE PROFILES FROM THE NORTHEASTERN AND MID-ATLANTIC UNITED STATES*

December 2014

PRIMARY CARE DEVELOPMENT CORPORATION

Supported by the RCHN Community Health Foundation

Partner Support

The Primary Care Development Corporation wishes to thank the RCHN Community Health Foundation (RCHN CHF), and particularly Feygele Jacobs, President and Chief Executive Officer, for providing the funding and guidance to make CHC State Profiles possible.

PCDC and RCHN CHF hope that CHC State Profiles will help to enrich local, state and national discussions about primary care access, the importance of safety net providers like Community Health Centers in making available access to essential high quality health care and enabling services, and the role Community Health Centers play in improving the health of our nation's most vulnerable residents, notably low-income and uninsured children and adults.

Report Preparation

Community Health Center Growth & Sustainability: State Profiles from the Northeastern United States (CHC State Profiles) was produced with the help of numerous people. It was produced by Dan Lowenstein, Nancy Lager and Tom Manning, with significant contributions by Julia Busch, Morgana Davids, Bill O'Brien, Ronda Kotelchuck, Jeremy Mand, Kimberly Mirabella, Alex Purdie, and our intern Rizpah Bellard. We are grateful to our two Fellows, Grahme Deasy and Julian Fraga, who collected, organized and analyzed most of the data presented in the Profiles, as well as to Peter Epp and Aparna Mekala of CohnReznick, LLP for financial performance methodology and analytic assistance.

We would also like to express our appreciation to the National Association of Community Health Centers, Capital Link, and the State Primary Care Associations and industry experts who reviewed and contributed to these profiles.

PRIMARY CARE DEVELOPMENT CORPORATION

Mission and Vision

PCDC (the Primary Care Development Corporation) is a nonprofit organization dedicated to transforming and expanding primary care in underserved communities to improve health outcomes, reduce healthcare costs, and lessen disparities. Since 1993, PCDC has worked with hundreds of community health centers and other healthcare providers to strengthen and expand access to high quality primary care in underserved communities. (www.pcdc.org)

Programs

Investing in Primary Care: As a certified Community Development Financial Institution (CDFI) with two decades of market experience, PCDC provides the capital and know-how to build, renovate and expand community-based health care, so providers can serve more patients.

Strengthening Primary Care Capacity: Using proven strategies, PCDC provides expert consulting, training and coaching to help practices deliver patient-centered care that improves patient access, meaningful use of health IT, care coordination and patient experience.

Shaping Public Policy: PCDC supports and leads initiatives with policymakers and stakeholders that create favorable policies and greater resources to expand access to high quality primary care.

Impact

- **$515 million** invested and leveraged in low-income communities
- **1 million square feet** improved
- **900 healthcare organizations** strengthened
- **765,000 patients** with improved primary care access
- **7,000 healthcare workers** trained
- **Successful advocacy** that advances policies and public funding for primary care

RCHN COMMUNITY HEALTH FOUNDATION

The RCHN Community Health Foundation is a not-for-profit operating foundation established to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the U.S. dedicated solely to community health centers, RCHN CHF builds on a long-standing commitment to providing accessible, high-quality, community-based healthcare services for underserved and medically vulnerable populations. (www.rchnfoundation.org)

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INTRODUCTION

An estimated 60 million Americans lack sufficient access to a primary care provider. As more patients become insured through Medicaid or private insurance and demand for primary care grows, community health centers (CHCs), which served some 21.7 million patients in 2013, are expected to play a critical role in meeting this demand.

As with any sector, health center growth – as well as initiatives to modernize and replace existing capacity – relies heavily on the ability to secure affordable capital. Those who provide capital to CHCs (community development financial institutions, commercial lenders, government and foundations) make investment decisions based on their analysis of a series of factors. Whereas many of these factors are specific to an individual CHC, the environment in which it operates can play a critical role in growth and sustainability, which are important considerations in the evaluation by an investor.

To help investors and other stakeholders better understand factors relevant to the operating environment of CHCs, the Primary Care Development Corporation (PCDC), a Community Development Financial Institution (CDFI) with extensive experience financing and supporting CHCs, prepared ***Community Health Center Growth and Sustainability: State Profiles from the Northeastern and Mid-Atlantic United States*** with support from the RCHN Community Health Foundation (RCHN CHF).

CHC State Profiles compiles key publicly available health and economic data, as well as aggregated health center financial data and relevant Medicaid policy information, from 13 Northeastern and Mid-Atlantic states (Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, Virginia and West Virginia) and the District of Columbia (referred to collectively as the "Profiled States"). Where relevant or available, ***CHC State Profiles*** compares state-specific data to national data and/or recognized benchmarks. [1]

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1 In referring to CHCs or health centers, in these Profiles, we are specifically and in all instances referring to "comprehensive" Federally Qualified Health Centers (FQHCs) that receive a federal operating grant. These are the CHCs that are often referred to as "Grantees." Due to limitations of data availability, the Profiles do not include "Look-Alike" health centers (which represent less than 10% of CHCs in the Profiled States as of April 2014). Similarly, the Profiles do not include data from "Special Population" FQHCs serving only public housing, migrant farmworkers and homeless populations.

CRITICAL FACTORS AND OBSERVATIONS REGARDING CHC GROWTH AND SUSTAINABILITY

The factors analyzed for ***CHC State Profiles*** fall into five categories:

1. Health Center Scale
2. Health Center Financial Status
3. Primary Care Need
4. Primary Care Transformation
5. Medicaid and Health Insurance Landscape, including CHC Medicaid reimbursement policies

The factors included were selected from among hundreds based on their relevance to CHC growth and sustainability. In deciding which factors and indicators to include, PCDC consulted a number of experts and drew on more than 20 years of experience providing financing, technical assistance and advocacy to the community health center sector. *For more information please see Methodology and Sources.*

1. HEALTH CENTER SCALE

Scale is an important factor because it can indicate CHC impact on the state's underserved population. This is essentially the "market" in which CHCs operate. Their share of that market, and the extent to which that share is growing, can indicate current impact and future growth opportunities. Among the questions this information can help answer are: What is the footprint of health centers in the state? What proportion of the population do they serve? What are the demographics and composition of the population served? How much growth have the health centers achieved over the years analyzed?

Observations

- In the profiled states, there were 285 CHC organizations as of 2014
- CHCs collectively served over 5.3 million people in 2012
- From 2010 to 2012, median annual growth in patients served was approximately 4.2%, similar to the 4.1% growth by CHCs nationally.
- In Profiled States with a higher than average number of CHC visits/patient, CHCs tend to have a lower proportion of medical visits and a higher proportion of non-medical visits than CHCs nationwide.

The CHC sector is an essential provider to low-income populations:

- CHCs typically served 1 in 5 Medicaid enrollees across the Profiled States in 2012 and 1 in 6 low-income persons (those living in a household earning below 200% of the federal poverty level).
- In 5 of the Profiles States, CHCs served more than 1 in 4 Medicaid enrollees,
- In 3 of the Profiled states, CHCs served over 40% of the low-income population.

Factors Analyzed

Population Served by CHCs, in terms of size and demographics of population served, and the comparable data for the sector in each state, as well as the volume of services they provide.

- **Total Population Served by CHCs** and **Percentage of Population Served by CHCs** indicate the size of the population served and CHCs' market share.
- **Percentage of Population Under 200% of the Federal Poverty Level (FPL)**

  Served by CHCs. 200% of the FPL is a generally accepted measure of "low-income", which is the subset of the population that CHCs predominantly serve. This consists primarily of people who are uninsured or insured through public programs like Medicaid. In the US overall, 40% of the population is deemed low-income, ranging from a low of 25% in one state to a high of 47% in six states. [2]

  Where CHCs serve a higher percentage of people living below 200% of FPL they play a more vital safety net role. Lower percentages may indicate market opportunities for CHC growth within a state, though further analysis would be needed to determine how and where low-income residents currently receive care.

- **Percentage of State's Medicaid Enrollees Served by CHCs**

  Medicaid usually pays CHCs at a rate more commensurate with the cost of delivering services than do other payers. Higher percentages of Medicaid patients in a state suggest a greater number of patients will generate a more robust revenue stream. As above, lower percentages suggest that low-income residents are receiving care elsewhere or not at all and may indicate an opportunity for CHC growth. States that have expanded Medicaid offer greater opportunities for patient growth than states that have not.

CHC Characteristics & Volume

- **Number of CHCs, Total CHC Service Delivery Sites, and Annual Visits (Total)** measure the size of the CHC sector.
- **Average Sites per CHC**

  This can be an indicator of both market share and organizational strength. With regard to market share, a higher average number of sites would likely provide individual CHCs with greater access to their target population of low-income residents. Also, a higher ratio of sites per organization better positions CHCs to realize economies of scale.

  One caveat, for which data is not readily available, is the size of these sites. Organizations with many small sites may be less able to reap the same market share or financial benefits experienced by their counterparts who operate larger, and possibly fewer, sites.

- **Annual Visits per CHC**

  This tends to be an indicator of organizational strength since: (i) more volume generally generates more revenue through fee-for-service reimbursement structure); (ii) more volume provides the opportunity for CHCs to achieve greater economies of scale; and (iii) stronger CHCs are better positioned to attract and retain personnel at all organizational levels.

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2 Kaiser State Health Facts 2013: http://kff.org/other/state-indicator/population-up-to-200-fpl/

- **Annual Visits per Patient**

  This can be an indicator of service diversity and organizational strength since organizations that have a higher number of total patient visits typically offer a broader array of services, such as dental and/or mental health services, in addition to medical services (See Visit Mix below).

- **Visit Mix (Medical, Dental, Mental Health)**

  Higher percentages of dental and mental health visits point to more developed CHC clinical programs that offer a more comprehensive and coordinated set of services. As suggested above, higher percentages of dental and mental health visits do appear related to a larger number of visits per patient.

  Greater visit mix diversity also may indicate state primary care and Medicaid eligibility and reimbursement policies that enable CHCs to offer a greater array of services.

- **Compound Annual Visit Growth Rate (Total, Medical, Dental, Mental Health)**

  Higher than average annual growth rates point to CHCs that have more aggressively expanded during an overall period of strong national growth and may indicate supportive state policies in terms of Medicaid eligibility, changes to support expanded services, availability of grant funding and other factors.

2. HEALTH CENTER FINANCIAL STATUS

Understanding CHCs' revenue mix and how CHCs perform on key financial indicators is critical to modeling financial growth and sustainability projections necessary for the analysis to support sound investment. While the financial status of CHCs within a state can vary widely, their aggregated financial status can provide context for analysis of individual CHCs including how they compare to state and national averages or benchmarks. [3]

Observations

Based on a review of data from 2009-2011, the health centers presents across a range of financial circumstances:

- In 8 states, CHC median days cash – an important indicator of operating liquidity – exceeded the 30-day benchmark in 2011. In 4 states, the median was below 20 days. Median days cash grew by more than 20% in 3 states from 2009-2011, but decreased by more than 20% in 5 states.
- Assets typically grew substantially from 2009-2011, with the median growing by 10% or more per year in 11 states.
- Changes in financial strength were mixed, as measured by growth of unrestricted net assets (UNA) relative to growth of assets. Median UNA grew relative to assets in 6 states and was essentially unchanged in 3 more. In the other 5 states, median UNA grew at approximately half the rate of assets or less.
- Median total margin exceeded 4% in 6 states in 2011, and exceeded 2% in 5 more states.

3 The majority of CHC financial data was collected from publicly available IRS Form 990s, which all nonprofits must file. Information in 990s have limitations and data can differ from audited financial statements. Certain indicators could not be accurately analyzed as a result. For a more complete picture of CHC financials, audited financial statements should be consulted. Additionally, *Capital Link* (www.caplink.org), an organization that regularly tracks and analyzes CHC financial data, produces numerous valuable CHC sector reports that investors should consult.

Factors Analyzed

Revenue by Source

- **Proportion of Revenue from Patient Care vs. Grants**

  Though revenue diversity is optimal, CHCs with a higher proportion of total revenue deriving from patient revenue, as opposed to grant revenue, generally have a more sustainable business model. Federal and state grants, whose continuation depends on government budget actions, are less reliable revenue sources with greater potential for CHC destabilization. Over-dependence on grants from private sources can be similarly risky.

Revenue by Payer

- **Proportion of Revenue from Medicaid, Medicare & Other Public Insurance, Private Insurance, and Self-Pay Patients**

  Payment rates differ widely by payer. Public insurance (Medicaid, Medicare and other state-specific government programs) tend to offer routine cost of living increases and therefore pay more, , than private (aka commercial) insurance. Medicaid is typically the highest payer, with a federal mandate to pay CHCs based on reasonable cost, and so higher percentages of Medicaid revenue can point to a more sustainable business model. However, CHCs with greater proportions of commercial insurance in their payer mix may be better positioned to attract and retain increasing numbers of patients enrolled though state health insurance exchanges.

- **Visits by Payer**

  Higher proportions of uninsured patients correlate with greater reliance on government grants, notably federal Sect. 330 operating grant funding and possibly state-specific indigent care funding, which do not always fill the funding gap.

Financial Performance

Six indicators provide a good snapshot of growth, profitability, and liquidity. These are predicated on CHCs' financial audits as reported in the IRS Form 990, the tax form required of all non-profit tax-exempt organizations.

Growth

Increases in Total Assets and in Total Revenues over a three-year period and consistent trends are signs of sectoral strength.

1. **Total Assets**, according to the International Accounting Standards Board, include all "resources controlled by the entity as a result of past events and from which future economic benefits are expected to flow to the entity." For CHCs, these primarily include: Current Assets (e.g., cash and receivables); Long-Term Investments; and Fixed Assets (e.g., property, plant and equipment). Growth, relative to national trends, can indicate the relative strength of the sector.
2. **Unrestricted Net Assets (UNA)** is the portion of an organization's assets that is in excess of liabilities and can be used for any mission-appropriate purpose without restriction.

Profitability

3. **Total Revenues** include revenues from all sources, both operating and non-operating revenue sources, net of allowances (i.e., contractual or other "discounts"). Increases over the period analyzed and consistent trends are signs of strength.
4. **Total Margin**, defined as Total Net Income or Surplus / Total Revenue, is an indicator of overall financial health. Figures consistently higher than national averages suggest a sector better positioned to weather short-term environmental fluctuations and also better positioned for future growth. *For a more accurate picture, unrestricted net operating income or surplus/unrestricted operating revenue should be analyzed. This information is available on audited financial reports, but not on Form 990s.*

Liquidity

5. **Days Cash on Hand**, defined as Cash / Total Expenses / 365 (Excluding Bad Debt and Donated services), is a measure of liquidity, specifically how long, in the absence of new cash, the organization can cover its expenses before running out of cash and having to use reserves/investments. The industry benchmark is >30 days. [4] Higher than average cash on hand may indicate that CHCs have capital available to invest in future facility and/or operating expansion.
6. **Days in Accounts Receivable**, defined as Total Accounts Receivable / (Total Revenue / 365 Days), is a measure of how effective CHCs are managing billing and collections. The industry benchmark is <60 days. [5] A lower figure is desirable, and indicates that CHC billing is timely and complete and that payers' remittances are also timely. Higher than average Days in Accounts Receivable could indicate inadequate cash management or poor billing practices by CHCs or payer delays or other payment issues that affect the sector or state. ***Days in Accounts Payable*** are not included because of the limitations of the Form 990 data. Accounts payable information is best determined from audited financial statements.

3. PRIMARY CARE NEED

How a state performs on key health indicators related to primary care access (e.g., prenatal care, diabetes, heart disease, avoidable hospitalizations) sheds light on the state's commitment to public health, healthcare workforce and primary care infrastructure. Information about what portion of the state's population lacks access to primary medical and dental care, and how many providers are needed to meet this need, can help us better understand the need for primary care expansion, as well as the challenges in attracting and retaining a primary care workforce.

Observations

- In 6 of the Profiled States, 5% or more of the population lacks access to a primary care provider.
- In 8 states, 5% or more of the population lacks access to a dental provider.
- 9 states rank in the top 25, with 5 states in the top 10, in America's Health Rankings

4 Capital Link, Financial and Operational Ratios and Trends of Community Health Centers, 2008-2011, July 2013, pg. 28.

5 Capital Link, Financial and Operational Ratios and Trends of Community Health Centers, 2008-2011, July 2013, pg. 30.

Factors Analyzed

Primary Care & Prevention Clinical Indicators

These measures are standard public health indicators, with higher rates indicative of insufficient investment in public health infrastructure and pronounced disparities in primary care access.

- **% Births to Women with Late/No Prenatal Care**
- **% Low Birthweight Births**
- **% Adults Diagnosed with Diabetes**
- **Adult Diabetes Deaths per 100,000 Population**
- **Adult Heart Disease Deaths per 100,000 Population**
- **Avoidable Hospitalizations** (number of Avoidable Medicare Hospitalizations per 1,000 Medicare Enrollees.)

Avoidable Hospitalizations are inpatient stays for Ambulatory Care Sensitive (ACS) conditions (e.g., asthma, hypertension, diabetes and bacterial pneumonia) that might have been prevented if primary and preventive care services were more readily accessible. The Agency for Health Care Research and Quality (AHRQ) defines Ambulatory Care Sensitive Conditions are conditions "for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease." [6] Avoidable hospitalization rates tend to be higher where residents lack adequate access to primary and preventive care, and studies link reductions in avoidable hospital use to insurance and primary/preventive care availability. Medicare enrollees are the only patients nationwide for whom ACS admissions are currently tracked.

America's Health Rankings, prepared annually by United Health Foundation, tracks "the state of our nation's health by studying numerous health measures to compile a comprehensive perspective on our nation's health issues, state by state." [7] The measures include, but are not limited to, rates of smoking, diabetes, asthma and preventable hospitalizations. The higher the ranking, the comparatively healthier a state's population is.

Primary Care Shortage & Workforce Indicators

In states with significant primary care shortages, residents likely encounter more difficulties in accessing care, and low-income residents tend to be even more adversely affected. Though CHCs in states with significant workforce shortages often experience challenges recruiting and retaining clinical staff for expansion, they have some salary and recruitment advantages relative to other providers serving low-income residents, such as the availability of federal and state programs to repay portions of student loan debt. This provides a potentially better vehicle for primary care expansion in underserved areas.

In many states, CHCs have increased their staffing ratio of nurse practitioners and physician assistants to physicians and established a more "team based" means of providing care. This approach allows all practitioners to work at the maximum scope of their training and licensure and has been shown to improve provider satisfaction and patient outcomes.

- **Estimated Underserved Population for Primary Care**

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6 Agency for Health Care Research and Quality, Prevention Quality Indicators Overview http://www.qualityindicators.ahrq.gov/. Updated 2003.

7 America's Health Rankings http://www.americashealthrankings.org/

This estimate was generated by multiplying the number of primary care physicians in the Federal Health Professional Shortage Area (HPSA) by a target population-to-practitioner ratio of 2,000:1, and subtracting this figure from the total HPSA population. This is an indicator of the size of the potential market of new CHC users and relative to total population, a broad indicator of expansion opportunities, with higher numbers and percentages suggesting larger markets for CHC growth. HPSAs are designations of critical geographic areas, population groups, medical facilities, and other public facilities with shortages of health care professionals. [8]

Important note: Aggregating HPSA data to a statewide level may mask significant primary care shortage areas in particular regions of some states. This is especially the case in states that have large urban and rural areas, as well as states with large areas with a diversity of socioeconomic regions. This report did not analyze regional variations within states.

- **Estimated Number of Primary Care Providers (PCPs) Needed to Achieve the Target PCP : Population Ratio**
- **Estimated Number of Dental Providers Needed to Achieve the Target Dental Provider: Population Ratio**

Estimates were derived by computing the number of primary care or dental practitioners that would be needed to achieve a population to full-time-equivalent practitioner ratio of 3,500:1 (or 3,000:1 in high-need areas). This ratio should be understood in the context of how primary care delivery is changing. The responsibility for managing patient health and the cost of care is increasingly becoming a responsibility of the primary care provider, which would argue for smaller panels of patients. However, conventional wisdom is that team-based care enables physicians to manage larger panels with a skilled team of professionals.

4. PRIMARY CARE TRANSFORMATION

Health care is going through a period of significant change and disruption that will provide both challenges and opportunities for health centers.

- Reforms to provider reimbursement, focusing on the outcomes rather than the volume of care provided, will put pressure on health centers' primary payment mechanism – the Medicaid Prospective Payment System (PPS).
- As funding becomes available to support more robust primary care models, health centers stand to benefit, but could also face competition as new entrants see business opportunities in the primary care sector.
- New technologies and consumer access to data are making patients more informed "shoppers" and may reduce reliance on the traditional office visit.

CHCs that understand the impact these forces may have and that embrace adaptability will be in a much better position to stay ahead of the change and to grow and sustain their organizations over time. The level

8 http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/designationcriteria.html

of adoption of electronic health records (EHR), Patient-Centered Medical Homes (PCMH), and federally-funded initiatives that support delivery system change and payment reform indicates their preparedness in a rapidly changing healthcare environment.

Observations

The data show the Profiled States to be typically among the leaders nationally:

- 10 states have more widespread adoption of EHR than the national average among CHCs, and the other 4 states are very close to the national average. It should be noted, nonetheless, that not all states report advanced use of their EHRs to manage their patients' conditions.
- 11 states have a higher percentage of their CHCs recognized as a PCMH by the National Committee on Quality Assurance (NCQA) or other accrediting body as of 12/31/13, including 8 states with 50% or more CHCs recognized.
- CHCs in all states are participating in some level of federally-funded transformation, with some in more advanced stages.

Factors Analyzed

Electronic Health Record (EHR) Adoption

EHR adoption has become a foundational tool for improving primary care delivery and care management of individuals and populations. The self-reported status of EHR adoption among CHCs in each state is described, looking at as a whole at the number of sites/providers using EHR and the use of 12 functional categories (defined below) plus ability to report Uniform Data Systems (UDS) data electronically (see footnote 12). EHR adoption is indicative of CHCs' positioning for future health system delivery change.

EHR Functional Categories

- Patient history and demographic information
- Clinical notes
- Computerized provider order entry (CPOE) for lab tests
- CPOE for radiology tests
- Electronic entry of prescriptions
- Reminders for guideline-based interventions or screening tests
- Capability to exchange key clinical information among providers
- Notifiable diseases notification sent electronically
- Reporting to immunization registries done electronically
- Ability to provide patients with a copy of their health information on request

- Capacity to provide clinical summaries for patients for each office visit
- Protection of electronic health information
- Use an EHR to report clinical UDS data

Patient-Centered Medical Home (PCMH) Initiatives

PCMH is a coordinated, team-based delivery model that emphasizes patient participation and practice engagement where a patient receives care in a regular, continuous, and patient-centered manner. Studies show that patients with a medical care home experience fewer non-urgent emergency room visits and lower rates of avoidable hospitalizations. [9] The measures indicate how many CHCs have become recognized as a PCMH by NCQA or another national accrediting organization. The capacity of CHCs to adopt PCMH principles is essential to their participation in a transformed, integrated delivery system with a greater focus on improving health outcomes while lowering health care costs.

Federally-Funded Transformation Initiatives

The Affordable Care Act authorized federal health agencies to launch state-based innovation initiatives to help transform how health care is delivered and paid for. The Center of Medicare and Medicaid Services (CMS) is the primary sponsor of these initiatives, which include the Comprehensive Primary Care Initiative, FQHC Advanced Primary Care Practice Demonstration, Prevention of Chronic Disease in Medicaid Demonstration and State Innovation Models.

9 (1) Starfield B. "Primary Care: Balancing Health Needs, Services, and Technology" New York: Oxford University Press, 1998; (2) Starfield B. "Primary Care and Health: A Cross-National Comparison," JAMA 266(16):2268-71 October 1991; (3) Starfield B. "Is Primary Care Essential?" 344(8930):1129-33 October 1994; (4) Sox C. et al "Insurance or Regular Physician: Which is the Most Powerful Predictor of Health Care?" March 1998 American Journal of Public Health 88(3):364-370.

5. MEDICAID AND HEALTH INSURANCE LANDSCAPE

To describe how the payment environment for CHCs may change and provide opportunities for CHC growth, we present information on policies affecting CHCs' two largest payer segments: the uninsured and those enrolled in Medicaid. This includes the states' responses to a key aspect of the Affordable Care Act (ACA), namely Medicaid expansion.

CHCs with a larger proportion of patient revenue from Medicaid and private health insurance have a more predictable revenue source and are less susceptible to negative public policy changes at the state and federal level. States that have expanded Medicaid and operate state-run health insurance exchanges are generally considered more favorable financial environments for CHCs. This is particularly true for Medicaid expansion, as Medicaid is usually a more favorable payer to health centers than private insurance (see State CHC Medicaid Reimbursement Policies below)

Important note: Many communities will have market conditions or health center capacity that are favorable to health center expansion, even if the state itself does not have a particularly favorable policy environment.

Observations

The Profiled States are more likely to support Medicaid as a strategy to provide health care to low-income populations than states in other regions, which is significant as Medicaid is typically the best revenue source for CHCs.

- Each of the Profiled States spends more per Medicaid enrollee than the national average, based on 2010 figures. On average, the Profiled States spent 27% more than the national per-enrollee average.
- 11 of the 14 Profiled States (79%) have chosen to expand Medicaid eligibility in accordance with the Affordable Care Act (ACA), as compared to 16 of the remaining 37 states (43%, as of April 2014).
- Medicaid expansion is an active issue in the remaining three Profiled States, with one pursuing an alternative expansion strategy and the other two others not participating at time of publication.
- 10 of the Profiled States (71%) have adopted state-run exchanges, or partnered with the federal government, as compared to 13 of the remaining 37 states (35%).

Factors Analyzed

Medicaid Payments per Enrollee

This is defined as total Medicaid dollars spent by each state in a given year, for all Medicaid services provided, divided by the total number of Medicaid enrollees in that year. A higher-than-average number suggests more generous state Medicaid policies, and might also suggest opportunities for primary care expansion – especially through CHCs, which are notable for being cost-effective primary care providers – as a means of reducing per-enrollee spending.

Federal Medical Assistance Percentage (FMAP)

This is the federal share of a State's Medicaid program. FMAP rates have a statutory minimum of 50%,with higher percentages for states with lower state income. [10] Higher federal contributions indicate that a state likely has fewer public resources to invest in primary care. This may be seen as a proxy for a state's ability to provide public resources for CHC expansion.

10 http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/

State Medicaid & Health Insurance Expansion

- **Supports Medicaid Expansion– Yes or No?**

  This indicates whether the state is/is not expanding per the ACA, as of the date of this publication. Medicaid expansion may be the single most important factor in CHC expansion viability, since Medicaid is the major source of revenue for most health centers. "Expansion" states provide major growth opportunities for CHCs. In non-expansion states, those in poverty will still use health centers, but without new financial resources, CHC expansion will be more challenging.

- **Type of Health Insurance Exchange**

  This indicates whether the state is implementing its own health insurance exchange or partnering with the federal government on the implementation, or deferring entirely to the federal government on implementation. Greater levels of state control tend to correlate with greater levels of policy support at the state level for the ACA. It is likely that, over time, this will lead to greater reductions in the uninsured population, potentially leading to more insured patients at CHCs, and hence, improved revenue streams.

- **Uninsured Non-Elderly Adults**

  This segment is the key target for new Medicaid and health insurance exchange enrollment. These newly insured individuals are a possible "new market" for CHCs (it has been well-documented that insured individuals seek care more than do uninsured individuals) and a newly-paying market that will bring new financial resources to CHCs.

- **Additional Medicaid Enrollment from Medicaid Expansion/Additional Medicaid Enrollment without Medicaid Expansion**

  These are estimates developed by the Urban Institute, and reported by the Kaiser Family Foundation, of the likely expansion to a state's Medicaid rolls expected, by 2022, (i) to result from a state formally expanding its Medicaid program in accordance with eligibility formulas in the ACA, or (ii) from enrollment growth in previously eligible categories. The percentage growth in the Medicaid rolls is generally higher for states with historically lower Medicaid eligibility thresholds.

- **Estimated Remaining Uninsured & Uninsured Rate after ACA (2022)**

  These are estimates developed by the Urban Institute, and reported by the Kaiser Family Foundation, of the number of state residents who will likely remain uninsured after ACA implementation due to ineligibility, most likely because they are undocumented immigrants. Health centers will continue to serve this population. If Massachusetts' health insurance reform experience is a guide, the number of uninsured patients served by CHCs held roughly steady, even as the statewide number of uninsured plunged, suggesting that the remaining residents without insurance increasingly turned to CHCs. As a policy matter, this suggests that CHCs will need to retain existing levels of resources – or increase resources – to cover the costs of caring for the uninsured.

CHC Medicaid Reimbursement Policies

CHCs receive Medicaid reimbursement (and Medicare as of October 2014) through a Prospective Payment System (PPS) rate based on a per-visit baseline payment rate set in 2000 equal to 100 percent of the center's average costs per visit. *Since 2001, states have been required to pay FQHCs a per-visit rate, which is equal to the baseline PPS payment rate increased each year by a standard medical inflation factor, known as the Medicare Economic Index ("MEI"), and adjusted "to take into account any increase or decrease in the scope of such services furnished by the center . . . during that fiscal year." Under PPS, State Medicaid agencies are required to pay centers their PPS per-visit rate (or an alternative payment methodology, or "APM") for each face-to-face encounter between a Medicaid beneficiary and one of the center's billable providers for a medically necessary (and covered) service, regardless of the actual cost to the FQHC of providing that visit or the number of services performed at the visit.* [11]

CHC Medicaid reimbursement policy is the arena in which states usually have the greatest direct impact on CHC finances. There is considerable variance across the Profiled States, including:

- Which states use PPS versus an Alternative Payment Methodology;
- The number of visits per day, type of visits and providers that trigger a reimbursement vary across the Profile States;
- The scope of services criteria that triggers a rate adjustment; and
- Timeliness of payments for Medicaid claims.

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11 NACHC State Policy Report #38: Emerging Issues in the FQHC Prospective Payment System, 2011

METHODOLOGY AND SOURCES

CHC State Profiles was produced from a vast array of quantitative and qualitative data, highlighting key factors to provide a profile of the CHC sector in 13 Northeastern and Mid-Atlantic states and the District of Columbia and the environment in which CHCs operate. The specific factors, and their relevance, are detailed below.

Overall Methodology

To carry out this assessment, PCDC collected quantitative and qualitative data pertaining to 13 Eastern states and the District of Columbia (referred to herein collectively as "Profiled States"). We sought out quantitative data from secondary sources to provide a snapshot for each state of:

- The scale and market penetration of the Federally Qualified Health Centers (CHCs) in each state, drawing primarily on the HRSA Uniform Data System (UDS) [12] and information compiled by the Kaiser Family Foundation and other aggregators of health data;
- The financial status of CHCs, working with CohnReznick to analyze key financial performance indicators extracted from the IRS Form 990 filed by each CHC; and
- Primary care need, analyzing such variables as: population living in health shortage areas (e.g., health professional shortage areas (HPSAs); prevalence of preventable chronic disease; maternal health indicators; and avoidable hospitalizations.

To present each state's perspective on primary care generally and CHCs specifically, we gathered qualitative data on Medicaid policies and the reimbursement and regulatory environment, and supplemented this with information provided by leaders and staff from Primary Care Associations and individual health centers.

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12 HRSA Uniform Data Systems (UDS) is a core set of information appropriate for reviewing the operation and performance of health centers. The UDS tracks a variety of information, including patient demographics, services provided, staffing, clinical indicators, utilization rates, costs, and revenues. At time of analysis, 2012 UDS data was the latest available. 2013 data is now available at http://bphc.hrsa.gov/healthcenterdatastatistics/index.html

Methodology for Analyzing Financial Performance Indicators

The financial indicators chosen for this analysis use data from the IRS Form 990, specifically in the Statement of Revenue, Statement of Functional Expenses, and Balance Sheet sections. The 990s provide uniform, publically-accessible data. The table below lists the indicators and the methodology for collecting the data from IRS Form 990:

Financial Indicator	Methodology	Source
Profitability		
Total Revenues	Total Revenue from all Sources	Form 990 Statement of Revenue
Total Margin	Total Net Income / Net Revenue	Form 990 Part I Summary
Growth		
Total Assets	Total Assets	Form 990 Balance Sheet
Unrestricted Net Assets	Unrestricted Net Assets	Form 990 Balance Sheet
Liquidity		
Total Days Cash-on-Hand	Cash /(Total Expenses / 365 Days) Excludes Bad Debt & Donated Services	Form 990 Statement of Revenue and Statement of Functional Expenses
Total Days in Accounts Receivable	Total Accounts Receivable / (Total Revenue / 365 Days)	Form 990 Balance Sheet and Statement of Revenue

Given the level of detail in the IRS 990, certain other financial ratios, such as the Current Ratio, Working Capital and Debt to Equity, could not be calculated.

For each indicator selected, State medians were compared to the optimal benchmark/range, where one exists, and to the US median for all CHCs. Since the "averages" include outliers which may skew the data, the median seemed to be a more accurate measure.

Benchmarks for these financial indicators are based on Federal expectations of CHCs. For Total Margin, Total Assets and Unrestricted Net Assets, where there is no industry benchmark, trends over time and comparison to the US median for all CHCs are more meaningful.

Data Issues and Caveats

Once the raw data was collected for each of the CHC grantees, we reviewed the information and determined a few limitations, outliers and inconsistencies with the way information was recorded on the IRS Form 990s across these health centers. The following is a list of issues as related to data collection and that determined whether the CHC was included in the analysis:

1. To ensure that the CHC program comprises a significant portion or is the only line of business, we evaluated the distribution of program services
2. Form 990s were available for all three years across all health centers with some exceptions
3. A few health centers did not record Cash and were noted in the dataset. For those health centers, the "Days on Cash" indicator may be lower than expected.
4. 990s can give a great deal of information about CHCs, but for more accurate information, audited financial statements should be consulted. For example, 990's do not provide the level of detail provided in an audit, such as the differentiation between unrestricted and restricted revenue and expenses
5. Other additional issues for consideration that impacts the quality of the data:

   Accounts Receivables – typically in analyzing collection experience, a review of the days outstanding in patient accounts receivable is analyzed. Since the 990s do not segregate patient accounts receivable from other receivables (e.g. government grants and contracts), days outstanding in "total" accounts receivable was analyzed since we were unable to exclude non-patient items.

   Accounts Payable were not included because the way this factor is reported 990s differs considerably from how it is reported on audited financial statements.

   Total Margin – when analyzing a health center's margin, the operating margin, excluding one-time, non-operating items, is typically compared to the operating revenue base. As non-operating items are not identified in the 990, we were unable to exclude non-operating items from the ratio.

   340-B Program Revenue – The 340B program is a U.S. government drug discount program that allows eligible health care organizations to purchase pharmaceuticals at discounted prices as compared to retail. 340B programs are an additional source of revenue for participating CHCs.

   Cost Report Settlements – In certain states, the Medicaid agency evaluates the health center's cost report filing and issues an adjusted PPS rate or Medicaid managed care "wraparound" rate, retroactively. In addition, adjustments in PPS rates for changes in scope of services may occur with sizable retroactive payments. It is not uncommon for states to take a lengthy period of time in settling these claims, resulting in sizable accounts receivable balances. These additional funds were transferred to Accounts Receivable to capture the full receivable and could create receivables that exceed the industry norm.

   Other Assets & Other Liabilities were analyzed to exclude, to the extent possible, all non-capital portions for these two categories. However, there is limited information in the supporting schedules to determine if all or any portion of the amount reported was related to capital.

Financial Indicator	Interpretation	Expectation
Profitability		
Total Revenues		Expectation is that there is a consistent upward trend, indicating CHC growth.
Total Margin	Measures the control of expenses relative to revenues	Expectation is that the margin is positive and constant or increasing over time. Note: this can be skewed by one-time non-operating items. Ideally it is best to analyze net unrestricted operating margin or surplus (from the audited financial statements)
Growth		
Total Assets		Expectation is that there is a consistent upward trend, indicating CHC growth.
Unrestricted Net Assets		Expectation is that there is a consistent upward trend, indicating CHC growth.
Liquidity		
Total Days Cash-on-Hand	Measures the number of days that a CHC could operate if no additional cash was obtained.	An increasing trend indicates that the CHC's cash position is strengthening. HRSA expects days cash-on-hand to be >30 days.
Total Days in Accounts Receivable	Measures the number of day, on average, that it takes a CHC to collect its receivables from third party payers, government grants/ contracts and other sources.	An increasing trend indicates that receivables are being paid more slowly and aging, and that deteriorating cash flow could hamper the CHC's ability to operate. The benchmark is <60 Days.

SOURCES

Links are clickable

The sources below were used in each of the State Profiles. Additionally, state-specific sources were used to better understand the environment in which CHCs operate. See individual state profile endnotes for sources used.

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www.healthinsruance.org (various states) Accessed Mar. 2014.

FQHC Health Center Data Center (various states) *Health Resources and Services Administration* [Accessed: Apr. 2014] http://bphc.hrsa.gov/healthcenterdatastatistics/index.html

State Decisions For Creating Health Insurance Marketplaces, 2014. *Henry J. Kaiser Family Foundation*. Jan. 2014. http://kff.org/health-reform/slide/state-decisions-for-creating-health-insurance-exchanges/

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