Health Center Financial Check-Up:

Prescriptions for Strengthening New York's Diagnostic and Treatment Centers

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Prepared by
Primary Care Development Corporation

NYS HEALTH FOUNDATION
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Ensuring access to high-quality, affordable primary care services is a central component of the New York State Health Foundation (NYSHealth)'s commitment to improve the health of all New Yorkers. The State's health centers (formally Comprehensive Diagnostic and Treatment Centers, or DTCs) serve as the backbone of the primary care delivery system, particularly for vulnerable patients who are uninsured and have low incomes. These centers are affordable and provide high-quality care, but the sector as a whole is in financial distress. Particularly as the Federal health reform law is implemented, it is imperative that health centers have solid financial footing and resources to meet the growing demand for primary care services.

This study and report, commissioned by NYSHealth and conducted by the Primary Care Development Corporation (PCDC), draws on robust quantitative data from the State Department of Health and qualitative insights from community health center leaders, providers, and advocates to paint a stark picture of the sector today. The report sheds light on the current financial picture for New York State's DTCs, looks at the nuances of how Federally Qualified Health Centers (FQHCs) compare to other health centers, and outlines key recommendations for multiple actors who can shore up the sector.

Since Massachusetts passed legislation that resulted in near-universal coverage, the state's health care system has continued to struggle to provide universal access to timely primary care. With Federal health reform, we will see similar challenges in New York.

Provisions in the Federal health care reform law will present opportunities that can help New York develop a more robust and sustainable primary care system, but we in New York State must ensure that our primary care safety net providers are strong and well-positioned to meet growing health care needs. The opportunity to develop our primary care system exists; now is the time to take it. We believe that the following report and recommendations offer an important first step.

James R. Knickman
President and CEO
New York State Health Foundation

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THE NEW YORK STATE HEALTH FOUNDATION (NYSHEALTH)

NYSHealth, a private foundation dedicated to improving the health of all New Yorkers, provided generous support and guidance to develop this study and report. NYSHealth's mission is to expand health insurance coverage, increase access to high-quality health care services, and improve public and community health by educating New Yorkers about health issues and empowering communities to address them.

THE PRIMARY CARE DEVELOPMENT CORPORATION (PCDC)

PCDC conducted and developed the study and report. Ronda Kotelchuck, Tom Manning, Nancy Lager, and Dan Lowenstein contributed to the writing of this study. PCDC is a nonprofit organization that transforms health care in underserved communities through high-impact financing, innovative services, and policy leadership that helps providers expand access to high-quality, patient-centered primary care. To undertake this analysis, PCDC partnered with Health Management Associates (HMA) an independent national research and consulting firm specializing in complex health care program and policy issues.

FINANCIAL STUDY ADVISORY COMMITTEE

We wish to thank the members of the advisory committee for their advice and contributions in the development of this study: Dr. Neil Calman, CEO, Institute for Family Health, NYC & Hudson Valley; Sean Cavanaugh, Director of Health Care Finance, United Hospital Fund; Georganne Chapin, CEO, Hudson Health Plan; Dan Dey, CEO, Northern Oswego Health Center; Peter Epp, Principal, RSM McGladrey; Astrid Gonzalez, CFO, Lutheran Family Health Network, Brooklyn; Rei Gonzalez, CEO, Settlement Health, Manhattan; Paloma Hernandez, CEO, Urban Health Plan, Bronx; Tom Murphy, PCDC Board Member Principal, Trailhead Advisors and former head of DASNY; Cindy Prorok, HRSA Consultant and Interim CFO, Hometown Health Center; Schenectady; Dr. Mark Raifman, Pediatrician, CEO, Nassau DTC & Triboro Management; Maurice Reid, former CEO, Brownsville Multi-Service Family Health Center, Brooklyn; Julie Boden Schmidt, Associate VP, National Association of Community Health Centers; Jim Sinkoff, former CEO, Whitney Young Health Center, Albany; and Elizabeth Swain, CEO, Community Health Care Association of New York State.

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Introduction and Background

During the last several years, the New York State Health Foundation (NYSHealth) has received a growing numbers of requests for financial assistance from financially distressed health centers seeking to maintain primary care access in their communities. Simultaneously, the Primary Care Development Corporation (PCDC), in its role as the largest nonprofit financer of health centers in New York, also began seeing signs of financial distress among a growing number of the health centers with which it works.

To better understand the viability of the health center sector and the factors that underlie it, NYSHealth engaged PCDC to conduct an in-depth assessment of the financial viability of New York State's nonprofit health centers. PCDC's work and mission to expand and enhance primary and preventive health care in underserved communities position it well to undertake the assessment. PCDC conducted this study with the assistance of Health Management Associates (HMA).

The assessment includes a first-of-its-kind quantitative analysis of financial and operating data from annual cost reports filed with the New York State Department of Health by nonprofit health centers (more precisely, comprehensive Diagnostic and Treatment Centers, or DTCs) between 2001 and 2007, as well as interviews with health center leaders. The study specifically examines:

- The breadth and depth of financial distress among DTCs;
- Its causes and contributors, including external factors like size, health center type, payment policies, and internal factors such as governance and financial management; and
- Recommendations for the multiple actors positioned to address the challenges facing DTCs: the State of New York, which is responsible for the reimbursement and regulation of community health providers; philanthropic organizations concerned about the viability of health centers and access to high-quality care; public and private payers that finance or reimburse for care and services delivered at community health centers; and health centers themselves.

Community health centers are a vital source of high-quality primary care for underserved communities in New York State. Residents of these communities tend to be low-income families who are either uninsured or enrolled in Medicaid and other public insurance programs. In 2007, there were 95 such comprehensive nonprofit health centers, according to the State Department of Health, operating more than 400 sites and providing more than 5 million visits to approximately 1.5 million patients. This set of Comprehensive DTCs is the universe of this study.

These health centers are located throughout the State—upstate and downstate, across urban, suburban, and rural communities. Most are located in areas that the Federal government has designated as medically underserved, where patients have access to few primary care resources.

This study includes two types of Comprehensive DTCs: Federally Qualified Health Centers (FQHCs) and non-FQHCs. Approximately two-thirds of the DTCs in the study are FQHCs (the figure varies slightly in each of the study years based on data reporting and DTC start-ups and closures). FQHCs are required by Federal law to provide or arrange for a wide array of primary, preventive, and enabling services, including dental, behavioral health, substance abuse, and specialty care services. They must be governed by independent, user-dominated boards.

Finally, they must serve patients regardless of ability to pay. Non-FQHCs are not subject to these Federal requirements and the services they provide and the patient populations they serve may be more limited.

In addition to their status as either FQHCs or non-FQHCs, the DTCs in the study are divided between those that are "freestanding"—independently governed organizations—and those that are directly or indirectly controlled by a parent organization, often a hospital. FQHCs are typically, but not exclusively, freestanding organizations, while many non-FQHCs are hospital-controlled. Only one FQHC of the approximately 40 in the study sample is hospital-controlled. In contrast, approximately 40% of the non-FQHCs are controlled by a parent hospital; some of the remaining non-FQHCs are part of a larger social service organization. It should be noted that there are other FQHCs in the State, including at least three that are either hospital-controlled or closely associated with a hospital network, that are not included in the State's "Comprehensive DTC" category and are thus excluded from this study.

In addition to the centers studied, limited DTCs, hospital-based outpatient centers, and private practitioners are also important sources of care for the same communities that rely on Comprehensive DTCs for care and services. Although not the focus of this study, they are subject to many of the same financial and policy factors as the Comprehensive DTCs.

Hereafter, the terms "DTCs" and "health centers" are used as shorthand for the set of Comprehensive DTCs studied.

IMPACT OF FINANCIAL DISTRESS ON DTCS

Financial distress in the primary care sector occurs at a time filled with enormous opportunities and threats. It is a moment when policymakers at all levels are recognizing the critical role primary care plays in reducing health care costs, improving the quality of care, and preventing and managing the rising tide of chronic illness that now accounts for some 75% of health care spending.

For example, Federal stimulus funds through the American Recovery and Reinvestment Act awarded nearly $80 million to community health centers throughout New York State. Moreover, the State has reformed how it pays for primary care, established standards and incentive payments to boost quality, and provided millions of dollars to expand the primary care infrastructure and implement health information technology through the Healthcare Efficiency and Affordability Law for New Yorkers (HEAL NY).

Beginning this year, the new Federal health reform law will make available an additional $11 billion in funding for community health centers nationwide and $1.5 billion for the National Health Service Corps over five years. As health reform is implemented and more people are seeking needed health care, DTCs' role as a source of high-quality primary care will become even more important, both for those who remain uninsured and for those who are newly covered.

Although DTCs are receiving an infusion of resources, these funds are largely for expansion and additional services and do not address their underlying financial condition. It is imperative that the sector be solidly situated to take advantage of these opportunities at a time when the State is asking more of the primary care sector and needs are growing.

Finally, the distress occurs during a period of economic recession. Health centers face many of the same economic pressures as other small businesses, such as higher health care costs for employees and a lack of access to credit. They may face additional pressure as a growing number of uninsured patients turn to them as the only source of care. Unlike a standard company where business might fall off during a recession, for a health center, demand can remain constant or even rise, with more customers uninsured and unable to pay.

A WORD ABOUT METHODOLOGY

The study relies on four sources:

1. quantitative analysis of financial and operating data from annual cost reports (Ambulatory Health Care Facility forms, or AHCF-1s) filed with the New York State Department of Health (NYSDOH) between 2001 and 2007 by nonprofit comprehensive DTCs;
2. qualitative analysis of feedback received from the study's Advisory Committee, which comprised DTC executive and financial leadership, consultants, and other sector experts;
3. case studies and interviews conducted by HMA and PCDC staff; and
4. additional research on the sector (e.g., policy initiatives elsewhere in the country) conducted by PCDC.

The methodology and data sources are described in detail in Appendix 3.

HEALTH CENTERS AND HEALTH CARE REFORM: CHALLENGES AND OPPORTUNITIES

Federal health care reform presents new challenges and opportunities for health centers, particularly Federally Qualified Health Centers (FQHCs). The new law expects that more than half of the newly insured—approximately 20 million new patients nationwide—will use FQHCs as their primary health care provider. Although many of these new patients will be covered through the expansion of Medicaid, FQHCs can also expect an influx of new patients with private insurance, because the law requires that all health plans offered through state insurance exchanges pay FQHCs no less than their Medicaid prospective payment system (PPS) rate.

The law also provides $11 billion over five years to help FQHCs double their capacity to serve new patients. Most of the funds are expected to be used for expanded medical capacity and service expansions (including dental health, behavioral health, and pharmacy services), new access points (including new FQHCs and new sites for existing ones), and enabling services such as health education and case management. The funding is available to existing FQHCs and to new entities that want to convert to FQHC status.

However, funding will be highly competitive across all 50 states, and health centers that exhibit the most viable plans will be in the strongest position to receive funding. Financial strength and organizational capacity varies widely among DTCs, and ensuring that New York can compete for and use this funding effectively should be a top priority.

Summary of Findings

1. **The DTC sector, as a whole, is under financial stress.** Based on DTCs' annual financial reports to the New York State Department of Health, our analysis found that:

   - 43% of the 95 health centers lost money in all or most of the seven years in the study period.
   - Health center margins have fallen dramatically, from 2.28% in 2001 to 0.56% in 2007.
   - With only 16.5 days of cash on hand—down from a high of 22 days in 2002—health centers were, on average, one payroll away from full-scale financial crisis.

2. **There are clear predictors of which types of health centers are likely to be the strongest financially.**

   - FQHC
   - Large size
   - Strong leadership
   - Strong financial and operational management systems
   - Effective governance bodies

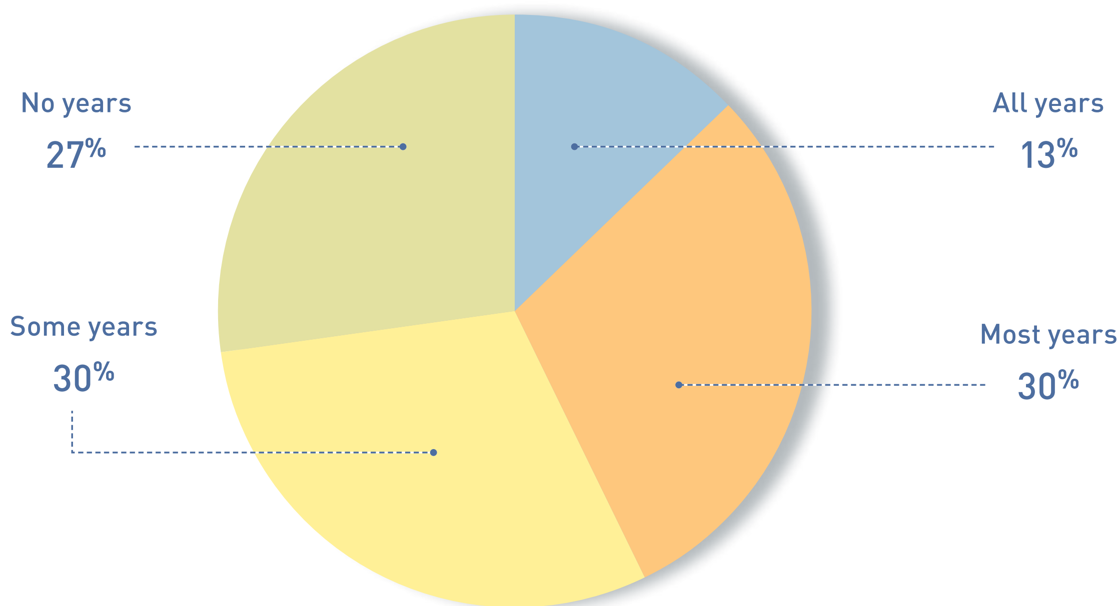
3. **External factors contribute to the overall distress of the sector.** The financial strength of the sector as a whole reflects a variety of external factors, including inadequate and delayed payments and a difficult regulatory environment.

Evidence of Distress

Three key indicators provide evidence of distress among health centers.

Years of Financial Loss. Nearly three-quarters of health centers lost money in at least some years of the study, and 43% of health centers lost money in most or all years of the study. The ability of those with continuing losses to survive is typically determined by the willingness of a benefactor, such as a parent hospital, to subsidize the loss.

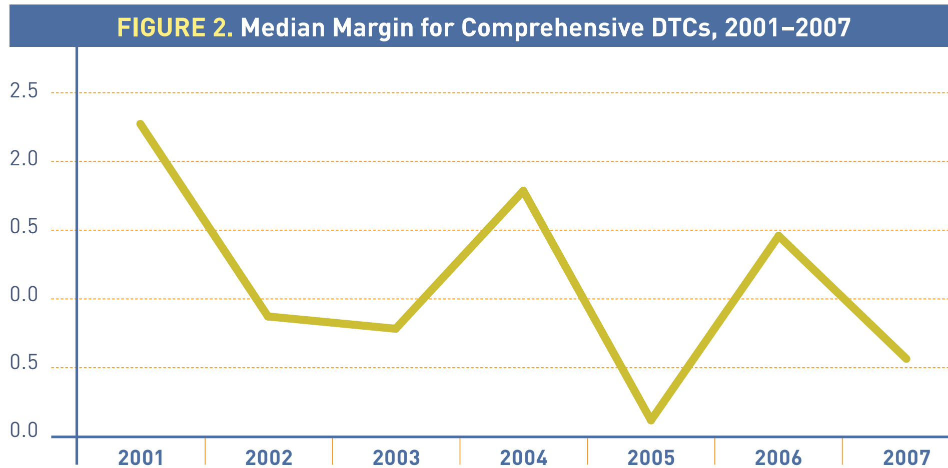
FIGURE 1. **Comprehensive DTCs that Lost Money in Multiple Years, 2001–2007**



Note: The source for all figures and tables in this study is HMA's analysis of data from AHCF-1 Cost Reports, 2001-2007, conducted in 2009, based on the most recent data available. The data were provided by the NYSDOH.

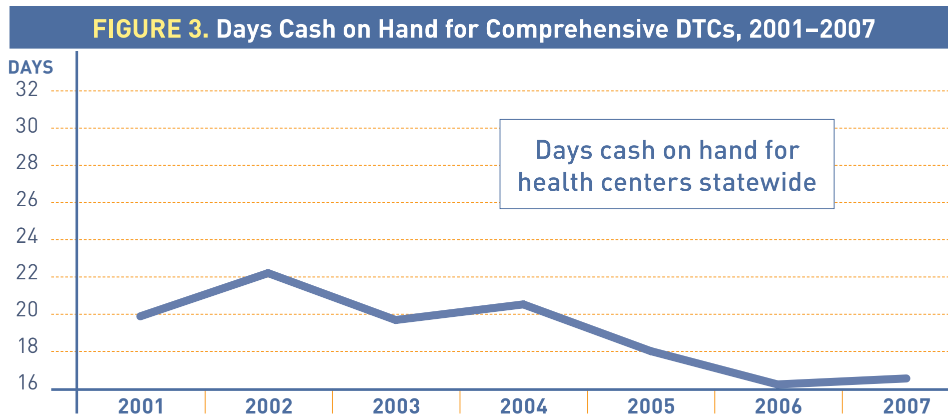
Small Median Financial Margins. Over the seven years in the study period, median health center margins dropped 75%, from 2.28% in 2001 to 0.56%, meaning that revenues were barely sufficient to cover expenses.

FIGURE 2. Median Margin for Comprehensive DTCs, 2001–2007



Declining Levels of Cash on Hand. Days Cash on Hand measures the cash a business has to meet payroll and to make other necessary payments, should revenues be interrupted or delayed. Median Days Cash on Hand fell to just more than 16 days for New York State's DTCs in 2007, an amount that would cover just more than one payroll period. Typically, 30 days cash is considered the minimum for a financially healthy organization; stronger organizations seek to maintain cash levels at 60 to 90 days. The ability to hold cash at these higher levels is well outside the experience of most New York State DTCs, and the levels at which New York's DTCs operate means that they are always close to a potential financial crisis.

FIGURE 3. Days Cash on Hand for Comprehensive DTCs, 2001–2007



Causes and Contributors to Health Center Financial Distress

WHY ARE SOME HEALTH CENTERS HEALTHIER THAN OTHERS?

A number of health centers in New York State are financially strong, despite the overall poor financial health of the sector. In addition, in the face of an overall downward trend in the financial performance of New York health centers over the past seven years, a number of centers have improved their performance, even to the point of turning their financial bottom lines from negative to positive.

In interviews with seven executives from health centers that (a) have been consistently financially strong or (b) have turned their financial performance from negative to positive during the study period, in contrast to the overall trend, certain common strategies emerged. The Interview Guide is provided in Appendix 3.

Each DTC executive acknowledged the difficulties of the environment, but each made it clear that they were able to overcome the standard obstacles by specifically and closely managing processes and factors that were creating losses or could generate more revenues.

The common factors that emerged from the interviews and the financial performance analysis are discussed below. A host of factors are associated with better performance:

- Being an FQHC rather than a Non-FQHC
- Being bigger is better (if you're an FQHC)
- Being run by executives with detailed understanding of operations and financial management and clear lines of management responsibility
- Improving provider productivity and patient recruitment
- Improving billing and collections
- Modernizing facilities
- Maintaining fiscal vigilance
- Raising unrestricted funding
- Developing and maintaining strong board governance

BEING AN FQHC RATHER THAN A NON-FQHC

FQHC status confers a series of significant financial advantages, including:

- a "wraparound" payment from the State ensuring that FQHCs receive cost-based reimbursement from Medicaid (thus restoring discounts taken by Medicaid managed care plans);
- Medicaid rates that rise each year in accordance with the Federal Medicare cost index;
- malpractice coverage provided by the Federal government at no cost to the health center; and
- access to Federal grants to offset the cost of medical care to uninsured patients.

The benefits and requirements of FQHC designation are summarized in Appendix 4.

The decision to become an FQHC is key to financial strength, as the data confirm. In fact, FQHCs were financially healthier than their non-FQHC counterparts on essentially every indicator in every year studied (see tables and figures below). Each executive questioned in interviews for this study stated that the advantages of FQHC status more than offset the additional expense of meeting FQHC requirements (e.g., providing enabling services and access for any patient regardless of ability to pay).

FQHCs had greater margins, more cash on hand, and stronger current ratios than non-FQHCs, and were less likely than non-FQHCs to incur losses. On the other hand, it is important to note that their strength is relative. On average, 22% of the FQHCs lost money in a given year during the study period, demonstrating a great deal of instability even among FQHCs. Nevertheless, that instability is far better than the 66% of non-FQHCs that lost money in any given year over that period, and particularly better than the 86% of hospital-controlled non-FQHCs that, on average, lost money in a given year over the seven-year period.

Moreover, the overall trends for FQHCs, as for the sector as a whole, generally went in the wrong direction over the study period:

- median net margins fell by more than 50%;
- the number of FQHCs with negative margins increased;
- cash levels fell; and
- receivable levels grew.

Slightly offsetting this picture, current ratios improved somewhat. These key measures are defined and benchmarks are provided in Appendix 3.

The single study measure for which non-FQHCs tended to outperform FQHCs was days in accounts receivable (AR), with non-FQHCs generally having fewer days in AR. The better performance of non-FQHCs may reflect more aggressive collection processes they have adopted for survival.

Organizations that choose not to pursue FQHC status most commonly cite the requirement that a majority of the board be made up of patients, and the loss of control they believe would result, as the reason for remaining as non-FQHCs. On the other hand, leaders who pursued FQHC designation for its financial advantages also cited the advantages of a well-chosen board (such as additional expertise and deeper ties to the health center's market and clientele) and saw no significant drawbacks to FQHC status.

All of the financially strong health centers in the study are FQHCs. For centers with improved financial results during the study period, executives interviewed often identified attaining FQHC status as the central strategic element in achieving the financial turnaround.

Note: So-called FQHC "Look-Alikes" are considered FQHCs under law. As summarized in Appendix 4, Look-Alikes receive some, but not all, FQHC benefits. Perhaps most important from a financial standpoint, Look-Alikes receive the wraparound payment. They do not receive 330 grant funding (Federal grants under Section 330 of the Public Health Services Act, which are intended to offset the costs of caring for the uninsured) or Federal malpractice coverage. This report does not differentiate Look-Alikes from those with full FQHC status.

The weakest subcomponent of the sector is non-FQHCs that are freestanding or independent of hospitals. This category has neither the financial support of a big parent nor the revenue enhancements of FQHC status. It is essentially impossible to survive as a freestanding non-FQHC, and freestanding non-FQHCs tend to solve their financial problems by converting to FQHC status.

Statistically, hospital-controlled DTCs as a group are by far the weakest financially, with double-digit negative margins in all but one year. Their level of performance would be far beyond sustainability without the support of the parent hospital. Despite their losses, none of the hospital-controlled DTC organizations closed during the study period, although a number of the parent hospitals have come under increasing financial pressure and are actively looking for ways to reduce their DTC subsidies. Strategies under consideration include closing sites, converting to FQHC status, and negotiating a takeover by an existing FQHC. For a hospital, establishing an FQHC is difficult because of the governance and other extensive changes required in the relationship between the hospital and the DTC, and the uncertainty of Federal approval.

The tables and figures below provide specific comparisons on a series of measures between FQHCs and non-FQHCs, including a breakdown between those non-FQHCs that are hospital-controlled and those that are not.

(Note: the 2007 data exclude those centers that filed their cost reports late. Not coincidentally, late filers tend to have weaker financial performance; therefore, the 2007 results likely overstate positive financial results.)

Median Net Margin of FQHCs vs. Non-FQHCs, 2001-2007

The median net margin for non-FQHCs plunged between 2001 and 2007, most notably for those that are hospital-controlled, and was negative in each of the last six years. The median net margin for FQHCs fell by more than two-thirds, but remained positive throughout the study period.

TABLE 1. Median Net Margin, FQHCs vs. Non-FQHCs

	MEDIAN NET MARGIN						
	2001	2002	2003	2004	2005	2006	2007*
Non-FQHC - Hospital-Affiliated	4.61%	-14.04%	-16.52%	-16.90%	-22.77%	-32.32%	-24.32%
Non-FQHC - Non-Hospital-Affiliated	0.26%	-2.22%	-4.99%	0.50%	-1.54%	3.67%	-0.28%
Non-FQHC - Total	2.42%	-7.89%	-5.74%	-4.00%	-5.84%	-0.68%	-5.85%
FQHC	3.95%	3.65%	2.13%	2.89%	1.12%	1.82%	1.29%
Total Comprehensive DTCs	**2.28%**	**0.87%**	**0.78%**	**1.75%**	**0.11%**	**1.46%**	**0.56%**

* 2007 data exclude centers that filed their cost reports late, which may lead to positive financial results being overstated.

Negative Margins: FQHCs vs. Non-FQHCs, 2001-2007

An average of 37% of DTCs lost money in any one year of the study period. For FQHCs, that figure was 22% (starting at 14% in 2001 and doubling to 28% in 2006). Virtually all hospital-controlled DTCs lost money in virtually every year. For the non-FQHCs that are not hospital controlled, about half had negative margins in a given year.

TABLE 2. Negative Margins, FQHCs vs. Non-FQHCs

CENTERS WITH NEGATIVE NET MARGINS	2001	2002	2003	2004	2005	2006	2007*	OVERALL
Non-FQHC - Hospital-Affiliated: Total	9	9	9	9	10	10	7	
Number of centers with negative margins	8	8	7	8	10	8	5	86%
% of total in study	89%	89%	78%	89%	100%	80%	71%	
Non-FQHC - Non-Hospital-Affiliated	11	11	13	14	14	13	14	
Number of centers with negative margins	4	7	11	6	8	4	7	52%
% of total in study	36%	64%	85%	43%	57%	31%	50%	
Non-FQHC - Total	20	20	22	23	24	23	21	
Number of centers with negative margins	12	15	18	14	18	12	12	66%
% of total in study	60%	75%	82%	61%	75%	52%	57%	
FQHC	37	38	41	41	42	43	38	
Number of centers with negative margins	5	6	9	10	11	12	8	22%
% of total in study	14%	16%	22%	24%	26%	28%	21%	
Total Comprehensive DTCs	**57**	**58**	**63**	**64**	**66**	**66**	**59**	
Number of centers with negative margins	17	21	27	24	29	24	20	37%
% of total in study	30%	36%	43%	38%	44%	36%	34%	

Note: Centers that switched from Non-FQHC to FQHC are counted as Non-FQHCs during the relevant years and as FQHCs thereafter.

* 2007 data exclude centers that filed their cost reports late, which may lead to positive financial results being overstated.

Years of Negative Margins: FQHCs vs. Non-FQHCs, 2001–2007

Two-thirds of FQHCs lost money in at least one year during the study period, whereas that was true of more than 90% of non-FQHCs.

TABLE 3. Years of Negative Margins, FQHCs vs. Non-FQHCs

	CENTERS WITH NEGATIVE NET MARGINS				
	DID NOT LOSE MONEY IN ANY YEAR	LOST MONEY IN SOME YEARS 1-3	LOST MONEY IN MOST YEARS 4+	LOST MONEY IN ALL YEARS	TOTAL
Non-FQHC—Hospital-Affiliated	0	0	5	6	11
Non-FQHC—Non-Hospital-Affiliated	2	4	7	3	16
Non-FQHC—Number by Net Margin Category	2	4	12	9	27
Non-FQHC—Percent of Total Non-FQHCs in Each Net Margin Category	7%	15%	44%	33%	100%
FQHC—Number by Net Margin Category	16	17	12	1	46
FQHC—Percent of Total FQHCs in Each Net Margin Category	35%	37%	26%	2%	100%
Total Comprehensive DTCs					
Number by Net Margin Category	18	21	24	10	73
Percent of Total Comprehensive DTCs in Each Net Margin Category	25%	29%	33%	14%	100%

Note: Accounts for each center only once; those centers that switched from Non-FQHC to FQHC are counted in the FQHC category ONLY.

Current Ratio: FQHC vs. Non-FQHCs, 2001-2007

Current ratio measures assets convertible to cash within a one-year period ("current assets") compared to bills that must be paid within that same time period ("current liabilities"). Current ratios for both FQHCs and non-FQHCs improved somewhat over the study period, as shown in Figure 4 and Table 4. The reason is unclear, given the generally negative trends in other financial factors. A current ratio of 1.0 means that the two are equal and connotes just getting by. A current ratio of 1.0 is considered the bare minimum acceptable level, with levels of 1.25 or higher preferred. The sector as a whole stood at 1.74 in 2007, up from 1.34 in 2001.

FIGURE 4. Median Current Ratio: FQHCs vs. Non-FQHCs, 2001–2007

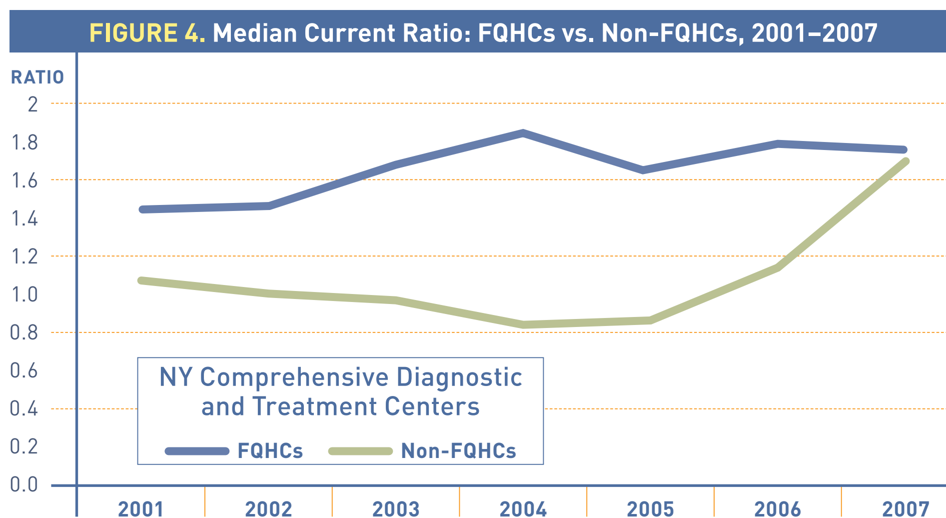


TABLE 4. Median Current Ratio, FQHCs vs. Non-FQHCs

MEDIAN CURRENT RATIO							
	2001	2002	2003	2004	2005	2006	2007
Non-FQHC - Hospital-Affiliated	0.81	2.24	1.34	0.73	0.68	0.47	0.92
Non-FQHC - Non-Hospital-Affiliated	1.09	0.93	0.87	1.09	1.03	1.16	2.35
Non-FQHC - Total	1.07	1.01	0.98	0.85	0.86	1.11	1.72
FQHC	1.43	1.45	1.68	1.85	1.67	1.79	1.77
Total Comprehensive DTCs	**1.34**	**1.43**	**1.58**	**1.43**	**1.45**	**1.64**	**1.74**

Median Number of Days Cash on Hand: FQHC vs. Non-FQHCs, 2001-2007

Median days cash on hand for FQHCs and non-FQHCs alike fell between 2001 and 2007, and for both groups remained below the generally accepted 30-day measure of financial health, as shown in Figure 5 and Table 5. Non-FQHCs showed greater volatility on this measure than did FQHCs and, at best, had half the median cash level of the FQHCs.

FIGURE 5. Median Number of Days Cash on Hand: FQHCs vs. Non-FQHCs, 2001–2007

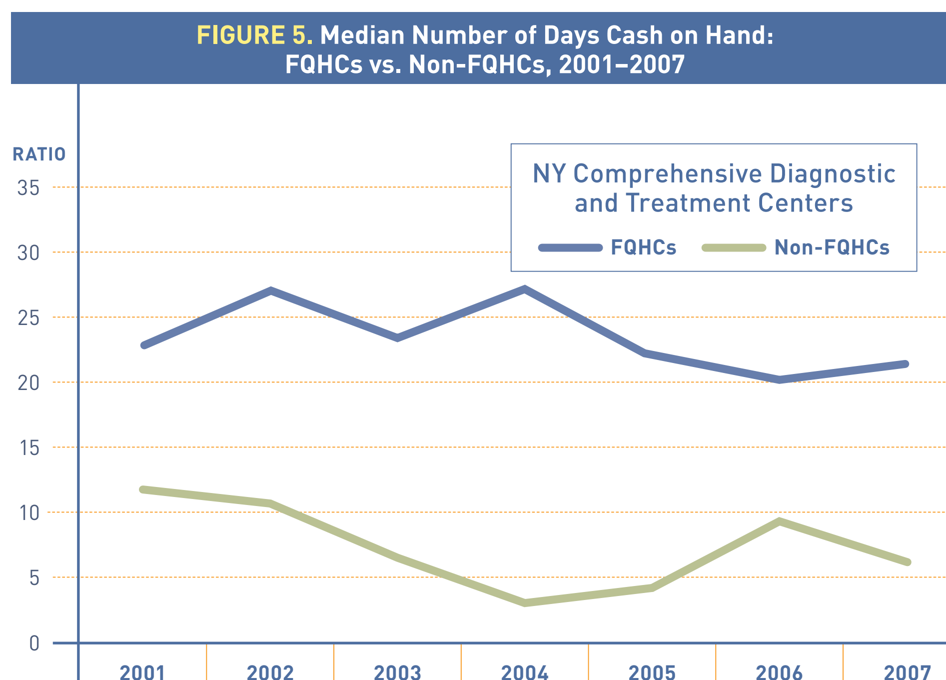


TABLE 5. Median Days Cash on Hand, FQHCs vs. Non-FQHCs

MEDIAN DAYS CASH ON HAND							
	2001	2002	2003	2004	2005	2006	2007
Non-FQHC - Hospital-Affiliated	13.93	10.82	12.12	1.89	9.17	16.14	7.23
Non-FQHC - Non-Hospital-Affiliated	9.26	9.65	2.07	4.44	2.63	4.88	5.55
Non-FQHC - Total	11.92	10.82	6.62	3.03	4.21	9.20	6.37
FQHC	22.79	27.10	23.46	27.31	22.11	20.28	21.48
Total Comprehensive DTCs	**19.86**	**22.39**	**19.76**	**20.69**	**18.23**	**16.18**	**16.49**

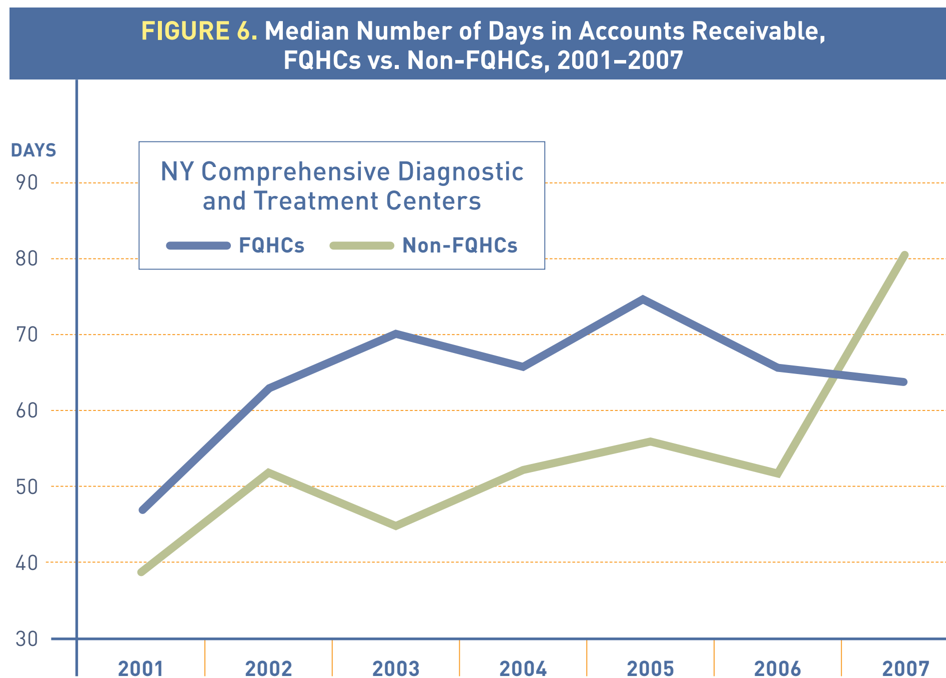
Median Number of Days in Accounts Receivable: FQHCs vs. Non-FQHCs, 2001-2007
Days in receivables, which measures the ability of a business to collect on payments due to it, have generally risen over the study period. There are two likely explanations:

First, State payments for Medicaid rate adjustments and add-ons, as well as grant revenues, are often delayed, sometimes by as much as two or three years. For example, centers serving a high percentage of uninsured patients earn indigent care revenues all year long, but receive payment two to three years later in one or two lump sums (see below). Similarly, organizations can earn revenue from rate adjustments months in advance of final approval and payment by the State. (In a recent positive development, the New York State Department of Health in 2010 began monthly payments for indigent care.)

Second, as the Medicaid program has increasingly switched to managed care, health centers experience greater difficulty in collecting from multiple companies using differing forms and procedures, compared with billing and collecting from a single source (see also below).

Better-performing centers have fewer days in AR and higher levels of cash on hand. In all years except 2007, the median number of days in AR was lower for non-FQHCs than for FQHCs, which may reflect more aggressive collections necessary to ensure non-FQHCs' survival, as noted earlier. Combined with their low level of days cash on hand, these indicators show how close to the bone non-FQHCs operated, with little margin for error. Among FQHCs, which showed higher median days cash, high days in AR may reflect an opportunity to improve collections and/or the need for the State to reduce delays in payments owed to health centers.

FIGURE 6. Median Number of Days in Accounts Receivable, FQHCs vs. Non-FQHCs, 2001–2007



BEING BIGGER IS BETTER (IF YOU'RE AN FQHC)

Size and financial success are correlated for FQHCs, but apparently not for non-FQHCs, as shown in Table 6. Correlation among non-FQHCs may be masked by support from an outside organization (e.g., an affiliated hospital or social service agency) which is more common among non-FQHCs. Large FQHCs (those with more than 100,000 visits) consistently performed better than their medium-sized counterparts (those with 15,000 to 100,000 visits) in cash on hand, margins, and current ratio. The analysis does not explain whether a center is financially successful because it is large or whether it is able to grow large because it is financially successful.

The number of health centers qualifying as "small" (fewer than 15,000 visits) was not large enough to draw a conclusion, and so have been excluded from this discussion. Table 6 shows the median performance on key financial indicators for large and medium-size FQHCs over the five-year period between 2003 and 2007 (2001 and 2002 are excluded because of insufficient data).

Large centers are able to achieve economies of scale and show overhead costs (e.g., facilities and administration) 4 to 6 percentage points below their smaller counterparts, as shown in Table 7. These lower levels of overhead typically outstrip total margins, creating a substantial advantage for larger DTCs. Lower overhead allows large centers to direct more resources to patient care, make critical IT and other system investments, and hire highly-qualified, essential personnel (e.g., qualified CFOs). One can also assume that larger organizations have become larger over time because of the skill and capabilities of their executive management. Size is no guarantee of better operations, but the added revenues create the opportunity to devote more resources to core functions.

TABLE 6. Key indicators by DTC size, 2003–2007

FQHC MEDIAN	2003	2004	2005	2006	2007
Margin—Medium FQHCs	2.13	2.73	0.96	1.82	0.56
Margin—Large FQHCs	4.76	8.01	4.55	1.10	1.69
Current Ratio—Medium FQHCs	1.61	1.54	1.54	1.65	1.70
Current Ratio—Large FQHCs	2.62	2.64	2.23	2.12	2.31
Days Cash on Hand—Medium FQHCs	26.44	28.52	18.23	14.85	23.03
Days Cash on Hand—Large FQHCs	24.99	46.79	30.26	42.23	27.47
Non-FQHC Median	2003	2004	2005	2006	2007
Margin—Medium non-FQHCs	1.63	.085	0.98	1.16	2.07
Margin—Large non-FQHCs	-0.18	-0.04	-0.09	0.04	0.02
Current Ratio—Medium non-FQHCs	1.63	0.85	0.98	1.16	2.07
Current Ratio—Large non-FQHCs	0.77	0.78	0.96	1.38	4.75
Days Cash on Hand—Medium non-FQHCs	18.87	1.89	6.28	4.88	4.73
Days Cash on Hand—Large non-FQHCs	1.74	3.01	16.04	25.47	46.67

TABLE 7. Share of total costs devoted to facilities/administration, 2006 and 2007

FACILITIES/ADMINISTRATION %	2006	2007
Statewide Median	32.4%	32.8%
Small DTCs	38.7%	34.5%
Medium DTCs	32.7%	33.5%
Large DTCs	31.5%	30.6%

BEING RUN BY EXECUTIVES WHO UNDERSTAND MANAGEMENT AND HAVE CLEAR RESPONSIBILITIES

During the interviews conducted as part of this study, health center executives described the following overall factors as critical to their financial success:

- having, or coming to have, a detailed executive-level understanding of health center operations;
- use of thorough and accurate data and reports, facilitated through the use of IT systems, alerting executives to problems and anomalies;
- establishing clear responsibilities for individual employees, including setting targets and priorities;
- establishing clear reporting structures for each employee and department and clear accountability for outcomes; and
- having, or coming to have, a clear understanding of costs and revenue sources.

The web of reimbursement regimes, with their differing rate methodologies, billing procedures, incentive payments, payment delays and other requirements, creates an unusually complex financial management environment. Systematic underfunding makes it difficult for health centers, especially smaller ones, to attract and retain the level of financial talent they need. Study advisors agreed that many health centers lack the expertise necessary to deal with this environment.

Strategies short of higher reimbursement or administrative simplification can help. Centers often encounter difficulty in understanding the nature of the expertise they need and in successfully identifying and recruiting qualified candidates, which could be addressed through the availability of technical assistance.

IMPROVING PROVIDER PRODUCTIVITY AND PATIENT RECRUITMENT

Provider productivity may be the single most powerful factor determining the relative financial health of different health centers. Low productivity can be explained by a variety of factors, including high patient no-show rates, inadequate demand, poorly managed workflow and patient scheduling, and inadequate provider support (reflected in excessive provider time spent in administrative or other non-billable activities).

Interviewees discussed using practice management systems to better quantify exactly how much provider time was spent with patients and to better understand productivity variations between providers.

Strategies to improve provider productivity included:

- ensuring strong bonds and working relationships between executives and providers;
- building multidisciplinary care teams that are flexible and provide functions that support the provider;
- redesigning workflows to eliminate inefficient and unnecessary steps;
- sharing provider performance data, along with the organization's financial data, with providers;
- ensuring each provider has access to at least two exam rooms per session; and
- instituting incentive plans.

Over a longer time frame, centers have altered facilities to create additional exam rooms per provider, so providers can more efficiently move from exam room to exam room, with patients ready and waiting. When necessary, executives also laid off providers, either because of inadequate performance or to adjust provider capacity to fit facility volume.

To address insufficient patient demand, successful managers have aggressively marketed health center services, often with an emphasis on patients covered by Medicaid. The most effective have established strategic relationships with community organizations in a position to direct many patients to the center. They have also developed partnerships with managed care plans to make sure that eligible patients are enrolled in Medicaid.

No-show rates as high as 80% were reported in certain centers, with an average of 50% not being unusual. Centers use a variety of strategies to reduce no-show rates, which pose a workflow challenge, with varying results. Advance reminder calls have proved most effective when they result in an actual conversation rather than just leaving a message. Some center use vans to pick up certain patients, or ensure a modicum of "open scheduling," leaving open time on providers' schedules to accommodate same-day and walk-in appointments. Regardless of these efforts, however, most health centers appear to have difficulty holding the no-show rate below 25%.

IMPROVING BILLING AND COLLECTIONS

Interviewees from sites that turned around their financial performance commonly found that they had lacked an efficient billing system, with some services never billed and many billed inaccurately, requiring re-submission (effectively duplicating the work needed to get paid). They described the necessity of understanding each step of the billing process and identifying steps that were insufficiently defined or where responsibility was unclear. Improved IT systems, used properly, have enabled them to bill far more efficiently and accurately, as well as to identify and correct the most common billing mistakes. These systems carefully tracked average collections per encounter by payer, and overall collection rates, which typically increased from the high-80% range to the high-90% range.

MODERNIZING FACILITIES

Virtually every interviewee associated with a strong or improving organization has modernized or otherwise altered his or her facility to improve care, increase productivity, improve operations, attract and retain patients, and/or attract and retain personnel. They have optimized space, creating more exam rooms (i.e., more revenue-generating space). Some optimize attractive space available for patient care by placing administrative functions in less desirable spaces and locations.

MAINTAINING FISCAL VIGILANCE

All those interviewed watch costs closely. They participate in some form of pooled purchasing, saving on medical and non-medical supplies, although these average 10% to 15% of total expenditures and the opportunities for savings have a limited impact on the overall budget. Most, at this point, participate in a 340B discount pharmacy plan through which they can purchase drugs at steeply discounted prices and earn money by selling them to patients at a positive margin (while also providing a discount to patients). They limit perks, like Blackberries, and are judicious about conference fees and other discretionary spending.

PURSUING UNRESTRICTED FUNDING

The fundraising strategies of successful health centers vary widely. Some, by virtue of location near and visibility to a wealthier community, have successfully adopted aggressive private fundraising efforts. Others concentrate solely on government grants or private foundation

opportunities. Small centers are clearly at a disadvantage, having fewer resources to devote to fundraising. But strong executives, regardless of center size, use their expertise to mobilize support to bring additional funding to their organizations. However, fundraising is an adjunct to their central strategy of close, careful, and engaged management of revenues, expenses, personnel, and all aspects of operations.

DEVELOPING AND MAINTAINING STRONG BOARD GOVERNANCE

FQHC boards are mandated to include a majority of consumer members. This is advantageous for effective program planning, outreach, and marketing purposes, but the requirement can limit the ability of FQHCs to recruit candidates who can provide strong technical expertise, business and strategic acumen, and/or financial and fundraising support. The most successful FQHCs retain a healthy balance of consumer and outside perspectives and heed the best advice among members of a diverse and dynamic board.

WHAT FACTORS AFFECT THE DTC SECTOR AS A WHOLE?

While some health centers perform better than others, the majority of distress is attributable to a challenging payment environment where centers:

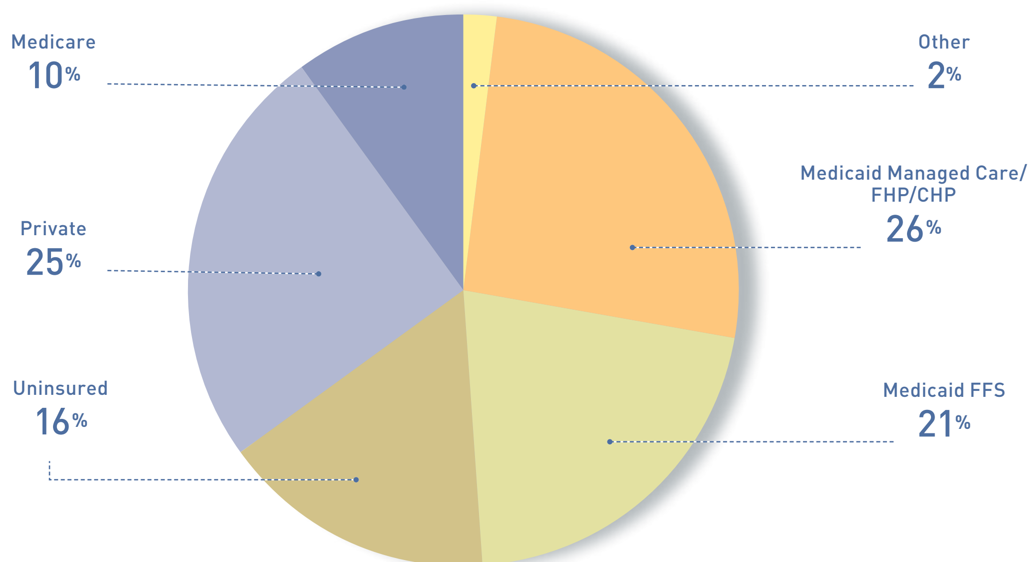
- are underpaid for ambulatory care services;
- experience significant delays in expected payments; and
- assume a large administrative burden of differing requirements from the multiple managed care plans that cover patients enrolled in public programs.

UNDERPAYMENT AND DELAYS

New York's health centers serve populations that are largely poor or uninsured. On average, 63% of their patients are uninsured or enrolled in Medicaid, Child Health Plus (CHP) or Family Health Plus (FHP), according to AHCF data collected for this study, making them heavily dependent on the policymakers who determine payment policy. As discussed below, the underpayments are attributable to three sources: Medicaid, commercial insurers, and indigent care payments from New York State.

While routine Medicaid patient reimbursement has been relatively prompt, payment of Medicaid rate add-ons and grants (and, until recently, indigent care compensation and rate adjustments) are subject to long and unpredictable delays, sometimes as long as two years. At the very least, these delays hinder financial planning and efficient management of resources. Fragile providers, with narrow financial margins and barely enough cash on hand to cover the next payroll, are less able to absorb delays without threatening full-scale financial crisis. [Note: In 2010, NYSDOH expects to implement monthly payments of add-ons; however, the State's budget crisis may delay implementation.]

FIGURE 7. DTC Payer Mix Statewide



UNDERPAYMENT AND DELAYS IN MEDICAID FEE-FOR-SERVICE REIMBURSEMENT

FQHCs versus Non-FQHCs: Medicaid is the single most important revenue stream to New York's health centers. Among these, FQHCs have a special reimbursement status under Medicaid which accounts for their stronger financial position. The federal Benefits Improvement and Protection Act (BIPA) of 2000 (Public Law No. 105-554) effectively requires state Medicaid programs to reimburse FQHCs at cost. New York State does this by providing "wrap-around" payments to make up the difference between cost and the lower rates paid to FQHCs by managed care plans. The base rate in New York reflects health center costs reported during 1999 and 2000, which are then inflated annually by the Medicare Economic Index (MEI).

While providing a more robust and predictable Medicaid revenue stream, the MEI clearly does not keep pace with the actual rise in health care costs. Thus, the MEI rose 2.4% per year over the past 17 years,[1] while health care spending averaged 7.5% annually between 2002 and 2004.[2]

Capital costs are reimbursed as an add-on to the Medicaid base rate. Even with this special reimbursement arrangement, Medicaid rates fall significantly below FQHC costs, as shown in the table and charts on following page.

[1] Between 1992 and 2009, the MEI has ranged from a low of 1.6%in 2009 to a high of 3.2% in 1992, for an average of 2.4% per year. Source: http://www.cms.hhs.gov/SustainableGRatesConFact/Downloads/sgr2009f.pdf kent.clemens@cms.hhs.gov, November 2008

[2] S. Heffler et al., "U.S. Health Spending Projections for 2004–2014," *Health Affairs* 24 (2005): w74–w86 (published online 23 February 2005; 10.1377/hlthaff.w5.74).

FIGURE 8. Medicaid Fee-for Service Base Rate vs. Cost Per Visit, FQHCs, 2001–2007

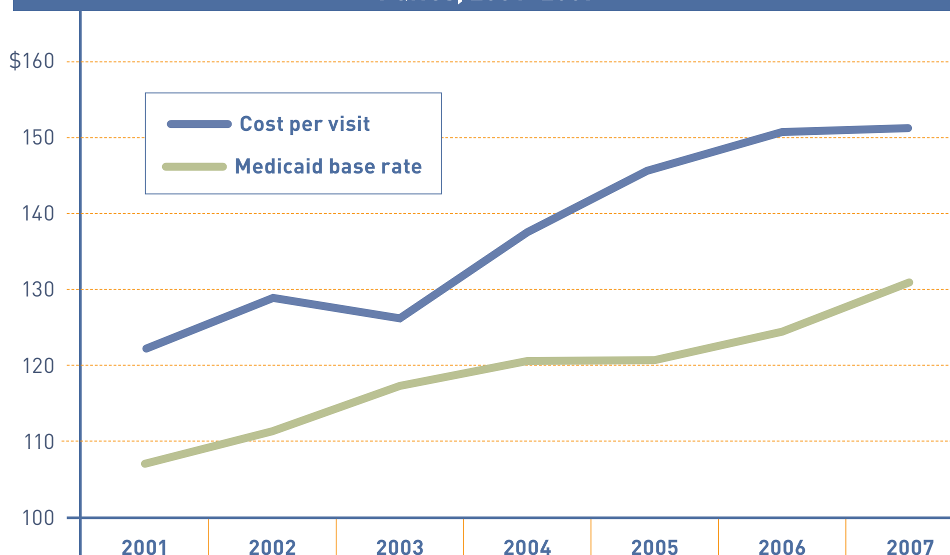


TABLE 8. Median Medicaid Fee-for-Service Base Rate Per Visit, FQHCs vs. Non-FQHCs

	MEDIAN MEDICAID BASE RATE						
	2001	2002	2003	2004	2005	2006	2007
Non-FQHC - Hospital-Affiliated	143.27	143.27	153.02	162.74	153.01	162.74	162.74
Non-FQHC - Non-Hospital-Affiliated	91.55	91.55	92.21	102.77	102.77	112.44	121.24
Non-FQHC - Total	102.77	102.77	102.77	125.18	112.49	129.12	131.33
FQHC	106.93	111.12	117.11	120.46	120.64	124.16	130.70
Total Comprehensive DTCs	**105.83**	**110.34**	**112.38**	**122.43**	**120.04**	**126.64**	**131.33**

TABLE 9. Median Medicaid Cost Per Visit, FQHCs vs. Non-FQHCs

	MEDIAN COST PER VISIT						
	2001	2002	2003	2004	2005	2006	2007
Non-FQHC - Hospital-Affiliated	158.36	143.67	130.90	131.74	158.32	152.21	162.43
Non-FQHC - Non-Hospital-Affiliated	133.19	166.18	147.97	135.04	136.46	150.96	140.18
Non-FQHC - Total	154.56	143.67	134.60	131.74	146.45	150.96	158.30
FQHC	121.97	128.73	126.30	137.08	145.70	150.55	151.39
Total Comprehensive DTCs	**123.72**	**132.89**	**131.24**	**137.03**	**145.70**	**150.75**	**154.15**

Non-FQHCs: Non-FQHCs are not protected by Federal reimbursement requirements and face Medicaid underpayment from two sources:

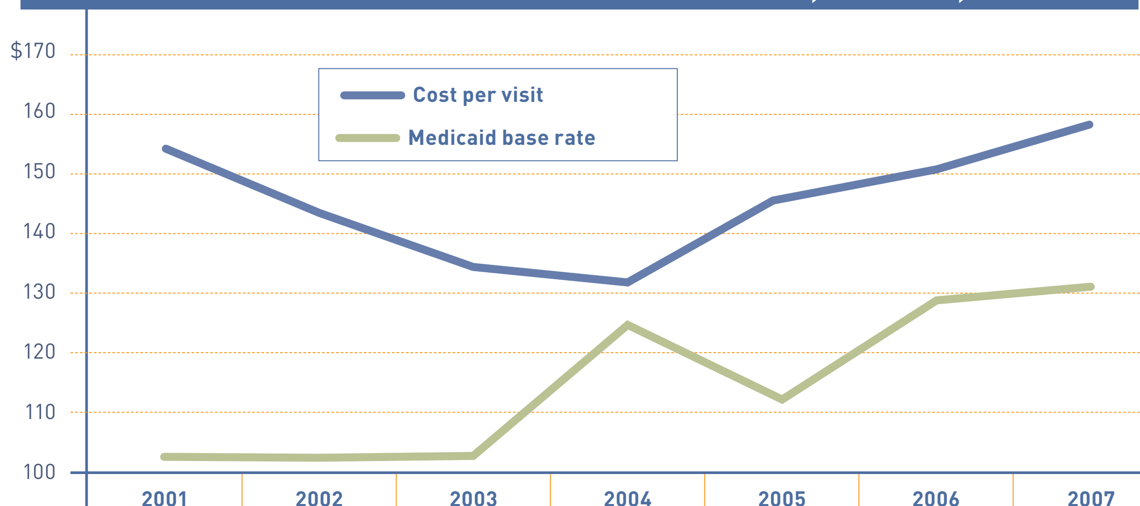
1. Fee-for-service rates, which until recently were determined in a manner similar to those for FQHCs, were frozen by the State from 1995 until September 2009, when the State revised the Medicaid reimbursement methodology (see below). Assuming a 3% annual increase, costs rose more than 50% during the period when rates were frozen.

   (The relative disadvantage of non-FQHCs is masked in Figures 8 and 9 because the rate freeze caused many older non-FQHCs to convert to FQHCs or go out of business during the study period, while new non-FQHCs have been created with fairly high Medicaid rates. Thus, even though the rate was frozen for each individual organization, the median for the group as a whole rose over time.)

2. Non-FQHCs receive discounted payment by Medicaid managed care plans without having the protection of the FQHC wrap-around. Although managed care payments vary by plan, a previous study shows payments to average 85% of the Medicaid base rate.[3] (In conversations conducted as part of this study, CFOs put the number below that level.) A health center with an average payer mix (see Figure 7 above) and an average mix of Medicaid fee-for-service and managed care patients (21% and 26%, respectively) will receive Medicaid revenues 8% lower than the base rate shown in Table 8 above and Figure 9 below.

Although the Medicaid base rates have been supplemented with certain add-on payments (discussed below), such severe and persistent underpayment calls into question the fiscal viability of any non-FQHC. The fact that some centers survive despite such large and persistent losses is explained by the number of hospital-backed DTCs in which the hospital subsidizes losses.

FIGURE 9. Medicaid Fee-for-Service Base Rate vs. Cost Per Visit, non-FQHCs, 2001–2007



[3] New York's Primary Care Reimbursement System, A Roadmap to Better Outcome, prepared by the Primary Care Development Corporation and RSM McGladrey, Inc., September 2006.

Medicaid Payment Reform: Beginning in 2008, New York State adopted a new method of paying for Medicaid fee-for-service ambulatory care visits, which is being phased in over a four-year period, and a new set of rate enhancements. Under the new system, ambulatory care visits are being reimbursed using Ambulatory Payment Groups (or APGs), which are weighted for the intensity of services rendered during the visit. The State implemented APGs for hospital DTCs as of December 2008, and just received Federal approval to implement them for freestanding DTCs and other non-FQHCs. Under the current plan, the approval will be retroactive to September 2009.

Although APGs clearly benefit non-FQHC DTCs, the advantage to FQHCs is unclear at this time. One study shows that of 60 FQHCs, 39 would receive slightly higher rates (on average 1.4% higher), while 21 would experience losses. For FQHCs, the APG system is optional, while for non-FQHCs it is mandatory.

For both FQHCs and non-FQHCs, APG payment is limited to fee-for-service Medicaid patients, a minority and shrinking portion of all health center patients (21% Medicaid fee-for-service compared to 26% managed care). To date, only two FQHCs in New York State have opted in to APGs, and one of these is operated by a hospital that wanted consistency with its other ambulatory care reimbursement.

In addition to the APG rate, the State adopted rate enhancements for certain measures that improve primary care quality or access, such as asthma and diabetes nurse educators, social work counseling, and centers that provide evening and weekend hours. Significantly, Medicaid recently created a $70 million incentive pool for doctors and clinics that meet national medical home standards.

UNDERPAYMENT AND DELAYS IN MEDICAID MANAGED CARE PAYMENT

While the State pays Medicaid wrap-around payments on an ongoing basis as health centers file evidence of paid Managed Care Organization (MCO) claims, FQHCs and others contacted for this study reported significant delays, in large part because of lags in the claims payment process, including adjudication of denials and appeals, by the Medicaid MCOs.

Additionally, health centers reported losing Medicaid payments for the care of presumptively eligible Medicaid or SCHIP enrollees who were not enrolled into a health plan until after the 90-day billing window elapsed. The high churn rate of publicly-insured patients presents a challenge to health centers that may lack the capacity to check whether each patient is to be billed under Medicaid fee-for-service or to the managed care plan. Exacerbating this problem are managed care plan rosters that are not fully electronic and searchable rosters that are not necessarily up to date.

Finally, health center directors also expressed frustration at delays when new providers are credentialed by health plans. Each physician must be credentialed separately with each plan, involving slightly different requirements and procedures, despite the fact that the information required is essentially identical (see below). It is not unusual for a provider to see patients for three to six months before being able to submit claims. Given the challenges of provider recruitment and retention, some centers could experience this problem several times each year.

Although some level of denials is necessary and appropriate, including for non-covered services, some denials appear to be a function of inefficient and complicated credentialing procedures and enrollment processes that may need to be re-evaluated.

Special Medicaid Add-On Payments: New York's DTCs have, in recent years, been eligible for two "add-on" payments that supplement their base Medicaid rates: a managed care transition payment (recently replaced by an electronic health record transition payment) and a workforce recruitment and retention payment. While helpful, these payments have not necessarily closed the gap between costs and rates. Moreover, they are an unreliable source of income for several reasons:

- funding is subject to annual legislative appropriation and may be subject to federal approval;
- receipt of payments is unpredictable and frequently delayed as a consequence; and
- total amounts vary from year to year (see Table 10 below).

Health centers typically budget conservatively for the managed care and recruitment add-on payments, because of their unpredictability, or exclude them from budget projections altogether. With regular Medicaid payments often falling short of costs of service, these extra payments are necessary to make up that shortfall in covering the regular daily expenses of many centers. The lack of predictability of the timing and amount of these payments, however, contributes to rather than alleviates health centers' chronic cash squeeze.

TABLE 10. Managed Care Transition Payments (Calendar Years 2002–2007)

MANAGED CARE TRANSITION PAYMENTS (IN MILLIONS)					
CY 2002	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007
$19.6	$9.8	$0	$9.8	$29.5	$9.8

Source: New York State Department of Health transition payment data.

Beginning with the 2008-9 budget year, the managed care transition payment has been eliminated and replaced with a new payment designed to compensate health centers for the costs of implementing electronic health records (EHR) systems that "meet such standards as may be established by the commissioner of health."[4]

The State set aside approximately $9.8 million annually for these payments in 2008; that amount was reduced to $7.4 million for 2009. Like the managed care transition payments that preceded them, future EHR payment amounts are not mandated in law and will be subject to legislative negotiations. While generally supportive, some health centers and other stakeholders interviewed for this study expressed concern that the payments would further exacerbate the gap between high- and low-performing health centers that lack the capacity to select and implement an EHR

[4] New York Social Services Law, Section 364-j-2 as revised. According to a NYS Department of Health letter to health center administrators (October 7, 2008), to qualify, health centers must meet minimum payer mix criteria and have in place an electronic health record (EHR) that is capable of and used for exchanging health information with other computer systems according to national standards; is certified by the Certification Commission for Health Information Technology; is capable of and used for supporting electronic prescribing; and is capable and used for providing relevant clinical information to assist clinicians in decision making.

system. Health centers and other stakeholders also noted that the time lags and unpredictability that plagued the managed care transition payments continue under the EHR payments.

The current status of both funding streams illustrates their level of unreliability:

- Three years after re-purposing the managed care transition payments to support the implementation of electronic medical records systems, health centers have not yet been told how much they will receive or when they will receive it, because NYSDOH is still awaiting the required annual Federal approval of the State Plan Amendment.
- Recruitment and retention payments are also subject to annual Federal approval of the State Plan Amendment and, in the absence of such approval, NYSDOH has informed centers that these payments have been suspended as of January 1, 2010.

UNDERPAYMENT AND DELAYS IN INDIGENT CARE PAYMENTS

Like many states, New York has created an Indigent Care Pool that offsets a portion of the losses incurred by health centers in caring for the uninsured. The pool is a fixed figure in the State budget, and payments are allocated according to a formula that pays for a greater share of losses to health centers treating a larger proportion of uninsured patients. In recent years, the pool has covered approximately 30% of health center indigent care losses; in contrast, hospital compensation from a similar indigent care pool averages 65% of hospital uninsured losses. Although the DTC pool is small relative to costs incurred, it is nevertheless a significant resource to health centers, often representing 5% to 10% of total income.

The indigent care pool has been funded in the range of $50 million in recent State budgets, and the State is working to secure a Federal waiver that would double the size of the pool. The prospects for approval are uncertain, as is the projected pay-out, because a new pool will include a new set of providers (outpatient mental health clinics) for the first time. Although this proposed expansion is a positive development in many ways, it will be eroded by continued expansion of the DTC sector resulting from the State's HEAL grant programs and Federal stimulus monies, as well as the conversion of hospital satellites and outpatient departments to DTC status. The only certainty it is that the pool is unlikely to address indigent care losses fully.

Indigent care payments are subject to two- to three-year delays between the time a service is delivered (when costs are incurred) and the time of payment. For instance, for services delivered in 2007, health centers submit cost reports, based on annual audits; the Health Department tallies the data in late 2008 and early 2009; and the pool is funded in the 2009-2010 State budget. Payments then typically come toward the end of the State fiscal year.

Until this year, annual DTC indigent care payments were made in one or two lump sums, in contrast to hospital indigent care, which (although also subject a two- to three-year delay) is paid on a monthly basis. It is far easier to manage cash with regular payments than with lump sums that come unpredictably once or twice a year. Recognizing this problem, the New York State Department of Health began monthly payments for indigent care in 2010.

Comparing monies available for indigent care to the total number of uninsured is a useful way of looking at the adequacy of indigent care payments. Data from selected states indicate that,

although New York is clearly ahead of some other states—indeed, many states provide little or no funding to compensate providers for the uninsured—it is not as generous as others.

TABLE 11. Indigent Care Pool Funds Per Uninsured:Selected State Examples

STATE	FY 09*	ESTIMATED UNINSURED IN STATE (2007)**	PRIMARY CARE UNCOMPENSATED CARE POOL FUNDS PER UNINSURED	ELIGIBLE ENTITIES***
California	$ 27,000,000	6,701,890	$ 4.03	FQHCs and other providers
Colorado	$ 33,951,786	813,188	$ 41.75	FQHCs and other providers
New Jersey	$ 40,000,000	1,344,323	$ 29.75	FQHCs
New York	$ 54,500,000	2,590,364	$ 21.04	FQHCs and other providers
Ohio	$ 2,150,000	1,229,769	$ 1.75	FQHCs
Texas	$ 0	5,832,884	$ —	None

*National Association of Community Health Centers. "Losing Ground: State Funding to Health Centers Declines Amid Economic Downturn (State Policy Report #21). August 2008."

**www.statehealthfacts.org Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2007 and 2008 Current Population Survey.

***National Association of Community Health Centers. "Securing State Funding for Health Centers (State Health Policy Report #13). November 2006."

UNDERPAYMENT AND DELAYS IN FEDERAL FQHC GRANTS

In addition to Indigent Care Pool payments, FQHCs (not Look-Alikes) receive Federal grants under Section 330 of the Public Health Services Act, which are intended to offset the costs of caring for the uninsured. Under Federal law, FQHCs are required to see all patients regardless of ability to pay.

Grants range from the low $100,000s to more than $1 million and, once established, continue annually as long as the FQHC continues to meet Federal standards. Although a reliable source of annual revenue, initial grant amounts reflect the level of funding available in that particular year and not necessarily the number of uninsured patients treated. While the Federal government periodically adjusts base grant amounts, these grants are not indexed to cost growth, nor are they directly related to changes in the uninsured burden borne by the health centers. As a result, Federal FQHC grants frequently bear little relationship to the actual volume or cost of uninsured patients served. FQHCs in New York and nationally consistently report that their Section 330 grants cover a decreasing proportion of their uninsured costs.

According to 2007 State and national Uniform Data System (UDS) data, the average Section 330 grant per medical user in New York FQHCs was $93, compared to the national average of $121 and the national median of $135. In addition, UDS data for New York FQHCs indicate that the Federal grant awards per uninsured health center user have been eroding in recent years as growth in the volume of the uninsured population has outpaced growth in grant dollars.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), many health centers received additional allocations to compensate for the increase in the uninsured attributable to the economic downturn. However, these are one-time only funds that must be spent over a two-year period, and they will not solve the system's underlying problems.

UNDERPAYMENT AND DELAYS BY COMMERCIAL INSURERS

Approximately 25% of patient visits across all health centers are commercially insured, making commercial insurance a significant source of revenue for DTCs. Actual levels differ by health center and by community. In particular, rural health centers tend to be the only or the major source of care in their communities and thus see higher percentages of privately insured patients. Among upstate non-FQHCs, commercial insurance pays for 40% of center visits, more than the visits provided to Medicaid beneficiaries and the uninsured combined.

A recent study of the adequacy of commercial insurance payments found that, for FQHCs, commercial insurance rates were on average $38 lower than Medicaid fee-for-service rates, $17 lower than Medicare rates, and $41 lower than the actual cost of providing care. The report did not analyze commercial insurance payments for other comprehensive DTCs, but discussions with health centers and other stakeholders indicate that reimbursement rates for these providers are also well below cost.

ADMINISTRATIVE BURDEN OF CONTRACTING WITH MULTIPLE MANAGED CARE PLANS

Prior to the managed care era, providers dealt with a single State Medicaid agency with a single set of requirements, a single payment method, and a single automated billing and collection process. With the move to managed care, the State effectively outsourced much of its Medicaid role to some 19 managed care plans, each of which has a small portion of the market, different requirements, and different payment methods, and each of which is in a different state of automation.

A single health center will typically contract with six to eight of these plans to ensure their ability to serve a significant portion of patients residing in their community. A single plan's members constitute a relatively small segment of a center's patient population. Similarly, a center's patients constitute a small segment of a single plan's membership. The price for this system is heavy: health centers shoulder a large and expensive administrative burden and have little clout to influence plan behavior.

To receive reimbursement from a managed care plan, each physician working for a health center must be credentialed by that plan. As described above, the credentialing process varies by plan and involves collecting data and validating a large number of documents, such as license, education and training, malpractice coverage, and claims history. A physician's services cannot be billed until credentials are approved, which typically takes three to six months, creating payment delays that can last for months after the physician has been hired.

This credentialing process is one example of onerous and wasteful administrative burdens with which DTCs must contend. Each physician must be credentialed separately with each of the six to eight plans doing business with that health center. Each plan has slightly different requirements and procedures, despite the fact that the information required is essentially identical.

Lack of standardization also neutralizes incentives that plans offer providers for improving outcomes. The State evaluates and rewards plans for the quality of care rendered. Plans, in turn, frequently offer incentives to providers that improve on the quality indicators that affect the plan's rating by the State. Those indicators differ by plan, so providers must face the varying incentives of six or eight plans, each having a small segment of a center's patient population.

The complexity and administrative burden of coping with multiple plans also includes preauthorization procedures, formulary requirements and differing referral networks, in addition to credentialing, billing and collections, and quality incentives. The net effect is an expensive and wasteful process that begs for standardization, either at the initiative of the managed care plans or imposed by the State as part of its contract requirements.

BUREAUCRATIC BARRIERS TO MERGERS AND ACQUISITIONS

Health center mergers, acquisitions, and consolidations offer potential strategies for strengthening or saving health centers at financial risk and with them, the essential access to care they offer vulnerable community members.

Health center leaders interviewed for this study perceive mergers and acquisitions to involve very long and complex processes with particularly confusing and burdensome State regulatory requirements. For example, in one complex health center acquisition, myriad regulatory processes resulted in delays of up to two years in certain State payments, causing financial uncertainty and severe cash flow problems for the parent organization. Another center CEO cited bureaucratic difficulties that discouraged him from pursuing a merger. Guidance, clear information, and coordination by regulatory authorities are clearly needed to streamline the steps and sequence of approvals. Also needed are resources for obtaining expert assistance in navigating the process. Interviewees reported difficulty in communicating to State officials the urgency of the fact that, without action, closure of a failing center was imminent.

Understandably, each situation is unique, presenting difficulty in establishing standard protocols for mergers and acquisitions. For example, a merger may be between two FQHCs, or between an FQHC and a non-FQHC, which involves a scope change with HRSA. There may be one site or multiple sites involved, each of which may require inspection. The centers may be in close proximity or in different parts of the State, presenting challenges to the federally required board configuration and often triggering a new, blended Medicaid reimbursement rate from the State.

Table 12 illustrates the complex nature of a merger, including steps necessary to complete the transaction. In some cases, State processes must be coordinated with Federal and legal processes. For example, the merging centers may need to request Federal government approvals for expansion of the FQHC 330 scope and new Medicare provider numbers; pursue legal and financial transactions such as an asset sale agreement; and receive State Attorney General and NY Supreme Court approval of asset sale by a nonprofit center, transfers of building ownership and leases, and transactions around securing grants, loans, and other sources of financing.

TABLE 12. NYSDOH Regulatory Processes Related to Health Center Mergers, Acquisitions & Consolidations

STATE REGULATORY REQUIREMENTS	UNDER WHAT CIRCUMSTANCES NEEDED	REVIEW AGENCY
Emergency Approval to Maintain an Operating Health Center	A provider may file an Emergency Certificate of Need (CON) application to maintain a health center as an operating entity while efforts are underway to comply with the complete set of regulatory requirements associated with a merger/acquisition. The approval of the Emergency CON application sets the retroactive date for licensing, rate changes and billing that will be accorded when a positive conclusion to the regulatory process has been reached.	Reviewed and approved by: Bureau of Project Management, Division of Health Facility Planning, Office of Health Systems Management, New York State Department of Health
Certificate of Need Approval for Change in Ownership or Merger	Per CON regulations, a provider must file a Full Review CON application for actions that entail "changes in ownership, mergers, consolidations, or creation of an active parent" regardless of the associated cost. This applies to the wholesale consolidation of two entities, as in the case of the Institute for Family Health assuming the full assets and liabilities of the Mid-Hudson Institute, and the Mid-Hudson Institute ceasing as both an independently governed organization and a licensed Article 28 provider. The Full Review CON application is also used to request approval to undertake any capital changes (renovations or new construction or equipment replacement) that the applicant provider proposes to undertake in connection with the merger/acquisition.	Reviewed by: Bureau of Project Management, Division of Health Facility Planning, NYS Department of Health Office of Health Systems Management, New York State Department of Health; Approved by: (1) State Hospital Planning and Review Council; and (2) Public Health Council
Certificate of Need Approval for Assumption of an Existing Health Center by Another Provider	Per CON regulations, a provider must file an Administrative Review CON application for actions that involve the "operation of extension clinics, addition of primary care sites, and addition or deletion of part-time clinic services" and that entail capital costs of less than $10 million (this figure will rise to $15 million under proposed new regulations). As in the case of Hudson River Healthcare and Valentine Lane, this applies when one provider "closes" an extension clinic and/or a provider "opens" an extension clinic by assuming the operations of a prior extension clinic at that site.	Reviewed and approved by: Bureau of Project Management, Division of Health Facility Planning, Office of Health Systems Management, New York State Department of Health
Medicaid Reimbursement Rate Setting Approval	A merger/acquisition may involve a provider appeal to NYSDOH for a change in the organization's Medicaid fee-for-service (FFS) rate, based on a significant change in the provider's scope and/or to reflect any new capital costs incurred during the transaction. If a new Medicaid FFS rate is granted, it is typically retroactive to the regulatory approval date—the Emergency CON approval, where applicable, or the Full Review CON approval.	Office of Medicaid Management, New York State Department of Health
New Medicaid Locator Codes/ Provider Numbers	Billing can occur only after NYSDOH issues site-specific billing codes to a new operator of a site—regardless of whether there was a prior operator at that site. This is supposed to be triggered internally by NYSDOH staff. Providers have experienced delays in the issuance of these billing codes which have in turn caused cash flow issues.	Office of Medicaid Management, NYS Department of Health
Licensing & Inspections of Acquired Facilities	Typically, NYSDOH inspects a new site prior to issuing an operating certificate. The requirements are less certain, and may be discretionary, in the case of provider changes at existing sites.	Bureau of Health Facilities Surveillance, NYS Department of Health

Sources: Communications with NYSDOH, Neil Calman (IFH), Peter Epp (RSM McGladrey) and Kate Breslin (CHCANYS).

A full acquisition or merger will typically require a full Certificate of Need (CON), involving a transfer of assets or governance, which typically takes about six to eight months (or longer if the State requires additional information). A shorter administrative review CON, with a two- to three-month process, may be possible when one organization assumes a site from another. An "emergency" CON can be approved in a much shorter period of time to allow the parent health center to operate the acquired sites, so that eventually any new, higher rates for the acquired entity would be retroactive to the emergency CON approval date. The acquiring health center would need the financial capacity to "carry" the acquired site pending the receipt of full CON approval and site-specific Medicaid "locator" codes, before the acquiring center actually receives any payments or rate increases associated with services provided at the acquired sites.

According to State officials, the CON process has improved in recent years and there are ongoing efforts to streamline the system further. The NYS Department of Health Bureau of Project Management, which oversees the CON process, is planning to create a web-based CON application, which should facilitate submissions of completed requests. The department is also placing more information and instructions about the CON process on its website. Officials also note that when a health center inquires about a merger or acquisition, the Bureau of Project Management will facilitate a face-to-face meeting with center leaders and individuals from various State offices to help determine the required processes. However, individuals interviewed for this study felt that, although these meetings are helpful, arranging them was difficult and required a long lead time.

These attempts to improve and streamline the process are welcome steps. Moreover, as Federal health reform is implemented and more people seek needed health care, additional funds will be available to help health centers meet that growing demand. In a reformed health care environment, DTCs' role as a source of high-quality, accessible primary care will become even more important, and it will be even more imperative that the underlying structure of the DTC system is sound. A range of actors—from State government to health care payers to philanthropic organizations to the centers themselves—have a critical role to play in strengthening New York State's health centers to allow them to take full advantage of new resources and continue to provide timely, high-quality care.

Recommendations

Strengthening New York's Comprehensive Diagnostic and Treatment Centers (DTCs) will require action by multiple sectors: State government, health care payers, philanthropic organizations, and the health centers themselves. We outline recommendations for each of these groups below, with a focus on four areas for change:

PROMOTE STRENGTHENING AND RESTRUCTURING OF THE PRIMARY CARE SECTOR.
Because FQHCs tend to be stronger than non-FQHCs, and large centers tend to be financially stronger and more sustainable than smaller ones, policymakers and foundations should support health centers to take full advantage of the FQHC expansion funding available under the Federal health reform law. Strategies include expanding existing sites and services, establishing new sites, and facilitating mergers and acquisitions of existing organizations. Significant hurdles include the need for resources to develop business plans, conduct due diligence, foot start-up costs, and navigate complex, bureaucratic regulatory barriers to obtaining State and Federal approvals and establishing reimbursement streams.

STRENGTHEN DTCS' BUSINESS AND FINANCIAL MANAGEMENT.
New York State's DTC leaders consistently report that strong business and financial management are essential for financially strong health centers. State policymakers, philanthropies, and health center advocates should provide targeted, coordinated support for management and governance interventions. Support for redesign of business operations offers the prospect of meeting many needs across a diverse range of health centers. Programs to provide consulting, redesign and technical assistance hold important potential, but development of the most effective interventions will also require careful assessment.

IMPROVE THE ADEQUACY, TIMING, AND PREDICTABILITY OF STATE PAYMENTS.
While routine Medicaid patient reimbursement has been relatively prompt, payment of Medicaid rate add-ons and grants (and, until recently, indigent care compensation and rate adjustments) are subject to long and unpredictable delays, sometimes as long as two years. These delays hinder financial planning and efficient management of resources. Fragile providers, with narrow financial margins and barely enough cash on hand to cover the next payroll, are less able to absorb delays without threatening full-scale financial crisis. It should be noted that in 2010, NYSDOH expects to implement monthly payments of add-ons, though the State budget crisis has hampered implementation.

ESTABLISH A SINGLE FOCUS ON PRIMARY CARE WITHIN THE NEW YORK STATE DEPARTMENT OF HEALTH.
New York State has made investment in primary care a key strategic priority to transform the State's health care system, but responsibility for primary care issues, policy, and planning are spread across different departments and staff. A State Office of Primary Care could provide a single point of contact and coordination within the Health Department for the full range of primary care issues and providers.

RECOMMENDATIONS FOR STATE GOVERNMENT

SUPPORT DEVELOPMENT OF LARGE HEALTH CENTERS AND HEALTH CENTER NETWORKS.

Make available technical assistance and due diligence resources to promote individual health center facility transitions or larger mergers and acquisitions.

Make available support for start-up costs of individual health center facility expansions and transitions or larger mergers and acquisitions. Interim financial support, such as for the period between receipt of an emergency Certificate of Need (CON) and receipt of final CON and Medicaid payment approvals would be particularly helpful. This work would support an important purpose of the Emergency Loan Fund recommended below .

Simplify acquisition and merger processes by providing clear information about regulatory requirements. Ensure single points of contact and coordination and streamlining of State approval processes, including for the Certificate of Need process, where changes are already underway.

Assess the impact and ensure the adequacy of new DTC rates under the Ambulatory Patient Group methodology which is just being implemented. Perhaps working in conjunction with philanthropic organizations, ensure that the payment methodology approximates actual cost growth and supports the additional services required by the medical home model of primary care.

Increase indigent care payment levels for DTCs. Although the timeliness of indigent care payments has improved in 2010, payment levels remain disproportionately low. In recent years, the pool has covered approximately 30%of health center indigent care losses. In contrast, the New York State compensates 65% of hospital uninsured losses. Achieve parity in coverage, taking into account new entrants (new DTCs, mental health organizations) in the coverage pool.

Enact prompt payment rules to ensure Medicaid rate add-ons and adjustments and other payments are made in a timely manner. New York is starting to pay on a regular monthly basis as it does for hospitals, rather than in one or two unpredictable annual lump sum payments. Even better would be a periodic interim payment mechanism similar to that used by Medicare to smooth cash flow for hospitals.

Standardize and streamline processes for managed care plans administering the State's public insurance programs. The State should require maximum feasible standardization of all possible credentialing, billing, collections, quality incentive and preauthorization processes. Lack of standardization has a double negative impact by both creating delays in health center payment and adding needless and wasteful administrative costs and burdens. Credentialing appears to be the most important of these processes to be standardized.

Establish an Emergency Loan Fund for health centers. Uncertain timing of guaranteed payments is an enormous burden that disrupts health center operations. The State should consider establishing an Emergency Working Capital Loan Fund to help health centers manage the cash flow uncertainties caused by payment delays and budget cuts. California offers a potential model (see Appendix 1).

Create a dedicated body within the Department of Health with a sole focus on primary care, to ensure coordination, efficiency and effectiveness throughout the sector. Consider as a first step convening a workgroup or advisory board of primary care stakeholders throughout the State. ***This role will be particularly important in coordinating the State's efforts to claim its share of the $11 billion in federal funds that will be available for community health centers via the health reform law.***

RECOMMENDATIONS FOR PHILANTHROPIC ORGANIZATIONS

Support efforts to leverage Federal health reform funding for FQHCs. Funding for FQHCs presents the most important opportunity to strengthen and restructure the DTC sector in New York State. Foundations should collaborate with and support the Community Health Care Association of New York State and NYSDOH to help bring Federal resources to New York State FQHCs and ensure that those resources are used effectively. This would include **making available the technical assistance** services that will be needed by new and expanding FQHCs to support organizational development, operations and health facility planning, and health center start-up; and **assisting organizations that are in the best position** to provide significant, sustainable primary care services growth to underserved communities to develop competitive applications for Federal FQHC funding.

Assess the impact of new DTC rates under the Ambulatory Patient Group methodology which is just being implemented. Foundations could support analysis and modeling to ensure that the payment methodology approximates actual cost growth and supports the additional services required by the medical home model of primary care.

Support and fund health centers in consolidating centers' "back office" and other functions to help streamline operations and reduce costs.

Support management and governance interventions that will strengthen health center performance, perhaps by adopting a similar approach to that used by the Federal Health Resources and Services Administration (HRSA). HRSA responds to requests for technical assistance by conducting assessments and, based on the findings, arranging for and funding appropriate TA. Support may run the gamut from targeted interventions to embedding temporary consultants to assist with more substantial improvements or organizational turnarounds.

Provide technical assistance to help DTCs jump-start their work to implement electronic health records, achieve medical home recognition, and improve quality. These initiatives have the potential for substantial incentive payments that could strengthen DTCs' bottom line. Both State and Federal resources are available to help DTCs progress in these areas, but private funders can help ensure that the State's DTCs are well-positioned to take on these activities and compete successfully for public dollars.

Convene key stakeholders in primary care, including State government, payers, and health centers, to share information, coordinate activities, and identify priorities and opportunities for the sector.

RECOMMENDATIONS FOR PAYERS

Standardize and streamline processes for credentialing, billing, collections, quality incentive, and preauthorization processes. Lack of standardization has a double negative impact by both creating delays in health center payment and adding needless and wasteful administrative costs and burdens. Credentialing appears to be the most important of these processes to be standardized for DTC providers.

Pay DTCs adequately for primary and preventive care. Most commercial payers reimburse DTCs at levels well below Medicaid. These payers must recognize that the care provided in DTCs is helping to save money by reducing avoidable complications and hospitalizations. Although health care reform will improve payments for some commercially-insured patients, it appears that wide gaps will remain for many or most commercially-insured patients cared for by DTCs.

Create incentive programs that support patient-centered medical homes and distinguished outcomes as evidenced by recognition programs.

Market DTC services to attract new patients and encourage growth in the sector.

RECOMMENDATIONS FOR HEALTH CENTERS AND ADVOCACY ORGANIZATIONS

Advocate for stable and rational Federal funding for FQHCs. FQHCs receive Federal grants under Section 330 of the Public Health Services Act, which are intended to offset the costs of caring for the uninsured. (Under Federal law, FQHCs are required to see all patients regardless of ability to pay.) Currently, the amount of 330 grants awarded an FQHC has more to do with funding available at the time of the award than the number of uninsured to be cared for. Base 330 grant amounts change only occasionally and incrementally; therefore, the level of 330 funding per uninsured patient varies significantly. Advocates should continue to make the case that 330 grants correspond to uninsured volumes, as well as cost growth.

Market DTC services to attract new patients and encourage growth in the sector.

Ensure coordination across DTCs to make the most of new Federal resources.

Invest in leaders' and managers' financial skills and training. One of the strongest indicators of a DTC's financial success is its management's skills and experience.

Appendix 1.

HEALTH CENTER FOUNDATION /GRANTMAKER INITIATIVES

The following is a scan of initiatives from national and state-based foundations whose purpose is to strengthen the ability of safety-net providers to care for their populations. This should not be considered a comprehensive analysis, but examples of programs that could serve as models for New York.

NATIONAL FOUNDATIONS

KRESGE FOUNDATION

Caring Communities supports safety-net institutions and those providing health services to underserved populations in high-need rural and urban settings through:

Health Clinic Opportunity Fund—a national grant program developed in response to the economic crisis to help charitably funded clinics, public health clinics, and those designated federally qualified health center look-alikes sustain or increase their capacity to meet growing demand for their services.

Safety-net Enhancement Initiative attempts to strengthen cross-sector collaboration among community-based health-care agencies that provide primary-care services to low-income and vulnerable individuals. This grant opportunity has two parts: (1) a program planning and design phase and (2) a demonstration phase. It is designed to foster new models and approaches for health-care delivery that reduce health disparities and improve the health outcomes of adults and children living in underserved communities.

Safety-net Facility Improvement Fund supports new construction and renovation of clinics and other health care organizations so they may expand their facilities in order to increase access and enhance the quality of their services for underserved populations. Most grants are awarded in the form of a challenge grant during an organization's capital campaign.

STATE-BASED FOUNDATIONS

CALIFORNIA

California HealthCare Foundation

Emergency Loan Fund: CHCF will make $10 million available to the Emergency Working Capital Loan Fund, a low-interest loan pool designed to ensure California's safety-net clinics provide uninterrupted care in the wake of a $24 billion budget shortfall has ignited a financial emergency, threatening the flow of reimbursement dollars from Medi-Cal, California's insurance program for low-income families.

Blue Shield of California Foundation & CHCF

Health Information Technology: California Networks for EHR Adoption initiative. The CNEA program was initiated in 2006 to speed adoption and lower the overall cost of electronic health records in California community clinics and health centers. In 2006, the Blue Shield of California Foundation, the California HealthCare Foundation and the Community Clinics Initiative, committed approximately $1.5 million to a three-year effort to assist community clinics in implementing EHR system The Community Clinics Initiative (CCI) to provide resources, evidence-based programming and evaluation, education and training to support community health centers and clinics. Through information sharing and major grants, CCI acts as a catalyst to strengthen California's community clinics and health centers to improve health outcomes in underserved communities.

California BlueCross Foundation

Proposal Development: The Proposal Development Award program provides $3,500 and is designed to help community nonprofit organizations develop high-quality, effective grant proposals for innovative services to improve the health of the community.

COLORADO

Colorado Health Foundation

Health Information Technology: The Healthy Connections initiative of The Colorado Health Foundation

Goal: To improve their information technology capabilities and allocated $2.5 million for the first year of the initiative.

Grantees: include nine Federally Qualified Health Centers (FQHC), four rural health clinics; six independent clinics; one family medicine training program; and one nonprofit community-based partnership. Phase I: awarded $10,000 each to 15 organizations to assess and develop plans for incorporating information technology. Phase II: Six clinics that were further along in the planning process received up to $300,000 each for staffing and equipment. Phase II will invest up to $6 million in 30 additional planning grants and up to 12 implementation grants.

MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts Foundation

Promote Enrollment: $485,000 in grants to 22 community-based organizations, community health centers, and select hospital-based programs to help low-income consumers enroll in MassHealth, Commonwealth Care, the Health Safety Net, and other public and private health access programs and connect with providers. The grants range from $20,000 to $25,000 (http://www.reuters.com/article/pressRelease/idUS193951+06-Jan-2009+BW20090106)

MINNESOTA

Blue Cross Blue Shield of Minnesota

Governance and Leadership: RESILIENT ORGANIZATIONS FUND (http://www.resilientnonprofits.org/announcing-the-convenings/) Blue Cross and Blue Shield of Minnesota Foundation, in partnership with MAP for Nonprofits, Fieldstone Alliance, and Nonprofits Assistance Fund, will be a convening of nonprofit leaders who seek ways of increasing their organization's health and resiliency during an extended economic downturn. Grants of up to $20,000 for up to one year are available for planning and implementation activities to address innovation, management, financial, governance, and/or structural issues.

NEW JERSEY

Horizon Foundation: New Jersey Health Center Initiative was created to expand access to health care for thousands of uninsured and underserved individuals throughout New Jersey. This $5 million, five-year grant Initiative provides needed resources to health centers across New Jersey. The Initiative funds charitable 501©(3) Federally Qualified Health Centers and independent health centers throughout the state that offer comprehensive primary health care services.

- Increase access to health care services for uninsured and underserved individuals
- Provide resources to enhance health center operations
- Expand services to health center patients

NORTH CAROLINA

BlueCross BlueShield Foundation of North Carolina

Care for the Uninsured (priority for free clinics): Grants from the Blue Cross and Blue Shield of North Carolina Foundation (BCBSNC Foundation) will help North Carolina's free clinics implement disease management programs, provide affordable prescription drugs, target services to seniors and immigrants, and take other steps to strengthen and expand services to uninsured residents of the state—general grants to the clinics and money linked to specific needs, including technology, program expansion, Hispanic services, or treatment of chronic diseases. Sixty-two grants totaling $1.5 million are being awarded to North Carolina's free clinics.

Appendix 2.

HEALTH CENTER POLICY INITIATIVES IN OTHER STATES

Policies impacting health centers across the country

Through the National Association of Community Health Centers and PCDC's own research, we have identified the following activities whose purpose is to strengthen the primary care safety net in several states. As with the foundations in Appendix 1, this list represents examples of initiatives, and should not be considered comprehensive.

FUNDING FOR HEALTH CENTERS

Transition of uncompensated care pool as health insurance coverage grows (Massachusetts): Massachusetts, which has nearly universal health coverage, has phased out its uncompensated care pool and transferred funds to a new fund—**the Health Safety Net Trust Fund**. The fund is supported through a continuation of payments made by acute hospitals, funds collected from the surcharge on uncovered individuals, and federal disproportionate share hospital funds. Under the fund, **Community Health Centers will be reimbursed at a rate no less than the Medicare Federally Qualified Health Center (FQHC) rate**, with additional payments for services not included in the Medicare rate such as Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. The measure anticipates the transfer of funds to the C-CHIP program as use of free care declines with increased health insurance coverage.

About $6 million from the Fund will be expended annually to fund case management and other demonstration projects aimed at reducing fund liability. Such demonstration projects will focus on persons with chronic illness, particularly those with substance abuse and psychiatric disorders, by enrolling patients in CHCs and community mental health centers coordinating with local hospitals.

An **Essential Community Provider Trust Fund** is also established, to support improvements in hospitals and CHCs ability to provide "community-based care, clinical support, care coordination services, disease management services, primary care services, and pharmacy management services."

Providing a guaranteed funding stream for health centers (New Jersey): In 1992 New Jersey passed the Health Care Subsidy Act that allocated $10 million to community health centers to expand access and help triage patients out of hospital emergency rooms. This funding was a tax on hospitals and charged them .53% of 1% revenue. Payments are made monthly to the Department of Health and the total amount paid into the fund may not exceed $40 million per year.

New Jersey also enacted **The Health Care Stabilization Fund** ($44 million) to provide emergency grants to hospitals and other licensed health care facilities (including health centers) to ensure continuation of access and availability of necessary health care services to residents in a community served by a hospital facing closure or significantly reducing services due to financial distress.

Increasing Private Payment Rates to Health Centers (Hawaii): In Hawaii, legislation (S.B.1140) was introduced that would require all health plans, including government payors and limited benefit health insurance policy insurers licensed to do business in the State, to pay FQHCs no less than their respective Medicaid PPS rates. Despite passing both houses, the legislation was defeated (vetoed, we believe) following intense pressure from the insurance industry.

Appropriate state funds: 38 states and D.C. allocated $518 million in direct state funding to health centers in FY 2009. Direct state funding for health centers often covers the cost of providing care for the uninsured or indigent populations, additional services or hours, capital, workforce, and health information technology.

Increase Medicaid and CHIP coverage and benefits: Medicaid is the largest insurer of health center patients and makes up 37% of health center revenue. Health centers serve 5 million children and would benefit from states taking advantage of the enhanced eligibility options in the recent CHIP reauthorization.

WORKFORCE DEVELOPMENT

New Hampshire—Moving funds from GME to Primary Care: In its latest budget, New Hampshire eliminated funding for Direct Medical Education for hospitals and redirected the funding to a loan repayment program for primary care providers who treat under-served citizens, particularly through the Community Health Centers.

Support workforce programs: As health centers grow, strategies for addressing clinical workforce shortages must include expansion and revitalization of state health care workforce programs. Loan repayment and other incentive programs should be supported for primary care providers working in medically underserved areas.

Requiring out-stationing of eligibility workers: Federal Medicaid stature requires that states outstation eligibility workers at FQHCs and DSH hospitals to allow for the acceptance of Medicaid applications from pregnant women, children and youth. However, this mandate has been ignored by a large number of states, forcing FQHCs to deploy their own staff.

ENROLLMENT

Make Enrollment easier: Making the Medicaid and CHIP enrollment process easier has a positive financial effect on health centers. This includes presumptive eligibility for Medicaid or CHIP.

Allowing health center employees to buy into the State Employees Health Benefit Program, which could save health centers additional costs associated with purchasing insurance for their staff. States can also protect and enhance Medicaid reimbursement for health centers allowing health centers to care for more uninsured while drawing down additional federal dollars for the state.

Appendix 3.

METHODOLOGY & DATA SOURCES

The Primary Care Development Corporation (PCDC) and Health Management Associates (HMA) used a combination of quantitative and qualitative analyses, described below, to examine the experience of New York's comprehensive Diagnostic and Treatment Centers (DTCs) over time in order: (i) to understand how broad and deep the financial distress is in the health center sector; (ii) to note factors associated with success or failure; and (iii) to use this information to identify policy options for maintaining access to health centers in New York. As will also be described below, we convened a group with expertise in New York's DTCs to advise this study.

ADVISORY COMMITTEE

In September 2008, PCDC and HMA convened a group with expertise in New York's DTCs to advise this study. The group included health center executives, representatives of the health center trade association, financial advisors, and sector advocates. Advisors and their affiliations are listed in Attachment 1. In addition to their critical perspectives on NY DTCs, several advisors additionally had experience with community health centers nationally or in other states, allowing them to identify issues unique to the New York environment.

To help inform and provide direction for the quantitative and qualitative analyses to be undertaken by PCDC and HMA, advisors discussed and debated three questions during a two hour focus group in September 2008:

- What are the predictors of success or failure for health centers, particularly in New York?
- Which factor is the most important predictor of success or failure of a center?
- What are the risks and opportunities on the horizon in NY that will affect health center viability?

The group identified a long list of factors that can affect a health center's financial success. Factors divided into two main categories—those related to internal design, operations, and leadership and those related to the environment in which centers operate, including the payer mix, payment rates, competition, population density, and regulatory atmosphere. The full list is presented in Table 1.

The Advisory Committee reached consensus on the two most important determinants of financial well-being, but declined to rank one as more important than the other:

- Speaking to all the internal management issues, Committee members identified the business model of the center—both having an actual business model and the model's relative emphasis on revenue generating strategies—as a major predictor of a center's success.
- Committee members agreed that reimbursement adequacy—all payers covering costs—was the most important external issue.

Committee members also pointed numerous threats to the sector's short- and long-term viability, including:

- The downturn in the economy and the resultant rise in unemployment & likely change in payer mix (with resultant strain on health center finances) if the number of uninsured grows as anticipated;
- Cuts in foundation grants;
- Workforce shortages;
- NYSDOH reimbursement inequities and cash lags
- Industry competition—new centers opening in areas served by existing centers that may then siphon off paying volume

TABLE 1. Factors Influencing DTC Financial Well-Being

INTERNAL FACTORS	
• Board members' capacity/capability	• Staff quality and quantity
• Management and business systems	• Turnover, recruitment and retention issues
• Infrastructure	• PMS/EHR implementation
• Fundraising sophistication	• Physical plan upkeep

EXTERNAL FACTORS
• Location
• Urban vs. rural factors
• Socioeconomic and demographic differences, e.g. payer mix
• Competition
• Reimbursement adequacy, e.g., commercial payers paying less than cost
• Grant availability and type/purpose
• Cash flow—impacted by timeliness of payment/payment lags
• Lack of clarity on state policy
• Hospital industry competition—strength in monopolizing "the conversation"
• OMIG auditing agenda & possibility of retroactive cuts
• Lack of access to capital
• Relationships between providers, e.g., referral relationships
• Proximity to other services—competition or dearth (& how latter effects relationships and ability to help patients access services)
• Hospital/primary care center closures
• Fallout on provision of uncompensated care & access by uncompensated patients

With little information yet available, Committee members were unable to classify either the new Medicaid reimbursement system nor the new quality standards being promulgated by NYSDOH as either an opportunity or a threat, but noted they were important factors to watch.

We previewed the findings of the quantitative financial analysis with the Committee in March 2009, and then reconvened the Committee in person in June 2009 to review the policy

discussion and potential recommendations. Specifically, we asked Committee members to consider the following questions as they pertained to the draft policy discussion:

1. Did we identify the major problems facing New York's comprehensive health centers?

2. Are the recommendations framed in such a way that they will lead to "fixes"?

3. How would you rank the recommendations in terms of their relative importance

4. How would you rank them in terms of their ability to be addressed?

5. How should they be addressed—what methodologies should we be suggesting to the NYSHF and the NYSDOH, in particular, for actualizing these recommendations?

6. Finally, are there additional recommendations beyond those outlined in the paper that you believe that we should we making, even if they extend beyond the scope of the paper but are "natural projections" of the topic?

QUANTITATIVE FINANCIAL ANALYSIS

With guidance from the Advisory Committee, we undertook a quantitative analysis of key financial and operating indicators, using data provided by the New York State Department of Health (NYSDOH) from the certified Ambulatory Health Care Facility reports (AHCF-1) filed by Comprehensive DTCs for calendar years 2001 through 2007. NYSDOH categorizes health centers by the services they provide and the population they serve, and in this study we focused on the set of centers that NYSDOH categorizes as DTC types 11, 12, or 13 which are non-government affiliated centers that provide a comprehensive range of services to the general population.

Study Sample: To be eligible for inclusion in this study, a center had to be categorized by NYSDOH as a Comprehensive DTC. The number of eligible centers increased from 77 in 2001 to 95 in 2007. While the overall growth in the number of Comprehensive DTCs could be interpreted as a sign of strength in the sector, closer analysis indicates that the growth is largely a result of: (i) hospital outpatient departments (OPDs) transitioning to DTC status in an effort to improve reimbursement, restructure hospital operations or both; and (ii) Special needs providers transitioning from "Limited" to "Comprehensive" DTC status to provide a broader array of services to their niche populations. While there were "true" new entrants to the DTC sector, these contributed only a small percentage to the growth over the six-year study period.

Not all eligible centers could be included in the study. As shown in Table 2, centers were excluded from the study for one of four reasons:

- The center did not submit a cost report to NYSDOH prior to December 15, 2008, the time of data collection for this report (or at all in years 2001-2007). As of this date, approximately 75% of the Comprehensive DTCs had submitted their 2007 AHCF-1 reports, compared to previous years, in which about 85%submitted reports. Centers are required but not specifically penalized for not submitting AHCF-1 cost reports, though, beginning with the 2009 cost reports, NYSDOH is implementing new procedures and will be enforcing penalties in order to improve overall data quality and integrity.

- The center's cost report did not provide sufficient data in certain fields that were essential to calculate key indicators.
- There were apparent errors in the center's report that were deemed significant by the authors.
- It was determined by the authors and/or Advisory Committee members that the center differs substantially from the other centers in the study in terms of its business model, mission or other factors (for example, a center serving a specialized population that was nonetheless receiving a rate as a comprehensive center.)

After taking into account these constraints, the number of centers remaining in the study ranged from a low of 57 in 2001 to a high of 66 in 2005 and 2006.

HMA compared the set of centers slated for exclusion to the set slate for inclusion. The comparison showed that the two sets were not statistically different in terms of federally qualified health centers (FQHC) status or geography and HMA concluded that the exclusions were unlikely to result in any bias in the overall analysis.

TABLE 2. NUMBER AND COMPOSITION OF DTCS INCLUDED IN ANALYSIS

DTC CHARACTERISTICS	2001	2002	2003	2004	2005	2006	2007
Total number of Comprehensive DTCs Eligible for Study	77	80	83	89	90	95	95
Comprehensive DTCs Eligible for Study that did NOT submit a Cost Report to the State	8	9	5	8	7	13	23
Number of Eligible DTCs Who Submitted Cost Report	69	71	78	81	83	82	72[1]
Eligible DTCs excluded for data reliability/completeness issues	12	13	15	17	17	16	13
Final Sample of Comprehensive DTCs for Study	57	58	63	64	66	66	59
FINAL SAMPLE COMPOSITION							
Location							
Upstate Rural	2	2	3	3	4	4	4
Upstate Urban	21	20	21	21	23	22	20
Downstate	34	36	39	40	39	40	35
FQHC Status							
FQHC	36	38	41	41	42	43	37
Non-FQHC	20	19	21	21	24	23	21
Switched Status During Year	1	1	1	2	0	0	1
Combined Location/FQHC Status							
Downstate FQHC	22	23	25	26	24	25	21
Downstate Non-FQHC	12	12	13	13	15	15	13
Upstate FQHC	14	15	16	15	18	18	16
Upstate Non-FQHC	8	7	8	8	9	8	8
Center Size (measured in annual visits)							
Small (<15,000 visits)	6	8	12	10	11	9	9
Medium	45	41	41	42	41	43	37
Large (>100,000 visits)	6	9	10	12	14	14	13

[1] This number includes centers who submitted a cost report in time for inclusion in the study (December 15, 2008)

Financial Analysis Indicators & Data Sources: Most indicators used in this analysis are drawn from the AHCF-1 cost reports and are derived from those sections of the cost report that are certified by each health center's independent auditor. HMA validated a sample of health center cost report data against actual audited financial statements. While some minor discrepancies were found (e.g., one health center characterized some assets as "other assets" that, arguably, based on a review of the audited financials and footnotes, could have been classified as cash), the review provided assurance that overall data quality was good. HMA drew some supplemental data from the Uniform Data Set (UDS) reports that are submitted by FQHCs to the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services.

HMA analyzed the financial performance of the study centers on key indicators of profitability and liquidity, namely:

Profitability Indicators, i.e., Indicators of Overall Performance

- Total Margin, defined as overall net income as a percentage of total revenue, provides a measure of the overall performance of an organization. This focuses on income from all sources, including direct patient care, subsidiary businesses, and investments. The higher the margin, the stronger the center's financial performance. A negative total margin indicates that a center had bottom-line losses attributable to one or more of its business lines and may be a sign that the center has serious financial difficulties.
- Operating Margin is defined as net operating income as a percentage of net operating revenue, and focuses on patient care operations. The higher the margin, the stronger the center's financial performance. A negative operating margin indicates that a center experienced losses from patient care operations.

Liquidity Indicators

- Current Ratio is a measure of the degree to which current assets cover current liabilities and is a strong indicator of near-tem solvency. Current Ratio is defined as:

$$\frac{\text{[Current Assets]}}{\text{[Current Liabilities]}}$$

Benchmark—1.0 means that current assets equal current liabilities with no margin, and figures above that, such as 1.25 are typically recommended levels for minimum financial health.

- Days Cash-on-Hand measures the number of days of average expenses a center maintains in cash or marketable securities. Days Cash-on-Hand is defined as:

$$\frac{\text{[Cash and short-term investments]}}{\text{[Total operating expenses minus depreciation]/365 days per year}}$$

Benchmark—Comfortable fiscal management would require at least thirty days cash on hand to pay essential expenses such as payroll.

- Days in Accounts Receivable, an indicator of timeliness of payments from major payers, is one of the factors that most directly affects health center cash flow. Although health centers can be captive to delinquent payors, this figure can also rise due to faulty billing and collection practices on the part of health centers. Days in Accounts Receivable is defined as:

$$\frac{\text{[Net accounts receivable from patient care delivery, grants, contracts and other sources]}}{\text{[Net revenues from those sources plus net assets released from restriction]/365 days per year}}$$

Benchmark—Days in net patient accounts receivable less than 75 days is considered reasonable.

HMA then analyzed whether and how the factors below, did, as hypothesized, influence the financial profile of centers. On Table 2, we have shown the composition of centers by these factors, namely:

- **Designation as a Federally Qualified Health Center:** Because FQHCs receive federal grant support and enhanced cost-based Medicare and Medicaid reimbursement, their financial position is expected to be stronger than that of non-FQHCs. Over half of NY's Comprehensive DTCs are FQHCs or FQHC Look-alikes. FQHC Look-alikes, which are centers that meet the same criteria for comprehensiveness but do not receive the federal grants provided to FQHCs, are included in this category because their reimbursement is comparable to that of the FQHCs in that they receive cost-based Medicare and Medicaid reimbursement (including wrap-around payments for Medicare and Medicaid recipients who receive their care through a managed care plan). The requirements for and benefits of FQHCs vs. FQHC Look-alikes is provided in Appendix 4.
- **Center Location:** Population density, access to providers, and access to referrals are greater downstate than upstate, which we hypothesized to be important factors in a health center's success. Of NY's Comprehensive DTCs, a slightly larger proportion are downstate (i.e., within the five boroughs of New York City or the two counties of Long Island.) Among the upstate centers, fewer than one-fifth serve rural areas.
- **Center Size as Measured by Patient Visit Volume:** Based on national experience, we expected very small centers, those providing fewer than 15,000 visits per year, have more difficulty achieving management efficiencies and financial sustainability, compared to very large ones providing over 100,000 visits per year. Similarly, medium-volume centers (providing between 15,000 and 100,000 visits per year) may not see the benefits of the economies of scale seen by large health centers. Where possible, we stratified the analysis by these factors to inform

the interpretation and policy discussion.

Though we hypothesized that other factors affect the financial performance of health centers, we had to exclude them from the quantitative analysis since reliable date are unavailable. We tried to address the role of these non-quantified influences in discussions with the Advisory Committee and in interviews with sector experts described below.

QUALITATIVE ANALYSIS

Key Informant Interviews: Using the guides provided in Attachments 2 and 3, HMA interviewed health center executives, sector supporters and NYSDOH staff, to better understand reimbursement practices and concerns, regulatory processes and their impact on centers' financial conditions and opportunities for coordination/consolidation, and management/ governance challenges health centers face.

Health Center Executive Interviews: Using the guide provided in Attachment 4, PCDC staff interviewed eight health center CEOs to identify the qualitative factors that have contributed to (i) their relative success (for stronger centers) or (ii) their improvement (for centers that have struggled but shown improvement.)

ATTACHMENT 1. Advisory Committee

NAME	AFFILIATION AS OF JUNE 2009
Neil Calman, MD	Institute for Family Health, NYC & Hudson Valley, President/CEO
Sean Cavanaugh	United Hospital Fund, Director of Health Care Finance
Georganne Chapin	Hudson Health Plan, President/CEO
Dan Dey	Northern Oswego County Health Services, Inc., Executive Director
Peter Epp	RSM McGladrey, Principal
Astrid Gonzalez	Lutheran Family Health Network, Brooklyn, CFO
Rei Gonzalez	Settlement Health and Medical Services, Inc., Manhattan, Executive Director
Paloma Hernandez	Urban Health Plan, Inc., Bronx, President/CEO
Tom Murphy	PCDC Board Member; former head of DASNY
Cindy Prorock	HRSA Consultant; Interim CFO Hometown Health Center, Schenectady
Mark Raifman, MD	Nassau DTC & Triboro Management, Long Island, Managing Member, CEO & Medical Director; Pediatrician
Maurice Reid	Brownsville Multi-Service Family Health Center, Brooklyn, President/CEO
Julie Boden Schmidt	National Association of Community health Centers (NACHC), Associate Vice President, Training and Technical Assistance; former health center CEO
Jim Sinkoff	Whitney Young Health Center, Albany, President/CEO
Elizabeth Swain	Community Health Center Association of NYS CEO; former health center CEO

ATTACHMENT 2. Interview Guide for Health Center Executives and Health Center Supporters

INTERVIEWEES

Dan Dey, Executive Director, Northern Oswego County Health Services, Inc.
Peter Epp, Principal, RSM McGladrey
Paloma Hernandez, CEO, Urban Health Plan
Elizabeth Swain, CEO, CHCANYS
Kate Breslin, CHCANYS
Cindy Prorock, HRSA Consultant, Interim CFO for Hometown Health Center, Schenectady
Dr. Mark Raifman, CEO, Nassau Diagnostic and Treatment Center

QUESTIONS RELATED TO ADEQUATE, TIMELY AND PREDICTABLE PAYMENTS

#	Question
1	We're trying to understand the financial challenges health centers are facing in terms of state payment timing and adequacy. For each of the following types of payments, could you tell us whether payments to your center from the state are regular or unpredictable, on time or usually delayed, whether it affects cash flow issues, and to what extent the amounts cover costs? ▶ Medicaid claims payments ▶ Medicaid wrap—around payments ▶ Managed care transition payments ▶ Provider recruitment and retention payments ▶ State grants and contracts (HEAL, others?)
2	Is the timeliness and adequacy a big or a small problem for you?
3	What are some changes the state could make to make payments more timely or predictable?
4	How different do you think APGs will be for centers? Do you think the APG system will result in payments that are more adequate?
5	What type of reimbursement system would you like to see put in place

QUESTIONS RELATED TO OTHER TARGETED STATE SUPPORT

#	Question
1	In what ways could the state better support health centers? (e.g., offsetting more of the cost of caring for the uninsured, supporting out-stationed eligibility workers, or support health center advancement and expansion)?
2	What areas do you think are most in need of grant support, either from the state or private sources? (e.g., IT, Other capital, Operating costs, Planning Support for new health centers, Other)

QUESTIONS RELATED TO REGULATORY PROCESSES

#	Question
1	Have you experienced, or do you know centers that have experienced, any problems with state regulatory processes, for example when adding new sites, requesting rate changes, applying for CON, other? (Other than IFH) How do you think the processes could be improved?
2	Are you aware of entities that wanted to become new health centers, but could not navigate the regulatory process? What issues were problematic?
3	For FQHCs, what policy changes do you think are needed at the federal level to better support health centers?
4	Who could provide NY centers support on navigating regulatory processes?

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	ATTACHMENT 2. Interview Guide for Health Center Executives and Health Center Supporters
	COMMERCIAL PAYER ISSUES
1	How problematic is it for health centers to negotiate with multiple managed care plans? Describe the process (i.e., do you negotiate rates or simply take the offered rates)? What kind of support would you find helpful in working more effectively with commercial payers and who is best-positioned in NY to provide that support? How much staff does it take? Other costs? What standardization would help?
2	What could the state do to support primary care providers in this area? Would uniform forms and processes help? Other ideas? Ask about Medicaid/FHP/CHP all together; and then commercial.
	FINANCIAL MANAGEMENT, STRATEGIC PLANNING, AND GOVERNANCE
	For CHCANYS:
1	We have heard that some centers need help with financial management, strategic planning, and governance. How widespread are these needs? What type of assistance would be valuable to centers?
2	CHCANYS, has anyone tried to assess where centers are on medical home?
	For Centers:
3	Do health centers need assistance with financial management, strategic planning, or governance? Does your health center take advantage of the financial, governance and other trainings offered by NACHC? If yes, are they useful? If not, why not? (What kind of assistance would help? Where do you get it? What else do you need? What works?
4	Some state primary care associations provide local/regional training sessions and also help to facilitate mentoring (usually upon request from a member health center). Does CHCANYS do this? Are health centers pleased with the array of offerings from CHCANYS or could they be doing more to support effective health center management?
5	Should CHCANYS take a more active role in identifying centers that are in distress and providing mentoring/assistance? Would you need help meeting medical home standards, or the state's primary care standards?
	For Both:
6	How could foundations play a role in supporting health centers? E.g., direct technical assistance to individual health centers, funding for organizing and/or attending training/educational sessions, funding up-front costs of merger planning/assessments, other?

ATTACHMENT 3. Interview Guide for NYSDOH Staff

INTERVIEWEES

OFFICE OF HEALTH INSURANCE PROGRAMS

Gregory Allen, Director, Division of Financial Planning and Policy
Terrence Cullen, Assistant Director, Financial Planning and Policy
Alan Maughan, Bureau Director, Strategic Planning & Data Analysis

OFFICE OF HEALTH SYSTEMS MANAGEMENT

Karen Lipson, Director
Lauren Tobias, Deputy Director, Division of Policy
John Gahan, Director, Primary and Acute Care Reimbursement
Neil Benjamin, Director, Division of Health Facility Planning
Charles Abel, Director, Bureau of Financial Analysis

GENERAL QUESTION RE PRELIMINARY STUDY FINDINGS

Was the state surprised by the findings from our financial analysis re the breadth and depth of financial distress among DTCs? Does the state see any expanded role for itself in monitoring and responding to financial distress when it believes access to care may be jeopardized? Please explain.

QUESTIONS RELATED TO MEDICAID, UNCOMPENSATED CARE AND COMMERCIAL INSURANCE PAYMENTS

1. We understand that New York recently (2/08) made some changes to its wrap-around payment methodology; please describe these changes. We've heard anecdotally that these payments have been delayed in the past. Have the changes to the methodology addressed this? If not, has the state considered any alternative methodologies? Are you hearing complaints re this?

2. The state has traditionally made two "add-on" payments to health centers for provider recruitment and retention and for managed care transition, which is being replaced with an EHR transition payment.
   - We understand that both of these payments are matched with federal Medicaid dollars; please confirm.
   - We understand that the methodology for the Recruitment and Retention (R&R) payments is changing/has recently changed from one based on personnel costs to one based on Medicaid utilization. Can you describe the new methodology and timing? Do you anticipate that some health centers will have to pay back R&R payments made under the previous methodology, or will there be a hold-harmless provision?
   - We've heard from health centers that R&R payments are frequently delayed. Have you heard complaints from health centers on this? Does the state have any plans to reduce payment delays?
   - Which centers will get the EHR payments? Have centers been notified of this change, and do they know if they qualify for payments, and how much they'll be? Can other centers qualify in the future? For how many years will centers get an EHR add-on?

3. The state has traditionally made payments to health centers and other providers (e.g., hospitals) to offset the cost of services to the indigent population.
   - We understand that the 2010 budget increases the total size of the DTC indigent care pool by $8 million to a total of $62.5 million; please confirm. We also understand that the state is seeking a waiver that would allow federal match on this additional $8 million bringing the total pool increase to $16 million. Please confirm and explain.
   - Is the state contemplating any other near or longer-term changes to either the size of the pool, the split between DTCs and other providers, or the distribution formulae?

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ATTACHMENT 3. Interview Guide for NYSDOH Staff	
QUESTIONS RELATED TO MEDICAID, UNCOMPENSATED CARE AND COMMERCIAL INSURANCE PAYMENTS (CONTINUED)	
3	The state has traditionally made payments to health centers and other providers (e.g., hospitals) to offset the cost of services to the indigent population. ▸ We have heard anecdotally that these payments have been subject to delays while the state waits for late cost report filings. Have you heard complaints from health centers about this? Does the state have any plans for speeding up indigent care pool payments (e.g., by requiring health centers to file on time or risk being excluded from the pool)?
4	We understand you've been working on an assessment of the impact of APGs on centers? Can we get a copy? If not, can you tell us, on average, what changes centers can expect? What range of increases can non-FQHCs expect? How does it compare to cost-based reimbursement? Please describe the state's plans and timing for the APG roll-out (e.g., base rate, adjustment factors, etc.).
5	We understand that the FQHCs have opted out of APGs but that a pilot is under development to test APGs with a handful of larger FQHCs. Can you explain the structure and timing of the pilot?
6	Is the state contemplating any other reimbursement changes that we should be aware of?
7	From our study and previous studies, we know that many health centers are also struggling with issues related to commercial payers, including payments that are well below cost and burdensome administrative requirements related to billing and credentialing. ▸ Has the state heard similar complaints? Is this an area that the state has actively engaged in and, if so, what potential solutions have been on the table? ▸ Has the state considered potential options for standardizing billing forms and credentialing processes to ease the burden on providers?
QUESTIONS RELATED TO REGULATORY PROCESSES/MERGERS	
1	We have heard that health centers that have any change in status (e.g., moving from non FQHC to FQHC, opening a new site, etc.) often face significant delays in getting their rates in place and receiving reimbursement (including PPS payments and wrap-around payments) based on the new rates. What is the process for a health center that is changing status to establish and begin getting paid on its new rate? What are the possible causes for payment delays?
2	Does the state have any clear guidelines or schedules for health centers that are undergoing merger/acquisitions/consolidations? We've heard that health centers felt there were no clear instructions, guidelines, or single point of contact at the state to guide the centers through all of the regulatory requirements involved in these transactions. How should a health center proceed with this process? What are the steps and sequence? (E.g., we understand they could involve Medicaid rate change request, emergency and full CON process, licensing and inspections of newly acquired facilities, new Medicaid locator codes and provider numbers, Medicaid wrap-around rates for new sites, NYS Attorney General & Supreme Court approval of asset sale by a nonprofit…) Or, how would a health center learn the steps and sequences? Are they informed about Emergency CONs as a short term bridge while undergoing the full CON process? Are there any plans for expediting any of the approvals (e.g., CON) for health centers when there is risk of centers closing and patients losing access to care? Are the CON reforms now being studies applicable to the merger/acquisition process, and if so, please describe.
3	Given that mergers/acquisitions/consolidations seems to be one way for failing centers to survive and maintain access to care, what are some things the state can do to support these transactions? E.g., has the state considered establishing a fund for supporting acquisitions/mergers or helping to determine when such transactions would be appropriate/helpful? Would these require administrative, regulatory, legislative changes?

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ATTACHMENT 3. Interview Guide for NYSDOH Staff	
	OTHER QUESTIONS
1	We know that New York has made a number of targeted investments in primary care in recent years, including, for example, the HEAL grants. Do you anticipate providing other state support, outside the reimbursement formula, to help centers either remain viable or grow stronger to fulfill your vision for a greater emphasis on primary care in NY? ▸ Has the state considered the creation of an "incubator" grant program to help entities (especially non-FQHC DTCs) become FQHCs?
2	We have heard from health centers that grant and contract payments from the state are frequently delayed, causing cash flow problems for the health center. What are the causes of this? What is the state doing to remedy this?
3	What is the state's policy with respect to placing outstationed eligibility workers in FQHCs? What are the criteria for placement? Who pays the non-federal share (state or health center)?
4	Are there things you would suggest a foundation do or support to help address/reduce financial distress among health centers?

ATTACHMENT 4. Interview Guide for Financially Strong or Financially Improved Health Centers

#	Question
1	For Financially Strong: What factors can you identify as the primary contributors to your financial strength? -Or- For Financially Challenged: Prior to your financial turnaround there were clearly factors holding you back from being financially stable. What factors can you identify as the primary contributors to previous financial trouble?
2	How much influence did reimbursement play in regards to your financial situation and overall health? ▶ Did rate of payment change? ▶ How have you handled significant payment lags/delays?
3	For Financially Strong: How do you organize your center's financial management to deal with reimbursement and other financial issues? ▶ How do you monitor collection rates? ▶ What is the Board's involvement and what expertise do they bring?
4	For Financially Challenged: How did you improve your center's financial management to deal with reimbursement issues? ▶ Did you hire a CFO? ▶ Did you improve collections?
5	What other management decisions influence your financial health? ▶ Particular operational efficiencies? ▶ Maintaining / improving provider productivity? ▶ Optimizing use of space? ▶ Any other efficiencies? ▶ Personnel decisions / changes? ▶ Fundraising or outreach strategies? ▶ Expanding your network? ▶ Facility improvements? ▶ Pooled purchasing? ▶ 340B?
6	Does FQHC status have any drawbacks?
7	Do you have a hospital or other affiliation that has helped you financially?
8	What is unique about the population you serve that may contribute to your financial situation? ▶ Special/niche population ▶ Unique geographic location
9	What are you doing now to further strengthen/secure your financial health?
10	What factors would you like to see improve? Or What factors continue to hold you back?
11	Do you think that upcoming changes in reimbursement will benefit your center's financial position?

Appendix 4.

FQHCS VS. FQHC LOOK-ALIKES

The table below compares federally qualified health centers (FQHCs) and FQHC Look-alikes—what defines the two categories and what requirements and benefits accrue to each. Note: a single organization may hold both designations encompassing different health center sites.

FQHCS VS. FQHC LOOK-ALIKES		
	FQHCS	FQHC LOOK-ALIKES
DEFINITION		
	A federally qualified health center (FQHC) is a type of provider defined by the Medicare and Medicaid statutes that receives grant funding under Section 330 of the Public Health Service Act. (PHSA) Section 330 of the Public Health Service Act defines federal grant funding opportunities for organizations to provide care to underserved populations. Types of organizations that may receive 330 grants include: Community Health Centers,* Health Care for the Homeless Programs, and Public Housing Primary Care Programs.	An FQHC Look-alike is an organization that meets all of the eligibility requirements of an organization that receives a PHS Section 330 grant, but does NOT receive grant funding.
APPLICATION PROCESS		
Initial Application Process	Entities seeking designating as an FQHCs (aka, new starts), must participate in a competitive application process. Application cycles and federal priorities for each cycle are announced by HRSA/BPHC. These funding cycles are periodic, i.e., as funds become available, and so the timing is inconsistent from year to year. To qualify, applicants must be operational within 90 days of approval. In support of their application, entities MUST supply letters of support from the Primary Care Association (CHCANYS in NYS) and from other FQHCs where there is service area overlap.	Entities seeking to become an FQHC Look-alike, or FQHCs seeking to qualify a new health center site as an FQHC Look-alike, must file a non-competitive application. Applications are accepted from operating entities, at any time, and are processed as received. In support of their application, entities MUST supply letters of support from the Primary Care Association (CHCANYS in NYS) and from other FQHCs where there is service area overlap.
Additional Funding Application	FQHCs can submit subsequent applications in response to announced opportunities for Expanded Medical Capacity grants to increase the amount of their 330 grant funding for existing sites where the organization plans to expand services or for one or more new sites the organizations intends to open.	—

*For more information on Migrant Health, see http://raconline.org/info_guides?public_health/migrant.php.

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Appendix 4. FQHCs vs. FQHC Look-Alikes *(continued)*

FQHCS VS. FQHC LOOK-ALIKES		
	FQHCS	FQHC LOOK-ALIKES
COMPLIANCE REQUIREMENTS	**Section 330 grantees must comply with all requirements stated in section 330 of the PHSA unless they are granted a waiver for any governance requirements.**	**Designated FQHC Look-alikes must comply with all requirements stated in section 330 of the PHSA.**
Governing Board	Must be governed by a board of directors that includes a majority (at least 51%) of active, registered clients of the health center who are representative of the populations served by the center. The governing board ensures that the center is community based and responsive to the community's health care needs. Under certain conditions the board composition requirements can be waived for migrant, homeless, and public housing only health centers.	Same as for FQHCs
Location	Each FQHC that receives PHS 330 grant funding must meet the requirements of that specific grant. Community Health Centers must serve a Medically Underserved Area (MUA) or Medically Underserved Population (MUP). If an area is eligible for MUA/MUP designation though not yet designated, the prospective FQHC can apply for such designation in tandem with its application for a PHS Section 330 grant. Migrant Health Centers, Health Care for the Homeless and Public Housing Primary Care Programs do not need to meet the MUA/MUP restriction. FQHCs may be located in rural and urban areas.	Same as for Section 330-funded Community Health Center FQHCs.
Services	FQHCs must provide primary care services for all age groups. FQHCs must provide preventive health services on site or by arrangement with another provider. Other requirements that must be provided directly by an FQHC or by arrangement with another provider include: dental services, mental health and substance abuse services, transportation services necessary for adequate patient care, hospital and specialty care. For more information, please see Health Center Program Expectations (PIN 98-23).**	Same as for FQHCs
Hours of Operation	32 hours per week is the minimum. FQHCs must also have professional call coverage when the practice is closed, directly or through an after hours care system. For more information, please see Health Center Program Expectations (PIN 98-23).	Same as for FQHCs

**ftp://ftp.hrsa.gov/bphc/docs/1998PINS/PIN98-23.PDF

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Appendix 4. FQHCs vs. FQHC Look-Alikes *(continued)*

FQHCS VS. FQHC LOOK-ALIKES		
	FQHCS	**FQHC LOOK-ALIKES**
COMPLIANCE REQUIREMENTS (CONTINUED)	**Section 330 grantees must comply with all requirements stated in section 330 of the PHSA unless they are granted a waiver for any governance requirements.**	**Designated FQHC Look-alikes must comply with all requirements stated in section 330 of the PHSA.**
Staffing	There are no specific requirements for staffing mix at FQHCs. FQHCs are required to have a core staff of full time providers but there is no specific definition of core staff. It is recommended that they maintain a staffing level that allows for between 4,200 and 6,000 visits per year for each full-time equivalent health care provider. Another guide to the appropriate number of providers is described in the Requirements of Fiscal Year 2005 Funding Opportunity for Health Center New Access Point Grant Applications (PIN 2005-01) as a physician to patient ratio of 1:1,500 and a midlevel practitioner to patient ratio of 1:750. Additional information about staffing and other requirements is available in Health Center Program Expectations (PIN 98-23).	Same as for FQHCs
Reporting	Section 330 grantees annually submit Uniform Data System (UDS) data.	Designated FQHC Look-alikes do not submit Uniform Data System (UDS) data; instead they have separate annual reporting requirements.
Maintaining Status	Section 330 grantees must submit a non-competing continuation application annually and a competing application every 3 to 5 years depending on the length of their project period.	Designated FQHC Look-alikes must submit a recertification application annually to maintain their FQHC status.
FUNDING BENEFITS	**Section 330 grantees receive enhanced FQHC Medicaid and Medicare reimbursement as well as grant funding.**	**Designated FQHC Look-alikes receive only enhanced FQHC Medicaid and Medicare reimbursement.**
Medicaid Fee-for Service	Prospective payment system (PPS) based on average reasonable cost per visit from 1999 and 2000.Base year costs were separated into operating and capital components and further broken down between six cost centers with ceilings applied to each cost center within each geographic region of the state. The operating component is inflated each year by the Medicare Economic Index (MEI).	Same as for FQHCs
Medicaid Managed Care	Managed care plans reimburse FQHCs at negotiated fee-for-service or capitated rates. FQHCs receive "wrap-around" payments from the state that make up the difference between the managed care payment and the fee-for-service PPS rate.	Same as for FQHCs

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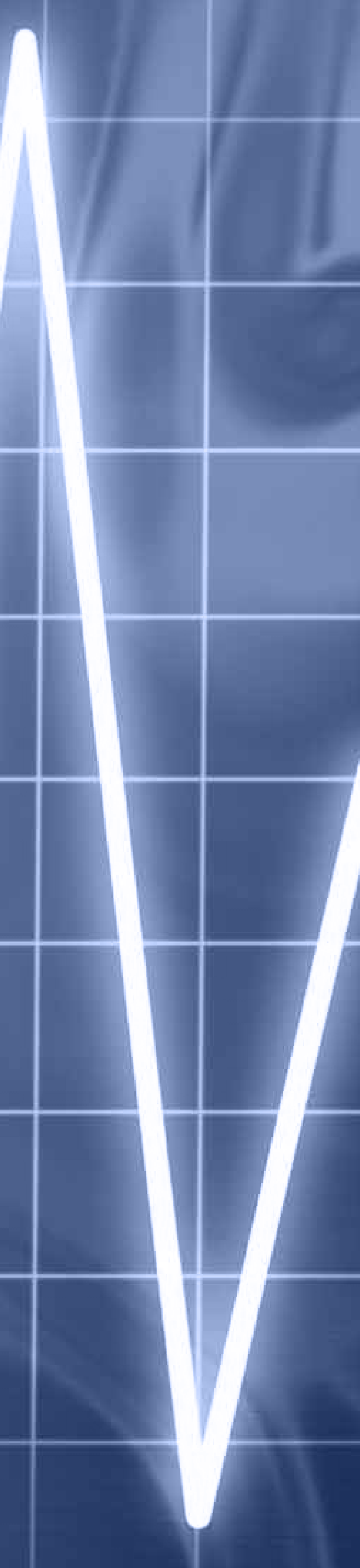
Appendix 4. FQHCs vs. FQHC Look-Alikes *(continued)*

FQHCS VS. FQHC LOOK-ALIKES		
	FQHCS	**FQHC LOOK-ALIKES**
FUNDING BENEFITS (CONTINUED)	**Section 330 grantees receive enhanced FQHC Medicaid and Medicare reimbursement as well as grant funding.**	**Designated FQHC Look-alikes receive only enhanced FQHC Medicaid and Medicare reimbursement.**
Medicare	Cost reimbursement methodology up to a federal cap, which is currently $117.41 for urban FQHCs and $100.96 for rural FQHCs. Certain services (e.g., most labs) are excluded from the encounter rate and may be billed separately through the Medicare Part B intermediary. FQHC services are exempted from the Medicare deductible. FQHCs receive "wrap-around" payments from Medicare that make up the difference between Medicare managed care payments and the Medicare fee-for-service rate. The Medicare rate is inflated each year by the Medicare Economic Index (MEI).	Same as for FQHCs
Self-Pay	FQHCs receive 330 funding to help cover the cost of caring for the uninsured. For new starts, funding up to $650,000 per year can be requested. FQHCs are required to see all patients regardless of ability to pay and to place uninsured patients on a sliding fee scale that ranges from a nominal or no charge (for patients below 100% FPL) to full charges (for patients above 200% FPL). FQHCs are eligible for payments from the state indigent care pool based on its charity care losses as a proportion of the total statewide charity care loss for voluntary comprehensive DTCs.	Designated FQHC Look-alikes do NOT receive Section 330 grant funds.
OTHER BENEFITS		
Federal Tort Claims Act (FTCA) Coverage	Section 330 grantees are eligible to apply for malpractice coverage under the FTCA.	Designated FQHC Look-alikes CANNOT apply for malpractice coverage under the FTCA.
340B Drug Pricing Program Participation	FQHCs are eligible to purchase prescription and non-prescription medications for outpatients at reduced cost through the 340B Drug Pricing Program†	Same as for FQHCs
HPSA Designation & Access to National Health Service Corps	FQHCs receive automatic designation as a Health Professional Shortage Area (HPSA). The HPSA designation provides eligibility to apply to receive National Health Service Corps (NHSC) personnel and eligibility to be a site where a J-1 visa physician can serve.	Designated FQHC Look-alikes receive automatic HPSA designation.
Other	FQHCs have access to the Vaccine for Children program,‡ and other federal grants/programs.	Similar to FQHCs

Sources: HRSA website, e.g.,: (a) Health Center Program Requirements at http://bphc.hrsa.gov/about/requirements.htm and health center benefits @ http://bphc.hrsa.gov/about/benefits.htm; (b) Program Assistance Letter (PAL) 06-01: Dual Status Health Centers (that are both FQHC Look-alikes and Section 330 grantees); (c) Unprecedented Growth: Health Center Expansion 2002-2007 at http://bphc.hrsa.gov/success/unprecedentedgrowth.htm

†http://www.hrsa.gov/opa/introduction.htm

‡http://www.cdc.gov/vaccines/programs/vfc/default.htm



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New York's health

VOICE: 212-664-7656
FAX: 646-421-6029
MAIL: 1385 Broadway,
23rd Floor
New York, NY 10018
WEB: www.nyshealth.org