



Special Report: The Deteriorating Financial Health of New York State's Health Centers

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PREPARED BY:

Primary Care Development Corporation



NYS HEALTH
FOUNDATION

Improving the state of New York's health

Introduction



about 1.5 million New York State residents depend on health centers for primary and preventive care. Financial distress among an increasing number of health centers has become a growing concern to the New York State Health Foundation (NYSHealth) and the Primary Care Development Corporation (PCDC).

Within the last several years, NYSHealth has received growing numbers of requests for financial assistance from financially distressed health centers seeking to maintain primary care access in their communities. In its role as the largest nonprofit financier of health centers in New York, PCDC also began seeing signs of financial distress among a growing number of the health centers with which it works.



To better understand the underlying factors that affect the viability of health centers, and the sector as a whole, NYSHealth engaged PCDC to conduct an in-depth assessment of the financial viability of New York State's health centers. PCDC's work and mission to expand and enhance primary and preventive health care in underserved communities made it well positioned to undertake the assessment. In partnership with researchers from Health Management Associates, PCDC undertook a thoroughgoing study of the financial condition of New York State's health center sector.

In this issue brief, PCDC presents key findings from the study, which examines financial trends from 2001 to 2007.¹ These preliminary findings are shared in advance of releasing the full study (projected for mid-April) because they have significant importance on current budget and health reform discussions in State government and in communities throughout New York State.

The issue brief seeks to answer the question, "How broad and deep is the financial distress in the health center sector?" The full report will address the causes and contributors to the financial distress; describe variation in financial wellbeing by health center geography, size, and Federal program participation; discuss the potential causes and contributors to these trends; and provide recommendations for policymakers and funders in their effort to respond to this looming crisis in New York State.

¹ This study drew primarily from auditor-prepared elements of the New York State Department of Health Ambulatory Health Care Facility reports (AHCF-1) for calendar years 2001 through 2007. Centers were included if data met standards of completeness and reliability. Sample size ranged from 57 centers in 2001 to 66 in 2007.

Background



Health centers (technically Comprehensive Diagnostic and Treatment Centers) are a vital source of primary care for underserved communities of New York State whose residents 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 health centers operating more than 400 sites and providing more than 5 million visits to approximately 1.5 million patients.

Located throughout the State—upstate and downstate, across urban, suburban, and rural communities—most of these health centers are in communities that the Federal government has designated as medically underserved, where patients have few—if any—primary care alternatives should the health centers close. The centers included in this study include both Federally Qualified Health Centers (FQHCs)² and non-FQHCs. In addition to health centers, hospitals and private practitioners are also important sources of care for these communities. These were not the focus of this study, but they are subject to many of the same financial and policy factors as health centers.

The financial distress evident in these findings occurs at a moment when policymakers are pointing to the critical need for primary care as part of the State's agenda for improving access and quality of care. Primary care provides crucial services known to reduce health care costs, improve quality of care, and prevent and manage the rising tide of chronic illness that accounts for 75% of health care spending. This distress occurs during an economic recession when health centers are more critical than ever for the community-based jobs they generate as a source of care for the most vulnerable populations, and for the access to care they offer to those losing jobs and their health insurance.

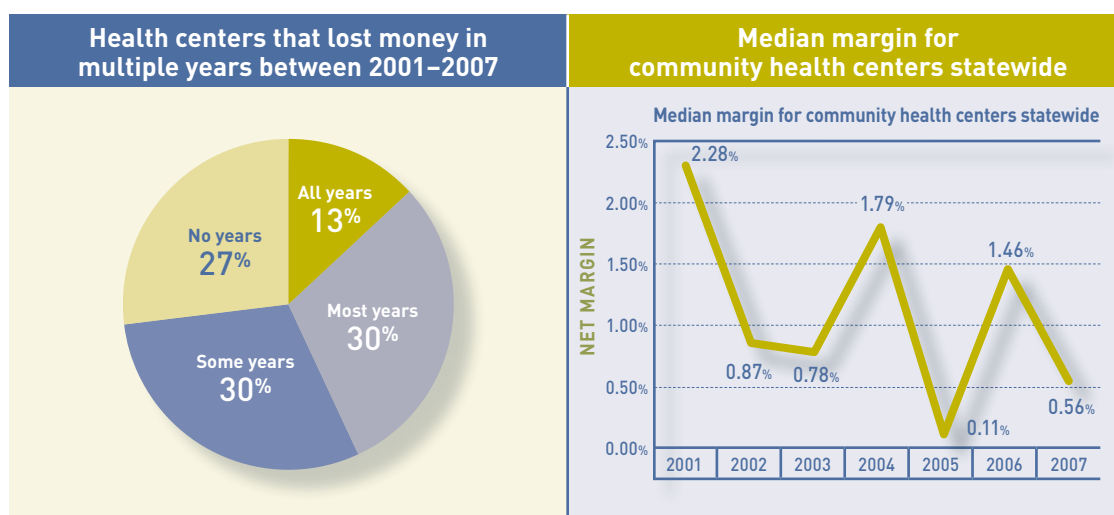
² FQHCs provide their services to all persons regardless of ability to pay. In return, FQHCs receive compensation from the Federal government in the form of a cash grant to help cover the costs of caring for the uninsured, cost-based reimbursement for their Medicaid patients, and free malpractice coverage.

Summary of Findings

Based on health centers' annual financial reports to the New York State Department of Health, our analysis found that health centers, for the most part, are in a tenuous position with regard to solvency, cash flow, and adequacy of payments.

- 43% of health centers lost money in all or most of the last seven years.
- 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 are one payroll away from full-scale financial crisis.
- Health centers are systematically underpaid for their services:
 - costs per visit exceed the Medicaid fee-for-service rate by nearly 20%, a gap partially closed by the State through special payments;
 - private payers pay \$38–\$55 less per visit than does Medicaid fee-for-service;³ and
 - the State pays health centers only 30% of the cost for care for the uninsured.

43% OF ALL HEALTH CENTERS LOST MONEY IN ALL OR MOST OF THE LAST SEVEN YEARS, WHILE MEDIAN HEALTH CENTER MARGINS DROPPED FROM 2.28% IN 2001 TO 0.56% IN 2007.



Source for all charts in this brief: HMA analysis of AHCF-1 Reports, 2001–2007, conducted in January 2009.

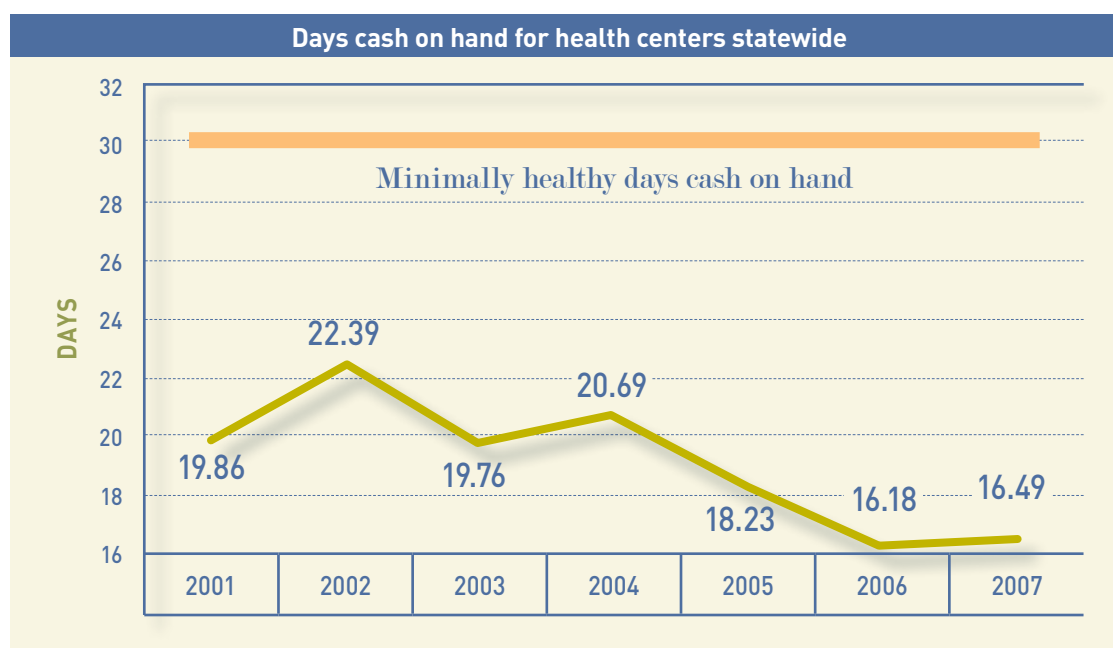
³ "Improving Commercial Reimbursement for Health Centers: Case Studies and Recommendations for New York," RCHN foundation, October, 2007

Summary of Findings *(continued)*

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. Over the last seven years, the median margin has declined 75%—from 2.28% to 0.56%—meaning that revenues are barely covering expenses.

WITH ONLY 16.5 DAYS CASH ON HAND, ON AVERAGE, HEALTH CENTERS ARE ONE PAYROLL PERIOD AWAY FROM A FULL-SCALE FINANCIAL CRISIS (AT LEAST 30 DAYS IS CONSIDERED MINIMALLY HEALTHY).

Cash on hand is a measure of liquidity—the number of days a health center can cover its operating expenses with cash immediately available to it. Cash on hand has declined steadily over the study period and currently stands at approximately 16.5 days. Good fiscal management would require at least 30 days cash on hand to pay essential expenses such as payroll.



HEALTH CENTERS ARE SUBSTANTIALLY UNDERPAID BY MOST PAYERS

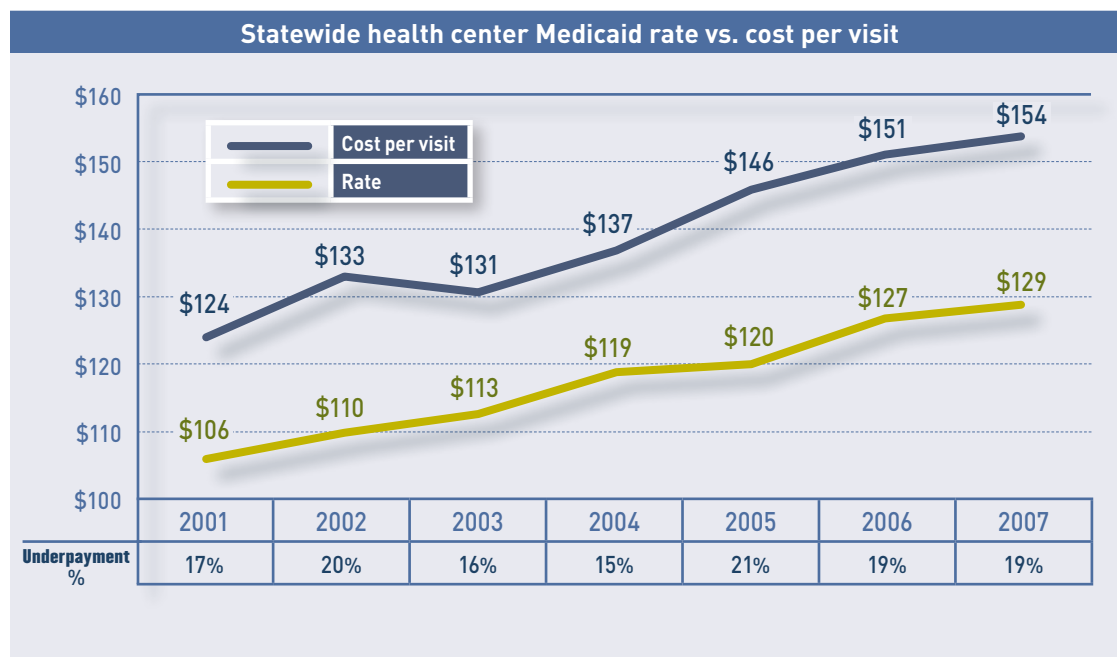
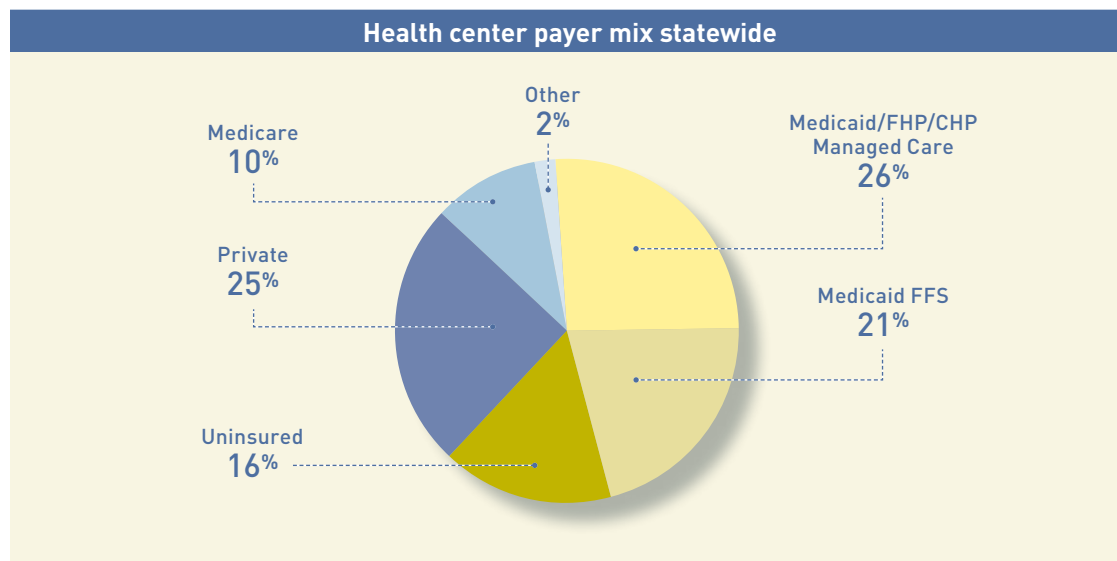
Although Medicaid fee-for-service is the best payer of health centers, the Medicaid rate covers only 79%–85% of health center costs, a gap partially closed by the State in recent years with special payments.⁴ While not included in this study, private (i.e., commercial) insurance payments underpay primary care services even more dramatically. A recent study shows their rates to be \$38 to \$55 per visit less than Medicaid fee-for-service.⁵ With regard to the uninsured, the State

⁴ Includes recruitment and retention add-ons and managed care transition payments

⁵ "Improving Commercial Reimbursement for Health Centers: Case Studies and Recommendations for New York," RCHN foundation, October, 2007

Summary of Findings *(continued)*

compensates only 30% of health center costs compared with 65% of uninsured costs experienced by hospitals. (Data are unavailable on the adequacy of payment of Medicaid managed care, Child Health Plus and Family Health Plus.)



Implications



While the full report will identify in some depth the many causes and contributors to financial distress in the health center sector and make recommendations accordingly, the findings presented in this issue brief allow for several significant conclusions.

Health centers are a vital source of primary care to New York State's underserved communities. Thousands of low-income families rely on health centers for their health care needs. Most of these health centers are in communities federally designated as medically underserved, so these families would have few primary care alternatives should health centers close.

Financial distress is severe and worsening, and will place health centers in jeopardy, just when New York needs health centers most. With slim and shrinking margins and little cash on hand, health centers are increasingly vulnerable to even minor downturns or crises. New York State could lose many of these centers at a moment when more people are losing health coverage or enrolling in public insurance programs, and when policymakers have committed to investing in primary care to control health care costs and improve the health of residents.

Sustained financial distress undermines the ability of health centers to serve their communities. Financial distress drains organizational resiliency. It limits health centers' ability to address routine needs, maintain adequate staffing, make internal investments, and expand services to families in need.

Recommendations

Community health care providers must be paid fully and fairly. All payers must pay for the cost of the services they purchase from health centers, including State programs such as Medicaid fee-for-service, Medicaid managed care, Family Health Plus and Child Health Plus, as well as commercial payers. Similarly, the State should pay more adequately for care of the uninsured.

Payments must be made in a timely manner. Health centers report delays—often in excess of a year—in receiving payments due from the State, including rate adjustments, transition funds, and payments for the uninsured. Such delays contribute to health centers’ deteriorating cash on hand and, in turn, the deteriorating cash on hand makes health centers even more vulnerable to late payments.

Health centers should be considered an important element of fiscal stimulus. Primary care in New York State has suffered decades of underinvestment. Moreover, investment in health centers has been shown to be an important source of community economic development in the number of direct and indirect jobs it produces and the primary and secondary spending it generates. Investment in primary care thus addresses dual public priorities: health care reform and community economic stimulus.

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About the Organizations

THE NEW YORK STATE HEALTH FOUNDATION

NYSHealth, whose mission is to expand health insurance coverage, increase access to high-quality health care services, and improve public and community health was established by the State of New York with charitable funds from the privatization of Empire Blue Cross/Blue Shield.

THE PRIMARY CARE DEVELOPMENT CORPORATION

The Primary Care Development Corporation is the only Community Development Financial Institution in New York State—and the largest and first in the U.S.—focusing solely on primary care. Since its inception in 1993, PCDC has invested \$165 million in 77 health center projects, leveraging a total investment of \$240 million in community health centers statewide; created health care facilities that have generated more than 2,100 permanent jobs; built or renovated 620,000 square feet of space; and created the capacity to serve approximately 525,000 New Yorkers and provide 1.6 million medical visits annually. PCDC has also helped more than 400 health center teams transform their operations by decreasing appointment backlogs, reducing no-show rates, implementing HIT systems, and increasing provider productivity.

PCDC partnered with Health Management Associates (HMA) to complete this analysis. HMA is an independent national research and consulting firm specializing in complex health care program and policy issues. Founded in 1985, HMA provides leadership, experience, and technical expertise to local, state, and federal governmental agencies, regional and national foundations, investors, multi-state health system organizations and single site health care providers, as well as employers and other purchasers in the public and private sectors. HMA has 10 offices around the country.



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