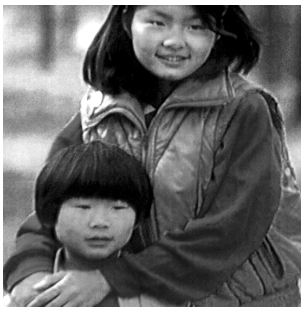
STRENGTHENING THE SAFETY NET

A FINANCIAL ANALYSIS OF NEW HAMPSHIRE'S COMMUNITY HEALTH CENTERS

FULL REPORT

(Pagination and Footnote Numbers are not as in the Printed Version)



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AHRQ
User Liaison Program

The New Hampshire Health Care Plan

In 1995, the Legislature directed the Department of Health and Human Services (DHHS) to prepare "a comprehensive and coordinated system of health and human services as needed to promote and protect the health, safety and well-being of the citizens of New Hampshire" (RSA 126A). The DHHS Office of Planning and Research responded by creating a statewide Health Care Planning Process that involved more than 1000 New Hampshire residents in 7 community councils, 22 focus groups, 18 town meetings, and 4 symposia.

This planning effort culminated in the issuance of the October 1998 report, ***The New Hampshire Health Care System: Guidelines for Change***. The report set forth 27 recommendations designed to improve the State's ability to: monitor and manage the rapidly evolving health care system; increase communities involvement in and direction of the health care system; enhance the ability of the market to perform effectively; and assure that New Hampshire citizens have access to needed health care. *Guidelines for Change* established the direction and goals of the State Health Care Plan. ***Strengthening the Safety Net: The Financial Status of New Hampshire's Community Health Centers*** is another in the series of reports that constitute the New Hampshire Health Plan (see the following page for a complete listing of the reports issued to date and how to obtain copies).

Beginning in the fall of 1998, the Department of Health and Human Services began taking steps to implement the recommendations contained in the *Guidelines for Change*. One of the first action steps completed was the statewide Household Insurance Coverage and Access Survey (recommendation 2) that established a baseline estimate of New Hampshire's uninsured (see *Health Insurance Coverage in New Hampshire*).

Another major step in the implementation of the *Guidelines for Change* - the analysis of New Hampshire's health care market - began in the spring of 1999. The DHHS, Office of Planning and Research, partnered with the Department of Insurance and the Attorney General's Office to begin the joint monitoring of the health care market (Recommendation 1) and to develop a data system that provided information on the performance of the market (Recommendation 15). During this same time, the DHHS and the Attorney General's Office conducted a series of workshops on the new community benefits legislation (Recommendation 27).

Strengthening the Safety Net: The Financial Status of NH's Community Health Centers represents the first report to be released from the New Hampshire health care market analysis. This analysis of the financial status of community health centers will inform the discussions (Recommendation 7) on the nature and funding of the State's "safety net" providers.

New Hampshire Health Care Plan Reports

The Elements of an Ideal Health Care Delivery System

An Inventory of Health Status Indicators

New Hampshire's Health Status Goals

Health Planning, Values and Preferences

The State, Communities, and Individuals: Roles and Responsibilities in New Hampshire's Health Care System

The New Hampshire Network Survey Report

Creating a Healthier New Hampshire: A Consumer Report on Proposed Changes to New Hampshire's Health Care System

The New Hampshire Health Care System: Guidelines for Change

Health Insurance Coverage in New Hampshire

PREFACE

The New Hampshire Department of Health and Human Services wishes to acknowledge the assistance that the User Liaison Program (ULP) of the U.S. Agency for Healthcare Research and Quality (AHRQ) provided for this statewide conference. The ULP assists states in conducting workshops for policymakers on issues of special concern to them.

The Department also wishes to thank the national program office for the Robert Wood Johnson State Coverage Initiative at the Academy for Health Services Research and Health Policy (AHSRHP), Washington, DC, for their help in making this statewide conference a reality.

Jennifer Scott MS, Paul Giaudrone and Nancy Kane DBA, Harvard School of Public Health, prepared the *Report on the Financial Status of Nine Community Health Centers in New Hampshire: 1994-1999* for the New Hampshire Department of Health and Human Services. The Robert Wood Johnson Foundation, under the auspices of The Access Project, Grant Number 031275, funded this project. The authors performed this work under subcontract to the SCG Consortium.

The Robert Wood Johnson Foundation, under the auspices of the State Coverage Initiatives Project, Grant Number 035401 (to the Department of Health and Human Services) also provided assistance.

Lori Real, MHA, Director, Office of Planning and Research, provided overall direction for the New Hampshire health care market analysis, of which this project is one component.

Christine Shannon, MS, Senior Health Planning and Policy Analyst, DHHS, Office of Planning and Research, designed the market analysis project, managed the day-to-day research and contributed to the writing of this report.

Bruce Spitz, SCG Consortium, assisted in securing the funds to do this work and contributed to the writing of this report.

The Office of Community and Public Health (OCPH) partnered with the Office of Planning and Research to develop this report. Kathleen Dunn, MPH, Director, OCPH, William Kassler, MD, Medical Director, OCPH, and Bryan Ayars, Primary Care/Rural Health Program Chief provided valuable input to this project. Steve Norton, Senior Health Policy Analyst, Office of Planning and Research (OPR), offered a national perspective on the safety net and John Bonds, Planning Coordinator, OPR, supplied history and insights on primary care services in New Hampshire.

Members of the Interagency Workgroup (a multi-State agency group composed of the Department of Health and Human Services, NH Department of Insurance and the Attorney General's Office) supported this work, assisted in the review of earlier drafts and contributed to the development of the recommendations. They were: Donald Shumway, Commissioner, Department of Health and Human Services (DHHS), Kathleen Sgambati, Deputy Commissioner, DHHS, Paula Rogers, Commissioner, NH Department of Insurance, Alex Feldvebel, Deputy Commissioner, Department of Insurance, Phillip McLaughlin, Attorney General, Michael DeLucia, Assistant Attorney General and Director, Charitable Trusts, Terry Knowles, Registrar, Charitable Trusts, Walter Maroney, Senior Assistant Attorney General and Tom Bunnell, Health Policy Advisor, the Governor's Office.

Catherine Dunham, Director, and Robert Seifert, Senior Policy Analyst, of The Access Project, provided technical expertise.

The Department thanks the BiState Primary Care Association and its member organizations that participated in this project.

AHRQ's User Liaison Program

Meeting the Information Needs of State and Local Officials

The Agency for Healthcare Research and Quality (AHRQ) develops and disseminates research-based information to increase the scientific knowledge needed to enhance consumer and clinical decisionmaking, improve health care quality, and promote efficiency in the organization of public and private systems of health care delivery.

The AHRQ was created to help the Nation's health care system provide high-quality, cost-effective services; be accountable and responsive to consumers and purchasers; and improve Americans' health status and quality of life. AHRQ is the health services research arm of the Public Health Service, a component of the U.S. Department of Health and Human Services. As such, AHRQ works closely with other Federal health agencies, including the National Institutes of Health--the Public Health Service's biomedical research arm.

AHRQ's goals are to work with the private sector and other public organizations to:

- Help consumers make better informed choices.
- Determine what works best in clinical practice.
- Measure and improve quality of care.
- Monitor and evaluate health care delivery.
- Improve the cost-effective use of health care resources.
- Assist health care policymakers.
- Build and sustain the health services research infrastructure.

The User Liaison Program (ULP)

The User Liaison Program (ULP), established in 1978, contributes to AHRQ's mission by synthesizing and distributing research results to local, State, and Federal health policymakers--"users" of such research. Small policy-thematic workshops form the core of ULP's activities, although skill-building workshops and written products such as research syntheses, technical assistance documents, and web-based materials may also be produced. In addition to providing information and tools with which informed health policy decisions can be made, ULP serves as a bridge between State and local health policymakers and the health services research community, by bringing back to the Agency the research questions being asked by key policymakers.

ULP workshops are user-driven and user-designed. They have been highly successful because ULP relies upon senior legislators, executive agency staff, and local officials to identify the key policy issues they are confronting and about which ULP should provide information. These key stakeholders also indicate the specific questions that should be addressed during each workshop session. Presenters' materials are thoroughly reviewed by ULP staff, experts, and stakeholders to ensure that research findings and other information imparted during workshop sessions, such as best practices, are framed so that it can be easily understood and used. Additionally, presenters' materials are reviewed carefully to ensure that information is objective and non-partisan; ULP recognizes the scope and limitations of specific research findings and that the same solution may not be feasible or workable in all cases.

Another key feature of ULP workshops is the emphasis on information sharing between participants as well as between presenters and participants. Workshops are planned to be highly interactive; time for questions and small groups are built into the day's activities and group meals are arranged. Furthermore, presenters are encouraged to stay and participate in the entire meeting, allowing participants greater time for interaction with these experts.

In addition to offering national workshops, the User Liaison Program is responsive to meeting the needs of individual states. State officials often approach ULP about conducting workshops for that State's policymakers on issues of special concern to them. In these instances, ULP will pay up to 50 percent of the cost of the meeting or $20,000, whichever is less. States are asked to provide the remainder of workshop support costs either in dollars or in-kind services. ULP sets aside funds each year to assist several states with these seminars.

Policy-thematic workshops and seminars sponsored or supported through the ULP over the years have covered a wide variety of issues including: Ensuring Quality Health Care: The Challenges of Measuring Performance and Consumer Satisfaction; What Do We Do About the Uninsured; Local Health Departments in a Managed Care Environment; Rural Health and Rural Managed Care; Managed Care and Integrated Delivery Systems; Providing Quality Services to Children with Special Health Care Needs; and Long-Term Care.

ULP also co-sponsors workshops and participates in technical assistance activities. For example, it has partnered with non-profit foundations and national organizations such as the National Conference of State Legislatures (NCSL); the Association of State and Territorial Health Officials (ASTHO); the National Association of County and City Health Officials; and the National Association of Counties (NACo). AHCPR's publication *Assessing Roles, Responsibilities, and Activities in a Managed Care Environment: A Workbook for Local Health Officials* is a direct result of ULP's collaborative effort with ASTHO, NACCHO, and the Association of Maternal and Child Health Programs (AMCHP). Additionally, ULP has designed a web-based, distance learning program based on its workshop entitled *Children's Health Insurance Program (CHIP): Implementing Effective Programs and Understanding Their Impacts*.

For more specific information regarding individual workshops or other ULP activities, write to the address below. The telephone number is (301) 594-6668; fax is (301) 594-2035; e-mail ulp@ahrq.gov

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Purpose

Community Health Centers (CHCs) are nonprofit comprehensive primary care providers committed to caring for the poor and the uninsured. New Hampshire has 10 CHCs. They are an integral part of the State's safety net. The purpose of this report is to: (1) describe the purpose and importance of these CHCs; (2) present the financial status and trends of these CHCs in a health care market that is in rapid transition; (3) propose recommendations to strengthen the State's core safety net – the Community Health Centers.

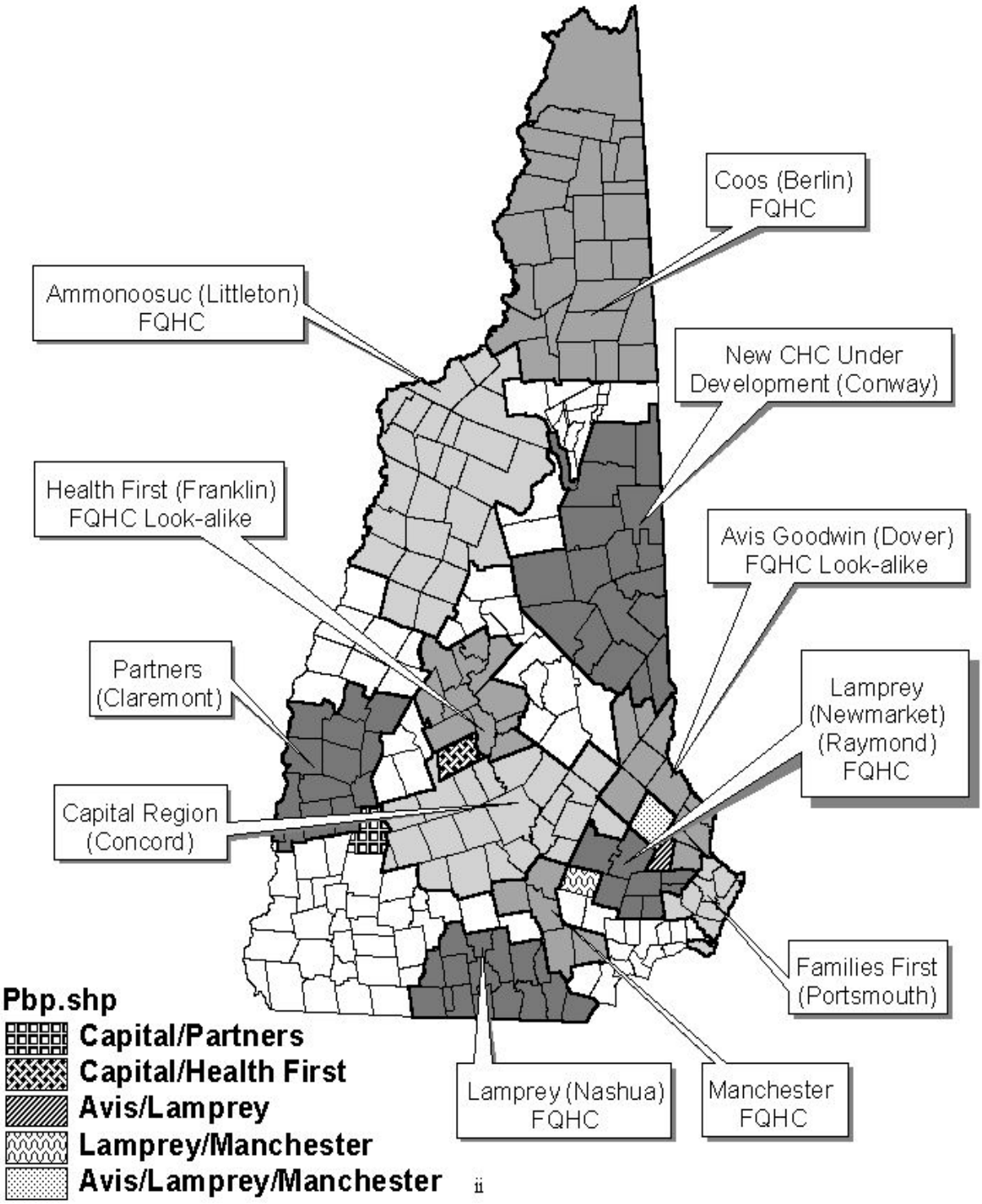
Introduction

During the 1990s, health care in New Hampshire has been characterized by a private restructuring of the market (increased competitive pressures, the creation of integrated hospital systems, and the consolidation of the insurance market); federal attempts to reduce public expenditures (the 1997 Balanced Budget Act and the subsequent 1999 Balanced Budget Refinement Act; the persistence of a significant number of uninsured New Hampshire residents (96,000 in 1999); and increased reliance by the uninsured on Community Health Centers. In this environment, concerned citizens, legislators, and policymakers need information in order to make fact-based decisions and to monitor changes in the market.

This detailed financial analysis of sectors of the State's health care market is the first such effort. The recommendations in the *Guidelines for Change* and the issues identified above both helped sharpen the focus and determine the starting point of the project to implement these recommendations. Data availability was another important consideration. Fortunately, the Department of Health and Human Services has collected annual audited financial statements from the Community Health Centers. Given the interest in the Legislature and District Health Councils on the State's uninsured and the fact that over 40% of the Community Health Centers' patients are uninsured, the CHCs were a logical starting point.

The Department of Health and Human Services played a major role in the development of the Community Health Centers. Six of these CHCs opened their doors in the mid-1990s. For these centers, this study represents an examination of how they have fared financially since then and allows for the first look at trends. For those newer sites and any future expansions, the data will help determine the financial base necessary to serve the poor, uninsured, and Medicaid clients that make up the majority of the population that use CHCs. Not only will this financial analysis become an integral part of the DHHS' operations, but it also sets the stage for expanding the study to other components of the State's health care system.

Community Health Center Market Areas



The Process

Seven years of audited financial statements (1994-1999) were analyzed for nine sites that deliver comprehensive primary care services. [1] Data from the financial statements were organized into Excel spreadsheets, standard financial ratios were calculated (profitability, liquidity, and solvency), and then an analysis of the ratios was done. Preliminary figures were presented to CHC and DHHS staff. Each CHC was then given an opportunity to review their spreadsheet data and to make any necessary revisions. Section II of this report contains the aggregate results of this analysis.

There are ten CHCs in New Hampshire; eight were included in this study. The map on the previous page includes the name and location of each of New Hampshire's CHCs (the map shows the 8 centers that participated in the study, the 2 who did not and the newest site that is expected to go online in January 2001). [2] The hospital-based CHCs were not included in this study because their financial statements are consolidated within the hospital statements. [3] Since this is the first time a study was conducted of the financial status of the State's CHCs, efforts will be made to construct the information that will allow their inclusion in future studies.

The Definition of a Safety Net Provider

The Institute of Medicine [4] defines a "safety net provider" as:

> *Those providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid and other vulnerable populations.*

They further distinguish a subset of "core safety net providers":

> *These providers have two distinguishing characteristics: (1) either by legal mandate or explicitly adopted mission they maintain an "open door," offering access to services for patients regardless of their ability to pay; and (2) a substantial share of their patient mix is uninsured, Medicaid, and other vulnerable patients.*

These "core safety net providers" are then defined as Community Health Centers, public hospitals, and local health departments.

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[1] Of these 9 sites, 8 are Community Health Centers (CHCs) who deliver primary and preventive health care to people of both genders, all ages, 24 hours per day, 7 days per week, 365 days per year. Manchester Child Health Services is included in the aggregate of the financial ratios presented in Section II of this report. Manchester Child Health Services delivers comprehensive primary care to clients 0-18 years old who live in families at 185% or less of the federal Poverty Level and has a caseload limit of 1,000 patients. The Department's report and recommendations address only the CHCs.

[2] Since this study was completed, the Neighborhood Health Center in Nashua became part of Lamprey Health Care. It shows up on this map as Lamprey (Nashua).

[3] Concord Hospital sponsors the Capital Region Family Health Center and Valley Regional Hospital sponsors the Partners in Health Center.

[4] These definitions adopted for use in this report are contained in the publication *America's Health Care Safety Net: Intact but Endangered* that was released by the Institute of Medicine (IOM) in Spring 2000. The deliberations of the IOM Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers are reflected in this publication.

Community Health Centers are the focus of this report. They are by no means the only components of the health care safety net. Community hospitals offer inpatient and outpatient services to the poor and uninsured, as do private physicians offices, community networks developed to serve the uninsured, and many different types of community-based providers such as children's health and family planning clinics. The safety net varies considerably from state-to-state and community-to-community.

The discussions that follow describe New Hampshire's "core safety net" providers. Most of the uninsured are seen by other providers both in New Hampshire and around the country (BiState Primary Care Association estimates that the NH CHCs see approximately 18% of the State's uninsured). However, CHCs provide a disproportionate amount of care - compared to other providers - to the most complicated cases among the poor, uninsured, Medicaid participants and other vulnerable populations.

An Outline of This Report

This report begins with a statement of the importance of the CHCs to the State's uninsured, Medicaid and other vulnerable populations, and to the health care delivery system. It offers an overview of the CHCs: who they are and where they are located, who they care for, what services they provide, and how they are financed. A brief summary of the findings from the financial analysis (which follows this section) is also included. Finally, this section concludes with recommendations for action by both the public and private sectors to stabilize and preserve this important component of the New Hampshire health care system. The Appendix contains definitions of the terminology contained in this section.

The next section contains the report on the aggregate financial status of the eight New Hampshire CHCs. It begins with an explanation of the methodology used and a set of definitions for the standard financial measures. An overall summary of findings is then presented, followed by an in-depth explanation of these financial benchmarks.

SECTION I

New Hampshire's Community Health Centers – Core Safety Net Providers

New Hampshire Department of Health and Human Services
October 2000

New Hampshire's Community Health Centers - "Core Safety Net Providers"

The health of New Hampshire's citizens can only be secured with the presence of a safety net provider system. Community Health Centers are "core safety net providers". Community Health Centers (CHCs) have a common mission to deliver primary and preventive health care services to underserved people who face barriers accessing mainstream health care, such as lack of insurance, inability to pay, cultural/ethnic issues and geographic isolation. While public and private efforts may be able to expand insurance coverage to some of the State's 96,000 uninsured residents, it is not likely that coverage will be available to everyone. Therefore, the State has a compelling interest to maintain its core safety net providers to ensure that the uninsured, underserved and vulnerable populations always have a source of care.

There is a clear and causal link between poor access to primary and preventive care and poor health outcomes. Those lacking access to primary care are more likely to be diagnosed with an illness at a later stage of disease, be admitted to a hospital more seriously ill and be more likely to die in the hospital, and have a higher general mortality rate than those with good access to preventive services and appropriate ambulatory care. Community Health Centers deliver quality community-oriented primary care and case management to the population that has difficulty accessing care and following treatment plans. These safety net providers integrate population-based and preventive care into the clinical services they deliver and can be held accountable for public health outcomes.

In recognition of the importance of these services, the State made a commitment in the mid-1990s to expand access to primary care services through the establishment of Community Health Centers. In 1995, the Legislature (in RSA 126 A:18) charged the New Hampshire Department of Health and Human Services (DHHS) to:

- develop primary preventive health services for low-income and underserved populations;
- recruit and establish retention of primary care practitioners in rural communities and areas of high primary care needs; and
- provide technical assistance to communities, health care agencies, and primary care providers developing comprehensive care services.

The DHHS responded with the "primary care initiative", initially funded through the Health Care Transition Fund, which allowed for the development of comprehensive primary care sites (now referred to as Community Health Centers) in New Hampshire. [5]

Community Health Centers have always operated within the narrowest of margins. The poor and uninsured simply do not have the resources to pay for the full cost of their care. The CHCs,

[5] Prior to this legislation, there had been only 1 federally funded CHC (Lamprey Health Care) in NH. During this same time, concerted local and State efforts led to the development of 3 more CHCs that were able to receive some federal funding (Manchester Community Health Center, Coos County Family Health Services, Inc. and Ammonoosuc Community Health Services, Inc.) and 4 State funded CHCs (Capitol Region Family Health Center, Avis Goodwin Community Health Center, Health First Family Care Center, and Partners in Health Center). Most recently, Community Grant Program funds have contributed to the development of 3 more State funded CHCs (Families First of the Greater Seacoast, the Neighborhood Health Center, now a component of Lamprey Health Care, and the Family Health Centre).

therefore, have depended on federal, State and local grants to offset their losses. Unfortunately, in the new and evolving competitive health care system, CHCs are experiencing increased demand for their services without increased grants to maintain their operations. Financial stability is key to the continued existence and ability of New Hampshire's Community Health Centers to meet their missions. The weak financial situation of these centers has – to borrow a phrase from the recent Institute of Medicine report on the health care safety net – created a situation where the system is "intact but endangered". To put it in other words – a tear is starting to develop in our safety net.

This section offers an overview of the CHCs: who they are and where they are located, who they care for, what services they provide, and how they are financed. A brief summary of the findings from the financial analysis report (which follows this section) is also included. Finally, this section concludes with recommendations for action by both the public and private sectors to stabilize and preserve this important component of the New Hampshire health care system.

A Description of New Hampshire's Community Health Centers

Who are the CHCs?

Community Health Centers share a vision of assuring access to high quality, affordable health care with the first step being access to preventive and primary health services. In the late 1960s, the federal government established the first CHCs. With the exception of Lamprey Health Care (serving the Newmarket and Raymond areas), CHCs are relatively new on the New Hampshire health care scene, which in itself has implications for these organizations' financial health. Most began comprehensive primary care services in the mid-1990s, although a few of them began operations in the late 1990s. [6]

Community Health Centers are private nonprofit ambulatory care providers whose missions are to serve all who seek care without regard to ability to pay or insurance status. These community-based organizations have boards of directors who, for the most part, are users of the health center's services.

A distinguishing characteristic of CHCs is that they provide so-called "enabling services" - translation, transportation, outreach, case management and psychosocial services - that lead directly to increased access to care and improved health outcomes.

The CHCs are considered a "core" component of the health care safety net because the majority of their clients are uninsured, Medicaid recipients and members of other vulnerable populations. The populations served by the CHCs have dictated their locations – all of the CHCs reside within rural and urban areas of the State that either have an inadequate supply of providers (referred to as Health Professional Shortage Areas or HPSAs) or are considered Medically Underserved Areas (MUAs), or are in economically distressed areas. (The map in the Introduction p. ii provides the name and location of each of New Hampshire's 10 Community Health Centers.)

Four of New Hampshire CHCs are designated as Federally Qualified Health Centers (FQHCs); 2 are FQHC Look-a-Likes. These designations have important financial implications for these centers. The

[6] A new site is starting up in Carroll County in 2001 – the Family Health Centre. The reader has to keep the relative youth of New Hampshire's CHCs in mind when interpreting the financial results in Section II, particularly for the newest sites that may be in the early stages of achieving their business plans.

FQHCs receive federal funds to deliver primary care to the uninsured and reasonable cost reimbursement for Medicaid patients. FQHC Look-a-Likes receive reasonable cost Medicaid reimbursement but no federal primary care funds.

Who receives health care services at the CHCs?

Health center patients are overwhelmingly low income – approximately 85% have incomes below 200% of the Federal Poverty Level ($34,100 per year for a family of 4). Women and children are the primary recipients of health center services. Income, age and sex are not the only distinguishing characteristics of these clients. They are often more costly to provide services to because of:

- underlying diagnoses (such as persistent mental illness, alcohol or chemical dependency) that make it hard to comply with treatment plans;
- the presence of more complex chronic illnesses than cared for by private physician practices; [7]
- diverse social/cultural barriers; and
- language barriers.

Some centers serve a large number of refugees and homeless; most see a small percentage of Medicare clients. Medicaid recipients (primarily children and pregnant women) also bring in other family members who, more often than not, are uninsured.

What types of services do CHCs deliver?

Community Health Centers focus on the delivery of comprehensive primary and preventive care to people of all ages, seven days per week, 24 hours per day, 365 days per year. As noted above, they also provide "enabling services" – usually not available in other venues - that help reduce a patient's barriers to care and improve health outcomes. [8]

Case management is an important "enabling" service that CHCs provide. Chronic health conditions such as asthma and diabetes, depression and high-risk pregnancy have a major impact on safety net providers' resources. In recognition of this impact, several NH centers have formed a network to develop organized disease management services for diabetes, asthma, and hypertension.

CHCs have also expanded their scope when other goods and services are out of their patients' reach. For example, prescription drugs are not only an issue for the elderly but for any low-income and/or uninsured individual. In response to this need, some NH CHCs have established (or are in the process of

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[7] The Kaiser Commission on Medicaid and the Uninsured issued a report in February 2000 titled *Health Centers' Role as Safety Net Providers for Medicaid Patients and the Uninsured* that contained information on a comparison of patient visits for selected conditions among patients at CHCs and at office-based physician practices. Higher proportions of CHC visits were for diagnoses associated with additional care costs and greater levels of morbidity and mortality (e.g., hypertension, chronic bronchitis, asthma, diabetes and mental disorders).

[8] Unfortunately, these are often the first set of services to go when funds are tight. A recent federal study found that the number of CHC "enabling" services decreased between 1996-1998, while the number of uninsured seeking care increased by 10%.

establishing) programs to help their patients purchase the medications they need, which are especially crucial for those who are chronically ill.

What types of providers deliver these services?

The health professionals that work in Community Health Centers are no different than those in the private sector. Primary care physicians (family practice, general practice, internal medicine, ob-gyn, and pediatricians) and others who deliver primary care services, such as Nurse Practitioners, Certified Nurse Midwives, registered nurses, physician assistants, nutritionists/dietitians, dentists and dental hygienists staff CHCs. Some CHCs employ mental health and substance abuse counselors or have shared staffing arrangements with other local providers. CHCs employ more social services personnel (such as social workers, family support counselors, and outreach workers) than are typically employed in a private physician practice.

CHCs experience similar problems recruiting staff that mainstream health care providers do (e.g., a tight job market, rural locations, etc.) with the additional problem of very limited budgets.

How are CHCs financed?

CHCs have a much smaller proportion of insured patients and a greater proportion of uninsured and Medicaid patients than other providers. Nationally, 40 percent of CHC clients are uninsured, 33 percent are Medicaid and only 16 percent had private insurance. In New Hampshire**, 41 percent** of the CHC patients are uninsured, **19 percent** are covered by Medicaid, and **32 percent** have other third party coverage. This patient mix means that patient revenue does not cover the full cost of care. For New Hampshire's CHCs, patient revenues cover only **40 percent** of the health center's costs of providing services. Community Health Centers depend on public (primarily federal and State government with some local assistance) and private grants and contracts for 56 percent of their revenues; the remaining 4 percent comes from contributions and fundraising.

Up until 1999, federal CHC grants (that the FQHCs receive) throughout the nation remained flat while the number of uninsured receiving care increased (the GAO reported that the uninsured increased 10 percent between 1996-1998 at these FQHCs). [9] At the same time, Medicaid became an important source of funds. By 1998, Medicaid was the largest single funding source for CHCs. Medicaid is particularly important for the FQHCs and FQHC Look-a-Likes, both because it represents the majority of insured patients at the CHCs and because of the reasonable-cost reimbursement Medicaid provides to these two types of NH Community Health Centers. [10]

There is a development, however, in regards to Medicaid reimbursement that could significantly impair Community Health Centers' ability to survive and continue to care for the special

[9] For the first time in many years, Congress appropriated additional funds for the FQHCs. Lamprey Health Care was the recipient of an expansion grant that allowed them to take over the struggling Neighborhood Health Center.
[10] A very simple explanation of reasonable cost reimbursement means that Medicaid pays its share of the costs of operating the FQHC or FQHC Look-a-Like. Say a CHC saw 10,000 patients in a year and half of them of them were Medicaid and the other half uninsured. All patients received the same kinds of services. Medicaid would not pay a fee for each of those services but for 50% of the cost of operating that clinic (up until 1983, this was how Medicaid and Medicare reimbursed hospitals). Medicaid is thus, a very important source of money in an environment in which the largest portion of the patients is unable to pay for most of their care.

populations they serve. The Balanced Budget Act (BBA) of 1997 called for the phase out of FQHC/FQHC Look-a-Likes reasonable cost reimbursement by 2003. Two years later, the Balanced Budget Refinement Act (BBRA) of 1999 called for a slow-down of the phase out until 2005 and a study of its impact on these centers.

A Summary of the Findings on the Financial Status of New Hampshire's Community Health Centers

Section II contains a report on the financial status of Community Health Centers in New Hampshire for the period 1994-1999. What follows below is a summary of the findings of that report upon which the *Recommendations for Action* are based.

- *Over the six-year period studied, total and operating margins of the CHCs fell dramatically, with some of the centers studied having negative total margins in 1999.*

- *For 4 of the 6 years analyzed, operating expenses grew faster than operating revenue as patient volume increased; this was the driving force behind the rapid decline in total and operating margins for the CHCs.*

- *CHCs are limited in what they can collect from patients. As a result, net patient service revenue only covered 40% of operating costs in 1999. CHCs relied upon grants and contracts for 56% of their total operating expense.*

- *Short-term liquidity worsened during this study period; for many of the CHCs this was due to low to negative profitability and the use of current liabilities to finance fixed assets.*

- *The majority of health centers had only one month cash on hand from all sources on their balance sheets.* [11]

- *The majority of CHCs slowed payment of accounts payable in order to compensate for declining cash balances and inability to collect patients accounts receivable.*

- *Over this period, the solvency of the majority of CHCs declined; many had poor equity financing ratios, with some centers having negative equity financing ratios in 1999 as losses on operations depleted their net assets.*

- *Short-term debt was the most significant source of cash for some of the CHCs.*

- *Over this period, the health centers as a group did not generate enough cash internally through operations to meet capital investment needs; because many of the centers were*

[11] The Health Services and Resources Administration (HRSA) suggests that federally funded CHCs maintain a reserve amount of 60-90 days of operating expenses. (Sections 309 (a) (3) and 309 (b) (3) of the Preventive Health Amendments of 1992 prohibited HHS from restricting the use of nonfederal funds to establish such reserves.)

unable to access long-term debt, they increased their financial risk by using short-term debt to help finance fixed assets.

RECOMMENDATIONS FOR ACTION

Perhaps, the most remarkable aspect about CHCs is their ability to stay in business and serve more patients. Some of this, no doubt, is due to their responses to the changing health care environment (e.g., the formation of networks); the strong commitment to the mission of CHCs; their ability to leverage community support and resources; and the actions of their boards of directors. However, it is unlikely that these strengths could overcome their fiscal problems without grants from federal, state and local governments. While Community Health Centers are still here, there are signs that their ability to survive over the long-term is in jeopardy.

One of these signs, the impact of changes in Medicaid reimbursement, was discussed above. Another sign is the continued increase in the number of uninsured - particularly those with incomes less than 200 percent of the Federal Poverty Level ($34,100 per year for a family of 4) - despite a robust economy. Recent news reports cite health insurance premium increases in the 10-30% range for large employers (small employers are often hit harder). If past experience holds true, further increases in the number of uninsured can be expected.

The changes in the private health care system pose another significant threat to CHC financial survival. Economic reforms in health care have created pressure on most providers that has resulted in reduction or elimination of free care to the poor and uninsured. One example of such reform is the consolidation of providers. While such market-driven changes in the delivery system can reduce financial risk (e.g., hospital ownership of physician practices or the formation of larger physician group practices), a recent study found that this also leads to the provision of less charity care. If private providers care for fewer poor and uninsured patients, the burden on CHCs will increase.

Competitive markets respond to buyers who have the ability to pay for the goods and services they demand. If an individual has no resources, they cannot enter the market. Competitive solutions in health care place the poor and uninsured at risk because they cannot pay for all of the care that they need. CHCs reach out to the poor and uninsured – they do not compete for them. The preservation and stabilization of this group of core safety net providers serving the uninsured, poor, underserved, Medicaid and other vulnerable populations is the challenge facing New Hampshire.

Incremental approaches to expanding health insurance will still leave significant numbers of New Hampshire citizens without coverage. For this reason, and for the unique expertise CHCs bring to caring for this special population, we believe it is in the State's best interests to take the lead role in shaping strategies to preserve and stabilize New Hampshire's Community Health Centers. These strategies are best accomplished through public/private partnerships.

These strategies are grouped under the following categories:

- Financial
- Technical Assistance
- Workforce Development
- Research, Planning and Information Management

An Advisory Committee consisting of public and private partners should be convened to advise the Department of Health and Human Services in the implementation of the recommendations that follow.

Financial

Patient revenues do not cover the costs of providing services. Out-of-pocket payments from the uninsured and self-pay are minimal. Medicaid covers clinical services but does not cover all of the enabling services. Private insurance may or may not cover the full costs, however, private insurance rarely covers any enabling services. The Department of Health and Human Services, the Community Health Centers, and other stakeholders, need to identify additional resources to cover the cost of services. The DHHS, CHCs and other stakeholders should:

1. Continue efforts to expand private health insurance coverage to New Hampshire's uninsured and to enroll all health center patients eligible for Medicaid and the State's Children's Health Insurance Program. Expanded insurance coverage will give some patients a source of payment, which could improve the CHCs' financial position. [12] The federal government should be encouraged to allow unspent State SCHIP fund allocations to be used for: (1) grants to reimburse CHCs for services to people who do not have health insurance coverage; and (2) insurance coverage expansions to low income adults.

2. Examine the Department of Health and Human Services resource allocation to CHCs and determine how to ensure appropriate cost reimbursement for services. Any strategy should include the cost and reimbursement of enabling services and psychosocial services that improve access to care and maximize health outcomes.

3. Maximize federal funding opportunities. State-funded health centers should compete for Section 330 (of the Public Health Services Act) new start funds and/or apply for FQHC Look-a-Like status. FQHCs should compete for expansion funds. Any new centers developed with State funds should be positioned to take advantage of future federal funding opportunities. There are, however, several State-funded CHCs that will not qualify for federal funds. Other avenues for funding will have to be pursued for these centers.

4. Develop and maximize partnerships with New Hampshire's community hospitals, businesses, charities and foundations to provide direct and indirect support of CHCs. There are many businesses and community leaders who are not only unaware of the CHCs' mission and services, but also unaware how many of their employees, friends and neighbors access care through CHCs.

5. Identify current and projected capital needs and seek out new opportunities to gain access to long-term capital sources, loan guarantors and lines of credit.

[12] The Adult Coverage Subcommittee of the Healthy Kids Corporation created by SB 183 is currently exploring options for expanding insurance coverage to adults. A report will be delivered to the Legislature by year's end.

Technical Assistance

New Hampshire's CHCs (with the exception of Lamprey Health Care) are young organizations. Much of the early technical assistance efforts focused on creating the infrastructure of a new Community Health Center and setting up the systems necessary to deliver primary care. As the centers mature and the health care market changes, technical assistance needs have changed. The DHHS, CHCs, and other stakeholders should:

1. Continue and expand technical assistance to strengthen CHC operations in areas such as data and financial management, billing and coding, and pricing structures. These efforts should be coordinated among the Department of Health and Human Services, BiState Primary Care Association, Community Health Access Network (CHAN), federal opportunities at the HRSA Bureau of Primary Health Care, membership benefits available through the National Association of Community Health Centers (NACHC), the universities and other educational institutions, and local efforts of hospitals, businesses and foundations.

2. Assist the CHCs in the development of federal funding proposals (e.g., Section 330 new start or expansion) and any other grant or foundation applications geared toward increasing access to primary and preventive health care services.

3. Identify strategies to assist CHCs' clients to receive needed prescription medications. This could be done via expansion of existing programs such as the Section 340B program (of the Public Health Services Act) and the Indigent Drug Programs.

Workforce Development

The tight labor market is affecting all health care providers. CHCs, as discussed above, have a particularly hard time recruiting and retaining providers because they simply do not have the resources to offer signing bonuses, incentives, and competitive salaries. Any assistance to CHCs should be part of an overall State strategy that builds on the success of the previous primary care efforts. Expanded efforts will require additional resources. The DHHS, CHCs, and other stakeholders should:

1. Continue to support efforts in primary care workforce development (including recruitment, training and retention of primary care practitioners), while expanding the scope to include nurses, dentists and dental hygienists, mental health and substance abuse professionals. Designation of underserved areas, such as Health Professional Shortage Areas (HPSAs), should also continue.

Research, Planning and Information Management

Timely and accurate data is needed in order to continue to assess the effectiveness, efficiency and financial viability of New Hampshire's Community Health Centers. Understanding the variations among CHCs is important to their future viability. The State is also in a key position to assess its safety net providers and they fit into the overall health care delivery system. The DHHS, CHCs, and other stakeholders should:

1. Monitor the impact of market forces on the structure, capacity, and financial stability of CHCs (e.g., annual financial analysis, household insurance survey, charity care offered by other community providers, and relationships among other providers).

2. Collect and analyze CHC data, with the priorities of: (1) building on existing FQHC data; (2) monitoring the demand for CHC services compared to revenues; and (3) assessing utilization and health outcomes of CHC patients. A new and important source of information on community health needs - available in the next one to two years - will supplement the data CHCs collect. The community needs assessments called for under New Hampshire's community benefits statute should result in a description of the predominant health issues in the community, as well as an estimate of unmet need for CHC services. Projections of how changes in the local economy and/or population shifts would affect these safety net providers are also needed. Assessment of CHC client utilization patterns and health status should allow for the creation of a case mix profile of New Hampshire CHCs which would (together with the other data discussed here) assist decision making and policy development.

3. Assess the need for CHC services in regions of the state that are presently not served by a CHC.

SECTION II

Report on the Financial Status of Nine Community Health Centers in New Hampshire 1994 – 1999

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October 2000

Report on the Financial Status of Nine Community Health Centers in New Hampshire

Introduction

Data from audited financial statements for fiscal years 1994 to 1999 were analyzed for nine nonprofit New Hampshire Community Health Centers (CHCs).[13] Health centers that were not freestanding (i.e., consolidated financial information with another entity, such as a hospital) were not included in this analysis.[14] Of those included, four were Federally Qualified Health Centers (FQHCs) and two were FQHC Look-a-Likes. The payer mix for the CHCs, based upon percentages of the total number of patients treated, were 43% self-pay[15], 20% Medicaid, 8% Medicare, and 29% other third party payer.

The following discussion contains an analysis – using traditional financial measures of profitability, liquidity, solvency and cash flow – of how New Hampshire's CHCs fared financially during the period 1994-1999. The use of the term "profitability" may be confusing when referring to nonprofit health care organizations. "Profits" are necessary for an organization to be able to meet its mission and to continue to provide quality health care. The total financial requirements of any viable financial organization include funds for growth, new programs, working capital needs, and replacement of equipment. [16]

Methods

To perform the analysis, we standardized the financial statements of each CHC. This allowed us to aggregate all the financial data to describe the group as a whole, and to facilitate comparison of the group and individual CHCs to national benchmarks.

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[13] There were eight CHCs included in this study. The financial analysis of the ninth site, Manchester Child Health Services (a comprehensive primary care site for children 0-18), was included in the aggregate set of indicators in this report. Since it is not a CHC, it is not included in the Department of Health and Human Services or BiState Primary Care Association discussions.

[14] The CHCs referred to here are Capital Region Family Health Center/Concord Hospital and Partners in Health Care/Valley Regional Hospital.

[15] Many of the self-pay are totally uninsured, however, self-pay can also include patients who have insurance co-pays, deductibles and coverage limitations.

[16] Suver, S., Neumann, B.R., and Boles, K. 1992. *Management Accounting for Healthcare Organizations.* Chicago, IL: Pluribus Press, Inc.

Standardization of CHC balance sheets required that net assets restricted by donors be separated from unrestricted net assets. The analysis was then performed using only the unrestricted net assets of the CHCs. Rationale for removal of restricted funds is to conservatively estimate the organization's financial position by including in the analysis only those assets that are available for operations. However, as restricted net assets are used for their intended purposes, they are included in the income statement as revenues in order to offset expenses arising from their use.

Separation of restricted from unrestricted assets and equities (net assets) presented challenges. In recent years, the change from fund balance to net asset accounting by the CHCs (FASB 117) aided in the identification of equity that was donor-restricted.[17] However, prior to the adoption of this practice, restricted and unrestricted funds were not presented separately within the audited financial statements. In addition, although many of the CHCs following FASB 117 guidelines identified the amount of equity that was restricted by donors, there was little indication in many of the audited financial statements as to what assets corresponded to the restricted equities. To remain consistent, when equity was identified as restricted without a clear description of the related assets financed by this equity, amounts were removed from pledges receivable, cash, and grants and contributions receivable (in that order), and placed into a restricted fund balance sheet.

Standardization of CHC income statements required that several distinctions be made between sources of revenue and expenses that were reported on the income statements. First of all, revenues were divided into operating and non-operating revenue. Operating revenue consists of revenues that are related to the ongoing and central activities of the CHCs, such as patient service revenue, and revenue from grants, contracts, and donated goods and services. Non-operating revenue, or those revenue sources that are peripheral to the central operations of CHCs, were separated from operating revenues in the analysis. Non-operating revenue, which includes primarily investment income, was a minimal source of income for the majority of the CHCs.

[17] The impact of this change on financial statements is that restricted assets are no longer clearly segregated from unrestricted assets. It also means that the Income Statement has an add-on, "Changes in Net Assets," which makes determination of the bottom line a little harder to tease out of some of the statements.

When disclosed in the audited financial statements, gross patient service revenue (GPSR) and revenue deductions were also included as line-items on the standardized income statement. However, while eight of the nine CHCs reported GPSR in 1999, fewer reported this figure in years prior to 1999. Specific deductions from GPSR, which would include free care, contractual allowances and bad debt, were disclosed even less often within the CHC audited financial statements, and bad debt was occasionally presented as an expense. When this occurred, the bad debt figure was removed from operating expenses and placed under revenue deductions.

Overview of Benchmarks

Traditional profitability, liquidity, solvency and cash flow measures were used to analyze the financial health of the nine CHCs. Some measures were modified or added to the analysis due to differences in the nature of CHCs and other nonprofits (e.g., hospitals). Each area of measurement is described below.

Profitability Indicators	
Total margin	Measures the organization's ability to cover expenses with revenues from all sources.
Operating margin	Measures the organization's ability to cover operating expenses with revenues.
Markup	Used to determine how much CHCs charge for patient services. A value of below "1" indicates that the CHC sets charges at less than the cost of providing those services. Formula: Gross patient service revenue/Total operating expense
Deductible	Indicates the discount off charges at which third parties, including self-payers, pay the CHCs for providing patient services. Free care could not be separately identified in most CHC statements. Formula: (Contractual allowance + Free care)/Gross patient service revenue
Free care/GPSR	Quantifies the percentage of total services that are provided to people who are charged, but do not pay their bill.
Net patient service revenue (NPSR) shortfall	Measures the dollar value of the shortfall of patient services revenue in meeting the operating expenses of the CHC. A high value indicates either poor profitability or a reliance upon other sources of revenue

NPSR/Total operating expense	Indicates the percent of total operating expense that is covered by net patient service revenue, and to what degree the CHC is able to cover expenses from patient service revenue collected from third party payers or the patients themselves. Higher values indicate less dependence upon donated services and grants and contracts, and is favorable to the organization.
Grants and contracts + net assets released from restrictions / Total operating expenses	Measures the percent of total operating expense that is covered by grants and contracts and revenue released from donor restrictions. Higher values indicate a dependence upon these sources for covering operating expenses.
Donated goods and contributions / Total operating expenses	Indicates the percent of total operating expenses that represent donated goods and services. Higher values indicate a dependence upon donations, which may be an unreliable source of support.
Investment income / Total operating expense	Indicates the dependence upon investment income as a source of revenue. Higher values indicate an increased reliance upon this income source, which is dependent upon the performance of capital markets, and the availability of cash.
Operating revenue % change	Measures the change in operating revenues from the prior year to the current year. High values indicate a fast rate of growth in revenue for the CHC. Formula : ((Total operating revenues for current year) – (Total operating revenues for prior year)) / (Total operating revenues for prior year)
Operating expense % change	Measures the change in operating expenses from the prior to the current year. High values indicate that the expense of providing patient care is growing. If accompanying an increase in operating revenue, a high ratio suggests that the organization is increasing its patient load. Formula : ((Total operating expenses for current year) – (Total operating expenses for prior year)) / (Total operating expenses for prior year)
Liquidity Indicators	
Current ratio	Measures the extent to which current assets are available to meet current liabilities.
Current ratio with board designated funds (BD)	Current ratio with noncurrent board designated assets added to current assets.
Acid test	The most rigorous test of liquidity; it only includes those things that can quickly be converted to cash (Account Receivable and Inventory are not counted). Formula: (Cash and marketable securities) / (Current Liabilities)
Days in accounts receivable (AR)	Measures how quickly revenues are collected from patients/payers.
Average pay period, accrued expenses and accounts payable (AE&AP)	Measures how quickly employees and outside vendors are paid by the CHC.
Days cash on hand	Measures how many days the CHC could continue to operate if not additional cash were collected.

Days cash on hand with board designated funds (BD)	Same as above, but includes noncurrent investments classified as board designated.
Solvency Indicators	
Equity financing ratio	Measures the percentage of the CHCs capital structure that is equity (as opposed to debt, which must be repaid).
Long-term debt to equity ratio	Measures the relationship of long-term debt to total equity.
Fixed asset financing ratio	Measures the relationship between long-term debt and net fixed assets.
Cash flow to total debt	Measures the ability of the CHC to pay off all debt with cash generated by operating and non-operating activities.

Because there are no publicly available comparative financial benchmarks for the CHCs, we used data from the Bureau of Primary Health Care (BPHC) to construct industry comparisons for several of our measures (see Figures 3, 4 and 6). Due to the difference in reporting format from audited financial statements, however, our ability to construct comparable benchmarks was limited.[18] It is also noteworthy that the national data set only includes Federally Qualified Health Centers (FQHCs) (Section 330 health centers), whereas only four of the nine health centers analyzed for this report are FQHCs.

Summary of Findings

Over the six-year period studied, the nine Community Health Centers experienced a decline in financial health. Profitability was low for the majority of the CHCs, with an operating margin range of 1.8 to –4.8% (75th and 25th percentile) by fiscal year 1999. The CHCs' total margin differed slightly from the operating margin in later years, as low levels of investment income helped lift the total margins of some of the CHCs. This occurred even though investment income rarely accounted for more than 2% of total operating expenses for a CHC in a given year.

Net patient service revenue (NSPR) covered 40% of operating costs as of 1999 because many of the centers charged less than the cost of providing services and then experienced large deductibles (including free care). In aggregate, the health centers relied upon grants and contracts to cover 56% of their total operating expenses. While fundraising and contribution revenue helped defray initial start-up costs of several CHCs during the period, this source of funds diminished as a percent of total operating expenses once the CHCs began collecting patient revenue.

The short-term liquidity over the period 1994 to 1999 was poor, and those CHCs with negative net incomes for a significant portion of this period experienced declining liquidity. The majority of the health centers had only one month of cash on their balance sheets considering all resources (board designated and

[18] The Bureau of Primary Health Care administers Section 330 funds and collects financial data from Section 330 CHCs. The information collected is limited mainly to Income Statement elements, and different reporting requirements mandate that health centers report elements using a mixture of accrual and cash accounting.

undesignated), and this low cash position was exacerbated by slow collection of accounts receivable. Furthermore, the current ratios of three of the nine health centers was below 1.0 in 1999, indicating that these organizations were unable to pay off their current liabilities with current assets. In order to compensate for declining cash balances and the inability to collect patient accounts receivable, the majority of CHCs slowed payment of their accounts payable and accrued expenses. However, several of the CHCs did maintain cash balances and liquidity ratios above their counterparts. These were also the Centers that had higher margins.

Over this period, the solvency of the majority of the CHCs declined. Cash flow from operations covered less than 11% of the total debt of seven of the nine CHCs, and was negative for several of the CHCs. Although some of the CHCs improved their solvency with increasing levels of equity, many of the CHCs equity financing ratios declined during the period analyzed due to losses.

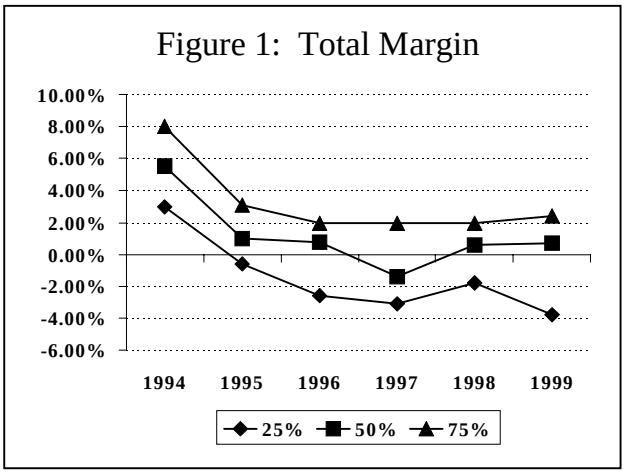
Over this period, the health centers as a group did not generate enough cash internally through operations to meet capital investment needs, although some notable exceptions generated over 25% of their cash from net income. Cash from operations accounted for 44.7% of the cash generated for the group (31.4% from depreciation), while capital improvements used 66.1% of the cash generated. Because many of the centers were unable to access long-term debt, the CHCs increased their financial risk by using short-term debt to help finance fixed assets. Cash from accounts payable and accrued expenses accounted for 28.9% of the cash generated by the CHCs, and transfers from restricted funds (basically, capital donations or grants) was the source of an additional 22.6%.

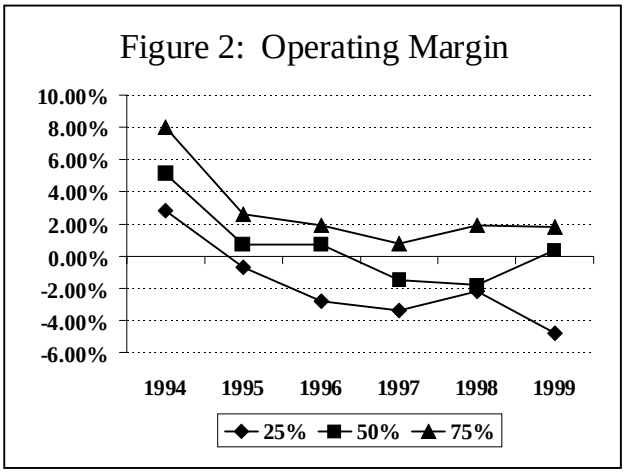
Financial Benchmarks - Profitability

Total and Operating Margin

The total margin for all of the CHCs fell dramatically over the period analyzed (Figure 1). The median margin, at 5.5% in 1994, fell to nearly breakeven levels (0.7%) in 1999. Four of the nine CHCs had negative total margins in 1999, and none of the CHCs improved their total margins over the period analyzed.

Overall, the CHCs experienced declining profitability in operations, as well (figure 2). Operating margins, which ranged from 1.8% to –4.8% in 1999, did not differ significantly from total margins between the years 1994 and 1996. From 1997 to 1999, several CHCs had investment income that improved their total margin, although investment income still remained a small percent of total revenue for all CHCs.

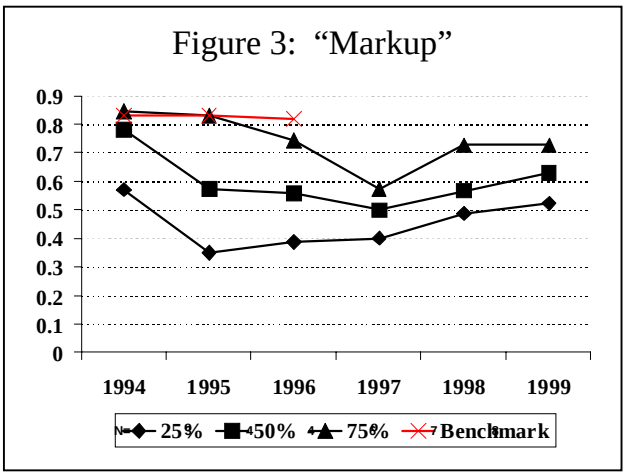




"Markup"

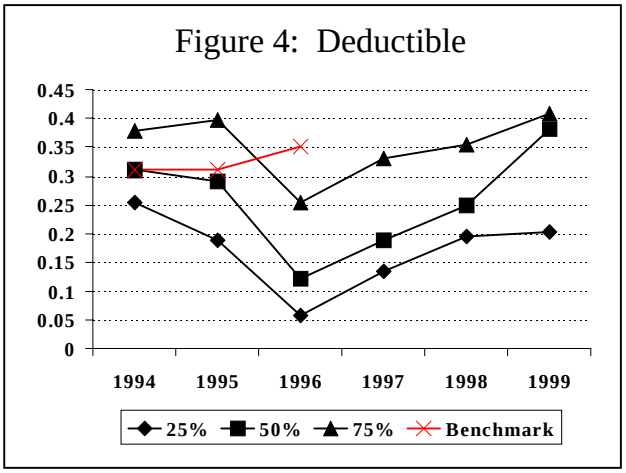
The CHCs charge patients considerably less than the cost of providing patient care services, as highlighted by the markup ratio (figure 3). Not all of the CHCs reported GPSR (allowing calculation of the markup and deductible ratios) during the period. In 1994, three CHCs reported GPSR, while six, seven, and eight CHCs reported GPSR in 1997, 1998, and 1999, respectively. Although the median markup was close to the national average in 1994, it dipped considerably in 1995 and was far below the average in 1996 (55% vs. 82%). While the markup has improved over the years 1997-1999, the median charge for patient

services for the CHCs was only 63% of the costs of providing services. In 1999, we calculated that the eight CHCs reporting gross patient service revenue ranged in markup values from 50% to 70%.



Deductible

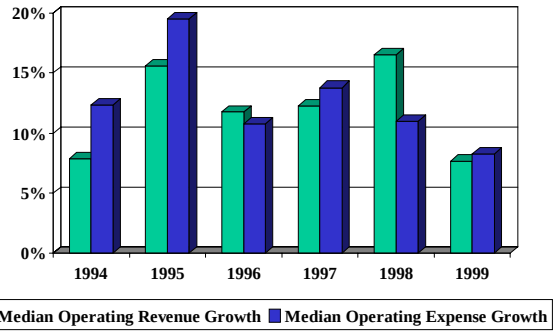
After dipping below the national average of 35% in 1996, the deductible ratio rose to a median of 35-40% (see Figure 4). However, trends in the deductible ratio are not reliable indicators as some CHCs started disclosing free care only after 1995, thus making comparisons between early and late years difficult.



Median Growth in Operating Revenue and Expense

For four of the six years analyzed, operating expense increased at a faster rate than operating revenues (figure 5). In 1998, due to favorable settlements from Medicaid, operating revenue grew faster than the growth in operating expenses. Other than in 1998, operating expenses increased at a faster rate than revenues. This change was the driving force behind the rapid decline in total and operating margins for the CHCs.

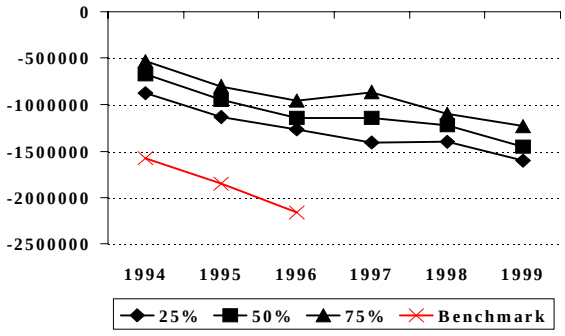
Figure 5: Median Growth in Operating Revenue and Expense



Net Patient Service Revenue Shortfall per CHC

Over the period analyzed, the Net Patient Service Revenue Shortfall per CHC increased (figure 6). While the shortfall per CHC is more favorable than our benchmark, New Hampshire CHC values may be smaller and less mature than the CHCs in the benchmark. One reason the shortfall increased was due to the growth

Figure 6: Net Patient Service Revenue "Shortfall" per CHC

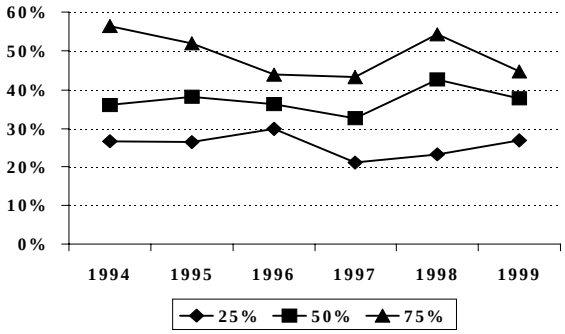


in the CHCs' patient volume. Without an increase in the percent of NPSR to total operating expenses, the shortfall will increase as more patients are treated.

Net Patient Service Revenue/Total Operating Expenses

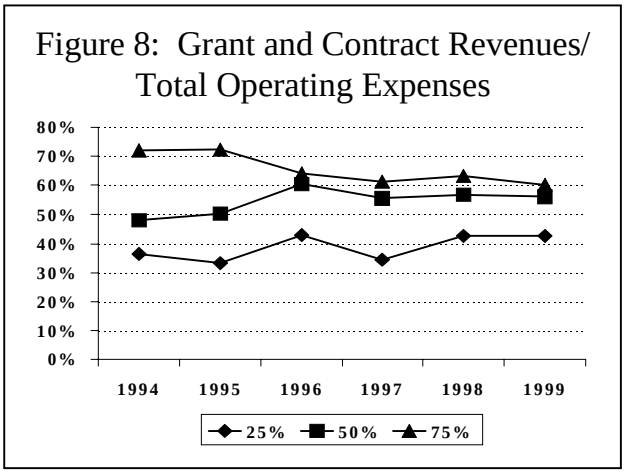
As can be seen in figure 7, NPSR as a percent of total operating expense remained relatively constant for the CHCs overall from 1994 to 1999, with the exception of the CHCs in the 75th percentile. As a result, the overall increase in the NPSR shortfall described above is not due to a decline in NPSR as a percent of total operating expense, but rather to growing expenses as patient volume increased. As the median of NPSR/Total operating expenses is only 38%, this suggests that the CHCs are highly dependent upon other sources of revenue.

Figure 7: Net Patient Service Revenue/ Total Operating Expenses



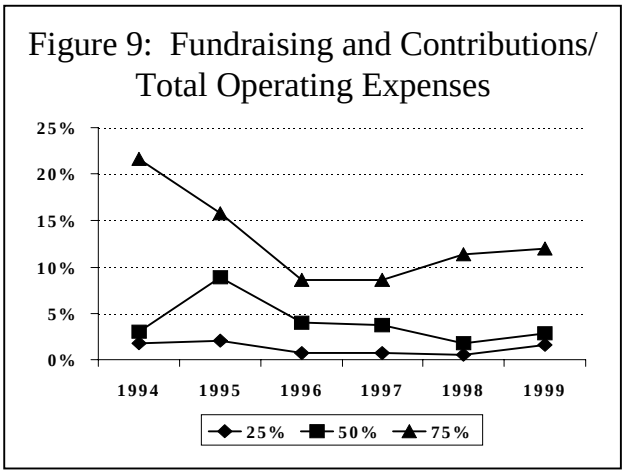
(Grant and Contract Revenue + Net Assets Released from Restrictions)/Total Operating Expenses

In 1994, dependence upon grants and contracts as a source of revenue varied from 36% to 72% between the CHCs in the 25th and 75th percentile (figure 8). In 1999, the range decreased to 43% and 60%, respectively. The CHCs depend upon grants and contracts revenue to cover just over half of their operating expenses, with a median of 56% in 1999. This value is significantly higher than that of NPSR/total operating expense, and indicates that the largest source of revenue for the CHCs is from grants and contracts.



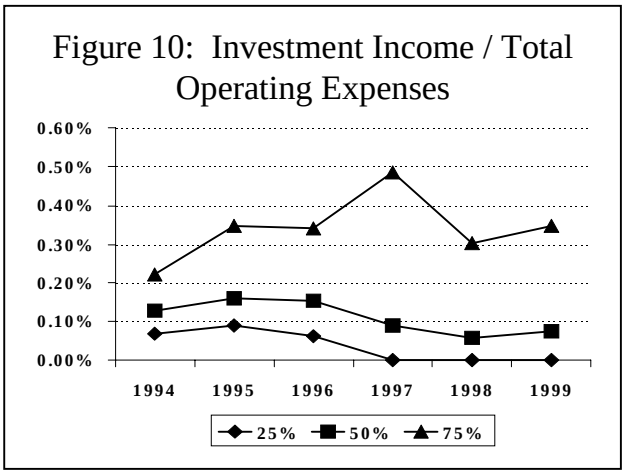
Fundraising and Contributions/Total Operating Expenses

As can be seen in figure 9, the percent of contributions to total operating expenses has decreased for the 75th percentile, but remained approximately even in the lower quartiles. In 1994, the CHCs in the 75th percentile for this ratio had dramatically higher levels of fundraising and contributions to total operating expenses. In many cases, this is because the CHC required donations at its inception to pay costs associated with start-up. Ignoring the early years, fundraising and contributions contributed less than 5% to total operating expenses for the majority of the CHCs.



Investment Income/Total Operating Expenses

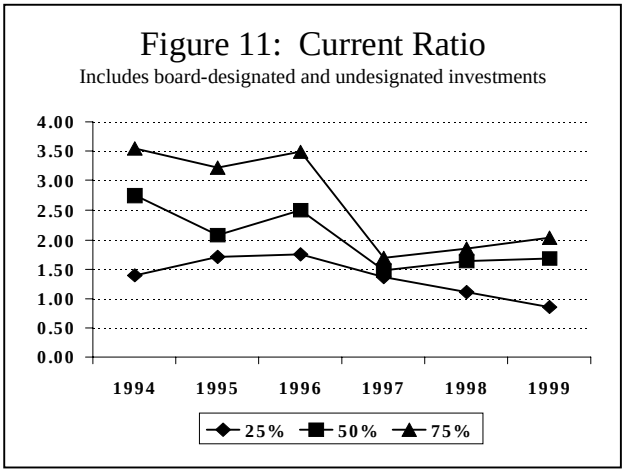
Investment income as a percent of total operating expenses (figure 10) was marginal compared to other income sources examined. Investment income for only two of the CHCs analyzed contributed more than 1% of income from investments to total operating expenses in 1999.



Financial Benchmarks - Liquidity

Current Ratio

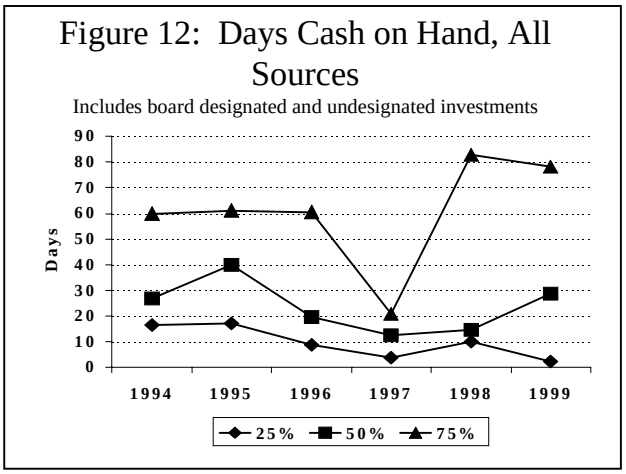
The short-term liquidity of the CHCs worsened considerably over the period analyzed. In 1999, three of the CHCs had current ratios below one (figure 11), indicating that they would be unable to pay off current



liabilities with their current assets. The worsening liquidity of many of the CHCs is due to low to negative profitability and the use of current liabilities to finance fixed assets.

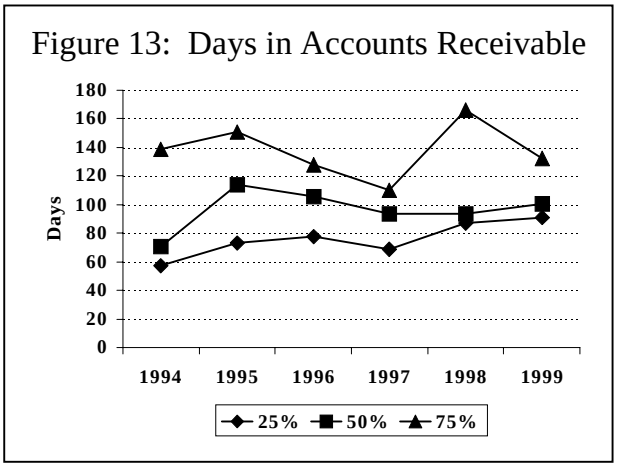
Days Cash on Hand, All Sources

The majority of the CHCs analyzed have little cash on hand (figure 12). The median value of the days cash on hand ratio in 1999 was 28.7 days, with a low of 12.6 days in 1997. Slow collections of accounts receivable contributes to low days cash on hand.



Days in Accounts Receivable

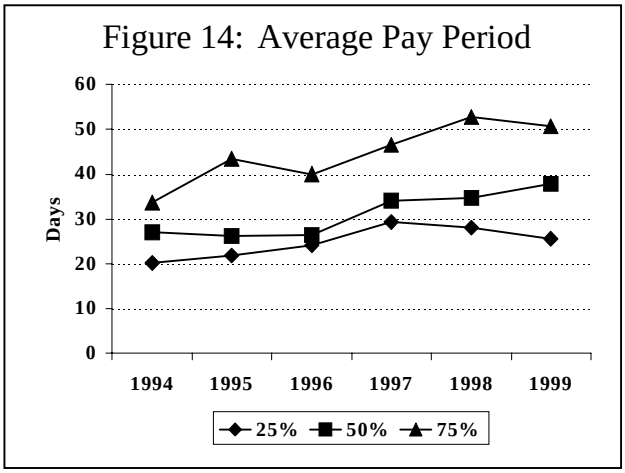
As mentioned, slow collection of accounts receivable has depleted the available working capital of the



CHCs, as the median days in accounts receivable was 100.4 days in 1999 (figure 13). Of the nine CHCs, none have shown a consistent decrease in days in accounts receivable over the period analyzed. Many have slowed the payment of their short-term liabilities (accounts payable and accrued expenses) to compensate for slow collections.

Average Pay Period

The CHC median average pay period (figure 14) increased by over 10 days during the period analyzed (from 27.0 to 37.9 days). The largest increases in average pay period came among slowest payers, increasing from 33.7 to 50.7 days. Overall, the better performers in terms of profitability paid creditors the quickest, while those with poor profitability generally had higher average pay periods that were increasing or remaining stagnant.

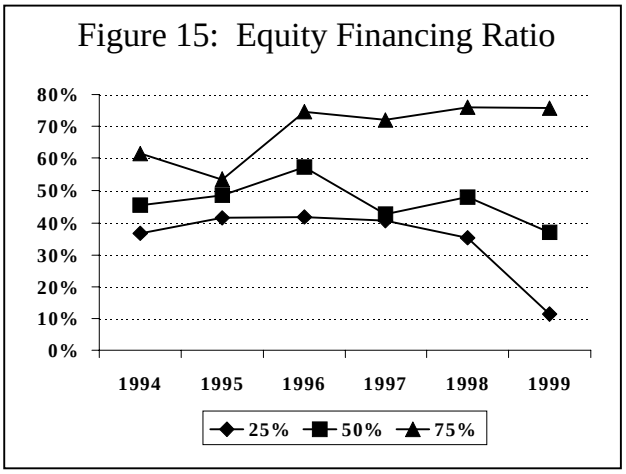


Financial Benchmarks - Solvency

Equity Financing Ratio

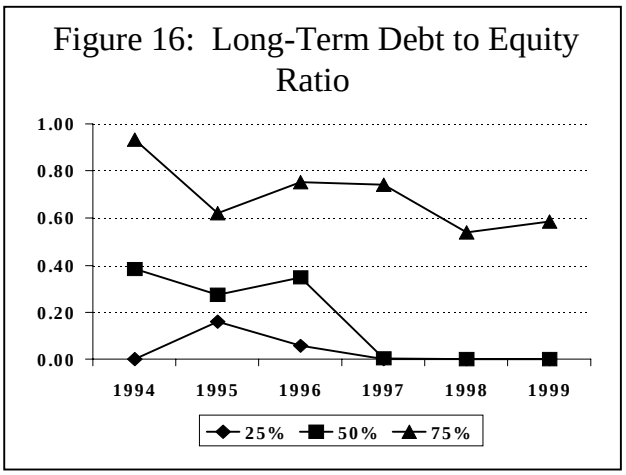
During the period analyzed, poor profitability, slow growth in net assets, and declining liquidity contributed to poor equity financing ratios for many of the CHCs (figure 15). Two of the CHCs had negative equity financing ratios in 1999, as losses on operations depleted their net assets. On the other hand, a minority of CHCs improved their equity financing ratios dramatically, or maintained a high ratio. These organizations

were, without exception, the CHCs with the best short-term liquidity, although profitability among this group varied.



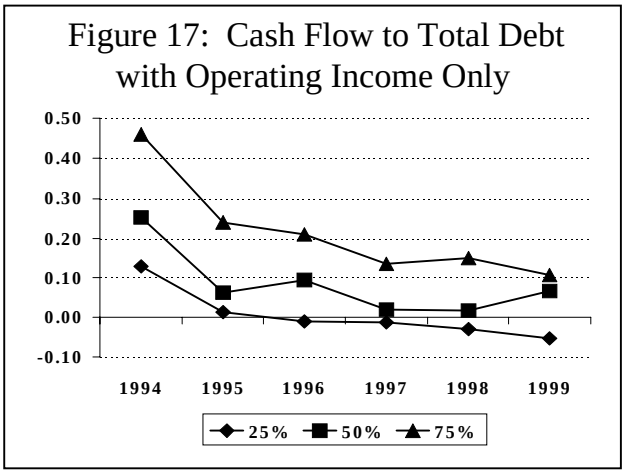
Long-Term Debt to Equity Ratio

The median value for the long-term debt (LTD) to equity ratio dropped and remained at zero in 1997 as the majority of CHCs did not have long-term debt (figure 16). Of the CHCs that did have significant LTD (75th quartile and above), several issued small amounts of LTD between 1996 and 1999.



Cash Flow to Total Debt with Operating Income Only

The cash flow to debt ratio (figure 17) indicates that most of the CHCs have difficulty servicing their largely short-term liabilities. Not only do some of the CHCs not have adequate current assets to cover current liabilities, but also they do not generate cash at a level sufficient to pay down their obligations. Only two of the CHCs had cash flow to total debt ratios that were higher than 11%, and four of the CHCs had negative ratios.



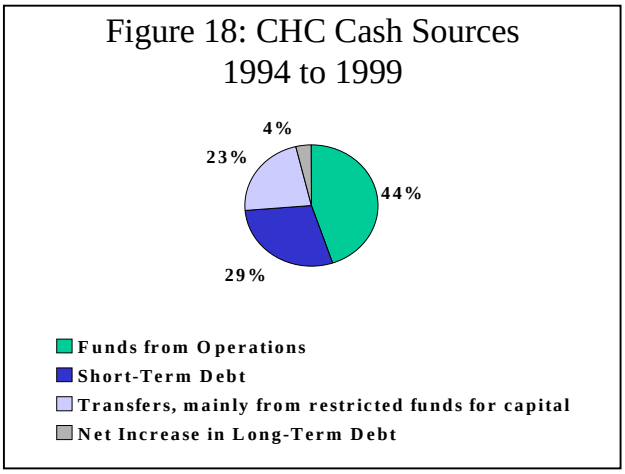
Financial Benchmarks – Sources and Uses of Cash

The largest source of cash generated by the CHCs came from operations (44.7%) (Figure 18). However, as many of the CHCs had net incomes of below 0, the majority of cash from operations were contributed by non-cash expenses, namely depreciation expense (31.4%). On the other hand, the top performing CHCs generated above 25% of their cash from net income alone.

Another significant source of cash was from short-term debt (28.9%). This was the most significant source of cash for those CHCs that generated little cash from operations and/or had difficulty collecting accounts receivable.

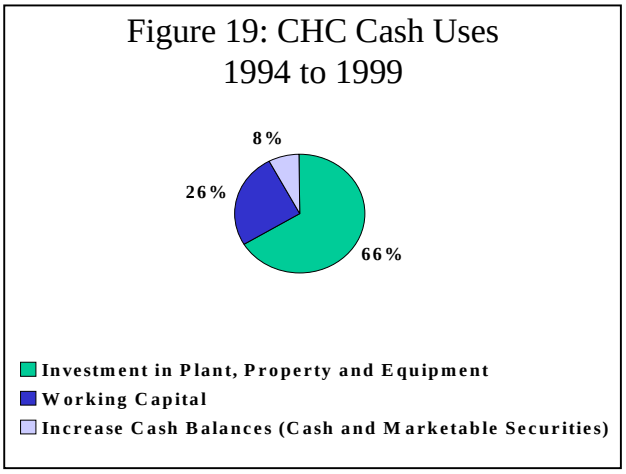
The third primary source of cash (22.6%) for the CHCs was transfers from restricted funds (capital grants and donations). For example, one CHC used restricted funds designated for capital improvements to

purchase PPE. This transaction accounted for over 60% of the sources and uses of cash for this CHC. Other CHCs also generated cash by transfers from restricted funds, although some of these transfers are difficult to characterize.



66.1% of the cash used by the CHCs was for PPE additions. This purchase of long-term assets occurred even though net long-term debt was not a significant source of cash (3.6%). Short-term debt and capital donations are the primary source of capital for property, plant and equipment.

26% of the CHC cash uses of cash were for working capital, including the payment of various short-term liabilities and the increase in accounts receivable. The use of cash for accounts receivable (9.6%) is due to the growth of the CHCs, as well as a slowdown in the collections of accounts receivable.



7.6% of the cash generated was used to increase cash balances. This includes cash reserves that were board designated or trustee designated (5.6%), and 2.0% that was undesignated. Generally, increasing cash reserves is a positive use of cash, although the CHCs still maintain a very low days cash on hand.

Conclusion

Community health centers in New Hampshire present a mixed financial picture, dominated by the majority that are barely surviving despite an increase in patient volume. With a payer mix that is 43% self-pay and 20% Medicaid, it is clear that the CHCs provide a vital safety net to vulnerable populations. However that safety net is not resting on a firm financial foundation.

APPENDIX

Definition of Terms

Balanced Budget Act of 1997 (BBA): One of many components of the BBA was the establishment of the Critical Access Hospital Program, also known as the Medicare Rural Hospital Flexibility Program. The purpose of the Program is to improve access to essential health care services through the establishment of limited service hospitals and the development of rural health networks.

Balanced Budget Refinement Act of 1999 (BBRA): This follow-up to the BBA included several enhancements to the Rural Hospital Flexibility Program, such as a 96 hour annual "average" length of stay, broader eligibility for participation in the program, flexibility in payment methods for outpatient services, and elimination of co-insurance for lab tests performed by CAHs (Critical Access Hospitals).

Barrier (to Health Care): One of many obstacles that keep individuals from gaining access to health care. Among these are; too few providers of care (doctors, dentists, etc.) who are ready, willing, or able to see patients, transportation issues, individual physical barriers, types or levels of providers available, lack of insurance, or insurance with high deductibles, etc.

Capitation or Capitated Rate: A payment schedule whereby an insurer (or Medicaid or Medicare), sets a reimbursement level for a provider to treat a patient over a period of time. The provider would get the same payment, regardless of the complexity of treating the patient.

CHAN: Community Health Access Network. A cooperative alliance of Community Health Centers sharing information services and clinical guidelines. This organization is unique to New Hampshire and has been used as a model by other areas across the country.

CHC: See Community Health Center.

CHIP: Child Health Insurance Plan.

Community Health Center: Health centers with a primary mission of functioning as a safety net provider. Includes Federally Qualified Health Centers (FQHCs) and FQHC Look-a-Like like Health Centers.

Cost-based Reimbursement: Some health care facilities are paid at a predetermined 'fair and reasonable' cost basis for specific services. This is an alternative to other payment and reimbursement options that often pay less. Some facilities that qualify for cost-based reimbursement from Medicaid and Medicare include Federally Qualified Health Centers, Rural Health Centers, and Critical Access Hospitals. For example: New Hampshire DHHS currently reimburses Federally Qualified Health Centers and FQHC Look-alikes cost based reimbursement or 133% of the Medicare rate, whichever is less.

DHHS: Department of Health and Human Services.

FQHC: Federally Qualified Health Center. A federal payment option that allows qualified providers in Medically Underserved Areas (MUA) to receive cost-based Medicaid and Medicare

reimbursement. 4 FQHCs are located in New Hampshire (Ammonoosuc Community Health Services, Inc. in Littleton; Coos County Family Health Services, Inc. in Berlin; Lamprey Health Care, in Newmarket, Raymond and Nashua; and Manchester Community Health Center).

HCTF: Health Care Transition Fund.

HPSA: See Health Professional Shortage Area.

Health Professional Shortage Area: This is a Federal acknowledgement that a geographic area does not have enough specific primary health care providers for the population.

Look-a-Like Health Centers: These centers 'look like' Federally Qualified Health Centers in that they provide the same services and participate in cost-based reimbursement, but do not receive federal grant money for their program. New Hampshire currently has 2 'Look-a-Likes' (Avis Goodwin Community Health Center, in Dover and Rochester, and Health First Family Care Center in Franklin).

Medicaid Managed Care: Program through Medicaid that reimburses providers at a preset payment, usually referred to as a capitated rate.

Medically Underserved Area: A federal designation that recognizes a specific area does not have an adequate supply of primary care providers. This designation allows for some federal funding programs to participate in the area.

Medically Underserved Population: A federal designation that recognizes a specific population does not have an adequate supply of health care providers. This designation allows for some federal funding programs to participate in the area.

MMC: See Medicaid Managed Care.

MUA: See Medically Underserved Area.

MUP: See Medically Underserved Population.

Primary Care: Health care focused on the point at which the patient first seeks medical assistance. The primary care provider, usually a family physician, Pediatrician, Obstetrician/Gynecologist, or Internal Medicine specialist takes responsibility for the overall coordination of the patient's health problems with the appropriate use of other consultants and community resources.

Rural Health Clinic: Also referred to as an RHC. A RHC is a federal designation that allows the providers to participate in cost-based reimbursement for the Medicare-related services that they provide. These are frequently one or two physician practices, and are not required to provide as comprehensive an array of services as FQHCs and Look-a-Likes. There are approximately 20 RHCs in New Hampshire.

Safety Net Providers: The community level agencies and providers that traditionally serve the medically vulnerable populations, such as the low income, unemployed, underinsured, and uninsured.

Section 330: This moniker refers to Section 330 of the Public Health Services Act that creates community health clinics known as Federally Qualified Health Centers (FQHCs), Migrant Health

Centers, and Healthcare Centers for the Homeless. To improve access to the population having difficulties getting primary care, these specially designated facilities receive a cost-based reimbursement for the services provided. New Hampshire currently has 4 FQHCs, and 2 health centers referred to as Look-a-Likes. Look-a-Likes receive the same reimbursement, but do not get federal grant monies that FQHCs receive.

Shortage Areas: There are a number of different federally designated shortage areas, based on population income levels, demographics, and the number of providers in an area. The Bureau of Rural Health and Primary Care, DHHS, is charged with working to identify areas to be designated and forward those recommendations to the Federal Office of Shortage Designation. The individual areas are titled as Health Professional Shortage Areas, Dental Health Professional Shortage Areas, Mental Health Professional Shortage Areas, Medically Underserved Populations, and Medically Underserved Areas.