



Health Center Financial Check-Up:

Prescriptions for Strengthening
New York's Diagnostic
and Treatment Centers

AUGUST 2010

Prepared by
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EXECUTIVE SUMMARY



Executive Summary

INTRODUCTION

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

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

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

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

HEALTH CENTERS (DTCs) IN NEW YORK STATE

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

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

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This study includes two types of Comprehensive DTCs: Federally Qualified Health Centers (FQHCs) and non-FQHCs. Approximately two-thirds of the DTCs in the study are FQHCs (the figure varies slightly in each of the study years based on data reporting and DTC start-ups and closures). FQHCs are required by Federal law to provide or arrange for a wide array of primary, preventive, and enabling services, including dental, behavioral health, substance abuse, and specialty care services. They must be governed by independent, user-dominated boards. Finally, they must serve patients regardless of ability to pay. Non-FQHCs are not subject to these Federal requirements and the services they provide and the patient populations they serve may be more limited.

In addition to their status as either FQHCs or non-FQHCs, the DTCs in the study are divided between those that are “freestanding”—independently governed organizations—and those that are directly or indirectly controlled by a parent organization, often a hospital. FQHCs are typically, but not exclusively, freestanding organizations, while many non-FQHCs are hospital-controlled. Only one FQHC of the approximately 40 in the study sample is hospital-controlled.

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

IMPACT OF FINANCIAL DISTRESS ON DTCS

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

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

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

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

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

KEY FINDINGS

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

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

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

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

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

RECOMMENDATIONS

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

Promote strengthening and restructuring of the primary care sector.

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

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Strengthen DTCs' business and financial management.

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

Improve the adequacy, timing, and predictability of State payments.

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

Establish a single focus on primary care within the New York State Department of Health.

New York State has made investment in primary care a key strategic priority to transform the State's health care system, but responsibility for primary care issues, policy, and planning are spread across different departments and staff. A State Office of Primary Care could provide a single point of contact and coordination within the Health Department for the full range of primary care issues and providers.

RECOMMENDATIONS FOR STATE GOVERNMENT

Support development of large health centers and health center networks.

- a. Make available technical assistance and due diligence resources to promote individual health center facility transitions or larger mergers and acquisitions.
- b. Make available support for start-up costs of individual health center facility expansions and transitions or larger mergers and acquisitions. Interim financial support, such as for the period between receipt of an emergency Certificate of Need (CON) and receipt of final CON and Medicaid payment approvals would be particularly helpful. This work would support an important purpose of the Emergency Loan Fund recommended below .
- c. Simplify acquisition and merger processes by providing clear information about regulatory requirements. Ensure single points of contact and coordination and streamlining of State approval processes, including for the Certificate of Need process, where changes are already underway.

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

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

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

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

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

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

RECOMMENDATIONS FOR PHILANTHROPIC ORGANIZATIONS

Support efforts to leverage Federal health reform funding for FQHCs. Funding for FQHCs presents the most important opportunity to strengthen and restructure the DTC sector in New York State. Foundations should collaborate with and support the Community Health Care Association of New York State and NYSDOH to help bring Federal resources to New York State FQHCs and ensure that those resources are used effectively. This would include making available the technical assistance services that will be needed by new and expanding FQHCs

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to support organizational development, operations and health facility planning, and health center start-up; and assisting organizations that are in the best position to provide significant, sustainable primary care services growth to underserved communities to develop competitive applications for Federal FQHC funding.

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

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

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

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

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

RECOMMENDATIONS FOR PAYERS

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

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

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

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

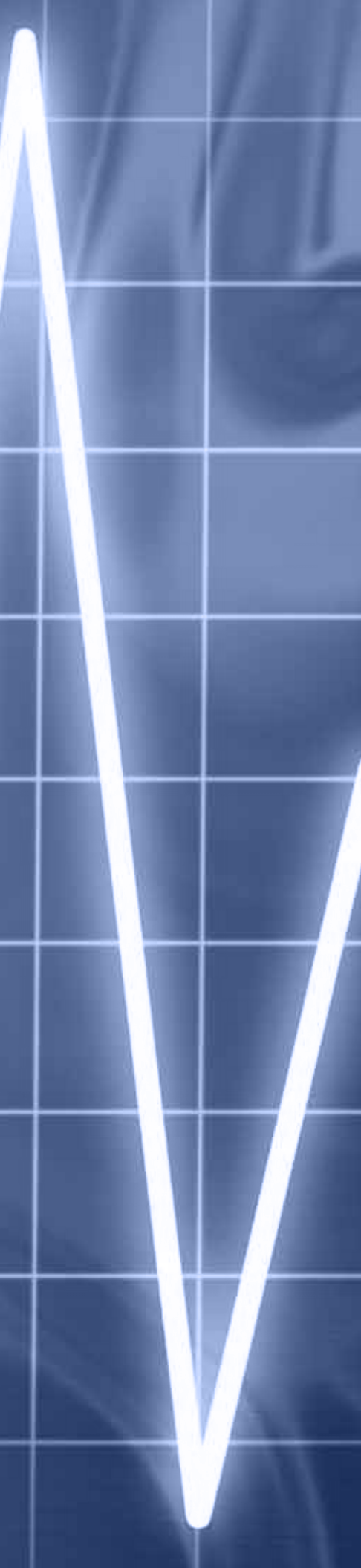
RECOMMENDATIONS FOR HEALTH CENTERS AND ADVOCACY ORGANIZATIONS

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

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

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

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



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