Issue Brief: Achieving Clinic Financial Stability: Follow the Money

Prepared by:
Annette Gardner, PhD, MPH
Sara Geierstanger, MPH
Coline McConnel, BA, ABD
Claire Brindis, DrPH

The Philip R. Lee Institute for Health Policy Studies
University of California, San Francisco (UCSF)
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EXECUTIVE SUMMARY

Clinic financial stability, or having the financial ability to meet the needs of underserved patient populations through the delivery of high-quality services, is often a struggle in the face of budget constraints and an increasing number of uninsured. The clinic consortia funded by The California Endowment through the Clinic Consortia Policy and Advocacy Program successfully increased their financial and operational stability and that of their member clinics. Grantees were successful despite several challenges, including a recovering state economy, public cutbacks at the federal level, and the fact that funding needs vary widely by clinics. From 2001-2006, grantees increased the amount of funding secured on behalf of clinics and consortia by a total of $753 million. Multiple strategies were used to achieve clinic financial stability, including funding diversification, developing relationships with private sector funders, and targeting key funding streams, such as federal 330-clinic expansion grants. Grantees clearly have demonstrated significant capacity to meet the challenges of an uncertain funding environment. Their ability to expand into new areas and activities has greatly benefited their member clinics and clinic target populations, while also contributing to grantee sustainability.

INTRODUCTION

As part of its commitment to increasing access to high quality and affordable health care for underserved Californians, The California Endowment (The Endowment) provided multi-year funding for the Clinic Consortia Policy and Advocacy Program. In early 2001, 15 California regional and local community clinic associations and four statewide clinic organizations ("consortia" or "grantees") received three years of funding (totaling $10 million) to strengthen the role and capacity of consortia in order to support the management, leadership development, policy, and systems integration needs of community clinics. Funding supported specific activities related to policy advocacy, technical assistance, media advocacy, and shared services in order to increase the collective influence of clinics. In 2004, 18 grantees were refunded for three years (totaling $8.8 million) to undertake or continue a similar set of activities.

The purpose of this Issue Brief is to review the changes in financial stability and sustainability of consortia and their member clinics through the analysis of secured funding as well as the strategies undertaken by clinic consortia to secure this funding. The Philip R. Lee Institute for Health Policy Studies (PRL-IHPS) UCSF is continuing to assess achievement of program outcomes, including the impact of grantee policy advocacy, technical assistance, and fund development on clinic financial stability.

BACKGROUND

While California's clinics have faired well in recent years with stable funding streams such as Medicaid, the funding environment is increasingly constrained. The number of uninsured continues to increase and states are discussing additional cuts to their Medicaid programs. In response, clinics and clinic consortia are targeting new funding sources (such as private foundations) while advocating to preserve public funding. Clinic consortia are involved in local level funding discussions, including the allocation of Tobacco Settlement funds and Proposition funding, as well as partnerships with private organizations such as Kaiser Permanente and the Blue Shield of California Foundation. Despite praiseworthy

fund development and maintenance strategies in the face of a turbulent and unstable funding environment, clinic consortia will need to continue to adapt to the ever-changing financial climate in order to maintain the financial strides made thus far.

METHODOLOGY

The findings described below draw on data collected about the amount and sources of funding secured by grantees on behalf of clinics and consortia from 2001 to 2006. In addition, UCSF analyzed grantee reports and counted and categorized federal, state, and local policies targeted by grantees, noting the outcomes or successful passage of each policy. UCSF also inventoried and assessed grantee shared services and fund development activities undertaken on behalf of member clinics.

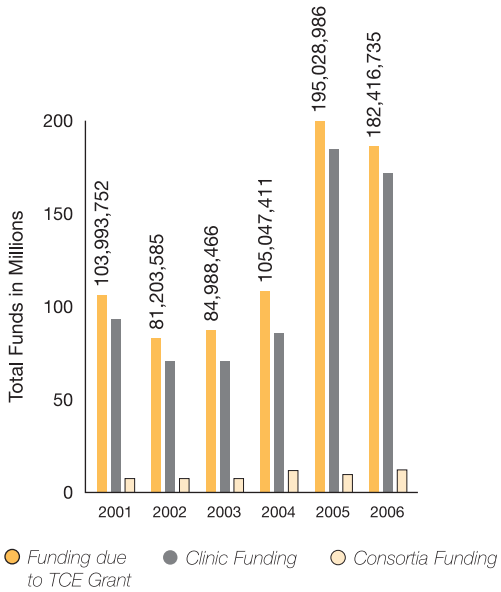
FINDINGS

The findings are broken into two sections: the first section describes the funding secured by grantees from 2001-2006, and the second section illustrates the more successful strategies that resulted in this funding.

Increased Funding to Clinics and Consortia

Grantee efforts to secure and/or maintain funding for clinics and consortia have been successful. In total, grantees reported securing over $2.2 billion between 2001-2006, with $753 million (34 percent) of that attributable to The Endowment's support. The funding secured by grantees that was attributable to The Endowment's policy advocacy and fund development activities increased from $104 million in 2001 to $182 million in 2006 (see **Figure 1**). Most of these funds (90 percent) were directed to clinics and the remainder went to consortia.

Figure 1: Total Funds Attributed to Clinic Consortia Policy and Advocacy program Activities, 2001-2006



Grantees secured a combination of public and private funding, with public funding undergoing some significant changes since 2001. **Figure 2** highlights the type of funding that was secured by grantees and how the funding varied each year. Public funding was the largest funding source for clinics.

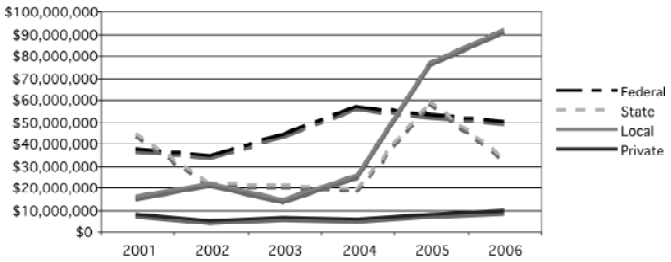
Federal funding was the largest public funding source with a total of $273 million over the six years. It continued to increase annually until 2004 and then declined to $49.1 million in 2006.

State funding became a significant source of funding for consortia and clinics in 2005, jumping from $19 million in 2004 to $58.65 million in 2005. Unique opportunities presented themselves at the state level, including farm worker funding, the Mental Health Services Act (MHSA), outreach and enrollment dollars for children's health insurance, and the receipt of clinic funds through the Cedillo-Alarcón Community Care Investment Act of 2000 and 2005 (an appropriation to community clinics for capital outlays). It is the third largest source of funding, with a total of $197.5 million over the six years.

Local funding continued to increase in 2006, from $76.2 million in 2005 to $91 million in 2006, due in large part to county contracts for clinics secured by one grantee in both years.[1] *Local funding* surpassed state funding to become the second largest funding source ($243.5 million over the six years). Community members and local organizations, including business, are increasingly willing to fund some clinic work. Grantees are leveraging the relationships that they have developed over the years while also pursuing new local opportunities such as MHSA funding.

Private funding increased slightly from $7.5 million in 2005 to $9 million in 2006, for a total of $38.2 million over the six years. Positive changes in the private funding environment included significant funding from Kaiser Permanente ($8 million) that leveraged additional collaborative projects.

Figure 2: Funding Secured by Type (Federal, State, Local, Private) and by Year



The shift from federal funding to state and local funding may have significant financial repercussions for grantees. In the analysis of federal funding secured from 2001-2006, there is a decline for the first time in 2006 by approximately $3.7 million. This suggests that the funding environment is increasingly constrained and the focus is on maintaining existing funding while seeking out new sources.

Table 1 distinguishes the *top grossing sources of funding,* with public funds dominating. Federal funds, particularly Clinic 330 Funding, were the most significant funding source through 2004 until they decreased significantly in 2005. State and local funding became the most significant sources of funding for consortia and clinics in 2005.

Table 1: Top Grossing Funds Attributed to The Endowment's Funding, 2001-2006

Funding Source	Funding Type	Total
Clinic 330 funding	Public-Federal	$222.6M
County Contracts	Public-County	$168.5M
Cedillo-Alarcon Community Clinic Investment Act of 2000 and 2005	Public-State	$62.1M
Tobacco Settlement	Public-County, State	$50.5M
Expanded Access to Primary Care (EAPC)	Public-State	$42.6M
Measure A	Public-County	$19.2M
Total		**$566M**

To identify new sources of funding, grantees indicated whether the funding secured was either new or maintained funding. In 2006, new funding (not received in the past) accounted for $38.5 million (21 percent) of total funding secured. Maintained funding (ongoing funding) accounted for $145 million (79 percent) of total funding secured. Much of this new funding was public funding (state funding).

Most of the funds secured in 2006 (90 percent) were directed to clinics and their target populations, including funding for patient services, clinic facilities, technical assistance, and programmatic expansions, such as information technology. Consortia also benefited from this funding, directing it to infrastructure support and the provision of additional services to clinic members, such as training in emergency preparedness.

Multiple Strategies to Secure and Maintain Funding

Grantees have been effective at multiple levels in securing funding and are versatile in their strategies. Specific activities used to increase clinic financial stability included policy advocacy, fund development (grant writing) and diversification, consortia fee-for-service activities, shared services, and maintaining or securing new clinic designations. Except for shared services to achieve clinic cost-savings, most of these are revenue-generating strategies.

Policy advocacy activities contributed to increased clinic funding in addition to increased financial and operational stability. In 2006, grantees secured upwards of $160 million (87 percent) through policy advocacy activities. Evaluation results suggest that a mix of activities were perceived to be the most effective in achieving a policy change to maintain or increase funding to clinics, including helping to draft regulations, serving on advisory commissions and boards, as well as member education and alerting elected officials. Grantees were involved with 72 pieces of legislation at the federal and state levels from 2004-2006. Of these 72 federal and state bills, six federal policies (18 percent) and 20 state bills (55 percent) were passed. (Please note that lobbying activities were not funded under this program and are assumed to be funded by other funding sources.)

The focus of successful policies ranged from securing additional funding, such as the Cedillo-Alarcon Community Clinic Investment Act of 2000 and 2005, which resulted in $62 million for clinic facility expansions, to policies that expand existing programs, such as Family PACT. Policies to create cost-savings also were emphasized. The impact on clinic target populations is particularly noticeable when focused on county-level decision-making to secure funding. County-level grantees were involved in local policy development that enhanced the ability of clinics to improve access to care, including participation on Proposition 10 or other health services committees, relationships with community leaders and stakeholders, and procurement of county and/or city funding for clinics, such as Tobacco Settlement funds and Proposition 63 (Mental Health Services Act) funds. As described in **Figure 3**, some of the greatest financial gains are achieved post-implementation or during negotiation of the allocation of funds with agency staff and decision-makers.

Figure 3: Policy Gain Benefiting Clinics: Prospective Payment System (PPS)

An example of a key state-level policy that consortia focused on was the implementation of the Prospective Payment System (PPS) or the transition from cost-based reimbursement of Medi-Cal services to a fixed, per-visit payment system for Federally-Qualified Health Centers (FQHC) and Rural Health Clinics (RHC). The role of consortia in the implementation of PPS could be characterized as a two-tier, centralized approach. At the state level, the California Primary Care Association (CPCA) took the lead in conducting the detailed negotiations with state and federal officials, while the local and regional consortia provided technical assistance and education to member clinics and decision-makers. The outcomes of the PPS negotiations were critical to clinic financial stability. As a cost control system that rewards clinics for being efficient, it fundamentally changed the way clinics provide services and are reimbursed by Medi-Cal, their biggest single payment source.

Fund development for programs and services was another strategy used by grantees to achieve clinic financial stability, including funding diversification. For example, grantees secured 12 percent ($22.1 million) of the total funding in 2006 by writing grants. Considered a very effective way to support clinics, grant writing on behalf of clinics and/or the consortia is a key strength of grantees. Fund development also is an opportunity for consortia to broaden their expertise and increase visibility in new areas. For example, some consortia

have been involved in Children's Health Initiatives, which are local programs to increase access to health insurance for children (see **Figure 4**).

Figure 4: Key Funding Streams

While Medi-Cal, California's Medicaid program, is a primary source of funding for California clinics, consortia tap into other sources of funding on behalf of clinics and consortia, including:

Federal
- Consolidated Health Center Program (Section 330 of the Public Health Service Act; also referred to as the Bush Initiative to Expand Health Centers)
- Medicare
- Healthy Community Access Program (HCAP) grants
- Integrated Services Delivery Initiative (ISDI) grants

State
- Expanded Access to Primary Care (EAPC)
- Cedillo-Alarcon Investment Act (facility funding)
- Tobacco Settlement Funding (50:50 split with counties)

Local/County
- Prop 63 (Mental Health Services Act)
- Tobacco Settlement Funding
- County contracts to provide services

Private
- Foundations (e.g., The California Wellness Foundation)
- Kaiser Permanente

Shared services also contributed to increased financial stability. Defined as the development and/or management of activities and products that cut across two or more member clinics (such as group purchasing of health insurance and/or supplies), shared services have the potential to achieve cost-savings to clinics and often go beyond the capacity of what individual clinics are able to do on their own. Successful activities that have been undertaken by grantees include network-wide strategic planning, quality improvement, information technology, Health Insurance Portability and Accountability Act (HIPAA) compliance technical assistance, fundraising and grant management, and coordination and management of clinic programs. Many of these activities have provided non-monetary benefits to clinics by increasing organizational capacity, such as staff education and improved billing, coding, and customer service.

Lastly, some consortia worked to *maintain and/or secure key clinic designations* that contribute to attracting providers to medically underserved areas. Clinic designations contribute to increased access to care, particularly in rural areas where there is a shortage of specialists and other types of providers (such as dentists). It also is a service that can be marketed to other types of providers on a fee-for-service basis.

CONCLUSION

From 2001-2006, grantees increased funding secured on behalf of clinics and consortia by a total of $753 million. Compared to the total funding secured ($2.2 billion) during this time period, this represents a significant accomplishment on the part of grantees and a significant amount of funding benefiting clinics and their communities. Moreover, clinic consortia have ably increased public and private funding for clinics from 2001-2006, increasing clinic financial stability. Consortia funding has resulted in a strengthened system of community clinics on a regional and statewide basis. The number of patients seen by clinics increased during the same time period, from 2.9 million patients in 2001 to 3.6 million patients in 2005. [2]

The analysis of policy "wins" and relatively stable number of federal and state policies targeted by grantees speaks to maintained capacity to influence decision-making during a time when there have been limited opportunities for new public funding. However, the gains in the early 2000s are increasingly being pitted against larger macro forces, such as the growing number of uninsured being seen at clinics. Also, funding streams are unstable as evidenced by the substitution of state and local funding for federal funding in 2005 and a decline in total funding secured in 2006. The ability of consortia to adapt to this uncertain funding environment speaks to their versatility and willingness to target traditional and new funding streams, work with new partners, and address new issues important to clinics and their patients.

Grantees attribute their success to a combination of policy advocacy activities and efforts to support clinic operations. While some activities may be more difficult than others (such as large-scale information technology projects), there is a plethora of services that result in significant gains to clinics. Consequently, clinics are more financially stable, more efficient in management and services, and more integrated into the broader system of health care. The expansion into new areas also benefits consortia, solidifying their funding base and expanding their capacity to undertake new activities.

Endnotes:

1 In 2005, this grantee secured $51 million in local contracts, increasing to $62 million in 2006

2 Source: California Office of Statewide Health Planning and Development (OSHPD)

For more information:

Annette Gardner, PhD, MPH
Principal Investigator
(415) 514-1543
annette.gardner@ucsf.edu

The Philip R. Lee Institute for Health Policy Studies
University of California, San Francisco
3333 California Street, Suite 265
San Francisco, CA 94118
http://ihps.medschool.ucsf.edu/