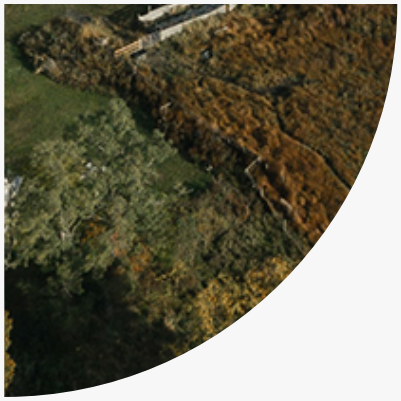
2017 - 2020

Financial and Operational Performance Analysis

RURAL

Federally Qualified Health Centers



CAPITAL LINK

INTRODUCTION

This report, prepared by Capital Link with support from the Health Resources and Services Administration (HRSA), provides an aggregate financial and operational profile of rurally-located Federally Qualified Health Centers[i] (herein referred to as rural FQHCs or rural centers). Rural FQHCs remain focused on improving health outcomes and expanding access to health care for the estimated 57 million people who live in rural areas. Through an evaluation of multi-year trends and median results, the following analysis provides a framework for identifying financial strengths and challenges for rural FQHC performance improvement. This report also highlights the variances between rural, urban, and national FQHC performance, as well as selected target benchmarks that support long-term financial sustainability.

The analysis incorporates health center financial audits as well as operational and utilization data reported by the Uniform Data System (UDS) from 2017 to 2020 for Section 330-funded health centers and Look-Alikes (LALs)—collectively, Federally Qualified Health Centers or FQHCs. The statistical measures and financial ratios in this report facilitate comparative analysis and provide important industry-specific context. Information on median performance, the level at which half of the centers rank higher and half lower, is provided throughout. Quartiles (the top and bottom 25th percentiles for performance, for example) and industry-recommended[ii] benchmarks are listed for specific financial measures where available and appropriate.

The report includes discussion and analysis of the following key performance areas for FQHCs:

- Growth & Expansion
- Patient & Payer Mix
- Revenue Growth & Mix
- Staffing & Productivity
- Operational Trends
- Financial Performance
- Quality of Care

To provide a sense of scale of the FQHC industry, the table below illustrates the 2019-2020 median revenue, patient, visit, and full-time equivalent employee (FTE) figures for rural FQHCs, with comparable metrics for urban, and national FQHCs.[iii]

In 2020, the median revenue for rural FQHCs was roughly $12.0 million, 28% lower than the national FQHC median ($16.5 million), and 43% lower than the urban FQHC median ($21.1 million). While median revenue increased from 2019 to 2020, each of the health center cohorts reported a decline in patients and visits, which can be directly attributed to service limitations during 2020 related to the COVID-19 global pandemic.

In 2020, rural FQHCs had a median staff FTE count of 86 employees who served over 9,200 patients and generated nearly 34,000 visits.

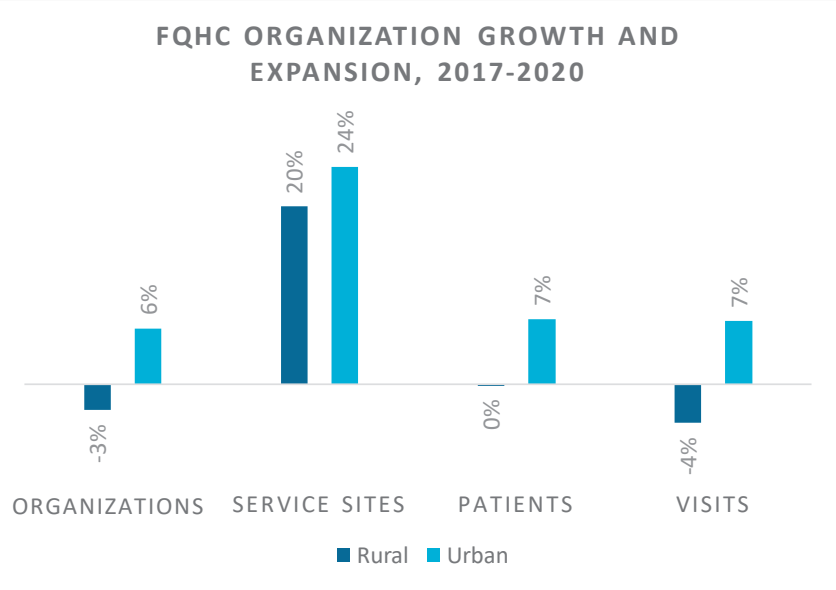
	2019			2020		
Median Health Center Profile, 2019-2020	**Rural**	**Urban**	**National**	**Rural**	**Urban**	**National**
Total Annual Operating Revenue	$11,332,088	$20,036,882	$15,956,941	$11,964,758	$21,141,740	$16,501,862
Total Annual Patients	9,665	15,204	12,670	9,233	13,859	11,877
Total Annual Visits	37,032	59,575	48,579	33,794	54,573	44,561
Total Annual Full-time Equivalent Employees (FTEs)	81	133	104	86	132	106

GROWTH AND EXPANSION

Rural FQHCs play an essential role in providing primary health, dental, and behavioral health services to marginalized populations in rural communities. Detailed in the chart below, rural centers served more than nine million patients at their 5,356 service sites in 2020. From 2017 to 2020, the total number of rural FQHC organizations, patients, and visits all decreased, whereas urban health centers reported continued growth. The greatest variance in growth trends between rural and urban FQHCs was in patient visits, with visits dropping by 4% for the median rural center and increasing by 7% for the median urban health center. The difference in visit growth trends may have been related to differential rates of telehealth capacity. The median urban health center had a substantially higher percentage of telehealth visits in 2020, with 28% of total visits delivered via telehealth while the median rural FQHC center provided 17% of total visits via telehealth. Patient totals at the median urban FQHC also increased 7% over the review period, while the number of patients for the median rural FQHC remained relatively level.

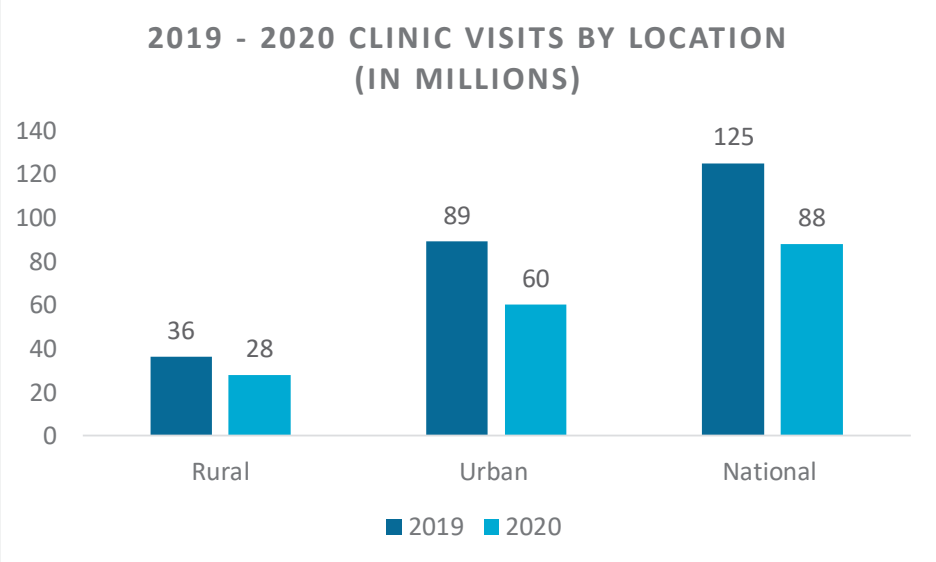
Organizationally, the number of rural FQHC organizations decreased 3% from 2017-2020, while the number of urban health centers increased 6%. Although rural FQHC organizations declined in number, they did see robust growth in the number of service delivery sites (20%). The decline in rural FQHC organizations, in combination with site growth, points to consolidation within the sector, with growth driven primarily by the existing health center organizations rather than new entrants into the industry.

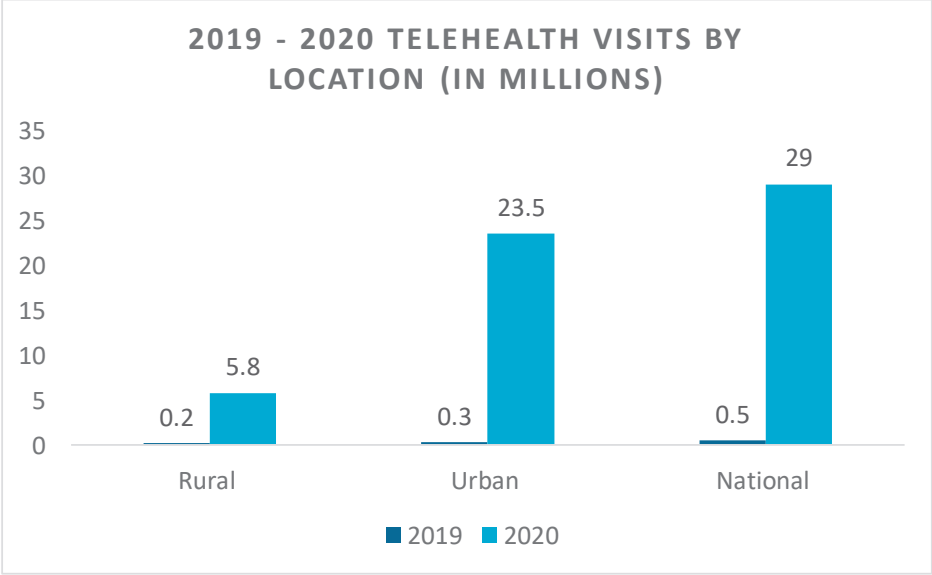
	2017		2020	
FQHC Organization Growth and Expansion	**Urban**	**Rural**	**Urban**	**Rural**
Organizations	810	619	861	601
Service Sites	6,838	4,464	8,511	5,356
Patients	18,881,975	9,014,319	20,267,288	9,002,619
Visits (Clinic & Telehealth)	77,682,653	35,341,621	83,207,977	33,811,982
Clinic Visits	-	-	59,704,241	28,003,102
Telehealth Visits	-	-	23,503,736	5,808,880



Visits by Location

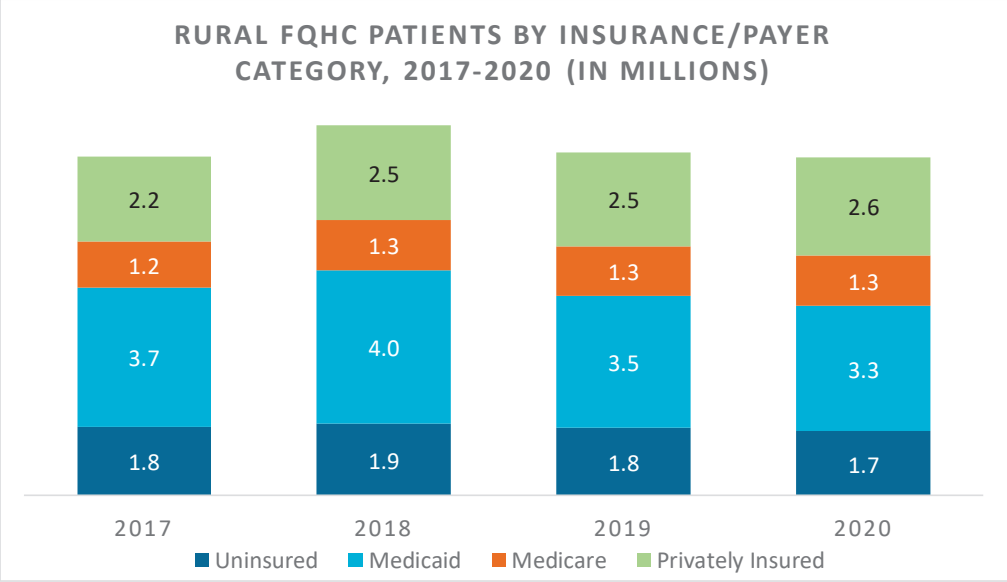
The charts below further detail the number of visits at national, rural, and urban health centers in 2019 and 2020, illustrating the sudden transition to telehealth due to the COVID-19 pandemic. Rural centers reported a 22% decrease in total clinic visits, from 36 million in 2019 to 28 million in 2020. The decline in patient visits was even higher at urban health centers, dropping from 89 million in 2019 to 60 million visits in 2020 (-33%). Inversely, telehealth visits increased dramatically in 2020 across both cohorts. Overall, national FQHC telehealth visits increased by 28.5 million visits from 2019 to 2020, with rural centers generating an increase of 5.6 million, and urban health centers increasing by 23.2 million.



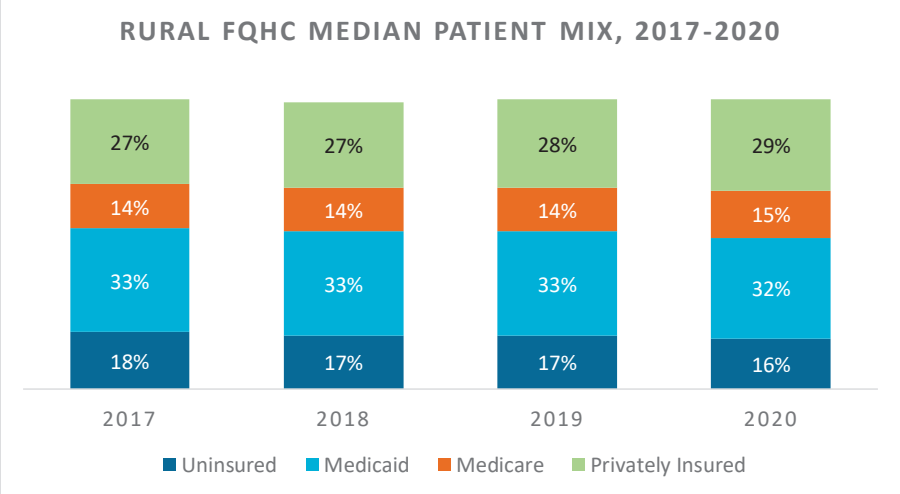


Patient Mix by Payer Source

Given that rural FQHCs often represent one of few primary care options in many rural communities, they are more likely to provide services to residents with a variety of insurance sources. Rural FQHCs centers experienced fluctuation in all patient payer categories from 2017 to 2020, with a notable decline in Medicaid patients in 2020. The number of Medicaid patients decreased 10.8% over the review period, dropping from 3.7 million in 2017 to 3.3 million in 2020 after peaking at 4.0 million in 2018. The number of uninsured patients decreased from 1.8 million in 2017 to 1.7 million in 2020, also following a peak in 2018 of 1.9 million. Despite being the smallest segment of the FQHC payer mix, Medicare patients increased by 8.3% from 2017 to 2020, reaching 1.3 million in 2020. The privately insured category grew 18.2% to 2.6 million in 2020. These data appear to reflect the differentially negative impact of the pandemic on low-income and uninsured patients.



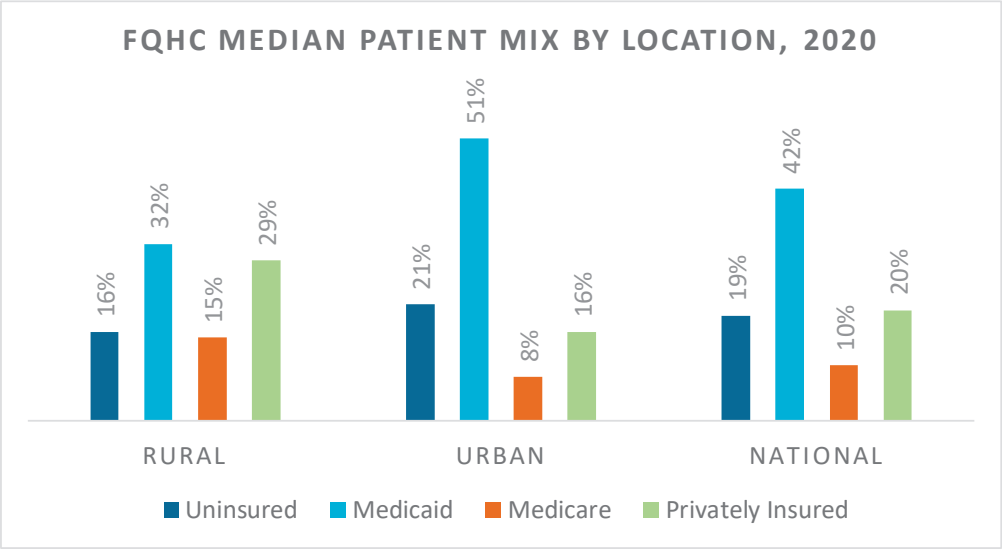
Similar to the changes in total patients by payer shown above, the median patient percentage mix for rural FQHCs reflects a slightly growing proportion of private pay and Medicare patients and a shrinking proportion of Medicaid and uninsured patients. In 2020, Medicaid patients comprised 32% of the total patient mix, down one percentage point from 33% over the three previous years. Privately insured patients, on the other hand, comprised 29% of the total in 2020, up from 27% in 2017. Medicare patients increased by one percentage point from 2017 to a level of 15% in 2020, while uninsured patients dropped two percentage points to 16% in 2020.



Note: Percentages represent the median result for each category and therefore do not sum to 100%

Patient Payer Mix by Location

The median patient mix in health centers differed significantly between rural and urban areas. In 2020, rural centers had a smaller proportion of uninsured patients, at 16%, compared to 21% in urban health centers. In addition, Medicaid patients made up 32% of the patient mix at the median rural center, compared to 51% at the median urban health center. On the other hand, Medicare covered 15% of patients for the median rural FQHC but just 8% for the median urban center. Similarly, the median rural FQHC reported 29% of its patients with private commercial insurance compared to 16% with private insurance at the corresponding urban health center. The relatively diversified payer mix of rural centers highlights the critical role they play in serving their entire communities, beyond the traditional safety net role they play in many urban communities.



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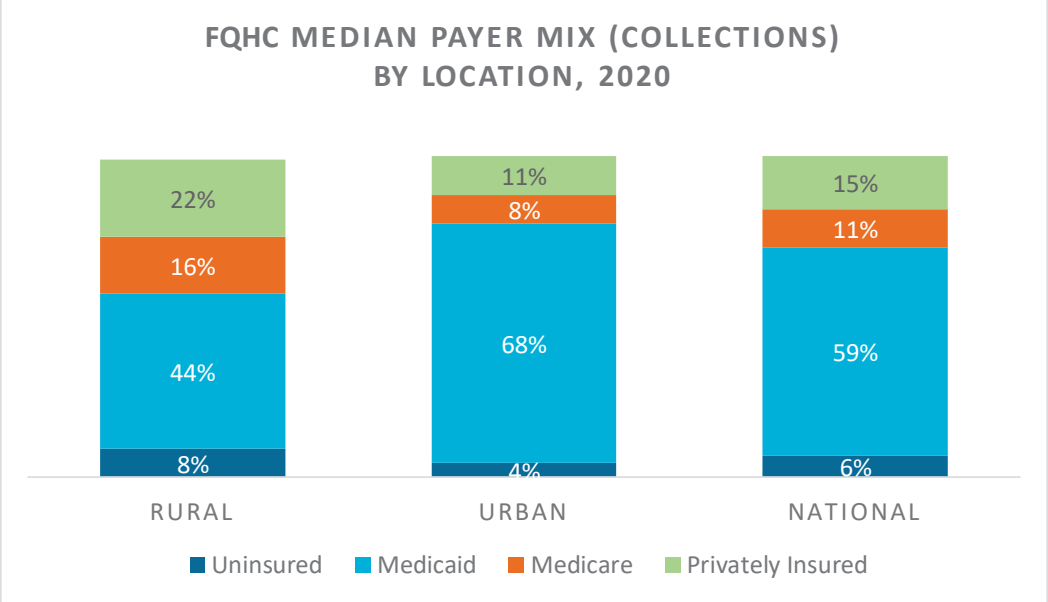
Patient Revenue by Payer Source

While Medicaid was consistently the largest payer for all health centers (59% of all patient revenue for the median health center nationally), rural FQHCs received a far lower percentage of their patient revenue from Medicaid compared to urban centers (44% vs 68% of patient revenue collections at the median, respectively). On the other hand, the median rural FQHC collected a comparatively higher portion of revenue from Medicare in 2020 (16%) than its urban counterpart (8%). Similarly, rural FQHCs reported a 22% median level for revenue collected from privately insured patients while urban FQHCs reported an 11% median result from this payer source. This variance illustrates the somewhat different patient populations served by rural FQHCs and the corresponding differences in health insurance coverage of their patients. From 2017 to 2020, rural FQHCs experienced some fluctuations in payer mix, with a two-point decline in Medicaid and the uninsured and a slight increase in Medicare and privately insured.



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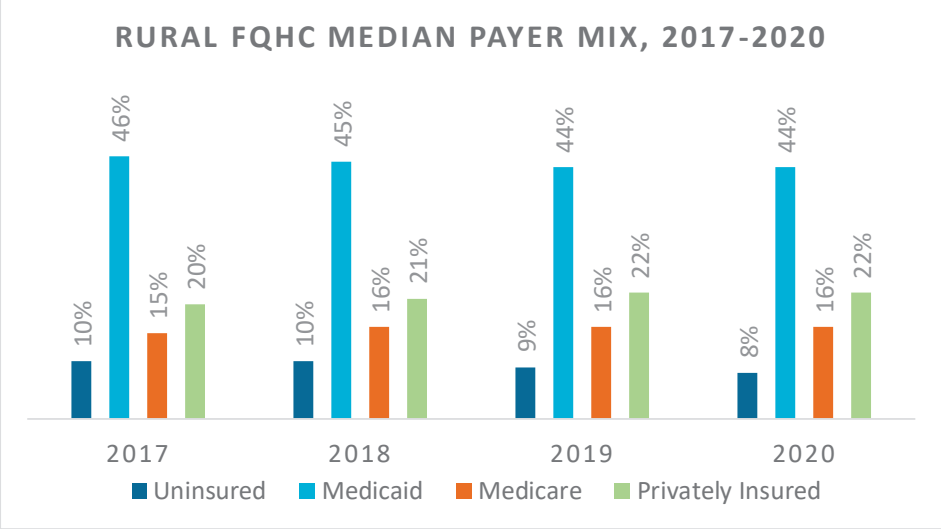

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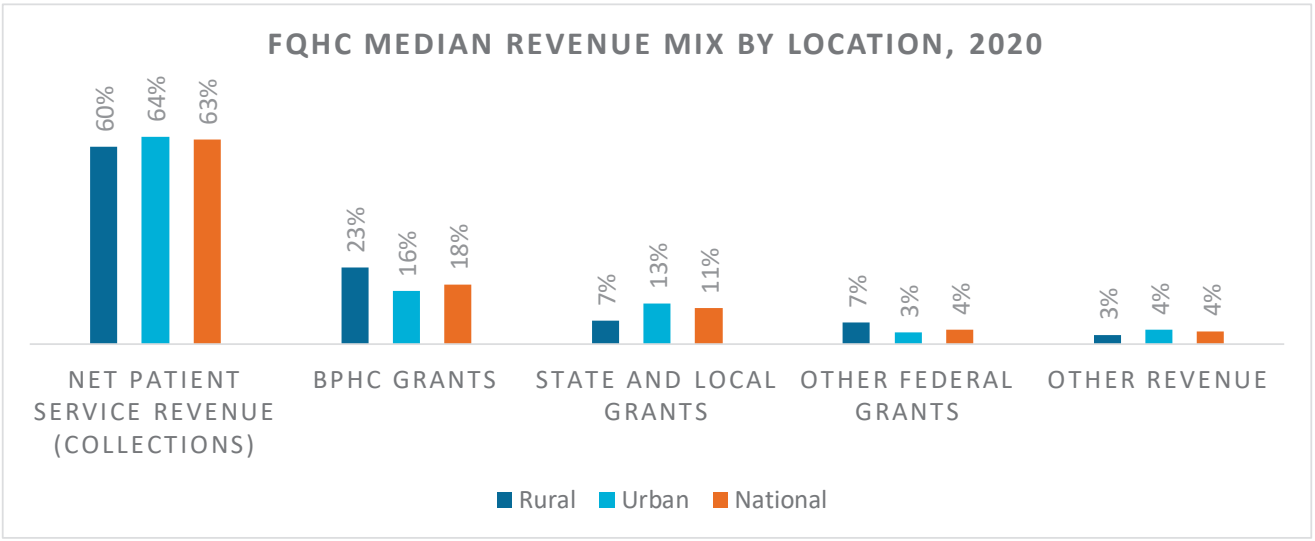
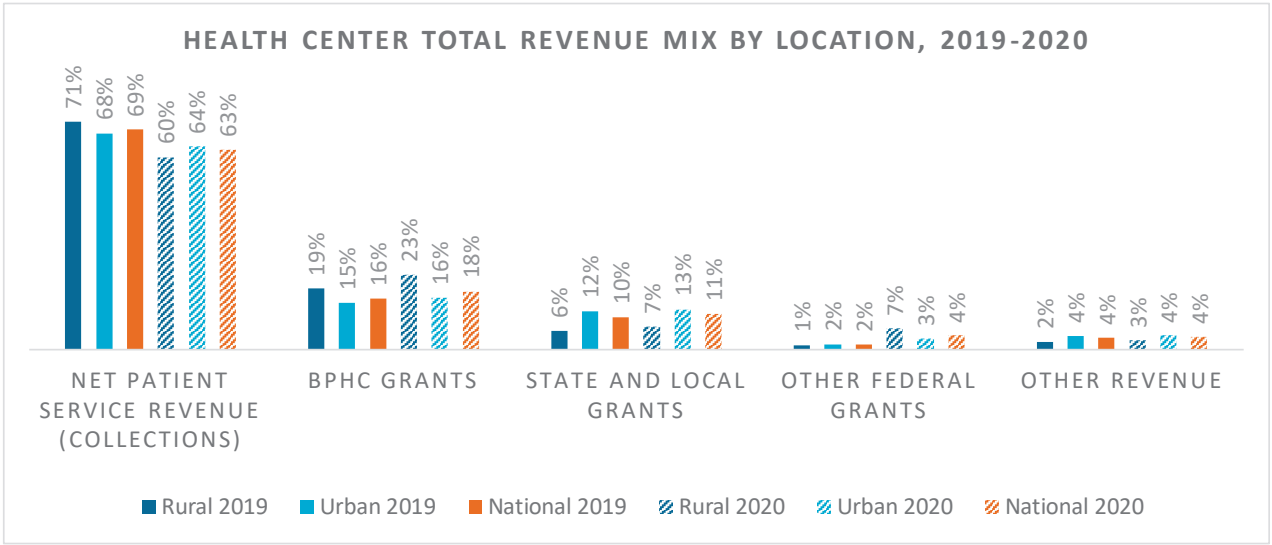
REVENUE GROWTH AND MIX

Net patient service revenue (NPSR) continued to be the primary source of revenue for health centers in 2020, accounting for 60% of all revenues at the median rural health center. NPSR was 64% of total revenues at the median urban health center, four points higher than the median rural health center. Grants from the Bureau of Primary Care (BPHC), as well as state and local grants, were two other key sources of funding for FQHCs. The median rural center received 23% of its revenue from BPHC funding in 2020, with the urban center's percentage (16%) seven points lower. State and local grants contributed 7% of total revenue at the median for rural centers, as compared to 13% at the median for urban centers.

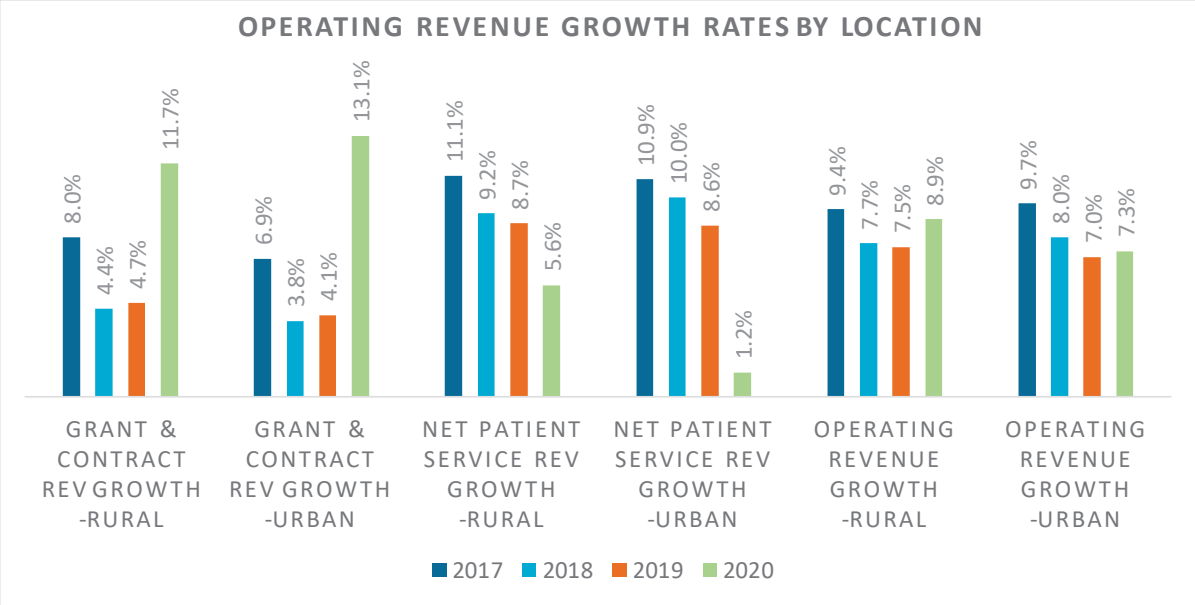


The chart below compares revenue mix by location for 2019 and 2020 to provide a perspective on the impact of the COVID-19 pandemic. At the outset of the pandemic in the United States, beginning in March 2020, most health centers experienced a rapid decline in patients visits and associated revenues, due to stay-at-home orders. By late March and continuing through 2020, the federal government, some states and private entities made available a range of relief funds, including grants and forgivable loans.[iv] Not surprisingly, between 2019 and 2020, NPSR declined as a percentage of revenue, while grants and contracts increased, particularly from BPHC and other federal sources. These changes are especially apparent for rural centers.

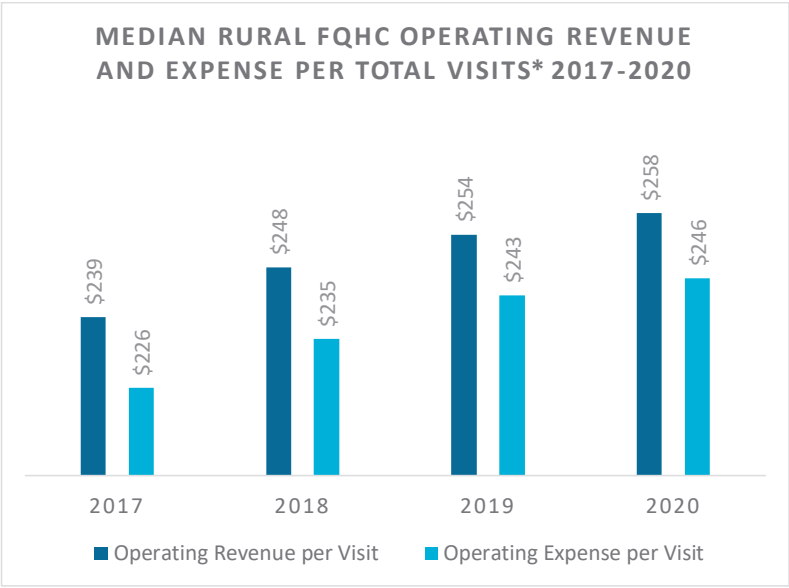


REVENUE GROWTH AND MIX

The median health center's revenue climbed every year over the review period, including a significant increase in grant and contract revenue in 2020. As discussed above and in the Endnotes, grants and contracts grew by almost 12% and 13% for the median rural and urban FQHC respectively, largely due to federal COVID relief funding, which supported health centers in preventing, preparing for, and responding to the global pandemic. Net patient service revenue was also notably affected by the global pandemic as median growth dropped to 5.6% for the median rural FQHC in 2020, and just 1.2% for the median urban center, after three years of nearly 10% annual growth for both groups. Nonetheless, driven by the increased grant and contract revenue, the median revenue growth rate for rural FQHCs was a healthy 8.9% in 2020, and 7.3% for urban centers, generally in line with previous years.



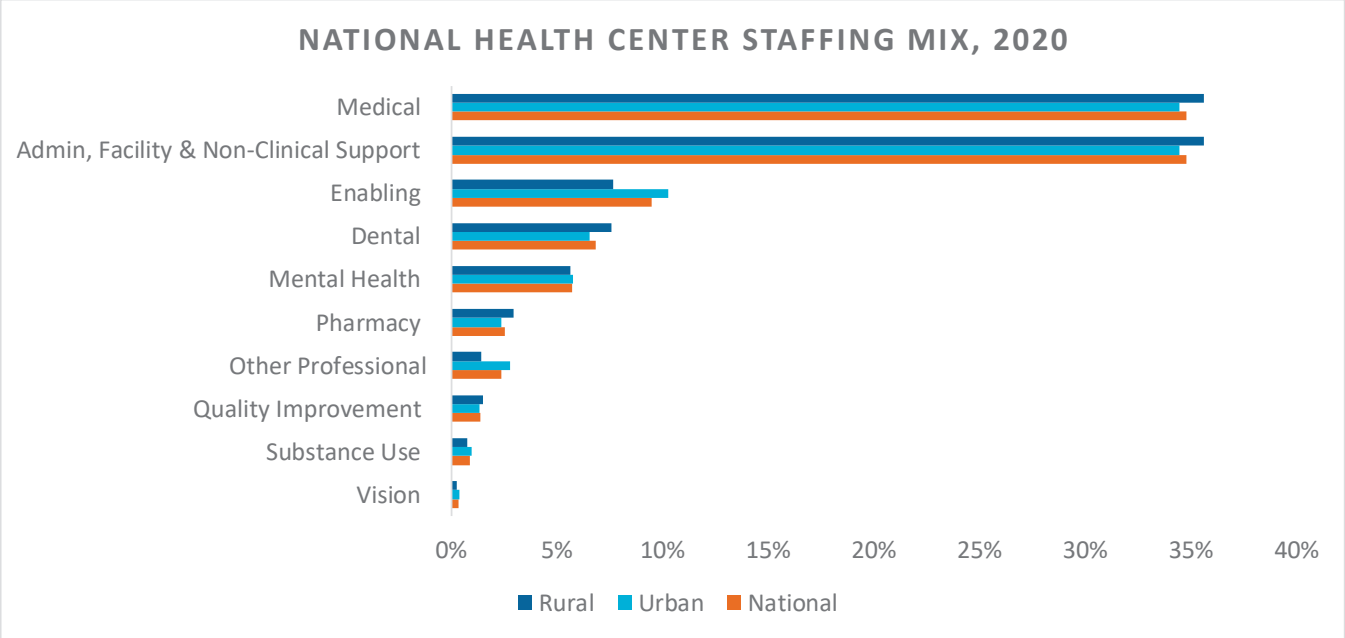
Average operating revenue per visit for the median rural FQHC rose 8% over the 2017-2020 review period to $258 in 2020. Over the same period, the average expense per visit increased by 9% to $246 per visit. In 2020, median revenue per visit exceeded expenses per visit by $12, a slightly narrower margin than the $13 differential between operating expense per visit and revenue per visit in 2017, but a $1 increase from the previous margin in 2019. FQHC success in balancing revenues and costs during the pandemic was greatly bolstered by COVID relief funding, which not only backfilled revenue losses, but also covered a range of direct costs related to responding to the pandemic.



**Includes virtual visits*

STAFFING AND PRODUCTIVITY

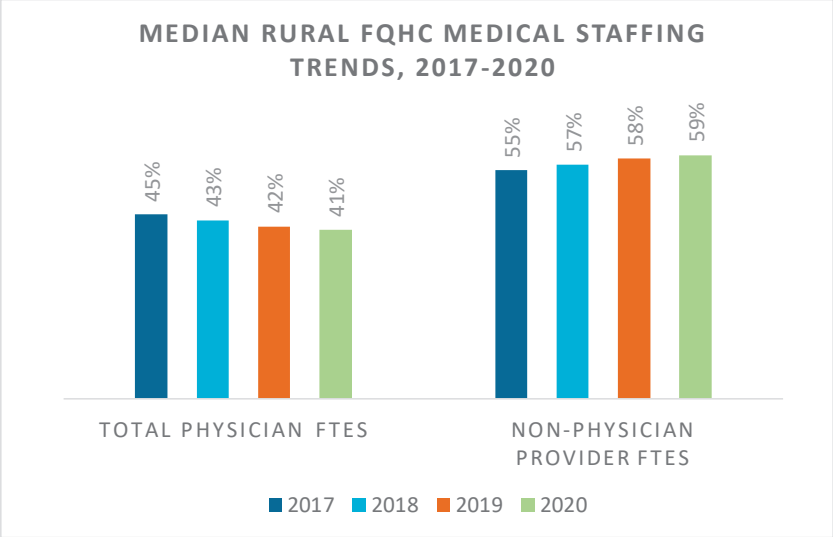
Though health center staffing models vary based on the needs of the communities they serve, medical service FTEs and administrative, facility and non-clinical support service FTEs generally make up the majority of the staffing mix, as illustrated. In 2020, rural and urban health centers showed similar staffing mix results, with slight variances in dental and enabling service FTEs. Dental services employed 8% of total FTEs at rural FQHCs and 7% at urban health centers. Eight percent of rural FQHC FTEs at the median were deployed to enabling services, compared to 10% at urban health centers.

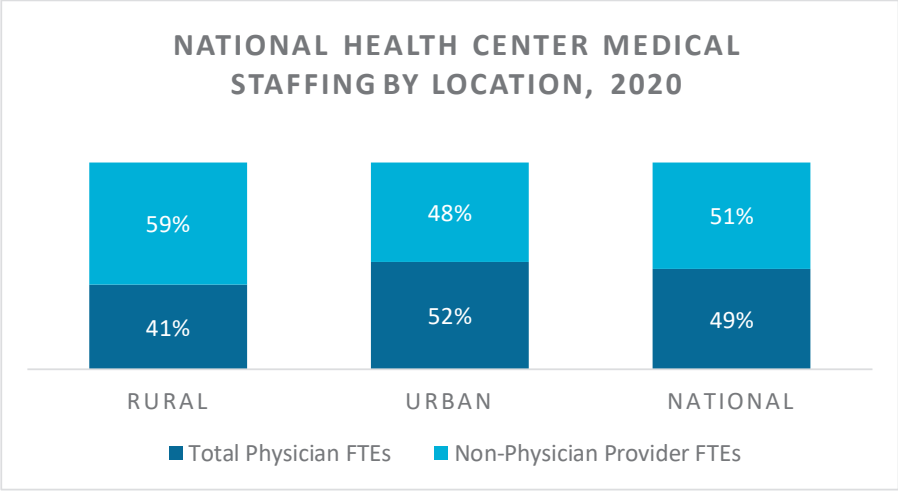


Staffing Mix

While the provider mix of a health center varies based on its individual community needs, there has been an evident trend toward employing more non-physician providers such as physician assistants, nurse practitioners, and certified nurse-midwives. For example, the medical provider staffing mix at the median rural health center shifted in recent years to non-physician providers accounting for 59% of all providers in 2020, up from 55% in 2017. Inversely, physician FTEs decreased to 41% in 2020 from 45% in 2017.

In comparison to urban centers, rural centers had a substantially larger ratio of non-physician practitioners to physicians. Given the overall high market demand for physicians, the predominance of non-physician providers in rural settings perhaps attests to the competitive disadvantages of rural communities when competing with their urban counterparts to recruit and retain physician providers. In 2020, 59% of total medical providers were non-physicians for the median rural FQHC while this figure was 48% for the corresponding urban FQHC.

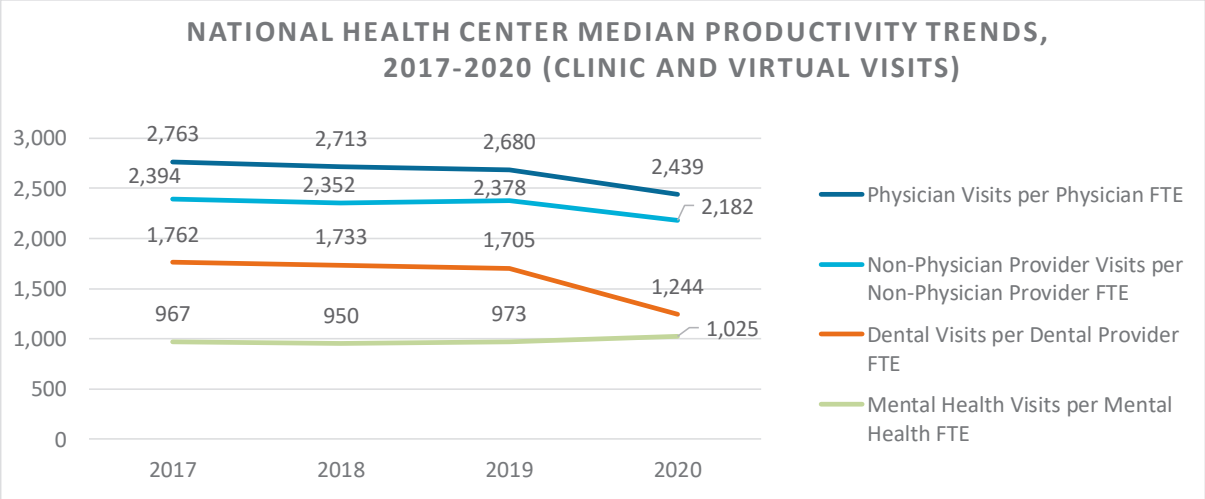




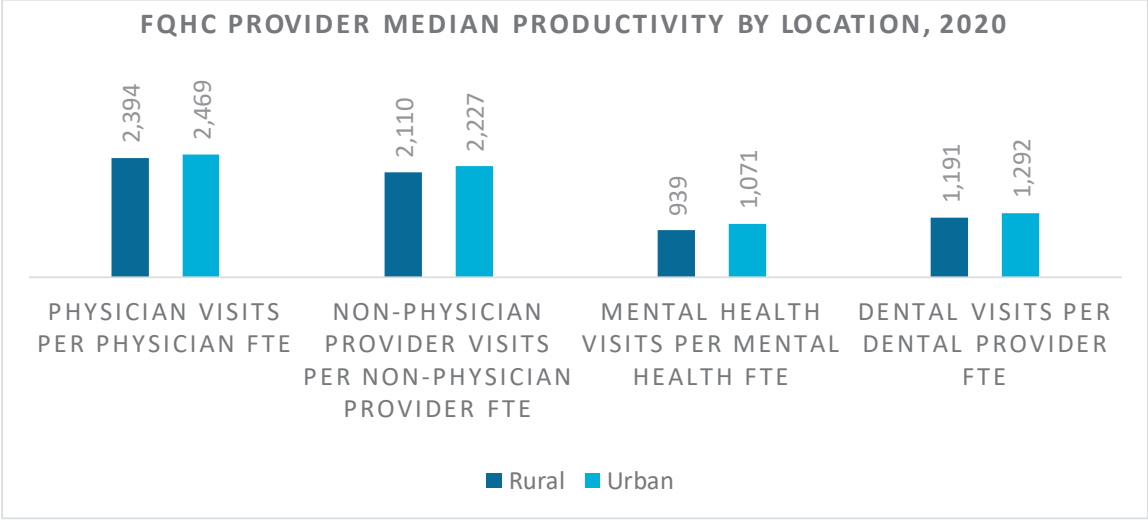
Provider Productivity

When measured by average patient visits per medical provider per year, provider productivity significantly declined in 2020. However, this decrease was largely due to the tumultuous circumstances brought on by the global pandemic and is not entirely representative of the overall scope of work done by providers and their support staff. Physician productivity for the median national health center decreased 9% in 2020 to 2,439 visits. Provider capacity was impacted in various ways by the pandemic, including an increase in safety protocols, staffing reassignments to support COVID-19 screenings (which were not counted as reportable visits), as well as systematic challenges in the rapid transition to telehealth services. These challenges were also likely drivers for the productivity decline of non-physician providers which experienced an 8% decrease in 2020 to a median of 2,181 visits per FTE. The pandemic was even more disruptive to dental operations, as dental provider productivity dropped 27% to 1,244 visits per dental provider FTE.

Mental Health productivity was the only area that increased, steadily improving from 967 visits per mental health provider in 2016 to 1,025 visits in 2020. This improvement was likely due to health centers' ability to facilitate mental health appointments through telehealth more effectively than medical or dental visits.

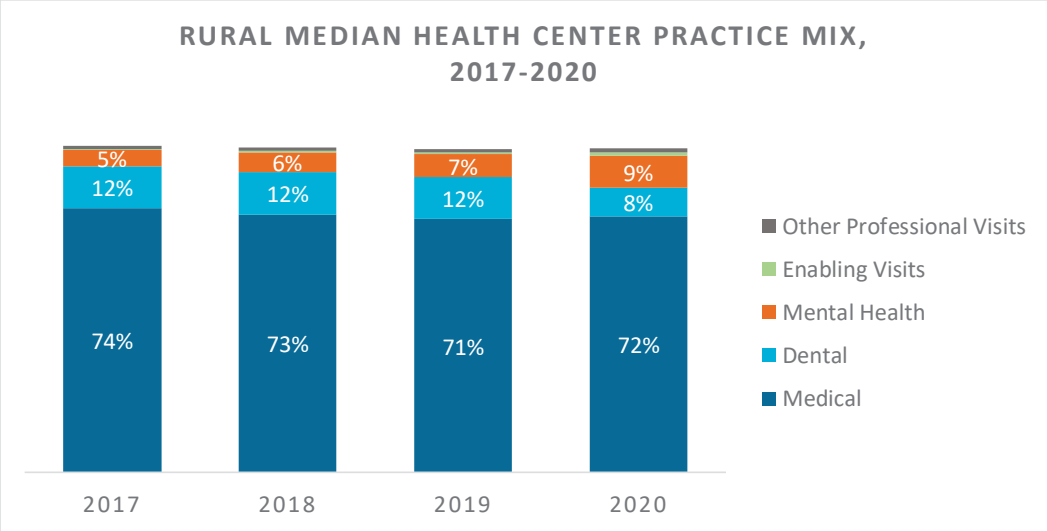


Visit productivity metrics for the median rural FQHC were consistently lower than the urban health center across most provider types. At 2,394 visits per physician FTE, rural FQHCs reported 3% lower visit productivity than their median urban counterparts, while rural mental health visit productivity was 12% lower.



Practice Mix

Over the review period, the median rural health center's practice mix remained predominantly focused on providing medical care, but did progress in integrating additional care services, particularly mental health. Medical visits accounted for 72% of the practice mix at the median rural health center in 2020, up one point from the previous year. Dental visits as a percentage of total visits decreased four percentage points at the median health center in 2020, which can be directly attributed to the pandemic as patients were urged to postpone routine visits while some dental operations closed completely for periods of time during the year. Mental health visits, on the other hand, increased four percentage points over the research period, reaching 9% of all visits in 2020. The shifting practice mix reflected the health centers' continued efforts to deliver a comprehensive variety of services to patients. The practice mix between rural and urban health centers was relatively similar for the median FQHC of each group.



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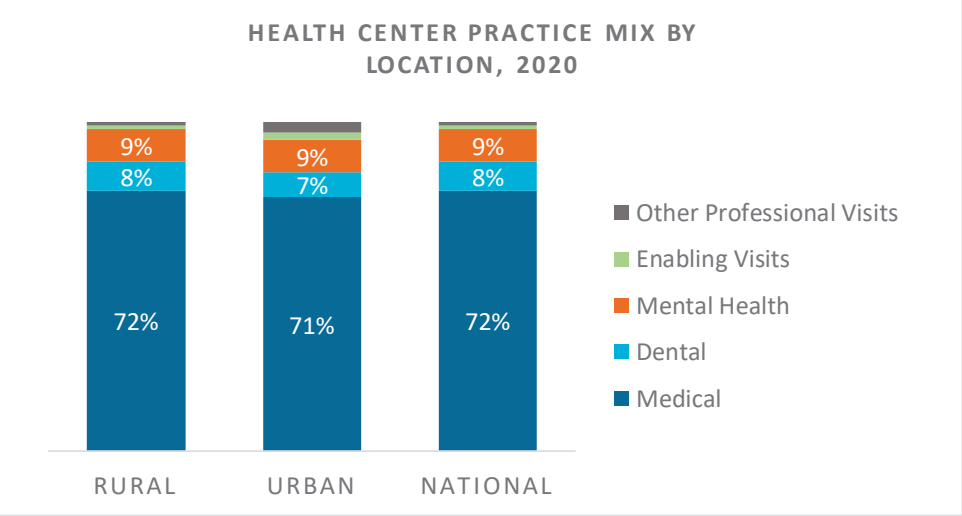

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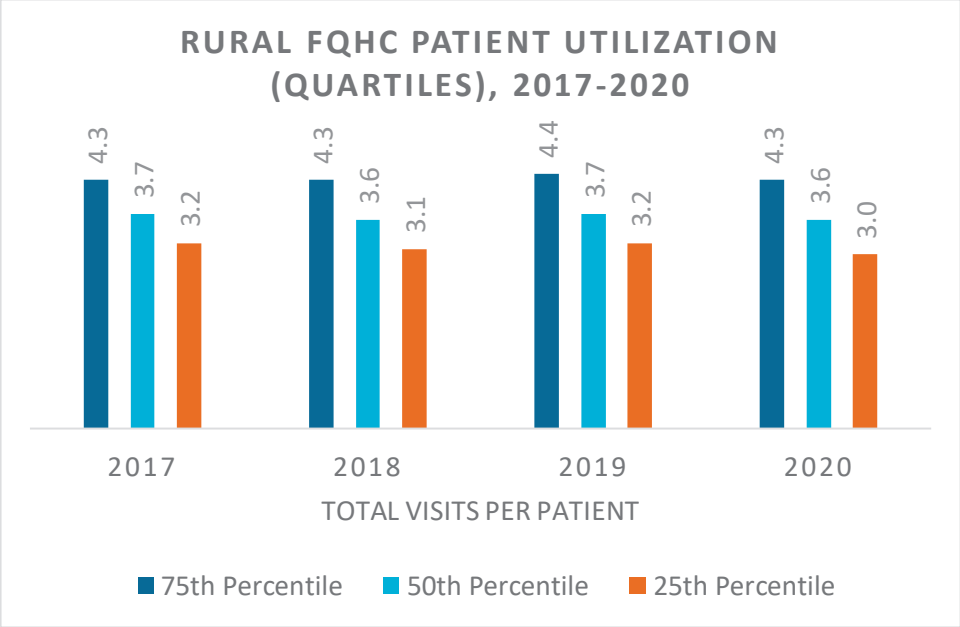
Patient Utilization

Patients served by rural FQHCs visited health centers 3.6 times per year at the median in 2020, consistent with the three previous years. Between 2017 and 2020, rural centers represented by the top quartile of usage rates reported 4.3-4.4 patient visits or more per year, while those in the lowest quartile generated 3.0-3.2 or less visits per year.



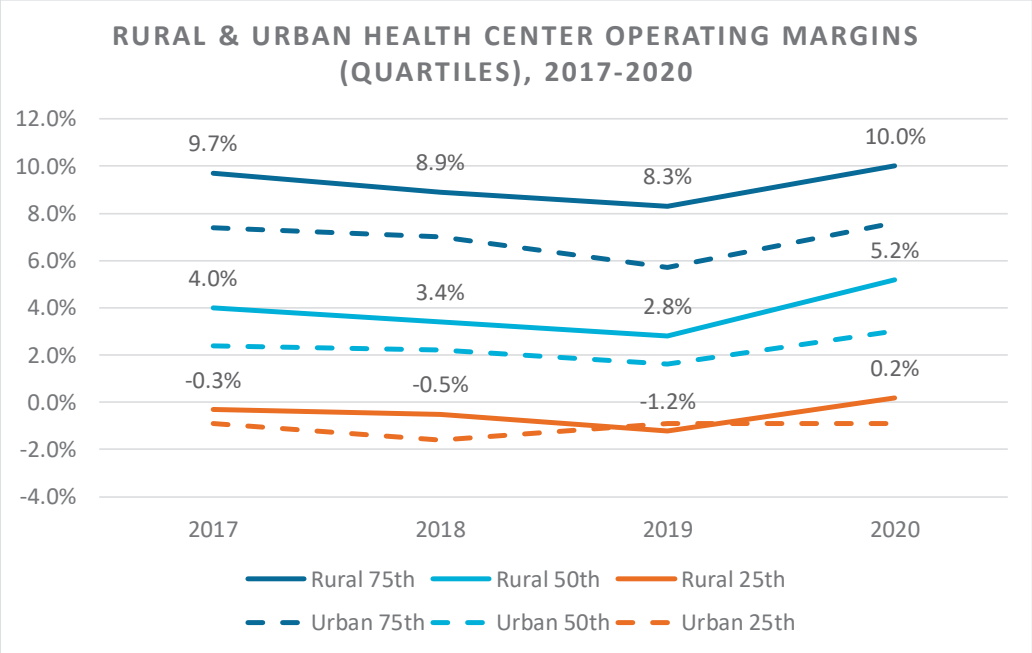
Operating Margin

Operating margins are a vital measure of a health center's business model and overall profitability. While operating margins for health centers are often modest, positive margins are critical to maintain the organization's long-term viability.

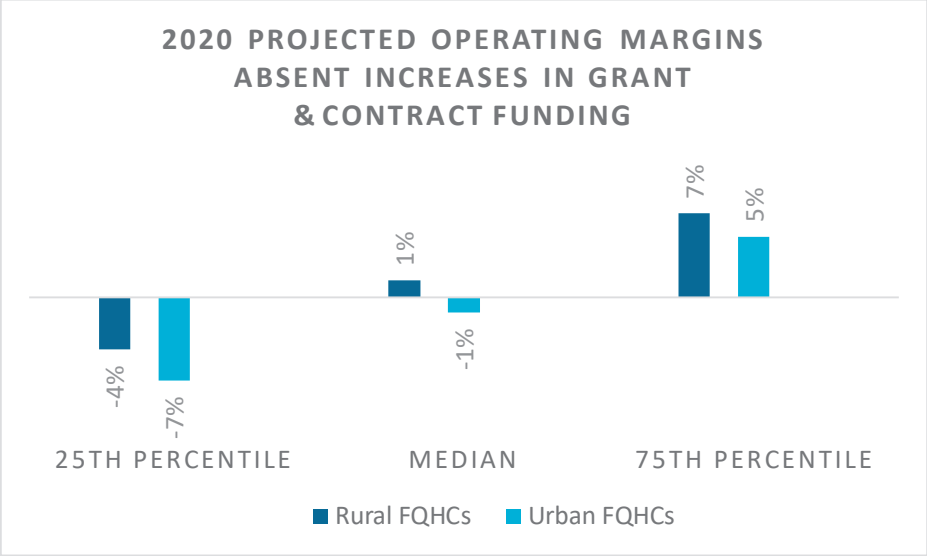
From 2017 through 2019, the median rural health center's operating margin declined from 4.0% to 2.8%, followed by a significant increase in 2020 to 5.2%. As further discussed below, the increased operating margins appear to be due in large part to increases in grant and contract funding related to pandemic response.

In 2020, the 75th percentile for rural centers, representing the best-performing FQHCs, had operating margins of 10.0% and above—more than triple the 3.0% industry-standard benchmark. However, centers in the lowest quartile (25th percentile and below) reported operating margins of just 0.2% or lower in 2020, raising concerns about their long-term sustainability, particularly once pandemic-related funding support abates.

Despite managing smaller operating budgets, rural centers consistently outperformed urban health centers in all quartiles. In 2020, the median rural health center generated a 5.2% operating margin, two points higher than the median urban health center. Rural FQHCs in the lowest quartile generated a breakeven margin of 0.2% or lower, while the highest quartile (75th percentile and above) recorded operating margins of 10% and above, again two points above that of their urban counterparts.

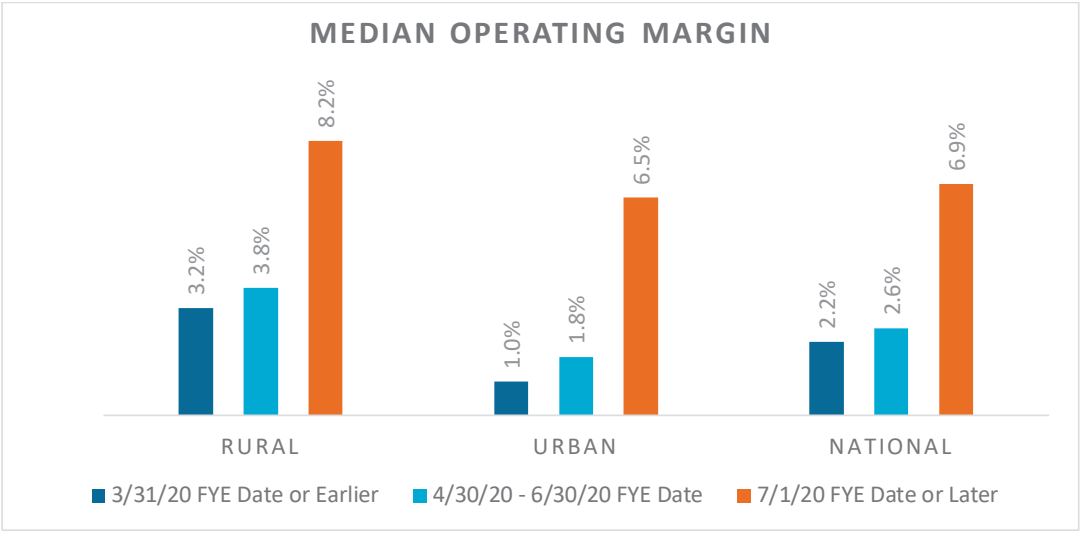


To evaluate the importance of COVID relief funding to operating results, Capital Link analyzed the impact of the change in grant and contract revenue between 2019 and 2020 and its impact on operating margin, assuming all other factors remained the same. Without the additional grant funding, the median operating margin for FQHCs would have declined significantly. The median margin would have declined to 1% and (-1%) for rural and urban centers respectively—in both cases, well below the recommended benchmark of 3%. Without the stabilizing effect of additional grant funding, many centers would have been forced to lay off staff to cut costs, decreasing their capacities to respond to the pandemic.



Operating Margin by Fiscal Year End Date

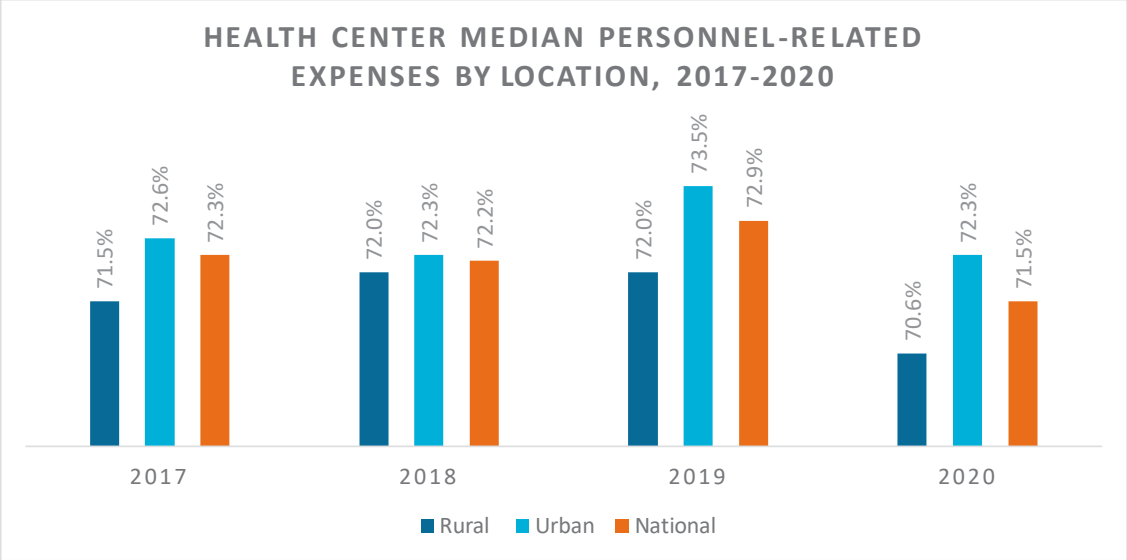
The impact of COVID-19 pandemic funding on health centers' financial performance was extremely significant and the likely driver of increased 2020 median operating margins. The chart below illustrates the impact COVID-19 supports have had on health centers by demonstrating the significant variance in median operating margins based on fiscal year-end (FYE) dates at rural, urban, and national health centers. As detailed in the Endnotes, the first tranche of pandemic relief funding was awarded at the end of March 2020, totaling approximately $100 million. Beginning in April 2020, an additional $2.6 billion was made available through successive award cycles through the remainder of 2020. Those health centers with an FYE date after July 1, 2020, which would have received the majority of the pandemic funding, had a median operating margin more than double the median for those with FYE dates in June or earlier. Nationally, health centers with a FYE of July 1, 2020 or later generated a median operating margin of 6.9%, while those with a FYE in March or earlier had a median of 2.2%. Rural centers with an FYE in March or earlier earned a median operating margin of 3.2%, while those with an FYE in July or later reached median margins of 8.2%. Similarly, urban health centers with a FYE in March or earlier generated a median margin of below 1.0%, but those with a FYE after July 1st earned a median margin of 6.5%. In all cases, those with FYE dates between April and June had margins in between their peers with earlier or later fiscal year ends, reflecting improvement in margins as the relief funding continued to roll out.



Personnel-Related Expenses

Personnel-related expenses are a key component of the operating budget for health centers, including salaries, benefits, contracts and professional services. It is generally recommended that health centers keep their personnel expenses at 70% or less of their annual operating revenues. Health centers spending 75% or more of their operating revenues on personnel-related costs often have less budgetary room to support overall needs and are at higher risk of reporting operating deficits.

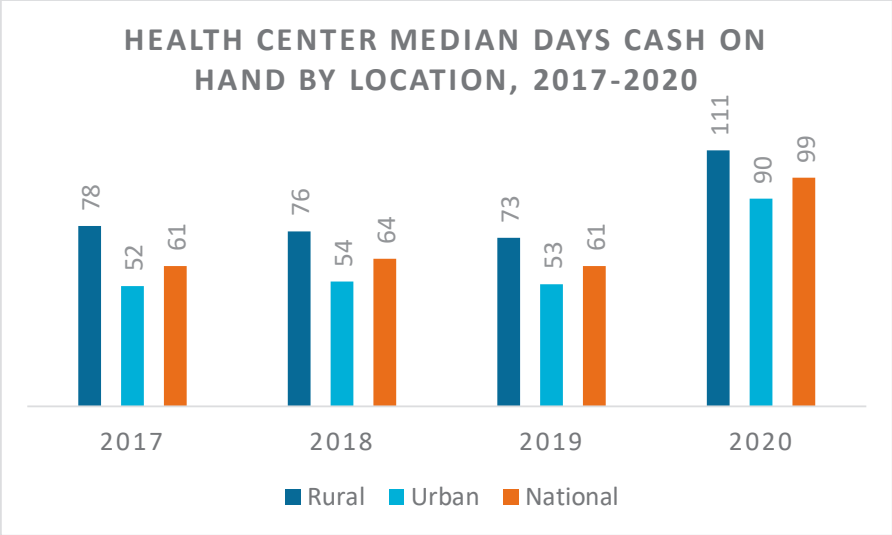
Personnel-related expenses as a percentage of operating revenues at the rural median health center hovered at about 72.0% from 2017 to 2019, followed by a notable 1.4% decrease in 2020 to 70.6%. The decrease in 2020 corresponded to an increase in health center operating margins, as illustrated previously. Urban health centers at the median were higher than their rural counterparts but also reported a decrease in 2020 of 1.2% to a level of 72.3%. While the median rural health center's personnel-related expenses as a percent of operating revenues was lower than the percentage for the median urban center for each of the years studied, both groups' relative costs decreased in 2020.



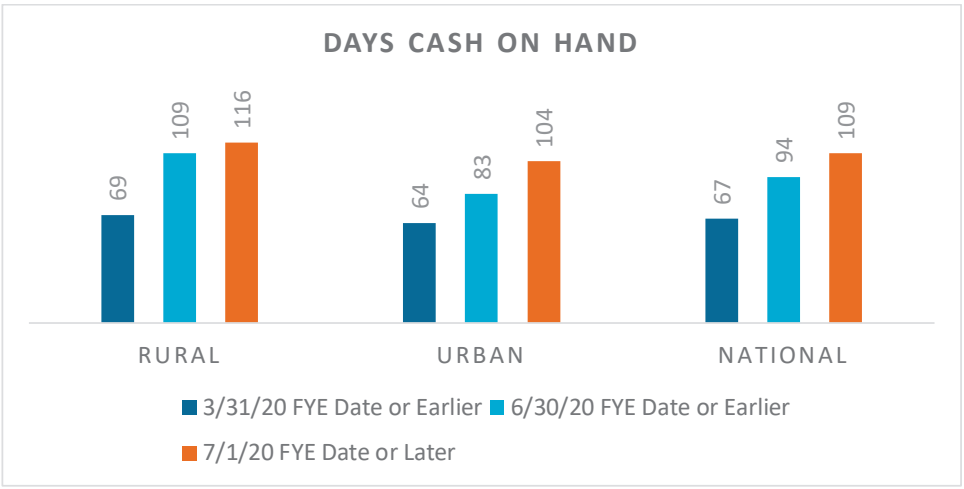
Days Cash On Hand

Health centers reported improved operating liquidity over the review period, with increased cash balances and lower days in patient accounts receivables. Days cash on hand refers to the number of days a health center can meet operating expenses with its present cash balances. From 2017 to 2019, the median rural health center's days cash on hand fluctuated between 73 and 78 days. In 2020, Days Cash on Hand at the median rural health center peaked to 111 days, 85% higher than the industry benchmark minimum of 60 days.[v]

At fiscal year end 2020, the median rural FQHC had 21 more days cash on hand than the median urban FQHC. This divergence was likely related to higher levels of targeted COVID relief funding available to rural centers through the Provider Relief Fund. Regardless of location, however, cash balances at virtually all health centers were significantly augmented by COVID relief funding by fiscal year end 2020, providing important operational flexibility and stability during a precarious time.

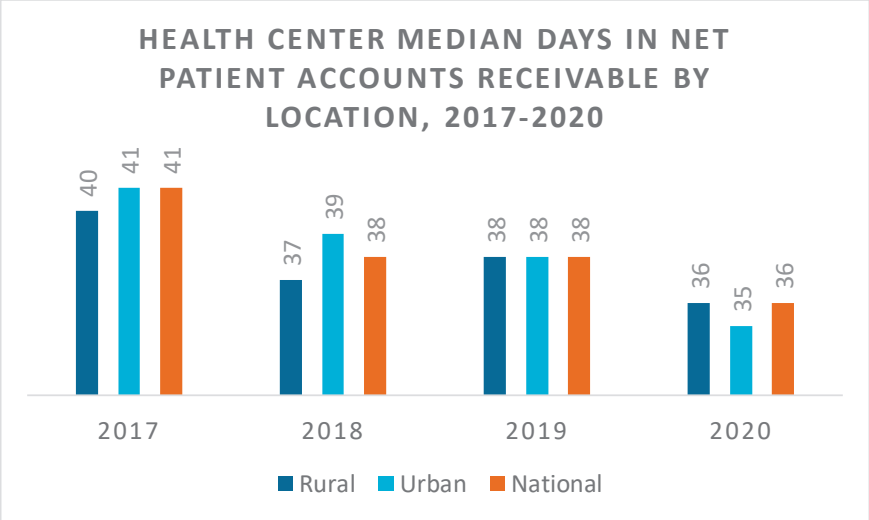


The chart below illustrates the impact that COVID-19 funding supports had on cash balances at health centers by demonstrating the significant differences between fiscal year end (FYE) dates at rural, urban and national health centers. Those health centers with an FYE date after July 2020, which would have received the majority of the pandemic funding, had 42 days more cash on hand, at the median, than those with FYE dates in March or earlier. Rural centers, at the median, had a 47-day difference from those with a March 31st or earlier FYE (69 days) versus those with a July 1st or later FYE (116 days), while urban health centers, at the median, saw a 40-day variance.



Days in Net Patient Accounts Receivable

A health center's cash position can be strongly influenced by the collections cycle, as measured by days in net patient accounts receivable. The median rural health center generated additional cash over the review period by accelerating its collections to 36 days in 2020, an improvement of four days from 2017. National and urban health centers also saw continued improvement in their patient collections cycle over the past three years, with the median national health centers accelerating five days to 36 collection days and urban health centers decreasing to 35 days, an improvement of six days over the review period. These results indicate a relatively efficient and improving revenue cycle, well under the industry benchmark of 45 days.



Health Center Median Quality of Care Measures, 2020

The table below summarizes nine HRSA Uniform Data System (UDS) quality measures covering both preventive and chronic care services at the median level for rural and urban FQHCs. For six of the measures, rural FQHCs out-performed their urban counterparts at the median in 2020, while urban centers out-performed on two measures and both groups had identical outcomes for one measure.

The Healthy People 2030 (HP2030) benchmark goal is also provided for five of the measures for benchmarking purposes. HP2030 identifies public health priorities to help organizations and communities across the nation set data-driven objectives to improve health and well-being. For three of the measures, significant portions of both urban and rural FQHCs have surpassed or are making significant progress toward meeting the 10-year goal. For two of the measures, only a small portion of FQHCs are currently meeting the goal. It may be helpful to further investigate the reasons behind these variances to inform improvement strategies.

Quality of Care Measures	Rural	Urban	Rural vs. Urban	HP2030 Goal	% Rural Centers Meeting HP2030 Goals in 2020 (ACTUAL)	% Urban Centers Meeting HP2030 Goals in 2020 (ACTUAL)
Patients ages 12 and over Screened for Depression and Follow-up Plan Documented (If Positive)	68%	66%	2%	13.5%	97%	97%
Patients age 3-17 with BMI, Nutrition & Physical Activity Documented	59%	66%	-7%	-	-	-
Patients age 18 and over with BMI & Follow Up Documented (If BMI outside normal)	70%	66%	4%	-	-	-
Patients with Controlled High Blood Pressure	59%	56%	3%	60.8%	45%	26%
Patients age 6-9 at Moderate to High Risk of Caries Receiving Sealant on First Permanent Molar	50%	50%	0%	42.5%	56%	61%
Patients Screened for Colorectal Cancer	41%	37%	4%	74.4%	2%	3%
Children Receiving Appropriate Vaccinations by Age 2	31%	37%	-6%	-	-	-
Patients with Diabetes and Hemoglobin A1c Poor Control *	32%	37%	5%	11.6%	1%	0%
Babies with Low Birth Weight Born to Prenatal Patients who Delivered During the Year *	7%	8%	1%	-	-	-

*For this metric, a lower percentage indicates better performance

SUMMARY AND CONCLUSION

In 2020, rural FQHCs served over nine million patients through 34 million visits, and continued to increase access to care with 20% growth in service sites from 2017 to 2020. After three years of steady expansion, health centers saw a drop in patients and visits in 2020 due to service limitations related to COVID-19. While overall visits decreased over the review period, telehealth visits skyrocketed in 2020, with rural FQHCs increasing telehealth visits by 5.6 million, up from just 500,000 the previous year. Given the long duration of the pandemic, these challenging access and growth trends are likely to persist for several years. However, the overall financial resiliency of the health center sector has been greatly bolstered by a range of federal funding supports, enabling the sector to emerge at the end of the first year of pandemic operations on a relatively stable financial footing—providing a platform for a return to growth as the initial impacts of the pandemic slow.

Rural FQHCs reported fluctuation across payer sources for the patients they served from 2017 to 2020, with a notable decline in Medicaid in 2020. Medicaid patients decreased by 10.8% over the review period from 3.7 million in 2017 to 3.3 million in 2020. The number of uninsured patients also decreased from 1.8 million in 2017 to 1.7 million in 2020. Despite being the smallest segment of the rural FQHC patient population, Medicare patients increased by 8.3% from 2017 to 2020, reaching 1.3 million in 2020. The privately insured patient category grew the most substantially (18%) to 2.6 million patients in 2020.

Net patient service revenue (NPSR) continued to be the primary source of revenue for health centers in 2020, accounting for 60% of total revenue at the median rural health center. Grants from the Bureau of Primary Health Care (BPHC), accounted for 23% of rural health center revenue in 2020, up from 19% in 2019, driven primarily by COVID relief funding, to assist center efforts in preventing, preparing for, and responding to the global pandemic. Due to the increased funding, rural FQHCs were not only able to keep operating but also report improved financial performance at the median level.

The medical provider staffing mix at the median rural health center has shifted in recent years, with non-physician providers accounting for 59% of all providers in 2020, up from 55% in 2017. Inversely, physician FTEs have decreased from 45% of total medical providers in 2017 to 41% in 2020. The median urban health center had a notably higher ratio with 52% of providers being physician FTEs, and 48% non-physician providers. Given the overall high market demand for physicians, the predominance of non-physician providers in rural settings perhaps attests to the financial and geographic disadvantages of rural FQHCs when competing with their urban counterparts to recruit and retain physician providers.

Provider productivity significantly declined in 2020 due to the tumultuous circumstances brought on by the global pandemic, with physician visit productivity declining by 9%, non-physician provider productivity down 8%, and dental provider productivity declining by 27%. Median rural FQHC productivity was consistently lower than the median urban health center across most provider types. At 2,394 visits per physician FTE, the median rural FQHC reported 3% lower productivity than its urban counterpart, while rural mental health productivity was notably 12% lower. While visits declined in 2020, provider capacity was also limited due to an increase in safety protocols, the additional capacity needed for COVID-19 screenings (which were not counted as reportable visits), as well as challenges in rapidly transitioning to increased telehealth services.

SUMMARY AND CONCLUSION

While patient growth and visits declined in 2020, the median rural health center's financial performance improved with the addition of supplemental COVID-19 funding. From 2017 through 2019, the median rural health center's operating margin declined from 4.0% to 2.8%, followed by a significant increase in 2020 to 5.2%, exceeding Capital Link's recommended minimum 3.0% operating margin benchmark. At the same time, approximately 25% of all FQHCs (urban and rural alike) operated at a loss in 2020, despite significant infusions of COVID-19 related supports—a reminder of the critical need for financial monitoring and improvement at many health centers. Absent increases in grant and contract funding due to COVID relief, Capital Link estimates that operating margins at rural FQHCs would have declined in 2020 to 1% at the median, all other factors remaining the same. Overall, it is clear that increases in grant funding contributed to stable operating margins, allowing health centers to maintain much of their capacities to respond to the pandemic.

Liquidity also improved substantially in 2020 due partly to the increased COVID-19 funding and was also supported by efficient patient revenue collections, which accelerated to just 36 days in 2020 at the median rural health center. The median rural FQHC reported 111 days cash on hand, an amount 85% higher than the 60 days industry benchmark minimum.

While health centers faced a challenging year in 2020 with the onset of the pandemic, increased operating margins and enhanced liquidity have left most centers reasonably well-positioned for recovery and growth as they enter the second year of pandemic-impacted operations. This positive result offers a shining example of a successful federal effort to address the immediate effects of the pandemic by ensuring health centers' financial survival during the devastating early months of the pandemic. The rapid infusion of grant funding offset operating losses and supported the significant additional costs incurred by FQHCs as they worked to diagnose and treat patients under difficult conditions. As a result, most health centers—especially those serving rural communities—emerged from the first phase of the pandemic financially intact and resilient, ready to continue their important work. Given that the duration of the pandemic is not known, time will tell whether additional supports may be necessary to ensure the survival of a robust FQHC system. But in the meantime, FQHCs will continue to play a critical role in pandemic response and in providing primary and preventive care for more than nine million rural Americans.

NATIONAL DATA SUMMARY

		TOTALS - Section 330 and Look-Alike			
Data		**2017**	**2018**	**2019**	**2020**
Financial Audits		1,308	1,307	1,308	989
UDS Data		1,429	1,446	1,458	1,462
Key Financial Metrics	**Target**	**2017**	**2018**	**2019**	**2020**
Operating Margin	> 3%	3.0%	2.7%	2.0%	3.6%
Bottom Line Margin	> 3%	4.3%	3.7%	3.3%	5.2%
Personnel-Related Expense as Percentage of Operating Revenue	< 70%	72.3%	72.2%	72.9%	71.5%
Days Cash on Hand	> 60 Days	61	64	61	99
Days in Net Patient Receivables	< 45 Days	41	38	38	36
Key Productivity Metrics		**2017**	**2018**	**2019**	**2020**
Physician Visits per Physician FTE		2,763	2,713	2,680	2,439
Mid-Level Visits per Mid-Level FTE		2,394	2,352	2,378	2,182
Medical Patients per Medical Staff FTE		296	290	287	266
Medical Patients per Medical Provider FTE		865	844	832	781
Dental Visits per Dental Provider FTE		1,762	1,733	1,705	1,244
Mental Health Visit per Mental Health Provider FTE		967	950	973	1,025
Key Operations & Utilization Metrics		**2017**	**2018**	**2019**	**2020**
Operating Revenue per Patient		$939	$974	$1,022	$1,183
Operating Expense per Patient		$885	$925	$978	$1,128
Operating Revenue per Patient Visit		$238	$245	$252	$253
Operating Expense per Patient Visit		$225	$234	$243	$241
Non-Provider Medical Staff per Medical Provider		1.9	1.9	1.9	1.8
Administrative, Facilities, and Patient Support FTEs as Percent of Total FTEs		37%	36%	36%	36%
Patient Growth Rate		4%	3%	3%	-5%
Visit Growth Rate		5%	4%	6%	-7%

RURAL DATA SUMMARY

		TOTALS - Section 330 and Look-Alike			
Data		**2017**	**2018**	**2019**	**2020**
Financial Audits		548	545	554	412
UDS Data		592	595	601	601
Key Financial Metrics	**Target**	**2017**	**2018**	**2019**	**2020**
Operating Margin	> 3%	4.00%	3.40%	2.80%	5.20%
Bottom Line Margin	> 3%	5.10%	4.60%	4.10%	6.60%
Personnel-Related Expense as Percentage of Operating Revenue	< 70%	71.50%	72.00%	72.00%	70.60%
Days Cash on Hand	> 60 Days	78	76	73	111
Days in Net Patient Receivables	< 45 Days	40	37	38	36
Key Productivity Metrics		**2017**	**2018**	**2019**	**2020**
Physician Visits per Physician FTE		2,707	2,618	2,602	2,394
Mid-Level Visits per Mid-Level FTE		2,361	2,352	2,361	2,110
Medical Patients per Medical Staff FTE		288	284	278	260
Medical Patients per Medical Provider FTE		826	806	804	764
Dental Visits per Dental Provider FTE		1,584	1,568	1,563	1,191
Mental Health Visit per Mental Health Provider FTE		894	904	922	939
Key Operations & Utilization Metrics		**2017**	**2018**	**2019**	**2020**
Operating Revenue per Patient		$913	$938	$989	$1,174
Operating Expense per Patient		$860	$897	$946	$1,098
Operating Revenue per Patient Visit		$239	$248	$254	$258
Operating Expense per Patient Visit		$226	$235	$243	$246
Non-Provider Medical Staff per Medical Provider		1.8	1.8	1.8	1.8
Administrative, Facilities, and Patient Support FTEs as Percent of Total FTEs		38%	37%	37%	37%
Patient Growth Rate		4%	4%	3%	-4%
Visit Growth Rate		5%	4%	7%	-8%

URBAN DATA SUMMARY

		TOTALS - Section 330 and Look-Alike			
Data		**2017**	**2018**	**2019**	**2020**
Financial Audits		760	762	754	577
UDS Data		837	851	857	861
Key Financial Metrics	**Target**	**2017**	**2018**	**2019**	**2020**
Operating Margin	> 3%	2.40%	2.20%	1.60%	3.00%
Bottom Line Margin	> 3%	3.50%	3.20%	2.60%	4.10%
Personnel-Related Expense as Percentage of Operating Revenue	< 70%	72.60%	72.30%	73.50%	72.30%
Days Cash on Hand	> 60 Days	52	54	53	90
Days in Net Patient Receivables	< 45 Days	41	39	38	35
Key Productivity Metrics		**2017**	**2018**	**2019**	**2020**
Physician Visits per Physician FTE		2,802	2,749	2,728	2,469
Mid-Level Visits per Mid-Level FTE		2,429	2,353	2,388	2,227
Medical Patients per Medical Staff FTE		301	295	292	270
Medical Patients per Medical Provider FTE		897	871	858	795
Dental Visits per Dental Provider FTE		1,894	1,908	1,844	1,292
Mental Health Visit per Mental Health Provider FTE		1,007	1,001	1,005	1,071
Key Operations & Utilization Metrics		**2017**	**2018**	**2019**	**2020**
Operating Revenue per Patient		$956	$1,001	$1,048	$1,189
Operating Expense per Patient		$908	$957	$999	$1,168
Operating Revenue per Patient Visit		$235	$243	$249	$247
Operating Expense per Patient Visit		$224	$233	$243	$237
Non-Provider Medical Staff per Medical Provider		1.9	1.9	1.9	1.9
Administrative, Facilities, and Patient Support FTEs as Percent of Total FTEs		36%	36%	35%	36%
Patient Growth Rate		5%	3%	3%	-7%
Visit Growth Rate		5%	4%	5%	-7%

METHODOLOGY

The analysis and information contained in this report are based on data from Capital Link's Financial and Operational Database for Section 330 Grantees and Look-Alikes. Except where otherwise indicated, median values are shown for each measure in each year.

Capital Link's proprietary Financial and Operational Database contains:

- Audited financial statements of FQHCs (both Section 330s and LALs) as reported by fiscal year
- Uniform Data System reports (both Section 330s and LALs) provided by the Health Resources and Services Administration (HRSA)

The number of audits included in the data set varies each year and Capital Link continues to add audits to its database as they become available. The database currently includes 68% or more of all national FQHC financial audits in each year measured.[vi] The database also reflects a broad geographic range, with all 50 states represented.

The health center data set used for the current analysis is summarized as follows:

Number of Audits

	2017		2018		2019		2020	
	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
Section 330 Grantees	540	737	534	737	543	731	409	555
Look-Alike	8	23	11	25	11	23	3	22
TOTAL	548	760	545	762	554	754	412	577

Trends reviewing patient utilization, payer mix, provider productivity, and quality of care were calculated from data reported to the HRSA Uniform Data System (UDS). The number of health centers included in the data set is summarized as follows:

Number of UDS Reports

	2017		2018		2019		2020	
	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
Section 330 Grantees	608	765	612	750	585	800	578	797
Look-Alike	11	45	19	65	21	51	23	64
TOTAL	619	810	631	815	606	851	601	861

ACKNOWLEDGMENT

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About Capital Link

Capital Link is a national, non-profit organization that has worked with hundreds of community health centers and primary care associations for over 25 years to plan for sustainability and growth, access capital, improve and optimize operations and financial management, and articulate value. Established through the health center movement, Capital Link is dedicated to strengthening health centers—financially and operationally—in a rapidly changing marketplace. For more information, visit us at www.caplink.org.

Endnotes

i Rural location determined by HRSA, based on location of the health center's main administrative site.

ii All industry-level recommendations are based on Capital Link benchmarks.

iii National FQHCs refers to the full national dataset of FQHCs, including both rural and urban FQHCs.

iv The following major federal programs provided funding to health centers for COVID relief during 2020:

- Through COVID Supplemental Appropriations passed into law on March 4, 2020, HRSA made "H8C" grants totaling $100 million to Section 330–funded health centers nationally. The grants were made via a formula to cover the costs of responding to COVID-19 and for maintaining or increasing grantee capacity. Awards were made on or around March 27, 2020, to cover costs incurred within one year of award, unless otherwise extended.
- Through the CARES Act passed into law on March 27, 2020, HRSA made "H8D" grants totaling $1.32 billion to Section 330–funded health centers nationally. The grants were made via a formula to cover the costs of responding to COVID-19 and for maintaining or increasing grantee capacity. Awards were made on or around April 7 and 8, 2020, to cover costs incurred within one year of award, unless otherwise extended.
- Through the Paycheck Protection Program and Health Care Enhancement Act (PPPHCEA) passed into law on April 24, 2020, HRSA made "H8E" grants totaling $600 million to Section 330–funded health centers and Look-Alikes nationally. The grants were made via a formula to cover costs to purchase, administer, and expand capacity for testing to monitor and suppress COVID-19. Awards were made on or around May 7, 2020, to cover costs incurred within one year of award, unless otherwise extended.
- The Provider Relief Fund, administered by Health and Human Services, was originally funded in the CARES Act ($100 billion), expanded in PPPHCEA ($75 billion), and further expanded by the Consolidated Appropriations Act, 2021 ($3 billion). Beginning in April 2020, it reimburses eligible health care providers for health care–related expenses or lost revenues that are attributable to coronavirus through July 31, 2021. Through December 2020, health centers had received several rounds of "General Distributions" totaling approximately $401 million, equal to 2% of 2018 net patient revenue.
- A portion of the PRF was distributed to certain providers in rural areas, including FQHCs, beginning in May 2020. Funds were distributed to eligible sites, totaling approximately $103,253 per site. Capital Link estimates that rural FQHCs received approximately $322 million in total.
- Funded through the CARES Act ($200 million nationally), the FCC made awards between April and July 2020 to FQHCs and others for devices and services related to telehealth. Capital Link estimates that FQHCs received approximately $74 million in total.

- Administered by the Small Business Administration, Paycheck Protection Program Loans were made available to businesses with fewer than 500 employees beginning in April 2020 through the CARES Act (many large FQHCs were not eligible). The program was extended and expanded through the PPPHCEA. The loans, which are forgivable if borrowers meet certain criteria, were meant to incentivize small businesses (including nonprofits) to retain staff on their payrolls. According to a study by Capital Link, FQHCs received approximately $2.3 billion from this source. During the 2020 period, it is unlikely that any of these loans were forgiven. As a result, while they would not be included in grant funding during this year, these funds would have augmented the cash balances of centers.

v As a result of "lessons learned" from the early days of the pandemic, when many health centers struggled with dangerously low cash balances due to "stay at home" orders and subsequent loss of patient visits and related revenue, Capital Link has increased its recommended days cash on hand benchmark from 45 days to 60 days.

vi Note that not all health centers produce separately-audited financial statements. Some are part of public entities and do not have separate audits. Others are part of larger health systems, whose audits Capital Link has determined are not comparable to other FQHCs; they have therefore been excluded from the dataset.