CAPITAL LINK

Rural Federally Qualified Health Centers

Financial and Operational Performance Analysis

2016-2019

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[1] (herein referred to as rural FQHCs). Rural FQHCs continue to improve health outcomes and build health care capacity for the estimated 62 million Americans living in rural communities. The report offers a framework for identifying the financial strengths, challenges, and benchmarks that support opportunities for rural FQHC performance improvement through an examination of multi-year trends and median results. The report also provides comparisons between rural, urban and national performance, as well as recommended benchmarks, where available.

The analysis incorporates health center financial audits as well as operational and utilization data reported by the Uniform Data System (UDS) from 2016 to 2019 for Section 330-funded health centers and Look-Alikes (LALs)—collectively, referred to as Federally Qualified Health Centers or FQHCs. Statistical measures and financial ratios facilitate comparisons and provide context. Information on median performance, the level at which half of the centers rank higher and half lower, is provided throughout the report. Quartiles (the top and bottom 25th percentiles) and industry-recommended benchmarks are listed for specific measures where available and appropriate.

Report Summary:

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

The table below illustrates the 2019 median revenue, patient, and full-time equivalent employee (FTE) figures for rural FQHCs, with urban, and national FQHC metrics shown for comparison purposes. The median revenue level for rural FQHCs was $11.3 million in 2019, with urban centers 77% higher ($20 million) and for the combined group of centers nationally 41% higher ($16 million). The median patient level at rural FQHCs was 9,665, and the median number of annual patient visits was 37,032. The median employee level for rural FQHCs was 81 FTEs, while the national median was 28% higher (104 FTEs).

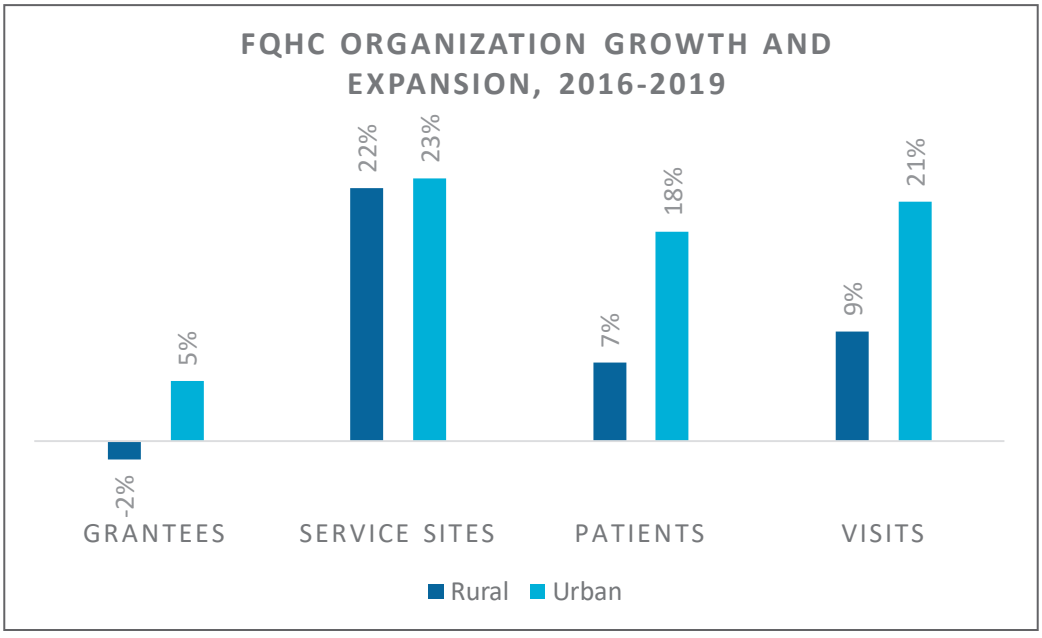
Median Health Center Profile, 2019	Rural n = 606 UDS	Urban x = 851 UDS	National n = 1,457 UDS
Total Annual Revenue	$11,332,088	$20,036,882	$15,956,941
Total Annual Patients	9,665	15,204	12,670
Total Annual Visits	37,032	59,575	48,579
Total Annual Full-time Equivalent Employees (FTEs)	81	133	104

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

GROWTH AND EXPANSION

Rural FQHCs reported modest growth from 2016 to 2019 in terms of patients served and visits. In 2019, rural FQHCs served 9.1 million patients and generated 36.1 million patient visits, equating to increases of 7% in patients and 9% in visits over the four-year review period. While rural FQHCs overall continued to see a positive growth trend, urban FQHCs outpaced rural FQHCs with 18% growth in patients and 21% growth in visits over the same time frame. Though individual clinic sites continued to increase rapidly in number for rural FQHCs, the total number of rural FQHC grantees declined by -2% from 2016 to 2019—with all of the decline occurring between 2018 and 2019, a shrinkage of 25 FQHCs from the prior year. The decline in rural FQHC organizations, in combination with clinic site growth, indicates possible consolidation within the sector, with growth driven primarily by the remaining health center organizations rather than new entrants into the industry.

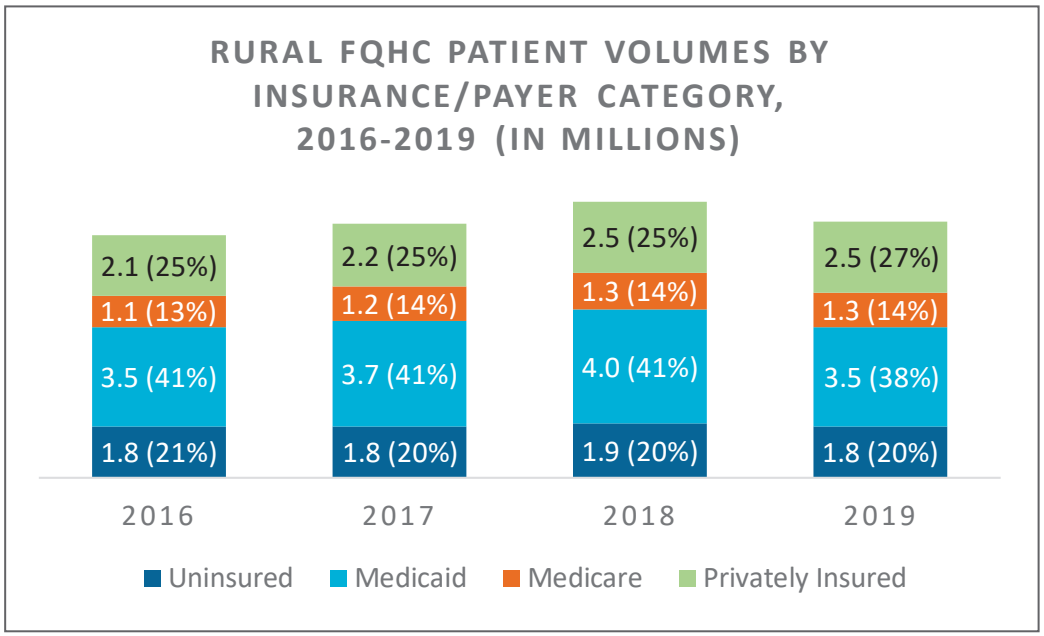
	2016		2019	
FQHC Organization Growth and Expansion	**Rural**	**Urban**	**Rural**	**Urban**
Rural FQHCs	616	809	606	851
Service Sites	4,148	6,495	5,054	7,968
Patients	8,556,679	18,036,771	9,132,834	21,298,809
Visits	33,007,526	73,770,085	36,132,510	89,010,728



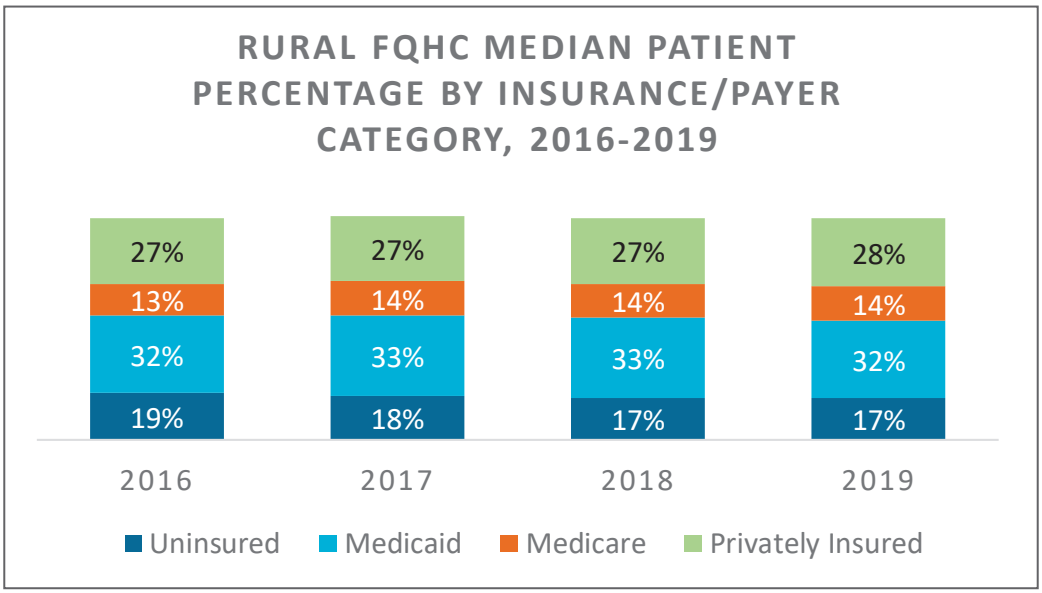
Patient Mix by Payer Source

Given that rural FQHCs may 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. Although patients grew over the four-year period, rural FQHCs experienced a decline of 700,000 patients overall between 2018 and 2019, with most of that loss affecting patients covered by Medicaid. This decline may be related to the loss of 25 rural FQHC organizations from 2018-2019, but given the size of the loss, it may also indicate a broader decline for many of the remaining centers as well. The rural FQHC patient mix, or number of patients by payer category, changed over the four-year review period, and most dramatically between 2018 and 2019.

The uninsured portion of the patient population remained fairly stable, reporting 1.8 million uninsured patients in 2019 (20% of the total). However, the Medicaid patient population rose by 14% from 2016 to 2018, but then declined notably by 13% in the last year to 3.5 million Medicaid patients in 2019, representing 38% of the total, down from 41% in the prior year. The Medicare patient population, consistently the smallest portion of health center patients, grew 9% to 1.3 million Medicare patients in 2019, remaining at 14% of the total. The privately-insured patient category experienced the largest percentage growth, increasing 19% over the review period to 2.5 million patients, representing 27% of all patients in 2019.



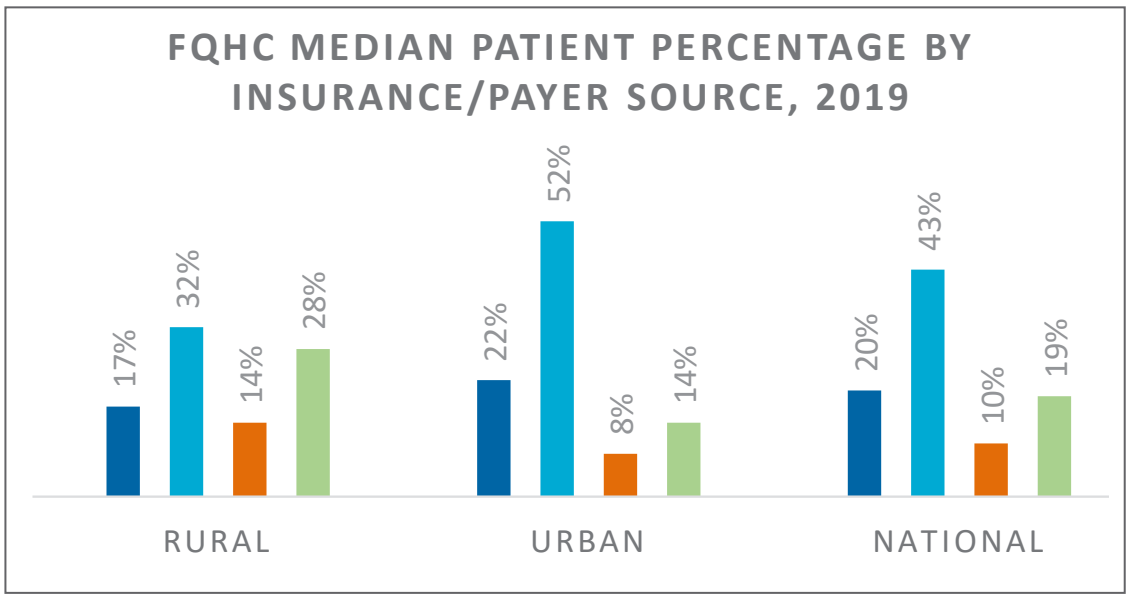
In contrast to the changes in total patients shown above, the median patient percentage mix for rural FQHCs remained fairly stable from 2016 to 2018 with a small increase in the privately insured and Medicare patient percentages, and a slight decrease in the uninsured patient mix. At the median, uninsured patients comprised 17% of the patient mix in 2019, a decrease of two percentage points over the four-year review period. The median percentage of Medicaid patients was relatively stable over the review period, and remained the largest payer source (32%) in 2019. Median percentage levels of Medicare and privately-insured patients each increased by 1% from 2016 to 2019, comprising of 14% and 28% of total patients, respectively.



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

Patient Mix by Location

The health center patient mix varied substantially between rural and urban locations due in part to relatively fewer primary care options for rural area residents. In 2019, the median patient mix for rural FQHCs consisted of 32% Medicaid patients, substantially lower than the median for urban health centers (52%). Rural FQHCs also had a lower proportion of uninsured patients (17%) at the median in comparison to urban centers (22%). The Medicare and privately-insured patient groups were six and 14 percentage points greater at the median for rural health centers than for urban centers, highlighting the broader primary care role of health centers in rural communities.

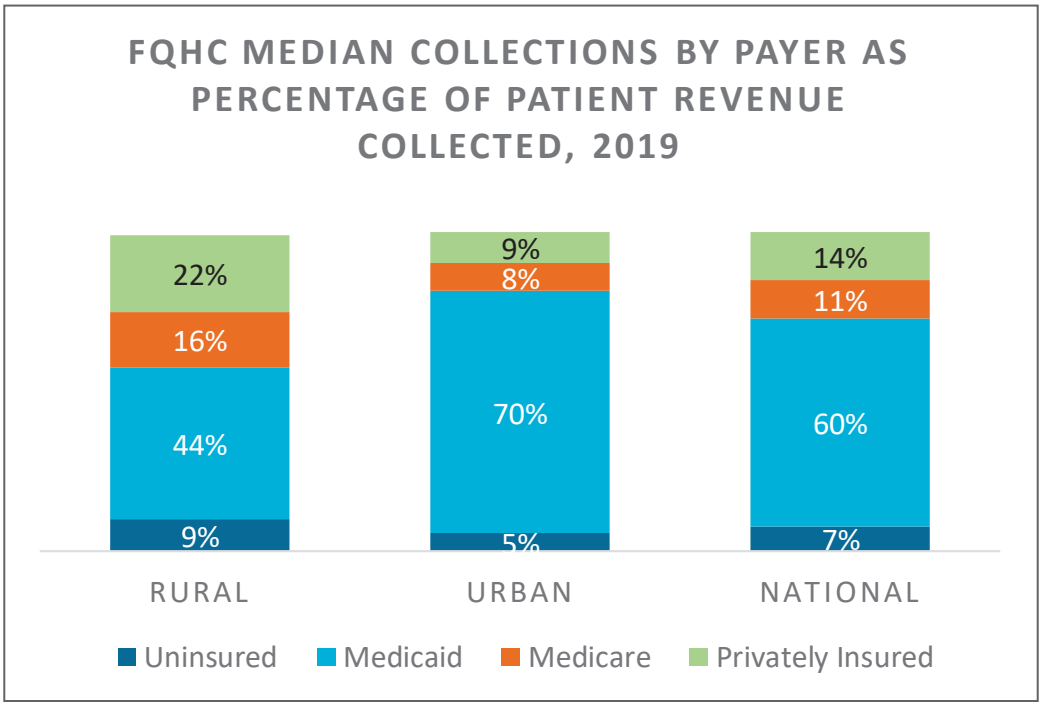


Note: Percentages represent the median result for each category and therefore do not sum to 100%.

Patient Revenue by Payer Source

While Medicaid was consistently the largest payer for all health centers (60% of all patient revenue at the median nationally), rural FQHCs received a far lower percentage of their patient revenue from Medicaid as compared to urban centers (44% vs 70%, respectively).

Notably, Medicare patient collections are a much more significant component of rural FQHC patient revenues than for urban centers. In 2019, median Medicare collections were 16% of all patient revenue collected for rural FQHCs, while for urban centers this percentage was 8%. Similarly, rural FQHCs reported a 22% median level for patient revenue collected from privately insured patients while urban FQHCs reported a 9% median result from these commercial payers. This variance serves to illustrate the somewhat different populations served by rural FQHCs and the related differences in payer mix.



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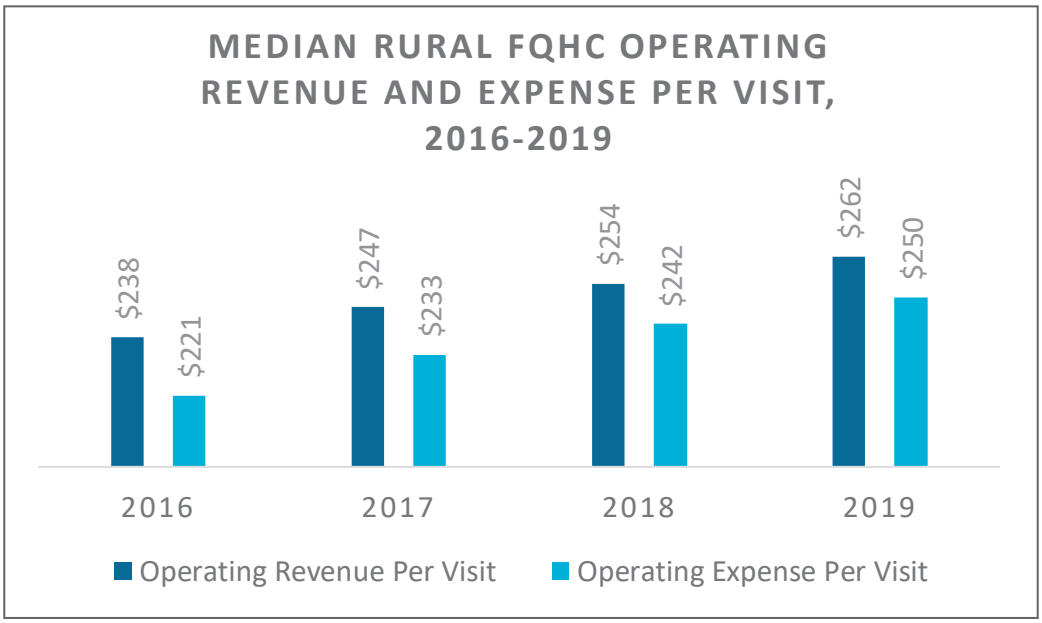
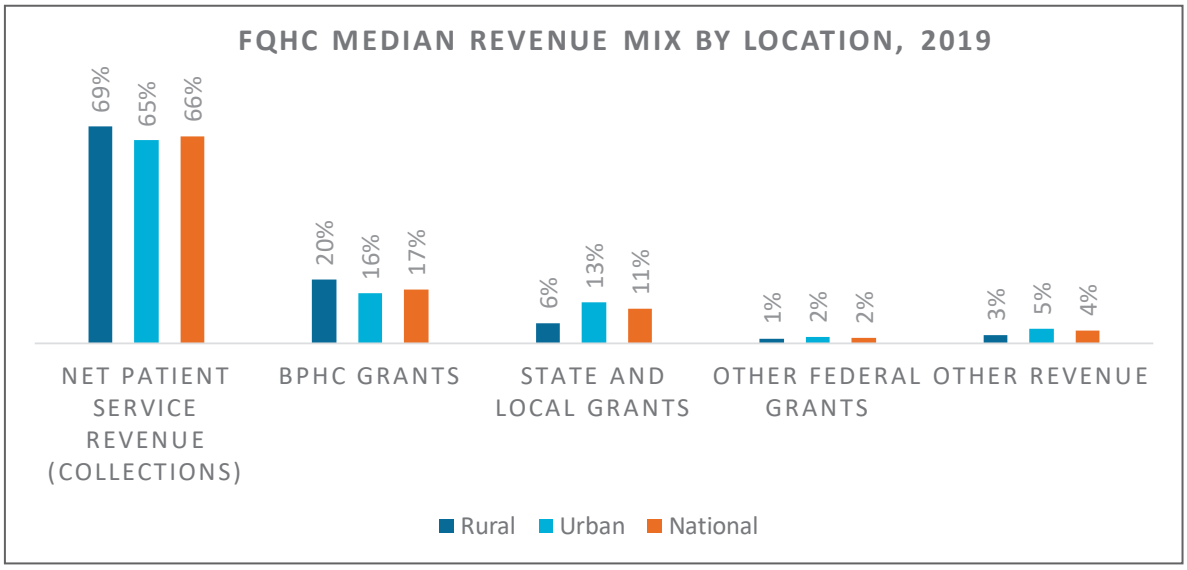
REVENUE GROWTH AND MIX

Median operating revenue per visit for rural FQHCs rose 10% over the review period to $262 in 2019. The average expense per visit increased by 13%, to $250 per visit. In 2019, revenue per visit exceeded expense per visit by $12, a relatively narrow margin compared to the $17 differential in 2016. The decreasing differential between average operating revenue and expense per visit corresponds with lower operating margins and liquidity, as discussed later in this report.



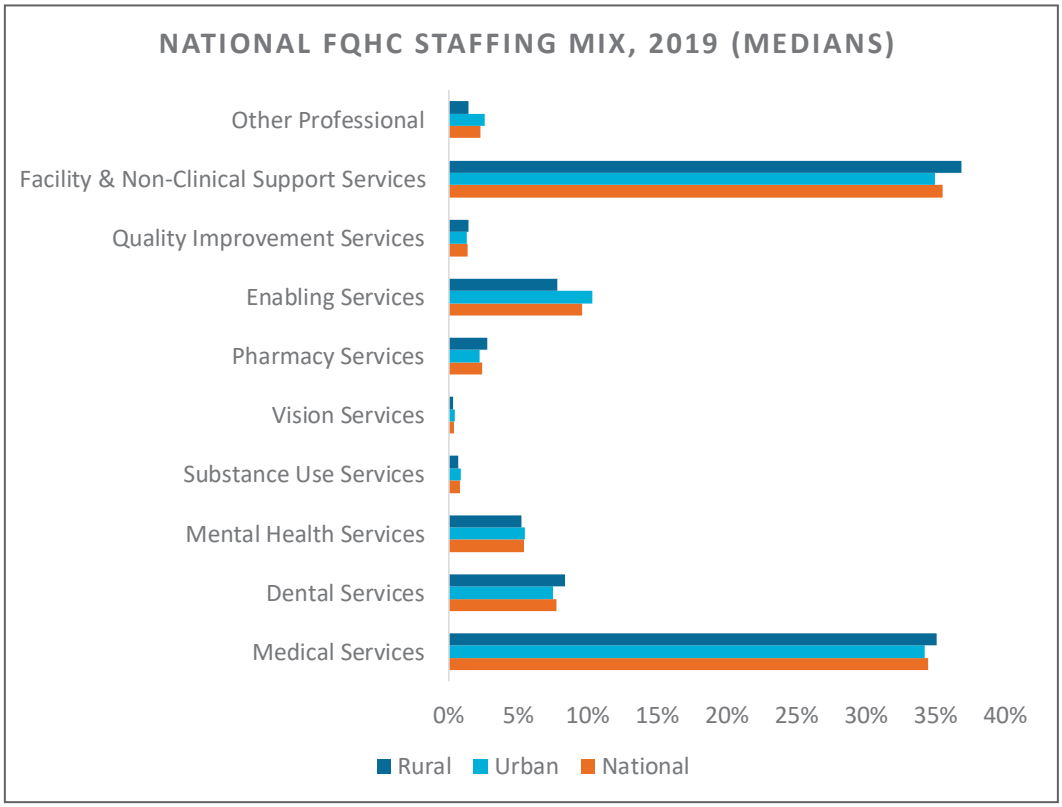
The primary component of revenue for FQHCs is net patient service revenue (NPSR), which comprised 69% of 2019 rural FQHC operating (median), somewhat higher than the 65% for urban centers. Rural FQHCs also obtain revenue through operating grants from HRSA's Bureau of Primary Health Care (BPHC), as well as state and local grants. BPHC grants contributed 20% of 2019 revenues for the median rural FQHC, somewhat higher than the 16% median level for urban centers. At just 6%, rural FQHC median revenue from state and local grants was considerably lower than the median for urban health centers at 13%.



Source: Health Resources & Services Administration Uniform Data System (UDS)

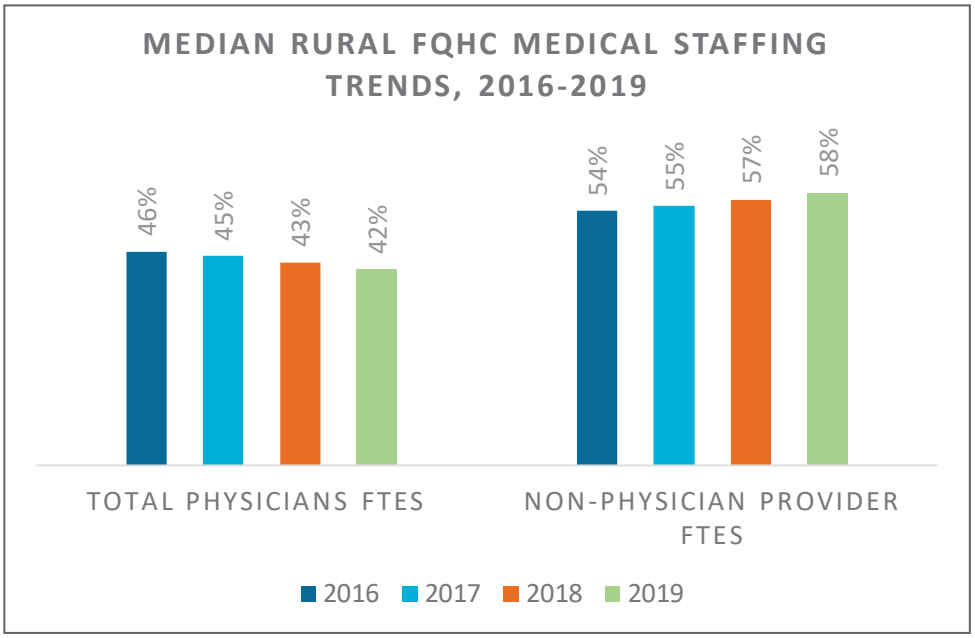
STAFFING AND PRODUCTIVITY

Though health center staffing models vary based on the needs of the communities they serve, medical service employees generally make up the majority of the staffing mix as illustrated below for the median rural and urban centers. At the median, medical service FTEs comprised 35% of national health center staffing, with rural and urban centers indicating similar results. Facility and non-clinical support service FTEs accounted for 37% of rural FQHC staffing at the median, with urban health centers slightly lower at 35%. Median results show that dental services accounted for 8% of FTEs at rural FQHCs and mental health services employed approximately 5%. Rural and urban centers had marginally different median staffing mixes for enabling services (8% vs. 10%) and pharmacy services (3% vs. 2%) but were generally comparable overall.

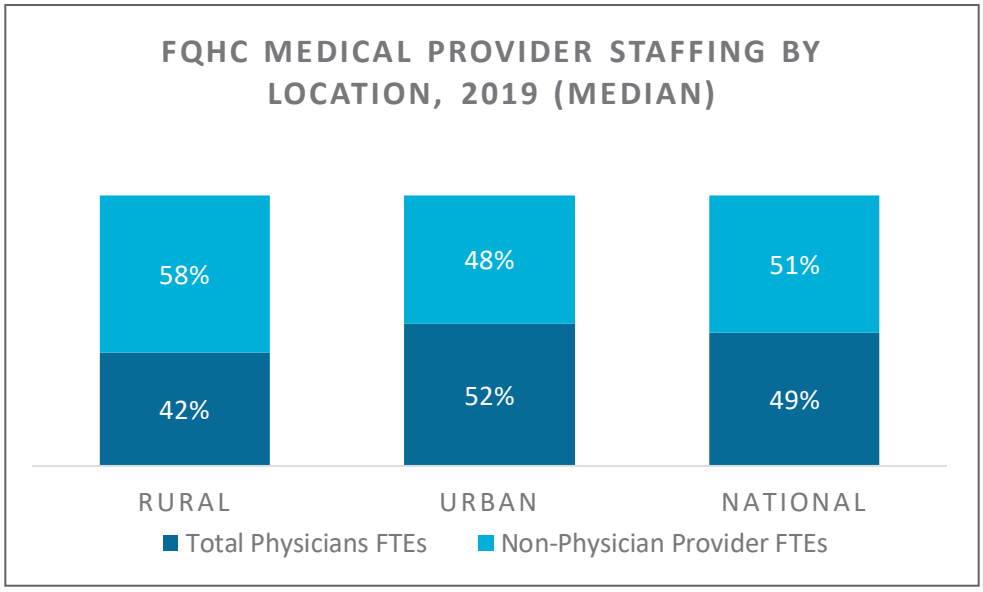


Staffing Mix

Rural FQHC medical staffing trends show increased reliance on non-physician providers, including physician assistants, nurse practitioners, and certified nurse-midwives over the review period. The median rural FQHC's physician FTEs decreased from 46% of medical staff in 2016 to 42% in 2019, while non-physician medical providers increased from 54% to 58% over the same time period.

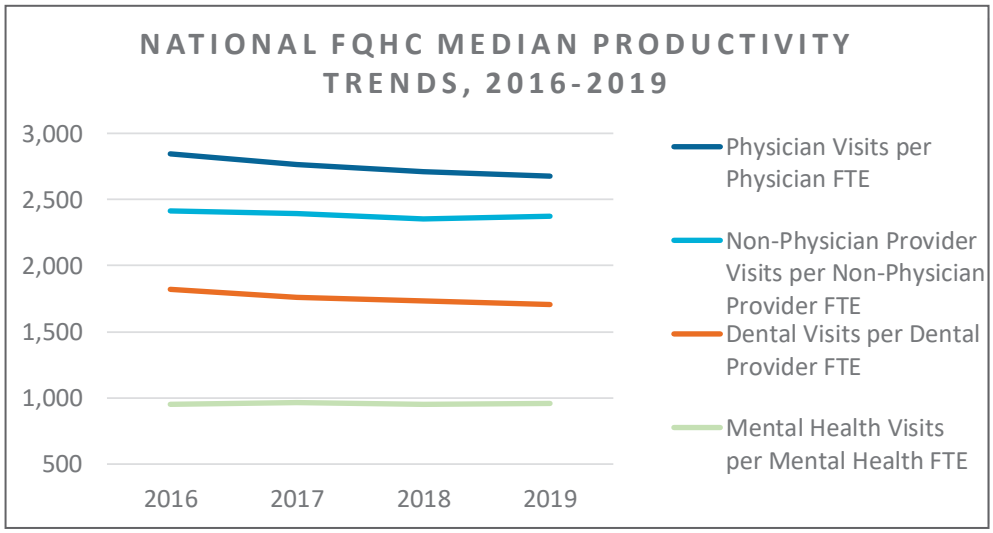


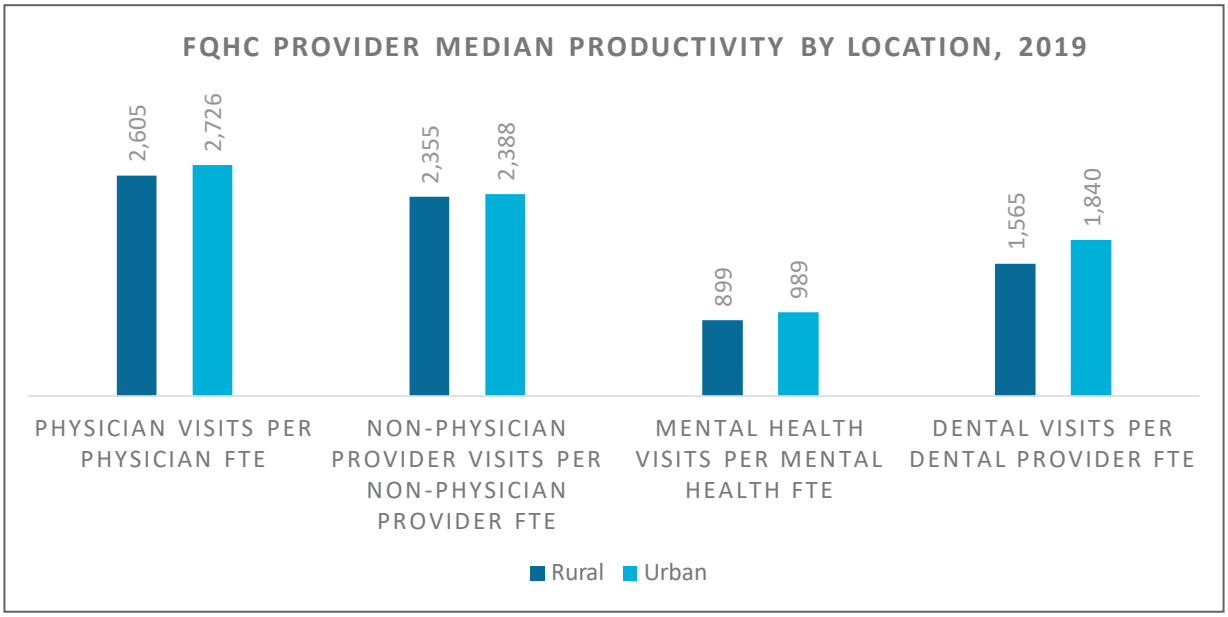
The proportion of non-physician medical providers continued to increase at both urban and rural FQHCs, but the growth rate and overall proportion was significantly higher at rural FQHCs, with a four-point increase at the median over four years. Given the overall high market demand for physicians, the predominance of non-physician providers in rural settings perhaps attests to the challenges rural FQHCs face when competing with their urban counterparts to recruit and retain physician providers. In 2019, while 58% of the median rural FQHC's medical providers were non-physicians, for the median urban health center the proportion was 48%.



Provider Productivity

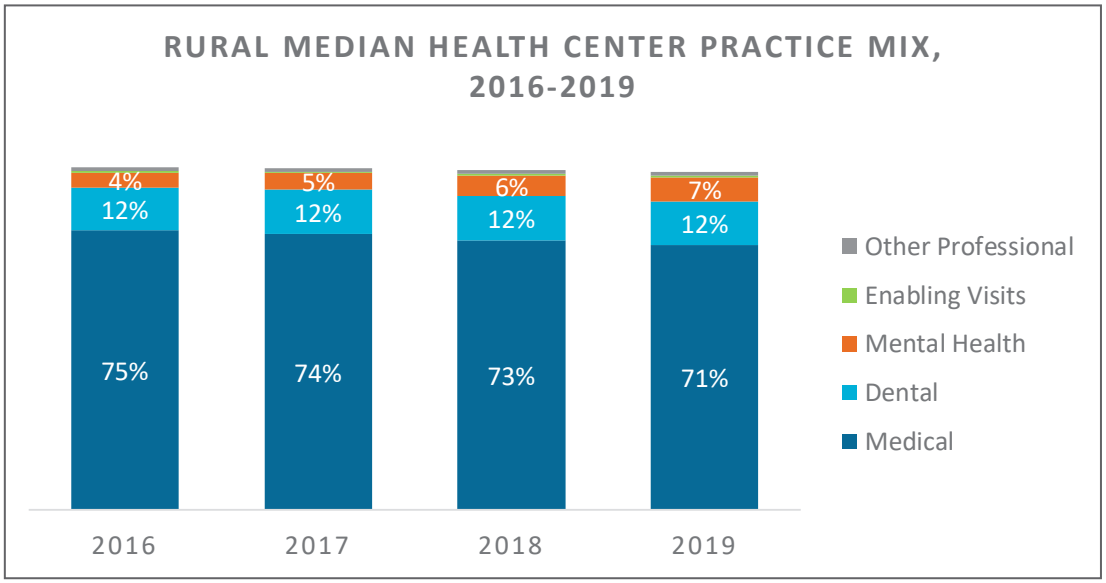
Provider productivity is a key driver of financial performance at health centers. Nationally, median health center physician productivity, measured by patient visits generated per provider, decreased 6% over the review period to 2,679 visits per physician in 2019. This overall decline in physician productivity nationally is likely related to implementation of electronic medical records and changes in the care model to emphasize patient-centered and team-based care. Dental providers and non-physician medical providers both reported slight decreases in median productivity as well, with non-physician providers producing 2,377 visits per FTE and 1,704 visits per dental provider FTE in 2019. Mental health provider productivity increased less than 1% over the review period to a median level of 957 visits per mental health FTE in 2019. Median rural FQHC productivity was consistently lower than the urban health center across most provider types. At 2,605 visits per physician FTE, rural FQHCs reported 5% lower productivity than their median urban counterparts, while rural dental productivity was notably 18% lower. Non-physician provider productivity was comparable for both groups in 2019.





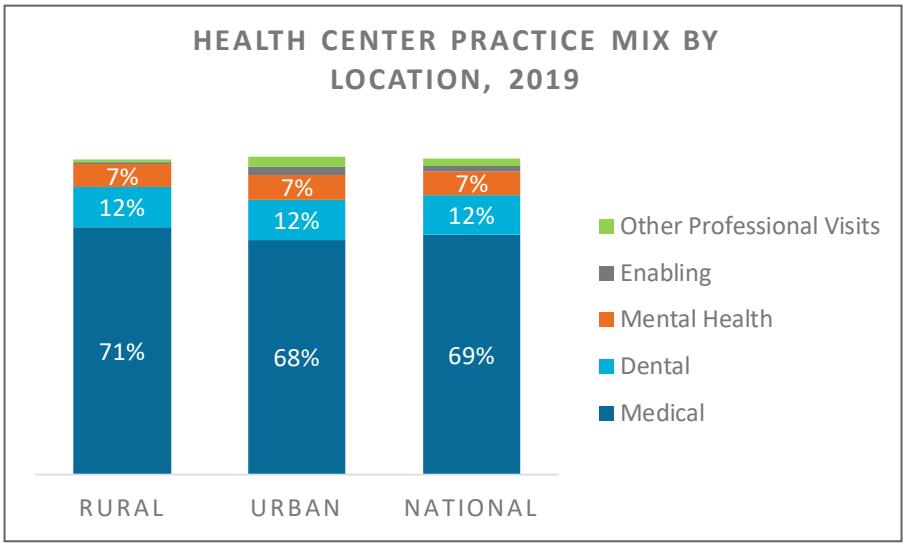
Practice Mix

Although declining as a percent of rural FQHCs' practice, medical services continue to be the primary service provided at rural FQHCs, representing 71% of overall visits at the median in 2019. Dental visits remained stable at 12% over the review period, while mental health visits increased three percentage points, albeit from a smaller base. These trends illustrate rural FQHCs' efforts to offer a more comprehensive set of services for their patients.



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

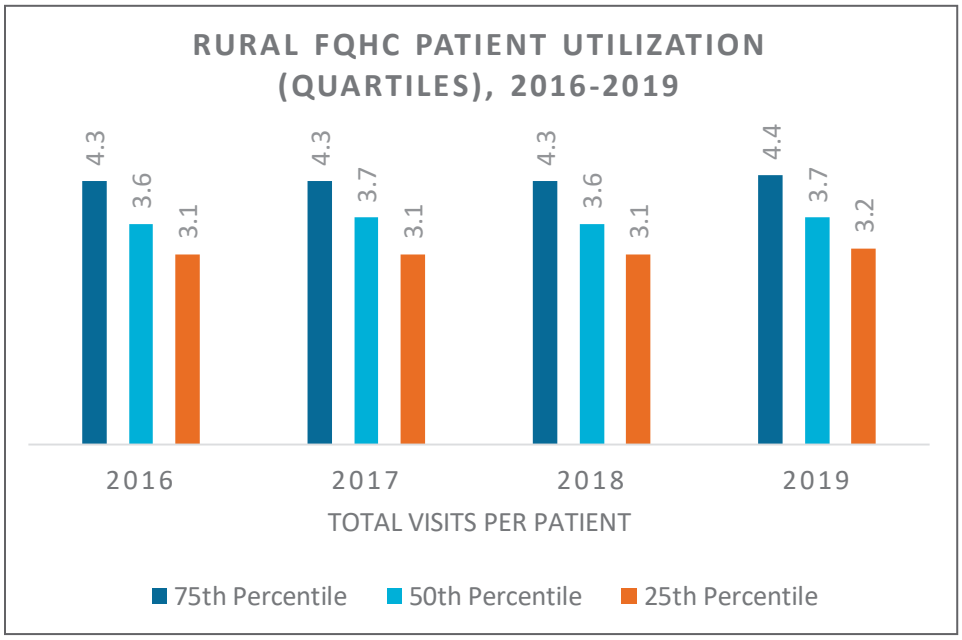
Rural FQHCs recorded a slightly higher percentage of medical visits at the median than urban centers (71% vs. 68%) in 2019, but variances in the remaining practice mix categories such as dental and mental health were minimal. The presence of a slightly larger proportion of "Other Professional Visits" at urban health centers may reflect the challenges rural FQHCs face in making available certain specialty services for their patients.



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

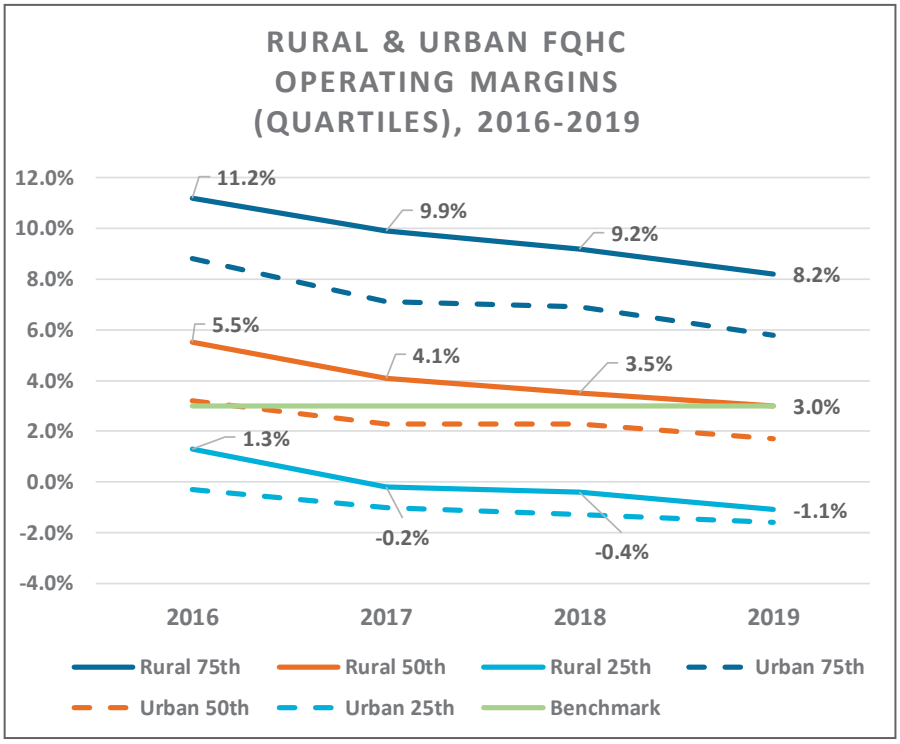
Patient Utilization

Patient utilization trended slightly upward over the four-year review period, due in part to continued growth of comprehensive services. Rural FQHC patients visited the median health center 3.7 times per year in 2019, increasing from 3.6 visits in 2016. Rural FQHCs in the top quartile of utilization rates generated 4.3-4.4 patient visits or more per year between 2016-2019, while the lowest quartile of rural FQHCs had 3.1-3.2 or fewer visits.



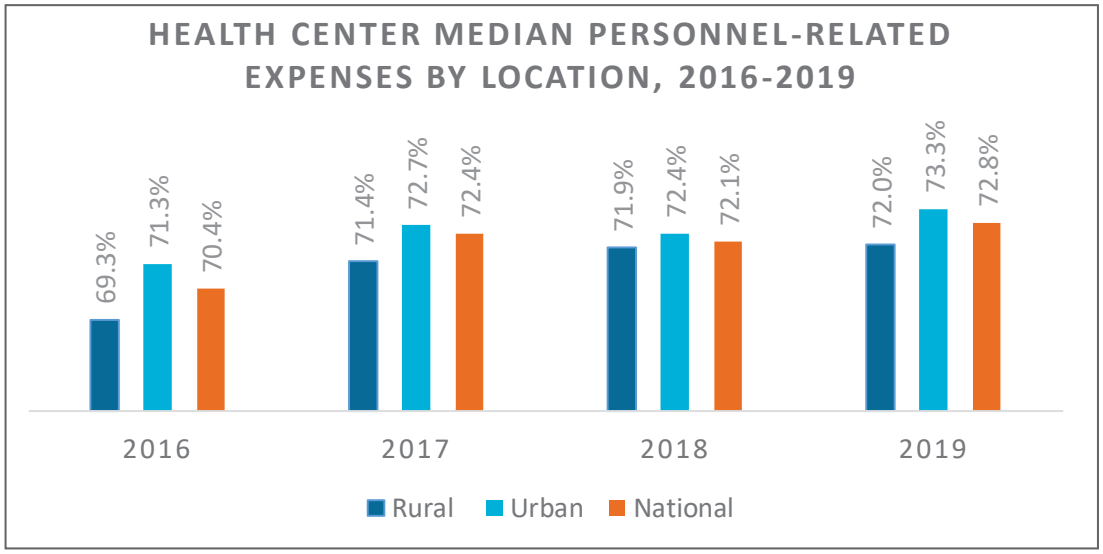
Operating Margin

At the median, rural FQHCs consistently generated positive operating margins from 2016 to 2019 but experienced a downward trend over the review period. The 3% median operating margin generated in 2019 represented a decrease from 5.5% in 2016, though is equal to the Capital Link suggested minimum benchmark. Although both rural and urban health centers trended downward in operating margins over the period, rural FQHCs consistently outperformed urban centers across all quartiles. The high-performing rural FQHCs, illustrated by the 75th percentile cohort, generated operating margins of 8.2% and above in 2019, more than double that of the industry-standard benchmark. However, those rural clinics at the 25th percentile and below reported increasingly negative operating margins in each of the three most recent years, reporting -1.1% or lower in 2019. These negative margins represent operating losses, highlighting the financial vulnerability of these centers.



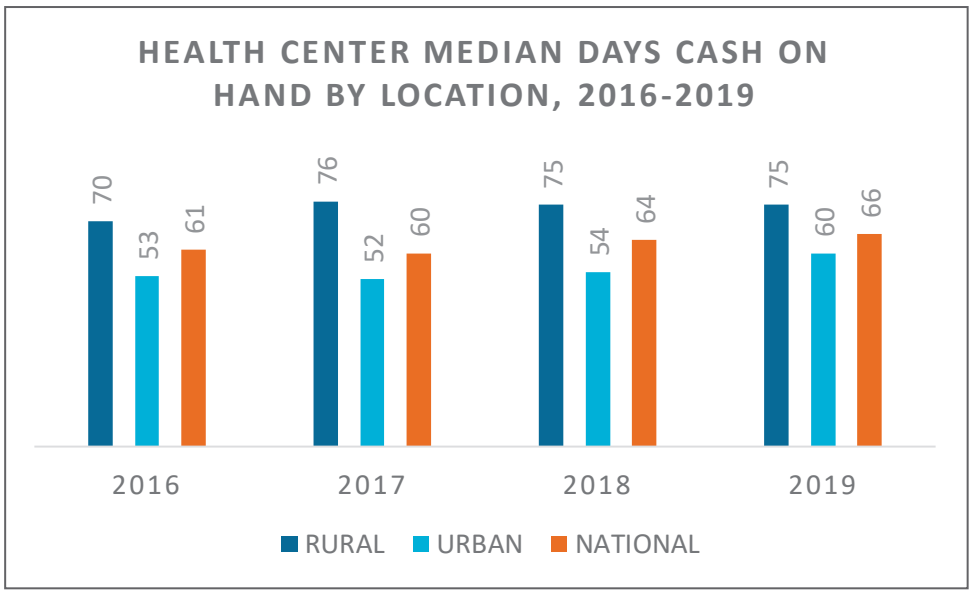
Personnel-Related Expenses

Rural FQHCs' downward trend in operating margins from 2016 to 2019 was related in part to the increase in the ratio of personnel-related expenses as a percentage of total operating revenue. As service-based organizations, personnel-related expenses are the primary component of the operating budget, particularly given the high cost of recruitment and retention of provider staff. At 72%, this ratio increased by nearly three points for the median rural FQHC from 2016 to 2019. In 2019, rural FQHCs personnel-related expenses were 1.3 points lower than urban peers (73.3%) but above the suggested 70% benchmark. Generally, health centers should try to maintain these expenses at 70% or less of their annual operating revenues. Health centers spending 75% or more of their operating revenues on personnel-related costs have less budgetary flexibility to support other operating expenses and are at higher risk of reporting operating deficits.



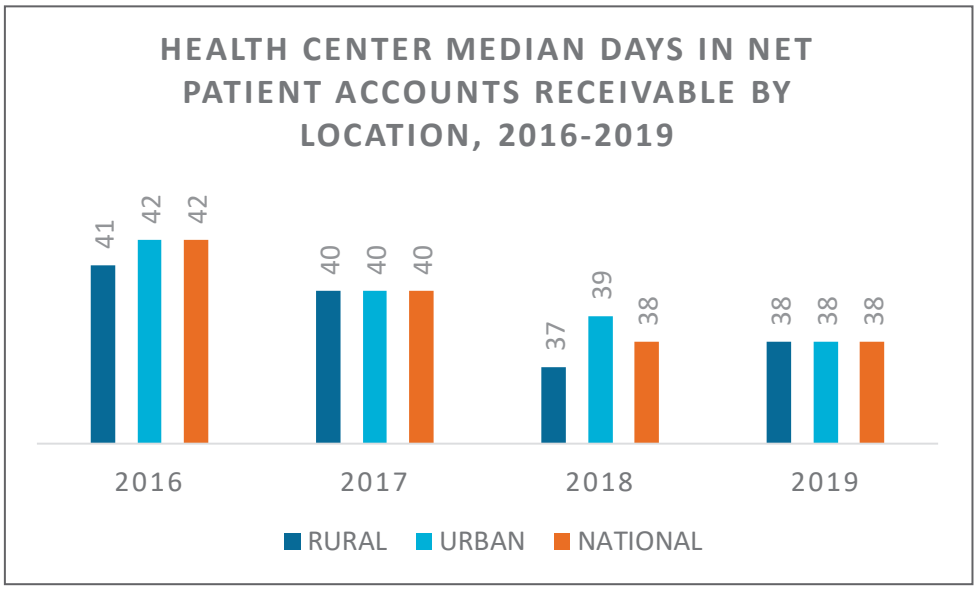
Days Cash On Hand

While health center operating margins trended downward from 2016 to 2019, operating liquidity remained generally consistent. Days cash on hand measures the number of days of operating expenses an organization can cover based on its current cash balances. The median days cash on hand for rural FQHCs increased five days over the review period to 75 days in 2019, well above the suggested industry benchmark minimum of 45 days. While the level of days cash on hand for both rural and urban FQHCs fluctuated over the period tracked, rural FQHCs consistently reported relatively higher liquidity at the median. Healthy cash reserves provide important operational flexibility and offer increased stability for health centers given uncertain funding streams.



FINANCIAL PERFORMANCE

The patient collections cycle, measured by days in net patient receivables, is a key contributor to a health center's cash position. The median rural FQHC generated additional cash over the review period by accelerating its collections from 41 days in 2016 to 38 days in 2019, an efficient revenue cycle well under the industry benchmark of 60 days. Both urban and rural FQHCs performed similarly on this measure at the median, and showed positive progress over the review period. The positive results may have resulted from ongoing attention to revenue cycle management, and improvements in billing efficiency and collections systems.



Health Center Median Quality of Care Measures, 2019

Based on key quality of care metrics reported to HRSA, health centers delivered high quality outcomes in 2019. The table below summarizes 10 HRSA Uniform Data System (UDS) quality measures covering both preventive and chronic care services at the median level for rural and urban health centers, and for all FQHCs nationally. The median rural FQHC generally recorded outcomes that varied only slightly from its urban counterpart, with the exception of BMI documentation/action plans for patients age 3-17 and childhood vaccination rates. Rural FQHCs scored six percentage points lower on BMI documentation action plans than the urban health center median and nine percentage points lower on the percentage of children receiving appropriate vaccinations by age two. In several areas, rural FQHCs performed slightly better at the median than their urban counterparts, including for patients with controlled high blood pressure, patients screened for colorectal cancer and patients with diabetes under poor control. It may be helpful to further investigate the reasons behind these variations to inform improvement strategies.

	Rural	Urban	National
Percent of Patients with Asthma Given an Asthma Treatment Plan	88%	89%	89%
Percentage of Patients 12 and over Screened for Depression and Follow-up Plan Documented (If Positive)	74%	74%	74%
Percentage of Patients 3-17 with BMI, Nutrition & Physical Activity Documented	67%	73%	71%
Percentage of Patients 18 and over with BMI & Follow Up Documented (If BMI outside normal)	73%	75%	74%
Percentage of Patients with Controlled High Blood Pressure	66%	64%	64%
Percentage of Patients 6-9 at Moderate to High Risk of Caries Receiving Sealant on First Permanent Molar	55%	57%	56%
Percentage of Patients Screened for Colorectal Cancer	44%	42%	43%
Percentage of Children Receiving Appropriate Vaccinations by Age 2	29%	38%	33%
Percentage of Patients with Diabetes and Hemoglobin A1c Poor Control	29%	32%	31%
Babies with Low Birth Weight Born to Prenatal Patients who Delivered During the Year	7%	8%	8%

CONCLUSION

Rural FQHCs grew modestly over the 2016 to 2019 review period, serving a growing number of patients and increasing visits. While the total number of health center grantees declined, possibly representing some level of consolidation in the sector, access to care grew significantly over the review period through the expansion of comprehensive services and with the addition of over 900 new rural sites.

The patient mix by payer source for rural FQHCs fluctuated over the four-year review period. The Medicaid patient population rose by 14% from 2016 to 2018, but then declined significantly by 13% in 2019 to 3.5 million Medicaid patients. The sharp decline in Medicaid patients was accompanied by smaller declines in Medicare and uninsured patients between 2018 and 2019, while the privately-insured total remained stable.

Net patient service revenue continued to constitute the major portion of health center operating support, comprising 69% of total rural FQHC revenue, somewhat higher than the 65% at urban centers. BPHC grants contributed 20% of 2019 revenues for the rural median health center, as compared to 16% for its urban counterpart, while 6% came from state and local grants, considerably lower than the median urban health center at 13%.

Patient utilization trended upward in 2019 with continued growth of comprehensive services. While medical care has consistently been the leading service type at rural FQHCs, mental health services grew significantly over the review period.

While the median operating margin for rural FQHCs remained at or above the recommended minimum benchmark of 3%, financial performance weakened across all quartiles over the review period. Operating margins declined sharply from 2016-2019, as expenses grew more quickly than revenues. At least a quarter of rural FQHCs operated at a loss in 2017, 2018 and 2019, a reminder of the financial vulnerability of these centers.

Operating liquidity remained fairly strong, supported by efficient patient revenue collections. The median rural FQHC's days cash on hand increased five days over the review period to 75 days in 2019, surpassing the suggested industry benchmark minimum of 45 days. While both rural and urban health centers' levels of days cash on hand fluctuated over the period tracked, rural FQHCs consistently outperformed urban centers at the median.

Quality of care was relatively high across all centers in 2019. For two measures, however, rural FQHC performed significantly less well than their urban peers at the median, while for several other measures they performed slightly better. The variation in results points to opportunities to identify potential reasons for the variation, with an eye toward improving results over time.

NATIONAL DATA SUMMARY

		TOTALS - Section 330 and Look-Alike			
Data		2016	2017	2018	2019
Financial Audits		1,269	1,253	1,269	1,066
UDS Data		1,425	1,429	1,446	1,457

Key Financial Metrics	Target	2016	2017	2018	2019
Operating Margin	> 3%	4.2%	3.0%	2.8%	2.0%
Bottom Line Margin	> 3%	5.3%	4.2%	3.8%	3.4%
Personnel-Related Expense as Percentage of Operating Revenue	< 70%	70.4%	74.4%	72.1%	72.8%
Days Cash on Hand	> 45 Days	61	60	64	66
Days in Net Patient Receivables	< 60 Days	42	40	38	38

Key Productivity Metrics	Target	2016	2017	2018	2019
Physician Visits per Physician FTE		2,848	2,763	2,713	2,679
Non-Physician Provider Visits per Non Physician Provider FTE		2,416	2,394	2,352	2,377
Medical Patients per Medical Staff FTE		299	296	291	287
Medical Patients per Medical Provider FTE		876	865	844	832
Dental Visits per Dental Provider FTE		1,818	1,762	1,733	1,704

Key Operations & Utilization Metrics	Target	2016	2017	2018	2019
Operating Revenue per Patient		$904	$934	$975	$1,015
Operating Expense per Patient		$846	$880	$924	$974
Operating Revenue per Patient Visit		$240	$248	$255	$263
Operating Expense per Patient Visit		$226	$235	$245	$253
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		37%	37%	36%	36%
Patient Growth Rate		5%	4%	3%	3%
Visit Growth Rate		7%	5%	4%	5%

RURAL DATA SUMMARY

		TOTALS - Section 330 and Look-Alike			
Data		**2016**	**2017**	**2018**	**2019**
Financial Audits		542	536	536	467
UDS Data		**616**	619	631	606

Key Financial Metrics	**Target**	**2016**	**2017**	**2018**	**2019**
Operating Margin	> 3%	5.5%	4.1%	3.5%	3.0%
Bottom Line Margin	> 3%	6.4%	5.1%	4.7%	4.1%
Personnel-Related Expense as Percentage of Operating Revenue	< 70%	69.3%	71.4%	71.9%	72.0%
Days Cash on Hand	> 45 Days	70	76	75	75
Days in Net Patient Receivables	< 60 Days	41	40	37	38

Key Productivity Metrics	**Target**	**2016**	**2017**	**2018**	**2019**
Physician Visits per Physician FTE		2,764	2,709	2,618	2,605
Non-Physician Provider Visits per Non Physician Provider FTE		2,431	2,362	2,353	2,355
Medical Patients per Medical Staff FTE		294	290	284	279
Medical Patients per Medical Provider FTE		843	829	809	807
Dental Visits per Dental Provider FTE		1,651	1,586	1,572	1,565

Key Operations & Utilization Metrics	**Target**	**2016**	**2017**	**2018**	**2019**
Operating Revenue per Patient		$882	$908	$939	$989
Operating Expense per Patient		$810	$856	$892	$944
Operating Revenue per Patient Visit		$238	$247	$254	$262
Operating Expense per Patient Visit		$221	$233	$242	$250
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%	38%	37%	37%
Patient Growth Rate		5%	4%	3%	3%
Visit Growth Rate		7%	6%	4%	6%

URBAN DATA SUMMARY

		TOTALS - Section 330 and Look-Alike			
Data		**2016**	**2017**	**2018**	**2019**
Financial Audits		727	717	733	599
UDS Data		809	810	815	851

Key Financial Metrics	**Target**	**2016**	**2017**	**2018**	**2019**
Operating Margin	> 3%	3.2%	2.3%	2.3%	1.7%
Bottom Line Margin	> 3%	4.5%	3.4%	3.2%	2.6%
Personnel-Related Expense as Percentage of Operating Revenue	< 70%	71.3%	72.7%	72.4%	73.3%
Days Cash on Hand	> 45 Days	53	52	54	60
Days in Net Patient Receivables	< 60 Days	42	40	39	38

Key Productivity Metrics		**2016**	**2017**	**2018**	**2019**
Physician Visits per Physician FTE		2,908	2,801	2,749	2,726
Non-Physician Provider Visits per Non Physician Provider FTE		2,415	2,429	2,350	2,388
Medical Patients per Medical Staff FTE		301	300	294	291
Medical Patients per Medical Provider FTE		907	895	871	858
Dental Visits per Dental Provider FTE		1,981	1,889	1,906	1,840

Key Operations & Utilization Metrics		**2016**	**2017**	**2018**	**2019**
Operating Revenue per Patient		$920	$956	$1,001	$1,041
Operating Expense per Patient		$878	$908	$957	$997
Operating Revenue per Patient Visit		$242	$248	$256	$263
Operating Expense per Patient Visit		$229	$236	$248	$257
Non-Provider Medical Staff per Medical Provider		1.9	2	1.9	1.9
Administrative, Facilities, and Patient Support FTEs as Percent of Total FTEs		36%	36%	36%	35%
Patient Growth Rate		5%	5%	3%	3%
Visit Growth Rate		7%	5%	5%	4%

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 70% or more of all national FQHC financial audits in each year measured.[1] 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

	2016			2017			2018			2019		
	Rural	Urban	National	Rural	Urban	National	Rural	Urban	National	Rural	Urban	National
Section 330 Grantees	535	711	1,246	529	703	1,232	530	714	1,244	463	584	1,047
Look-Alike	7	16	23	7	14	21	6	19	25	4	15	19
TOTAL	542	727	1,269	536	717	1,253	536	733	1,269	467	599	1,066

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

	2016			2017			2018			2019		
	Rural	Urban	National	Rural	Urban	National	Rural	Urban	National	Rural	Urban	National
Section 330 Grantees	606	761	1,367	608	765	1,373	612	750	1,362	585	800	1,385
Look-Alike	10	48	58	11	45	56	19	65	84	21	51	72
TOTAL	616	809	1,425	619	810	1,429	631	815	1,446	606	851	1,457

1. 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.

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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 more than 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.